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Title 38 - Pensions, Bonuses, and Veterans' Relief
Chapter I - Department of Veterans Affairs
Part 17 - Medical
Enrollment Provisions and Medical Benefits Package

§ 17.38 Medical benefits package.

(a) Subject to paragraphs (b) and (c) of this section, the following hospital, outpatient, and extended care services constitute the "medical benefits package" (basic care and preventive care):

(1) Basic care.

(i) Outpatient medical, surgical, and mental healthcare, including care for substance abuse.

(ii) Inpatient hospital, medical, surgical, and mental healthcare, including care for substance abuse.

(iii) Prescription drugs, including over-the-counter drugs and medical and surgical supplies available under the VA national formulary system.

(iv) Emergency care in VA facilities; and emergency care in non-VA facilities in accordance with sharing contracts or if authorized by§ 17.52(a)(3), § 17.53, § 17.54, §§ 17.120 through 17.132, or §§ 17.4000 through 17.4040.

(v) Bereavement counseling as authorized in § 17.98.

(vi) Comprehensive rehabilitative services other than vocational services provided under 38 U.S.C. chapter 31.

(vii) Consultation, professional counseling, marriage and family counseling, training, and mental health services for the members of the immediate family or legal guardian of the veteran or the individual in whose household the veteran certifies an intention to live, as necessary and appropriate, in connection with the veteran's treatment as authorized under 38 CFR 71.50.

(viii) Prosthetic and rehabilitative items and services as authorized under §§ 17.3200 through 17.3250, and eyeglasses and hearing aids as authorized under § 17.149.

(ix) Home health services authorized under 38 U.S.C. 1717 and 1720C.

(x) Reconstructive (plastic) surgery required as a result of disease or trauma, but not including cosmetic surgery that is not medically necessary.

(xi)

(A) Hospice care, palliative care, and institutional respite care; and

(B) Noninstitutional extended care services, including but not limited to noninstitutional geriatric evaluation, noninstitutional adult day health care, and noninstitutional respite care.

(xii) Payment of beneficiary travel as authorized under 38 CFR part 70.

(xiii) Pregnancy and delivery services, to the extent authorized by law.

(xiv) Newborn care, post delivery, for a newborn child for the date of birth plus seven calendar days after the birth of the child when the birth mother is a woman veteran enrolled in VA health care and receiving maternity care furnished by VA or under authorization from VA and the child is delivered either in a VA facility, or in another facility pursuant to a VA authorization for maternity care at VA expense.

(xv) Completion of forms (e.g., Family Medical Leave forms, life insurance applications, Department of Education forms for loan repayment exemptions based on disability, non-VA disability program forms) by healthcare professionals based on an examination or knowledge of the veteran's condition,

but not including the completion of forms for examinations if a third party customarily will pay health care practitioners for the examination but will not pay VA.

(2) Preventive care, as defined in 38 U.S.C. 1701(9), which includes:

(i) Periodic medical exams.

(ii) Health education, including nutrition education.

(iii) Maintenance of drug-use profiles, drug monitoring, and drug use education.

(iv) Mental health and substance abuse preventive services.

(v) Immunizations against infectious disease.

(vi) Prevention of musculoskeletal deformity or other gradually developing disabilities of a metabolic or degenerative nature.

(vii) Genetic counseling concerning inheritance of genetically determined diseases.

(viii) Routine vision testing and eye-care services.

(ix) Periodic reexamination of members of high-risk groups for selected diseases and for functional decline of sensory organs, and the services to treat these diseases and functional declines.

(b) ***Provision of the "medical benefits package".*** Care referred to in the "medical benefits package" will be provided to individuals only if it is determined by appropriate health care professionals that the care is needed to promote, preserve, or restore the health of the individual and is in accord with generally accepted standards of medical practice.

(1) ***Promote health.*** Care is deemed to promote health if the care will enhance the quality of life or daily functional level of the veteran, identify a predisposition for development of a condition or early onset of disease which can be partly or totally ameliorated by monitoring or early diagnosis and treatment, and prevent future disease.

(2) ***Preserve health.*** Care is deemed to preserve health if the care will maintain the current quality of life or daily functional level of the veteran, prevent the progression of disease, cure disease, or extend life span.

(3) ***Restoring health.*** Care is deemed to restore health if the care will restore the quality of life or daily functional level that has been lost due to illness or injury.

(c) In addition to the care specifically excluded from the "medical benefits package" under paragraphs (a) and (b) of this section, the "medical benefits package" does not include the following:

(1) Abortions and abortion counseling.

(2) In vitro fertilization. Note: See § 17.380.

(3) Drugs, biologicals, and medical devices not approved by the Food and Drug Administration unless the treating medical facility is conducting formal clinical trials under an Investigational Device Exemption (IDE) or an Investigational New Drug (IND) application, or the drugs, biologicals, or medical devices are prescribed under a compassionate use exemption.

(4) Gender alterations.

(5) Hospital and outpatient care for a veteran who is either a patient or inmate in an institution of another government agency if that agency has a duty to give the care or services. This exclusion does not apply to veterans who are released from incarceration in a prison or jail into a temporary housing program (such as a community residential re-entry center or halfway house).

(6) Membership in spas and health clubs.

[64 FR 54217, Oct. 6, 1999, as amended at 67 FR 35039, May 17, 2002; 73 FR 36798, June 30, 2008; 75 FR 54030, Sept. 3, 2010; 76 FR 11339, Mar. 2, 1011; 76 FR 26172, May 5, 2011; 76 FR 78571, Dec. 19, 2011; 82 FR 6275, Jan. 19, 2017; 84 FR 26306, June 5, 2019; 86 FR 84259, Dec. 28, 2020]

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Title 38 —Pensions, Bonuses, and Veterans' Relief
Chapter I —Department of Veterans Affairs
Part 17 —Medical
Enrollment Provisions and Medical Benefits Package

Authority: 38 U.S.C. 501, and as noted in specific sections. Section 17.30 also issued under 38 U.S.C. 1701. Section 17.32 also issued under 38 U.S.C. 7331-7334. *See Part 17 for more*

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(x) Reconstructive (plastic) surgery required as a result of disease or trauma, but not including cosmetic surgery that is not medically necessary.

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(A) Hospice care, palliative care, and institutional respite care; and

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(i) Periodic medical exams.

(ii) Health education, including nutrition education.

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(ix) Periodic reexamination of members of high-risk groups for selected diseases and for functional decline of sensory organs, and the services to treat these diseases and functional declines.

(x) Chiropractic services.

(b) ***Provision of the "medical benefits package".*** Care referred to in the "medical benefits package" will be provided to individuals only if it is determined by appropriate health care professionals that the care is needed to promote, preserve, or restore the health of the individual and is in accord with generally accepted standards of medical practice.

(1) ***Promote health.*** Care is deemed to promote health if the care will enhance the quality of life or daily functional level of the veteran, identify a predisposition for development of a condition or early onset of disease which can be partly or totally ameliorated by monitoring or early diagnosis and treatment, and prevent future disease.

(2) ***Preserve health.*** Care is deemed to preserve health if the care will maintain the current quality of life or daily functional level of the veteran, prevent the progression of disease, cure disease, or extend life span.

(3) ***Restoring health.*** Care is deemed to restore health if the care will restore the quality of life or daily functional level that has been lost due to illness or injury.

(c) In addition to the care specifically excluded from the "medical benefits package" under paragraphs (a) and (b) of this section, the "medical benefits package" does not include the following:

(1) Abortions, except when:

(i) The life or the health of the pregnant veteran would be endangered if the pregnancy were carried to term; or

(ii) The pregnancy is the result of an act of rape or incest. Self-reporting from the pregnant veteran constitutes sufficient evidence that an act of rape or incest occurred.

(2) In vitro fertilization. Note: See § 17.380.

(3) Drugs, biologicals, and medical devices not approved by the Food and Drug Administration unless the treating medical facility is conducting formal clinical trials under an Investigational Device Exemption (IDE) or an Investigational New Drug (IND) application, or the drugs, biologicals, or medical devices are prescribed under a compassionate use exemption.

(4) Gender alterations.

(5) Hospital and outpatient care for a veteran who is either a patient or inmate in an institution of another government agency if that agency has a duty to give the care or services. This exclusion does not apply to veterans who are released from incarceration in a prison or jail into a temporary housing program (such as a community residential re-entry center or halfway house).

(6) Membership in spas and health clubs.

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38 USC 1710: Eligibility for hospital, nursing home, and domiciliary care
Text contains those laws in effect on February 12, 2025

From Title 38-VETERANS' BENEFITS
PART II-GENERAL BENEFITS
CHAPTER 17-HOSPITAL, NURSING HOME, DOMICILIARY, AND MEDICAL CARE
SUBCHAPTER II-HOSPITAL, NURSING HOME, OR DOMICILIARY CARE AND MEDICAL TREATMENT

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§1710. Eligibility for hospital, nursing home, and domiciliary care

(a)(1) The Secretary (subject to paragraph (4)) shall furnish hospital care and medical services which the Secretary determines to be needed-

(A) to any veteran for a service-connected disability; and

(B) to any veteran who has a service-connected disability rated at 50 percent or more.

(2) The Secretary (subject to paragraph (4)) shall furnish hospital care and medical services, and may furnish nursing home care, which the Secretary determines to be needed to any veteran-

(A) who has a compensable service-connected disability rated less than 50 percent or, with respect to nursing home care during any period during which the provisions of section 1710A(a) of this title are in effect, a compensable service-connected disability rated less than 70 percent;

(B) whose discharge or release from active military, naval, air, or space service was for a disability that was incurred or aggravated in the line of duty;

(C) who is in receipt of, or who, but for a suspension pursuant to section 1151 of this title (or both a suspension and the receipt of retired pay), would be entitled to disability compensation, but only to the extent that such veteran's continuing eligibility for such care is provided for in the judgment or settlement provided for in such section;

(D) who is a former prisoner of war, who was awarded the medal of honor under section 7271, 8291, or 9271 of title 10 or section 491 [1] of title 14, or who was awarded the Purple Heart;

(E) who is a veteran of-

(i) the Mexican border period;

(ii) World War I; or

(iii) World War II;

(F) who is a toxic-exposed veteran, in accordance with subsection (e); or

(G) who is unable to defray the expenses of necessary care as determined under section 1722(a) of this title.

(3) In the case of a veteran who is not described in paragraphs (1) and (2), the Secretary may, to the extent resources and facilities are available and subject to the provisions of subsections (f) and (g), furnish hospital care, medical services, and nursing home care which the Secretary determines to be needed.

(4) The requirement in paragraphs (1) and (2) that the Secretary furnish hospital care and medical services, the requirement in section 1710A(a) of this title that the Secretary provide nursing home care, the requirement in section 1710B of this title that the Secretary provide a program of extended care services, and the requirement in section 1745 of this title to provide nursing home care and prescription medicines to veterans with service-connected disabilities in State homes shall be effective in any fiscal year only to the extent and in the amount provided in advance in appropriations Acts for such purposes.

(5) During any period during which the provisions of section 1710A(a) of this title are not in effect, the Secretary may furnish nursing home care which the Secretary determines is needed to any veteran described in paragraph (1), with the priority for such care on the same basis as if provided under that paragraph.

(b)(1) The Secretary may furnish to a veteran described in paragraph (2) of this subsection such domiciliary care as the Secretary determines is needed for the purpose of the furnishing of medical services to the veteran.

(2) This subsection applies in the case of the following veterans:

(A) Any veteran whose annual income (as determined under section 1503 of this title) does not exceed the maximum annual rate of pension that would be applicable to the veteran if the veteran were eligible for pension

under section 1521(d) of this title.

(B) Any veteran who the Secretary determines has no adequate means of support.

(c) While any veteran is receiving hospital care or nursing home care in any Department facility, the Secretary may, within the limits of Department facilities, furnish medical services to correct or treat any non-service-connected disability of such veteran, in addition to treatment incident to the disability for which such veteran is hospitalized, if the veteran is willing, and the Secretary finds such services to be reasonably necessary to protect the health of such veteran. The Secretary may furnish dental services and treatment, and related dental appliances, under this subsection for a non-service-connected dental condition or disability of a veteran only (1) to the extent that the Secretary determines that the dental facilities of the Department to be used to furnish such services, treatment, or appliances are not needed to furnish services, treatment, or appliances for dental conditions or disabilities described in section 1712(a) of this title, or (2) if (A) such non-service-connected dental condition or disability is associated with or aggravating a disability for which such veteran is receiving hospital care, or (B) a compelling medical reason or a dental emergency requires furnishing dental services, treatment, or appliances (excluding the furnishing of such services, treatment, or appliances of a routine nature) to such veteran during the period of hospitalization under this section.

(d) In no case may nursing home care be furnished in a hospital not under the direct jurisdiction of the Secretary except as provided in section 1720 of this title.

(e)(1)(A) A Vietnam-era herbicide-exposed veteran is eligible (subject to paragraph (2)) for hospital care, medical services, and nursing home care under subsection (a)(2)(F) for any disability, notwithstanding that there is insufficient medical evidence to conclude that such disability may be associated with such exposure.

(B) A radiation-exposed veteran is eligible for hospital care, medical services, and nursing home care under subsection (a)(2)(F) for any disease suffered by the veteran that is-

(i) a disease listed in section 1112(c)(2) of this title; or

(ii) any other disease for which the Secretary, based on the advice of the Advisory Committee on Environmental Hazards, determines that there is credible evidence of a positive association between occurrence of the disease in humans and exposure to ionizing radiation.

(C) Subject to paragraph (2) of this subsection, a veteran who served on active duty between August 2, 1990, and November 11, 1998, in the Southwest Asia theater of operations during the Persian Gulf War is eligible for hospital care, medical services, and nursing home care under subsection (a)(2)(F) for any disability, notwithstanding that there is insufficient medical evidence to conclude that such disability may be associated with such service.

(D) Subject to paragraphs (2) and (3), a veteran who served on active duty in a theater of combat operations (as determined by the Secretary in consultation with the Secretary of Defense) during a period of war after the Persian Gulf War (including any veteran who, in connection with service during such period, received the Armed Forces Expeditionary Medal, Service Specific Expeditionary Medal, Combat Era Specific Expeditionary Medal, Campaign Specific Medal, or any other combat theater award established by a Federal statute or an Executive order), or in combat against a hostile force during a period of hostilities after November 11, 1998, is eligible for hospital care, medical services, and nursing home care under subsection (a)(2)(F) for any illness, notwithstanding that there is insufficient medical evidence to conclude that such condition is attributable to such service.

(E) Subject to paragraph (2), a veteran who participated in a test conducted by the Department of Defense Deseret Test Center as part of a program for chemical and biological warfare testing from 1962 through 1973 (including the program designated as "Project Shipboard Hazard and Defense (SHAD)" and related land-based tests) is eligible for hospital care, medical services, and nursing home care under subsection (a)(2)(F) for any illness, notwithstanding that there is insufficient medical evidence to conclude that such illness is attributable to such testing.

(F) Subject to paragraph (2), a veteran who served on active duty in the Armed Forces at Camp Lejeune, North Carolina, for not fewer than 30 days during the period beginning on August 1, 1953, and ending on December 31, 1987, is eligible for hospital care and medical services under subsection (a)(2)(F) for any of the following illnesses or conditions, notwithstanding that there is insufficient medical evidence to conclude that such illnesses or conditions are attributable to such service:

(i) Esophageal cancer.
(ii) Lung cancer.
(iii) Breast cancer.
(iv) Bladder cancer.
(v) Kidney cancer.
(vi) Leukemia.
(vii) Multiple myeloma.
(viii) Myelodysplastic syndromes.
(ix) Renal toxicity.
(x) Hepatic steatosis.
(xi) Female infertility.
(xii) Miscarriage.
(xiii) Scleroderma.
(xiv) Neurobehavioral effects.
(xv) Non-Hodgkin's lymphoma.

(G) Beginning not later than the applicable date specified in paragraph (6), and subject to paragraph (2), a veteran who participated in a toxic exposure risk activity while serving on active duty, active duty for training, or inactive duty training is eligible for hospital care (including mental health services and counseling), medical services, and nursing home care under subsection (a)(2)(F) for any illness.

(H) Beginning not later than the applicable date specified in paragraph (6), and subject to paragraph (2), a covered veteran (as defined in section 1119(c) of this title) is eligible for hospital care (including mental health services and counseling), medical services, and nursing home care under subsection (a)(2)(F) for any illness.

(I)(i) Beginning not later than the applicable date specified in paragraph (6), and subject to paragraph (2), a veteran who deployed in support of a contingency operation specified in clause (ii) is eligible for hospital care (including mental health services and counseling), medical services, and nursing home care under subsection (a)(2)(F) for any illness.

(ii) A contingency operation specified in this clause is any of the following:

(I) Operation Enduring Freedom.

(II) Operation Freedom's Sentinel.

(III) Operation Iraqi Freedom.

(IV) Operation New Dawn.

(V) Operation Inherent Resolve.

(VI) Resolute Support Mission.

(2)(A) In the case of a veteran described in paragraph (1)(A), hospital care, medical services, and nursing home care may not be provided under subsection (a)(2)(F) with respect to-

(i) a disability that is found, in accordance with guidelines issued by the Under Secretary for Health, to have resulted from a cause other than an exposure described in paragraph (4)(A)(ii); or

(ii) a disease for which the National Academy of Sciences, in a report issued in accordance with section 3 of the Agent Orange Act of 1991, has determined that there is limited or suggestive evidence of the lack of a positive association between occurrence of the disease in humans and exposure to a herbicide agent.

(B) In the case of a veteran described in subparagraph (C), (D), (E), (F), (G), (H), or (I) of paragraph (1), hospital care, medical services, and nursing home care may not be provided under subsection (a)(2)(F) with respect to a disability that is found, in accordance with guidelines issued by the Under Secretary for Health, to have resulted from a cause other than the service, testing, or activity described in such subparagraph.

(3) In the case of care for a veteran described in paragraph (1)(D), hospital care, medical services, and nursing home care may be provided under or by virtue of subsection (a)(2)(F) only during the following periods:

(A) Except as provided by subparagraph (B), with respect to a veteran described in paragraph (1)(D) who is discharged or released from the active military, naval, air, or space service after September 11, 2001, the 10-year period beginning on the date of such discharge or release.

(B) With respect to a veteran described in paragraph (1)(D) who was discharged or released from the active military, naval, air, or space service after September 11, 2001, and before October 1, 2013, but did not enroll to receive such hospital care, medical services, or nursing home care under such paragraph pursuant to subparagraph (A) before October 1, 2022, the one-year period beginning on October 1, 2022.

(4) For purposes of this subsection-

(A) The term "Vietnam-era herbicide-exposed veteran" means a veteran who-

(i) performed covered service, as defined in section 1116(d) of this title; or

(ii) the Secretary finds may have been exposed during active military, naval, air, or space service to dioxin during the Vietnam era, regardless of the geographic area of such service, or was exposed during such service to a toxic substance found in a herbicide or defoliant used for military purposes during such era, regardless of the geographic area of such service.

(B) The term "radiation-exposed veteran" has the meaning given that term in section 1112(c)(3) of this title.

(C) The term "toxic exposure risk activity" means any activity-

(i) that requires a corresponding entry in an exposure tracking record system (as defined in section 1119(c) of this title) for the veteran who carried out the activity; or

(ii) that the Secretary determines qualifies for purposes of this subsection when taking into account what is reasonably prudent to protect the health of veterans.

(5) When the Secretary first provides care for veterans using the authority provided in paragraph (1)(D), the Secretary shall establish a system for collection and analysis of information on the general health status and health care utilization patterns of veterans receiving care under that paragraph. Not later than 18 months after first providing care under such authority, the Secretary shall submit to Congress a report on the experience under that authority. The Secretary shall include in the report any recommendations of the Secretary for extension of that authority.

(6)(A) The Secretary shall determine the dates in subparagraphs (G), (H), and (I) of paragraph (1) as follows:

(i) October 1, 2024, with respect to a veteran described in such subparagraph (G) or (H) who was discharged or released from the active military, naval, air, or space service during the period beginning on August 2, 1990, and

ending on September 11, 2001.

(ii) October 1, 2026, with respect to a veteran described in such subparagraph (G) or (H) who was discharged or released from the active military, naval, air, or space service during the period beginning on September 12, 2001, and ending on December 31, 2006.

(iii) October 1, 2028, with respect to a veteran described in such subparagraph (G) or (H) who was discharged or released from the active military, naval, air, or space service during the period beginning on January 1, 2007, and ending on December 31, 2012.

(iv) October 1, 2030, with respect to a veteran described in such subparagraph (G) or (H) who was discharged or released from the active military, naval, air, or space service during the period beginning on January 1, 2013, and ending on December 31, 2018.

(v) October 1, 2032, with respect to a veteran described in such subparagraph (I).

(B)(i) The Secretary may modify a date specified in subparagraph (A) to an earlier date, as the Secretary determines appropriate based on the number of veterans receiving hospital care, medical services, and nursing home care under subparagraphs (G), (H), and (I) of paragraph (1) and the resources available to the Secretary.

(ii) If the Secretary determines to modify a date under clause (i), the Secretary shall-

(I) notify the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives of the proposed modification; and

(II) publish such modified date in the Federal Register.

(f)(1) The Secretary may not furnish hospital care or nursing home care (except if such care constitutes hospice care) under this section to a veteran who is eligible for such care under subsection (a)(3) of this section unless the veteran agrees to pay to the United States the applicable amount determined under paragraph (2) or (4) of this subsection.

(2) A veteran who is furnished hospital care or nursing home care under this section and who is required under paragraph (1) of this subsection to agree to pay an amount to the United States in order to be furnished such care shall be liable to the United States for an amount equal to-

(A) the lesser of-

(i) the cost of furnishing such care, as determined by the Secretary; or

(ii) the amount determined under paragraph (3) of this subsection; and

(B) before September 30, 2025, an amount equal to $10 for every day the veteran receives hospital care and $5 for every day the veteran receives nursing home care.

(3)(A) In the case of hospital care furnished during any 365-day period, the amount referred to in paragraph (2)(A)(ii) of this subsection is-

(i) the amount of the inpatient Medicare deductible, plus

(ii) one-half of such amount for each 90 days of care (or fraction thereof) after the first 90 days of such care during such 365-day period.

(B) In the case of nursing home care furnished during any 365-day period, the amount referred to in paragraph (2)(A)(ii) of this subsection is the amount of the inpatient Medicare deductible for each 90 days of such care (or fraction thereof) during such 365-day period.

(C)(i) Except as provided in clause (ii) of this subparagraph, in the case of a veteran who is admitted for nursing home care under this section after being furnished, during the preceding 365-day period, hospital care for which the veteran has paid the amount of the inpatient Medicare deductible under this subsection and who has not been furnished 90 days of hospital care in connection with such payment, the veteran shall not incur any liability under paragraph (2) of this subsection with respect to such nursing home care until-

(I) the veteran has been furnished, beginning with the first day of such hospital care furnished in connection with such payment, a total of 90 days of hospital care and nursing home care; or

(II) the end of the 365-day period applicable to the hospital care for which payment was made,

whichever occurs first.

(ii) In the case of a veteran who is admitted for nursing home care under this section after being furnished, during any 365-day period, hospital care for which the veteran has paid an amount under subparagraph (A)(ii) of this paragraph and who has not been furnished 90 days of hospital care in connection with such payment, the amount of the liability of the veteran under paragraph (2) of this subsection with respect to the number of days of such nursing home care which, when added to the number of days of such hospital care, is 90 or less, is the difference between the inpatient Medicare deductible and the amount paid under such subparagraph until-

(I) the veteran has been furnished, beginning with the first day of such hospital care furnished in connection with such payment, a total of 90 days of hospital care and nursing home care; or

(II) the end of the 365-day period applicable to the hospital care for which payment was made,

whichever occurs first.

(D) In the case of a veteran who is admitted for hospital care under this section after having been furnished, during the preceding 365-day period, nursing home care for which the veteran has paid the amount of the inpatient Medicare deductible under this subsection and who has not been furnished 90 days of nursing home care in connection with such payment, the veteran shall not incur any liability under paragraph (2) of this subsection with respect to such hospital care until-

(i) the veteran has been furnished, beginning with the first day of such nursing home care furnished in connection with such payment, a total of 90 days of nursing home care and hospital care; or

(ii) the end of the 365-day period applicable to the nursing home care for which payment was made,

whichever occurs first.

(E) A veteran may not be required to make a payment under this subsection for hospital care or nursing home care furnished under this section during any 90-day period in which the veteran is furnished medical services under paragraph (3) of subsection (a) to the extent that such payment would cause the total amount paid by the veteran under this subsection for hospital care and nursing home care furnished during that period and under subsection (g) for medical services furnished during that period to exceed the amount of the inpatient Medicare deductible in effect on the first day of such period.

(F) A veteran may not be required to make a payment under this subsection or subsection (g) for any days of care in excess of 360 days of care during any 365-calendar-day period.

(4) In the case of a veteran covered by this subsection who is also described by section 1705(a)(7) of this title, the amount for which the veteran shall be liable to the United States for hospital care under this subsection shall be an amount equal to 20 percent of the total amount for which the veteran would otherwise be liable for such care under subparagraphs (2)(B) and (3)(A) but for this paragraph.

(5) For the purposes of this subsection, the term "inpatient Medicare deductible" means the amount of the inpatient hospital deductible in effect under section 1813(b) of the Social Security Act (42 U.S.C. 1395e(b)) on the first day of the 365-day period applicable under paragraph (3) of this subsection.

(g)(1) The Secretary may not furnish medical services (except if such care constitutes hospice care) under subsection (a) of this section (including home health services under section 1717 of this title) to a veteran who is eligible for hospital care under this chapter by reason of subsection (a)(3) of this section unless the veteran agrees to pay to the United States in the case of each outpatient visit the applicable amount or amounts established by the Secretary by regulation.

(2) A veteran who is furnished medical services under subsection (a) of this section and who is required under paragraph (1) of this subsection to agree to pay an amount to the United States in order to be furnished such services shall be liable to the United States, in the case of each visit in which such services are furnished to the veteran, for an amount which the Secretary shall establish by regulation.

(3) This subsection does not apply with respect to the following:

(A) Home health services under section 1717 of this title to the extent that such services are for improvements and structural alterations.

(B) Education on the use of opioid antagonists to reverse the effects of overdoses of specific medications or substances.

(h) Nothing in this section requires the Secretary to furnish care to a veteran to whom another agency of Federal, State, or local government has a duty under law to provide care in an institution of such government.

(Pub. L. 85–857, Sept. 2, 1958, 72 Stat. 1141 , §610; Pub. L. 87–583, §1, Aug. 14, 1962, 76 Stat. 381 ; Pub. L. 89–358, §8, Mar. 3, 1966, 80 Stat. 27 ; Pub. L. 89–785, title III, §304, Nov. 7, 1966, 80 Stat. 1377 ; Pub. L. 91–500, §4, Oct. 22, 1970, 84 Stat. 1096 ; Pub. L. 93–82, title I, §102, Aug. 2, 1973, 87 Stat. 180 ; Pub. L. 94–581, title II, §§202(d), 210(a)(1), Oct. 21, 1976, 90 Stat. 2855 , 2862; Pub. L. 96–22, title I, §102(a), June 13, 1979, 93 Stat. 47 ; Pub. L. 97–37, §5(a), Aug. 14, 1981, 95 Stat. 936 ; Pub. L. 97–72, title I, §102(a), Nov. 3, 1981, 95 Stat. 1047 ; Pub. L. 98–160, title VII, §701, Nov. 21, 1983, 97 Stat. 1008 ; Pub. L. 99–166, title I, §103, Dec. 3, 1985, 99 Stat. 944 ; Pub. L. 99–272, title XIX, §19011(a), (d)(3), Apr. 7, 1986, 100 Stat. 372 , 379; Pub. L. 99–576, title II, §237(a), (b)(1), Oct. 28, 1986, 100 Stat. 3267 ; Pub. L. 100–322, title I, §102(a), May 20, 1988, 102 Stat. 492 ; Pub. L. 100–687, div. B, title XII, §1202, Nov. 18, 1988, 102 Stat. 4125 ; Pub. L. 101–508, title VIII, §8013(a), Nov. 5, 1990, 104 Stat. 1388–346 ; Pub. L. 102–4, §5, Feb. 6, 1991, 105 Stat. 15 ; Pub. L. 102–54, §14(b)(10), June 13, 1991, 105 Stat. 283 ; renumbered §1710 and amended Pub. L. 102–83, §§4(a)(3), (4), (b)(1), (2)(E), 5(a), (c)(1), Aug. 6, 1991, 105 Stat. 404–406 ; Pub. L. 102–405, title III, §302(c)(1), Oct. 9, 1992, 106 Stat. 1984 ; Pub. L. 103–210, §§1(a), 2(a), Dec. 20, 1993, 107 Stat. 2496 , 2497; Pub. L. 103–446, title XII, §1201(d)(2), Nov. 2, 1994, 108 Stat. 4684 ; Pub. L. 103–452, title I, §103(a)(1), Nov. 2, 1994, 108 Stat. 4786 ; Pub. L. 104–110, title I, §101(a)(1), Feb. 13, 1996, 110 Stat. 768 ; Pub. L. 104–262, title I, §§101(a), (b), (d)(2)–(4), 102(a), Oct. 9, 1996, 110 Stat. 3178 , 3179, 3181; Pub. L. 104–275, title V, §505(c), Oct. 9, 1996, 110 Stat. 3342 ; Pub. L. 105–33, title VIII, §§8021(a)(1), 8023(b)(1), (2), Aug. 5, 1997, 111 Stat. 664 , 667; Pub. L. 105–114, title II, §209(a), title IV, §402(a), Nov. 21, 1997, 111 Stat. 2290 , 2294; Pub. L. 105–368, title I, §102(a), title X, §1005(b)(3), Nov. 11, 1998, 112 Stat. 3321 , 3365; Pub. L. 106–117, title I, §§101(f), 112(1), title II, §201(b), Nov. 30, 1999, 113 Stat. 1550 , 1556, 1561; Pub. L. 106–419, title II, §224(b), Nov. 1, 2000, 114 Stat. 1846 ; Pub. L. 107–135, title II, §§202(b), 209(a), 211, Jan. 23, 2002, 115 Stat. 2457 , 2464, 2465; Pub. L. 107–330, title III, §308(g)(6), Dec. 6, 2002, 116 Stat. 2829 ; Pub. L. 108–170, title I, §102, Dec. 6, 2003, 117 Stat. 2044 ; Pub. L. 109–444, §2(a), Dec. 21, 2006, 120 Stat. 3304 ; Pub. L. 109–461, title II, §211(a)(3)(B), title X, §§1003, 1006(b), Dec. 22, 2006, 120 Stat. 3419 , 3465,

3468; Pub. L. 110–161, div. I, title II, §231, Dec. 26, 2007, 121 Stat. 2273 ; Pub. L. 110–181, div. A, title XVII, §1707, Jan. 28, 2008, 122 Stat. 493 ; Pub. L. 110–329, div. E, title II, §224, Sept. 30, 2008, 122 Stat. 3713 ; Pub. L. 110–387, title IV, §409, title VIII, §§803, 804(a), Oct. 10, 2008, 122 Stat. 4130 , 4141; Pub. L. 111–163, title V, §§513, 517, May 5, 2010, 124 Stat. 1164 , 1167; Pub. L. 112–154, title I, §§102(a), 112, Aug. 6, 2012, 126 Stat. 1167 , 1176; Pub. L. 113–37, §2(c), Sept. 30, 2013, 127 Stat. 524 ; Pub. L. 113–175, title I, §107, Sept. 26, 2014, 128 Stat. 1903 ; Pub. L. 113–235, div. I, title II, §243, Dec. 16, 2014, 128 Stat. 2568 ; Pub. L. 114–2, §7, Feb. 12, 2015, 129 Stat. 36 ; Pub. L. 114–58, title I, §101, title VI, §601(4), Sept. 30, 2015, 129 Stat. 532 , 538; Pub. L. 114–198, title IX, §915(b), July 22, 2016, 130 Stat. 765 ; Pub. L. 114–223, div. A, title II, §243(b), Sept. 29, 2016, 130 Stat. 884 ; Pub. L. 114–228, title I, §101, Sept. 29, 2016, 130 Stat. 936 ; Pub. L. 114–315, title VI, §603(b), title VIII, §802(3), Dec. 16, 2016, 130 Stat. 1570 , 1591; Pub. L. 115–62, title I, §101, Sept. 29, 2017, 131 Stat. 1160 ; Pub. L. 115–232, div. A, title VIII, §809(n)(1)(B), Aug. 13, 2018, 132 Stat. 1843 ; Pub. L. 115–251, title I, §101, Sept. 29, 2018, 132 Stat. 3168 ; Pub. L. 116–23, §2(f), June 25, 2019, 133 Stat. 969 ; Pub. L. 116–159, div. E, title I, §5101, Oct. 1, 2020, 134 Stat. 748 ; Pub. L. 116–283, div. A, title IX, §926(a)(21), Jan. 1, 2021, 134 Stat. 3830 ; Pub. L. 117–168, title I, §§102(a), (c), 103(a), 111(a), (b), title IV, §403(c), Aug. 10, 2022, 136 Stat. 1761 , 1762, 1765, 1766, 1781; Pub. L. 117–180, div. E, title I, §101, Sept. 30, 2022, 136 Stat. 2136 ; Pub. L. 117–328, div. U, title I, §101(a), Dec. 29, 2022, 136 Stat. 5407 ; Pub. L. 118–83, div. B, title III, §301, Sept. 26, 2024, 138 Stat. 1539 .)

Editorial Notes

References in Text

Section 491 of title 14, referred to in subsec. (a)(2)(D), was redesignated section 2732 of title 14 by Pub. L. 115–282, title I, §116(b), Dec. 4, 2018, 132 Stat. 4226 , and references to section 491 of title 14 deemed to refer to such redesignated section, see section 123(b)(1) of Pub. L. 115–282, set out as a References to Redesignated Sections of Title 14 note preceding section 101 of Title 14, Coast Guard.

Section 3 of the Agent Orange Act of 1991, referred to in subsec. (e)(2)(A)(ii), is section 3 of Pub. L. 102–4, which is set out as a note under section 1116 of this title.

Codification

The text of subsec. (f) of section 1712 of this title, which was transferred to this section, redesignated subsec. (g), and amended by Pub. L. 104–262, §101(b)(2), was based on Pub. L. 86–639, §1, July 12, 1960, 74 Stat. 472 ; Pub. L. 91–102, Oct. 30, 1969, 83 Stat. 168 ; Pub. L. 93–82, title I, §103(a), Aug. 2, 1973, 87 Stat. 180 ; Pub. L. 94–581, title I, §103(a)(3)–(7), title II, §202(f)(2), Oct. 21, 1976, 90 Stat. 2844 , 2856; Pub. L. 96–22, title I, §102(b), June 13, 1979, 93 Stat. 47 ; Pub. L. 97–37, §5(b), Aug. 14, 1981, 95 Stat. 937 ; Pub. L. 97–72, title I, §103(b)(2), Nov. 3, 1981, 95 Stat. 1049 ; Pub. L. 97–295, §4(17)(C), Oct. 12, 1982, 96 Stat. 1306 ; Pub. L. 99–166, title I, §104, Dec. 3, 1985, 99 Stat. 944 ; Pub. L. 99–272, title XIX, §19011(b)(2), Apr. 7, 1986, 100 Stat. 375 ; Pub. L. 99–576, title II, §§202(1), 237(b)(2), Oct. 28, 1986, 100 Stat. 3254 , 3267; Pub. L. 100–322, title I, §101(e)(1), May 20, 1988, 102 Stat. 491 ; Pub. L. 101–508, title VIII, §8013(b), Nov. 5, 1990, 104 Stat. 1388–346 ; Pub. L. 102–83, §§4(a)(3), (4), (b)(1), (2)(E), 5(c)(1), Aug. 6, 1991, 105 Stat. 404–406 .

Prior Provisions

A prior section 1710 was renumbered section 3510 of this title.

Amendments

2024-Subsec. (f)(2)(B). Pub. L. 118–83 substituted "September 30, 2025" for "September 30, 2024".

2022-Subsec. (a)(2)(E). Pub. L. 117–328 designated existing provisions as introductory provisions, substituted "of-" for "of the Mexican border period or of World War I;", and added cls. (i) to (iii).

Subsec. (a)(2)(F). Pub. L. 117–168, §102(a), substituted "who is a toxic-exposed veteran, in accordance with subsection (e)" for "who was exposed to a toxic substance, radiation, or other conditions, as provided in subsection (e)".

Subsec. (e)(1)(D). Pub. L. 117–168, §111(b), inserted "(including any veteran who, in connection with service during such period, received the Armed Forces Expeditionary Medal, Service Specific Expeditionary Medal, Combat Era Specific Expeditionary Medal, Campaign Specific Medal, or any other combat theater award established by a Federal statute or an Executive order)" after "Persian Gulf War".

Subsec. (e)(1)(G) to (I). Pub. L. 117–168, §103(a)(1)(A), added subpars. (G) to (I).

Subsec. (e)(2)(B). Pub. L. 117–168, §103(a)(1)(B), substituted "(F), (G), (H), or (I)" for "or (F)" and "service, testing, or activity" for "service or testing".

Subsec. (e)(3)(A). Pub. L. 117–168, §111(a)(1), substituted "September 11, 2001" for "January 27, 2003" and "10-year period" for "five-year period".

Subsec. (e)(3)(B). Pub. L. 117–168, §111(a)(2), amended subpar. (B) generally. Prior to amendment, subpar. (B) read as follows: "With respect to a veteran described in paragraph (1)(D) who is discharged or released from the active military, naval, air, or space service after January 1, 2009, and before January 1,

2011, but did not enroll to receive such hospital care, medical services, or nursing home care pursuant to such paragraph during the five-year period described in subparagraph (A), the one-year period beginning on the date of the enactment of the Clay Hunt Suicide Prevention for American Veterans Act."

Subsec. (e)(3)(C). Pub. L. 117–168, §111(a)(3), struck out subpar. (C) which read as follows: "With respect to a veteran described in paragraph (1)(D) who is discharged or released from the active military, naval, air, or space service on or before January 27, 2003, and did not enroll in the patient enrollment system under section 1705 of this title on or before such date, the three-year period beginning on January 27, 2008."

Subsec. (e)(4)(A). Pub. L. 117–168, §403(c), added subpar. (A) and struck out former subpar. (A) which read as follows: "The term 'Vietnam-era herbicide-exposed veteran' means a veteran (i) who served on active duty in the Republic of Vietnam (including offshore of such Republic as described in section 1116A(d) of this title) during the period beginning on January 9, 1962, and ending on May 7, 1975, and (ii) who the Secretary finds may have been exposed during such service to dioxin or was exposed during such service to a toxic substance found in a herbicide or defoliant used for military purposes during such period."

Subsec. (e)(4)(C). Pub. L. 117–168, §102(c), added subpar. (C).

Subsec. (e)(6). Pub. L. 117–168, §103(a)(2), added par. (6).

Subsec. (f)(2)(B). Pub. L. 117–180 substituted "September 30, 2024" for "September 30, 2022".

2021-Subsec. (a)(2)(B). Pub. L. 116–283 substituted "air, or space service" for "or air service".

Subsec. (e)(3). Pub. L. 116–283 substituted "air, or space service" for "or air service" in subpars. (A) to (C).

2020-Subsec. (f)(2)(B). Pub. L. 116–159 substituted "September 30, 2022" for "September 30, 2020".

2019-Subsec. (e)(4). Pub. L. 116–23 inserted "(including offshore of such Republic as described in section 1116A(d) of this title)" after "served on active duty in the Republic of Vietnam".

2018-Subsec. (a)(2)(D). Pub. L. 115–232 substituted "section 7271, 8291, or 9271 of title 10" for "section 3741, 6241, or 8741 of title 10".

Subsec. (f)(2)(B). Pub. L. 115–251 substituted "September 30, 2020" for "September 30, 2019".

2017-Subsec. (f)(2)(B). Pub. L. 115–62 substituted "September 30, 2019" for "September 30, 2017".

2016-Subsec. (a)(2)(D). Pub. L. 114–315, §603(b), inserted ", who was awarded the medal of honor under section 3741, 6241, or 8741 of title 10 or section 491 of title 14," after "war".

Subsec. (e)(1)(F). Pub. L. 114–315, §802(3), inserted comma after "1953" in introductory provisions.

Subsec. (f)(2)(B). Pub. L. 114–228 substituted "September 30, 2017" for "September 30, 2016".

Subsec. (g)(3). Pub. L. 114–198 and Pub. L. 114–223 amended par. (3) identically, substituting "with respect to the following:" for "with respect to home health services", inserting subpar. (A) designation and "Home health services" before "under section 1717 of this title", and adding subpar. (B).

2015-Subsec. (e)(1)(D). Pub. L. 114–58, §601(4)(A), struck out "(as defined in section 1712A(a)(2)(B) of this title)" after "hostilities".

Subsec. (e)(1)(F)(viii). Pub. L. 114–58, §601(4)(B), substituted "Myelodysplastic" for "Myleodysplasic".

Subsec. (e)(3). Pub. L. 114–2 amended par. (3) generally. Prior to amendment, par. (3) read as follows: "Hospital care, medical services, and nursing home care may not be provided under or by virtue of subsection (a)(2)(F) in the case of care for a veteran described in paragraph (1)(D) who-

"(A) is discharged or released from the active military, naval, or air service after the date that is five years before the date of the enactment of the National Defense Authorization Act for Fiscal Year 2008, after a period of five years beginning on the date of such discharge or release; or

"(B) is so discharged or released more than five years before the date of the enactment of that Act and who did not enroll in the patient enrollment system under section 1705 of this title before such date, after a period of three years beginning on the date of the enactment of that Act."

Subsec. (f)(2)(B). Pub. L. 114–58, §101, substituted "September 30, 2016" for "September 30, 2015".

2014-Subsec. (e)(1)(F). Pub. L. 113–235, §243, substituted "August 1, 1953" for "January 1, 1957," in introductory provisions.

Subsec. (f)(2)(B). Pub. L. 113–175 substituted "September 30, 2015" for "September 30, 2014".

2013-Subsec. (f)(2)(B). Pub. L. 113–37 substituted "September 30, 2014" for "September 30, 2013".

2012-Subsec. (e)(1)(F). Pub. L. 112–154, §102(a)(1), added subpar. (F).

Subsec. (e)(2)(B). Pub. L. 112–154, §102(a)(2), substituted "(E), or (F)" for "or (E)".

Subsec. (f)(2)(B). Pub. L. 112–154, §112, substituted "September 30, 2013" for "September 30, 2012".

2010-Subsec. (e)(1)(C). Pub. L. 111–163, §513(2), substituted "paragraph (2)" for "paragraphs (2) and (3)" and inserted "between August 2, 1990, and November 11, 1998," after "on active duty".

Subsec. (e)(3). Pub. L. 111–163, §513(1), substituted "subsection (a)(2)(F)" for "subsection (a)(2)(F)-" in introductory provisions, struck out subpar. (C) designation before "in the case", redesignated cls. (i) and (ii) of former subpar. (C) as subpars. (A) and (B), respectively, realigned margins, and struck out former subpars. (A) and (B), which read as follows:

"(A) in the case of care for a veteran described in paragraph (1)(A), after December 31, 2002;

"(B) in the case of care for a veteran described in paragraph (1)(C), after December 31, 2002; and".

Subsec. (f)(2)(B). Pub. L. 111–163, §517, amended subpar. (B) generally. Prior to amendment, subpar. (B) read as follows: "before September 30, 2010, an amount equal to $10 for every day the veteran receives hospital care and $5 for every day the veteran receives nursing home care."

2008-Subsec. (e)(1)(E). Pub. L. 110–387, §803(b), substituted "paragraph (2)" for "paragraphs (2) and (3)".

Subsec. (e)(3)(B). Pub. L. 110–387, §803(a)(1), inserted "and" after the semicolon at end.

Subsec. (e)(3)(C). Pub. L. 110–387, §803(a)(2), substituted a period at end for "; and".

Pub. L. 110–181 amended subpar. (C) generally. Prior to amendment subpar. (C) read as follows: "in the case of care for a veteran described in paragraph (1)(D), after a period of 2 years beginning on the date of the veteran's discharge or release from active military, naval, or air service; and".

Subsec. (e)(3)(D). Pub. L. 110–387, §803(a)(3), struck out subpar. (D) which read as follows: "in the case of care for a veteran described in paragraph (1)(E), after December 31, 2007".

Subsec. (f)(1). Pub. L. 110–387, §409(1), inserted "(except if such care constitutes hospice care)" after "nursing home care".

Subsec. (f)(2)(B). Pub. L. 110–387, §804(a), which directed substitution of "September 30, 2010" for "September 30, 2008", was executed by making the substitution for "September 30, 2009" to reflect the probable intent of Congress and the amendment by Pub. L. 110–329. See below.

Pub. L. 110–329 substituted "September 30, 2009," for "September 30, 2008,".

Subsec. (g)(1). Pub. L. 110–387, §409(2), inserted "(except if such care constitutes hospice care)" after "medical services".

2007-Subsec. (f)(2)(B). Pub. L. 110–161 substituted "September 30, 2008," for "September 30, 2007,".

2006-Subsec. (a)(4). Pub. L. 109–461, §211(a)(3)(B), struck out "and" before "the requirement in section 1710B of this title" and inserted ", and the requirement in section 1745 of this title to provide nursing home care and prescription medicines to veterans with service-connected disabilities in State homes" after "a program of extended care services".

Subsec. (e)(3)(D). Pub. L. 109–461, §1006(b), provided that as of the enactment of Pub. L. 109–461, the amendments made by Pub. L. 109–444 were deemed for all purposes not to have taken effect and that Pub. L. 109–444 ceased to be in effect. See Amendment notes below and section 1006(b) of Pub. L. 109–461, set out as a Coordination of Provisions With Pub. L. 109–444 note under section 101 of this title.

Pub. L. 109–461, §1003, substituted "December 31, 2007" for "December 31, 2005".

Pub. L. 109–444, which substituted "December 31, 2007" for "December 31, 2005", was terminated by Pub. L. 109–461, §1006(b). See Amendment notes above.

2003-Subsec. (e)(1)(E). Pub. L. 108–170, §102(1), added subpar. (E).

Subsec. (e)(2)(B). Pub. L. 108–170, §102(2), substituted "subparagraph (C), (D), or (E) of paragraph (1)" for "paragraph (1)(C) or (1)(D)" and "service or testing described in such subparagraph" for "service described in that paragraph".

Subsec. (e)(3)(D). Pub. L. 108–170, §102(3), added subpar. (D).

2002-Subsec. (e)(1)(D). Pub. L. 107–330 substituted "November 11, 1998" for "the date of the enactment of this subparagraph".

Subsec. (e)(3)(B). Pub. L. 107–135, §211, substituted "December 31, 2002" for "December 31, 2001".

Subsec. (f)(1). Pub. L. 107–135, §202(b)(1), inserted "or (4)" after "paragraph (2)".

Subsec. (f)(2)(B). Pub. L. 107–135, §209(a), substituted "September 30, 2007" for "September 30, 2002".

Subsec. (f)(4), (5). Pub. L. 107–135, §202(b)(2), (3), added par. (4) and redesignated former par. (4) as (5).

2000-Subsec. (a)(4). Pub. L. 106–419 inserted "the requirement in section 1710A(a) of this title that the Secretary provide nursing home care," after "medical services," and struck out comma after "extended care services".

1999-Subsec. (a)(1). Pub. L. 106–117, §101(f)(1), struck out ", and may furnish nursing home care," after "medical services" in introductory provisions.

Subsec. (a)(2)(A). Pub. L. 106–117, §101(f)(2), inserted "or, with respect to nursing home care during any period during which the provisions of section 1710A(a) of this title are in effect, a compensable service-connected disability rated less than 70 percent" after "50 percent".

Subsec. (a)(2)(D). Pub. L. 106–117, §112(1), inserted "or who was awarded the Purple Heart" after "former prisoner of war".

Subsec. (a)(4). Pub. L. 106–117, §101(f)(3), inserted ", and the requirement in section 1710B of this title that the Secretary provide a program of extended care services," after "medical services".

Subsec. (a)(5). Pub. L. 106–117, §101(f)(4), added par. (5).

Subsec. (g)(1). Pub. L. 106–117, §201(b)(1), substituted "in the case of each outpatient visit the applicable amount or amounts established by the Secretary by regulation" for "the amount determined

under paragraph (2) of this subsection".

Subsec. (g)(2). Pub. L. 106–117, §201(b)(2), substituted "which the Secretary shall establish by regulation." for "equal to 20 percent of the estimated average cost (during the calendar year in which the services are furnished) of an outpatient visit in a Department facility. Such estimated average cost shall be determined by the Secretary."

1998-Subsec. (e)(1)(D). Pub. L. 105–368, §102(a)(1), added subpar. (D).

Subsec. (e)(2)(A)(ii). Pub. L. 105–368, §1005(b)(3), substituted "section 3" for "section 2".

Subsec. (e)(2)(B). Pub. L. 105–368, §102(a)(2), inserted "or (1)(D)" after "paragraph (1)(C)".

Subsec. (e)(3)(A). Pub. L. 105–368, §102(a)(3)(A), struck out "and" at end.

Subsec. (e)(3)(B). Pub. L. 105–368, §102(a)(3)(B), substituted "December 31, 2001; and" for "December 31, 1998."

Subsec. (e)(3)(C). Pub. L. 105–368, §102(a)(3)(C), added subpar. (C).

Subsec. (e)(5). Pub. L. 105–368, §102(a)(4), added par. (5).

1997-Subsec. (a)(2)(B). Pub. L. 105–114, §402(a), struck out "compensable" before "disability".

Subsec. (a)(2)(F). Pub. L. 105–114, §209(a)(1), substituted "other conditions" for "environmental hazard".

Subsec. (e)(1)(C). Pub. L. 105–114, §209(a)(2), substituted "served" for "the Secretary finds may have been exposed while serving" and "associated with such service" for "associated with such exposure" and struck out "to a toxic substance or environmental hazard" after "Persian Gulf War".

Subsec. (e)(2)(B). Pub. L. 105–114, §209(a)(3), substituted "the service" for "an exposure".

Subsec. (f)(2)(B). Pub. L. 105–33, §8021(a)(1), inserted "before September 30, 2002," after "(B)".

Subsec. (f)(4), (5). Pub. L. 105–33, §8023(b)(1), redesignated par. (5) as (4) and struck out former par. (4) which read as follows: "Amounts collected or received on behalf of the United States under this subsection shall be deposited in the Treasury as miscellaneous receipts."

Subsec. (g)(4). Pub. L. 105–33, §8023(b)(2), struck out par. (4) which read as follows: "Amounts collected or received by the Department under this subsection shall be deposited in the Treasury as miscellaneous receipts."

1996-Subsec. (a). Pub. L. 104–262, §101(a), amended subsec. (a) generally, revising and restating provisions in former pars. (1) to (3) relating to eligibility for care as pars. (1) to (4).

Subsec. (c)(1). Pub. L. 104–262, §101(d)(2), substituted "section 1712(a)" for "section 1712(b)".

Subsec. (e)(1)(A), (B). Pub. L. 104–262, §102(a)(1), added subpars. (A) and (B) and struck out former subpars. (A) and (B) which read as follows:

"(A) Subject to paragraphs (2) and (3) of this subsection, a veteran-

"(i) who served on active duty in the Republic of Vietnam during the Vietnam era, and

"(ii) who the Secretary finds may have been exposed during such service to dioxin or was exposed during such service to a toxic substance found in a herbicide or defoliant used in connection with military purposes during such era,

is eligible for hospital care and nursing home care under subsection (a)(1)(G) of this section for any disability, notwithstanding that there is insufficient medical evidence to conclude that such disability may be associated with such exposure.

"(B) Subject to paragraphs (2) and (3) of this subsection, a veteran who the Secretary finds was exposed while serving on active duty to ionizing radiation from the detonation of a nuclear device in connection with such veteran's participation in the test of such a device or with the American occupation of Hiroshima and Nagasaki, Japan, during the period beginning on September 11, 1945, and ending on July 1, 1946, is eligible for hospital care and nursing home care under subsection (a)(1)(G) of this section for any disability, notwithstanding that there is insufficient medical evidence to conclude that such disability may be associated with such exposure."

Subsec. (e)(1)(C). Pub. L. 104–262, §101(d)(3), substituted "hospital care, medical services, and nursing home care under subsection (a)(2)(F)" for "hospital care and nursing home care under subsection (a)(1)(G) of this section".

Subsec. (e)(2). Pub. L. 104–262, §102(a)(2), added par. (2) and struck out former par. (2) which read as follows: "Hospital and nursing home care may not be provided under subsection (a)(1)(G) of this section with respect to a disability that is found, in accordance with guidelines issued by the Under Secretary for Health, to have resulted from a cause other than an exposure described in subparagraph (A), (B), or (C) of paragraph (1) of this subsection."

Subsec. (e)(3). Pub. L. 104–262, §102(a)(2), added par. (3) and struck out former par. (3) which read as follows: "Hospital and nursing home care and medical services may not be provided under or by virtue of subsection (a)(1)(G) of this section after December 31, 1996."

Pub. L. 104–110 substituted "after December 31, 1996" for "after June 30, 1995, or, in the case of care for a veteran described in paragraph (1)(C), after December 31, 1995".

Subsec. (e)(4). Pub. L. 104–262, §102(a)(2), added par. (4).

Subsec. (e)(4)(A). Pub. L. 104–275 substituted "during the period beginning on January 9, 1962, and ending on May 7, 1975," for "during the Vietnam era," in cl. (i) and "such period" for "such era" in cl. (ii).

Subsec. (f)(1). Pub. L. 104–262, §101(d)(4)(A), substituted "subsection (a)(3)" for "subsection (a)(2)".

Subsec. (f)(3)(E). Pub. L. 104–262, §101(d)(4)(B), substituted "paragraph (3) of subsection (a)" for "section 1712(a) of this title" and "subsection (g)" for "section 1712(f) of this title".

Subsec. (f)(3)(F). Pub. L. 104–262, §101(d)(4)(C), substituted "subsection (g)" for "section 1712(f) of this title".

Subsec. (g). Pub. L. 104–262, §101(b)(2), redesignated subsec. (f) of section 1712 of this title as subsec. (g) of this section and substituted "subsection (a)(3) of this section" for "section 1710(a)(2) of this title" in par. (1). See Codification note above.

Pub. L. 104–262, §101(b)(1), redesignated subsec. (g) as (h).

Subsec. (h). Pub. L. 104–262, §101(b)(1), redesignated subsec. (g) as (h).

1994-Subsec. (e)(3). Pub. L. 103–452 substituted "June 30, 1995" for "June 30, 1994" and "December 31, 1995" for "December 31, 1994".

Subsec. (f)(3)(E). Pub. L. 103–446 substituted "section 1712(a)" for "section 1712(f)" and "section 1712(f)" for "section 1712(f)(4)".

1993-Subsec. (a)(1)(G). Pub. L. 103–210, §1(a)(1), substituted "substance, radiation, or environmental hazard" for "substance or radiation".

Subsec. (e)(1)(C). Pub. L. 103–210, §1(a)(2)(A), added subpar. (C).

Subsec. (e)(2). Pub. L. 103–210, §1(a)(2)(B), substituted "subparagraph (A), (B), or (C)" for "subparagraph (A) or (B)".

Subsec. (e)(3). Pub. L. 103–210, §2(a), substituted "June 30, 1994" for "December 31, 1993".

Pub. L. 103–210, §1(a)(2)(C), inserted before period at end ", or, in the case of care for a veteran described in paragraph (1)(C), after December 31, 1994".

1992-Subsec. (e)(2). Pub. L. 102–405 substituted "Under Secretary for Health" for "Chief Medical Director".

1991-Pub. L. 102–83, §5(a), renumbered section 610 of this title as this section.

Subsec. (a)(1). Pub. L. 102–83, §5(c)(1), substituted "1151" for "351" in subpar. (C) and "1722(a)" for "622(a)" in subpar. (I).

Pub. L. 102–83, §4(b)(1), (2)(E), substituted "Secretary" for "Administrator" in two places in introductory provisions.

Subsec. (a)(1)(H). Pub. L. 102–54 substituted "the Mexican border period" for "the Spanish-American War, the Mexican border period,".

Subsec. (a)(3). Pub. L. 102–83, §5(c)(1), substituted "1703" for "603" and "1720" for "620".

Pub. L. 102–83, §4(b)(1), (2)(E), substituted "Secretary" for "Administrator".

Pub. L. 102–83, §4(a)(3), (4), substituted "Department" for "Veterans' Administration".

Subsec. (b). Pub. L. 102–83, §4(b)(1), (2)(E), substituted "Secretary" for "Administrator" wherever appearing.

Subsec. (b)(2)(A). Pub. L. 102–83, §5(c)(1), substituted "1503" for "503" and "1521(d)" for "521(d)".

Subsec. (c). Pub. L. 102–83, §5(c)(1), substituted "1712(b)" for "612(b)".

Pub. L. 102–83, §4(b)(1), (2)(E), substituted "Secretary" for "Administrator" wherever appearing.

Pub. L. 102–83, §4(a)(3), (4), substituted "Department" for "Veterans' Administration" wherever appearing.

Subsec. (d). Pub. L. 102–83, §5(c)(1), substituted "1720" for "620".

Pub. L. 102–83, §4(b)(1), (2)(E), substituted "Secretary" for "Administrator".

Subsec. (e)(1). Pub. L. 102–83, §4(b)(1), (2)(E), substituted "Secretary" for "Administrator" in subpars. (A)(ii) and (B).

Subsec. (e)(3). Pub. L. 102–4 substituted "1993" for "1990".

Subsec. (f)(3)(E), (F). Pub. L. 102–83, §5(c)(1), substituted "1712(f)" for "612(f)" and "1712(f)(4)" for "612(f)(4)" in subpar. (E) and "1712(f)" for "612(f)" in subpar. (F).

Subsec. (g). Pub. L. 102–83, §4(b)(1), (2)(E), substituted "Secretary" for "Administrator".

1990-Subsec. (a)(1)(I). Pub. L. 101–508, §8013(a)(1)(A), substituted "section 622(a)" for "section 622(a)(1)".

Subsec. (a)(2). Pub. L. 101–508, §8013(a)(1)(B), added par. (2) and struck out former par. (2) which read as follows:

"(A) To the extent that resources and facilities are available, the Administrator may furnish hospital care and nursing home care which the Administrator determines is needed to a veteran for a non-service-connected disability if the veteran has an income level described in section 622(a)(2) of this title.

"(B) In the case of a veteran who is not described in paragraph (1) of this subsection or in subparagraph (A) of this paragraph, the Administrator may furnish hospital care and nursing home care which the Administrator determines is needed to the veteran for a non-service-connected disability-

"(i) to the extent that resources and facilities are otherwise available; and

"(ii) subject to the provisions of subsection (f) of this section."

Subsec. (f)(1), (2). Pub. L. 101–508, §8013(a)(2)(A), added pars. (1) and (2) and struck out former pars. (1) and (2) which read as follows:

"(1) The Administrator may not furnish hospital care or nursing home care under this section to a veteran who is eligible for such care by reason of subsection (a)(2)(B) of this section unless the veteran agrees to pay to the United States the applicable amount determined under paragraph (2) of this subsection.

"(2) A veteran who is furnished hospital care or nursing home care under this section and who is required under paragraph (1) of this subsection to agree to pay an amount to the United States in order to be furnished such care shall be liable to the United States for an amount equal to the lesser of-

"(A) the cost of furnishing such care, as determined by the Administrator; and

"(B) the amount determined under paragraph (3) of this subsection."

Subsec. (f)(3)(A), (B). Pub. L. 101–508, §8013(a)(2)(B), substituted "paragraph (2)(A)(ii)" for "paragraph (2)(B)".

1988-Subsec. (b). Pub. L. 100–233 amended subsec. (b) generally. Prior to amendment, subsec. (b) read as follows: "The Administrator, within the limits of Veterans' Administration facilities, may furnish domiciliary care to-

"(1) a veteran who was discharged or released from the active military, naval, or air service for a disability incurred or aggravated in line of duty, or a person who is in receipt of disability compensation, when such person is suffering from a permanent disability or tuberculosis or neuropsychiatric ailment and is incapacitated from earning a living and has no adequate means of support; and

"(2) a veteran who is in need of domiciliary care if such veteran is unable to defray the expenses of necessary domiciliary care."

Subsec. (e)(3). Pub. L. 100–687 substituted "December 31, 1990" for "September 30, 1989".

1986-Subsec. (a). Pub. L. 99–576, §237(a), inserted "who is in receipt of, or" after "veteran" in par. (1)(C).

Pub. L. 99–272, §19011(a)(1), amended subsec. (a) generally. Prior to amendment, subsec. (a) read as follows: "The Administrator, within the limits of Veterans' Administration facilities, may furnish hospital care or nursing home care which the Administrator determines is needed to-

"(1)(A) any veteran for a service-connected disability; or

"(B) any veteran for a non-service-connected disability if such veteran is unable to defray the expenses of necessary hospital or nursing home care;

"(2) a veteran whose discharge or release from the active military, naval, or air service was for a disability incurred or aggravated in line of duty;

"(3) a person (A) who is in receipt of, or but for the receipt of retirement pay would be entitled to, disability compensation, or (B) who, but for a suspension pursuant to section 351 of this title (or both such a suspension and the receipt of retired pay), would be entitled to disability compensation, but only to the extent that such person's continuing eligibility for such care is provided for in the judgment or settlement described in such section;

"(4) a veteran who is a former prisoner of war;

"(5) a veteran who meets the conditions of subsection (e) of this section; and

"(6) any veteran for a non-service-connected disability if such veteran is sixty-five years of age or older."

Subsec. (e)(1)(A), (B). Pub. L. 99–272, §19011(d)(3)(A), substituted "is eligible for hospital care and nursing home care under subsection (a)(1)(G)" for "may be furnished hospital care or nursing home care under subsection (a)(5)".

Subsec. (e)(2), (3). Pub. L. 99–272, §19011(d)(3)(B), substituted "subsection (a)(1)(G)" for "subsection (a)(5)".

Subsec. (f). Pub. L. 99–272, §19011(a)(2), added subsec. (f).

Subsec. (f)(3)(F). Pub. L. 99–576, §237(b)(1), added subpar. (F).

Subsec. (g). Pub. L. 99–272, §19011(a)(2), added subsec. (g).

1985-Subsec. (e)(3). Pub. L. 99–166 substituted "after September 30, 1989" for "after the end of the one-year period beginning on the date the Administrator submits to the appropriate committees of Congress the first report required by section 307(b)(2) of the Veterans Health Programs Extension and Improvement Act of 1979 (Public Law 96–151; 93 Stat. 1098)".

1983-Subsec. (a)(3). Pub. L. 98–160 inserted "(A)" after "a person" and, after "disability compensation", inserted "or (B) who, but for a suspension pursuant to section 351 of this title (or both such a suspension and the receipt of retired pay), would be entitled to disability compensation, but only to the extent that such person's continuing eligibility for such care is provided for in the judgment or settlement described in such section".

1981-Subsec. (a). Pub. L. 97–72, §102(a)(1), added cl. (5) and redesignated former cl. (5) as (6).

Pub. L. 97–37 added cl. (4) and redesignated former cl. (4) as (5).

Subsec. (e). Pub. L. 97–72, §102(a)(2), added subsec. (e).

1979-Subsec. (c). Pub. L. 96–22 inserted provisions relating to the furnishing of dental services and treatment and related dental appliances for non-service-connected dental conditions or disabilities of veterans.

1976-Pub. L. 94–581, §202(d)(1), inserted ", nursing home," in section catchline.

Subsec. (a). Pub. L. 94–581, §§202(d)(2), 210(a)(1)(A), (B), substituted "the Administrator determines" for "he determines" in provisions preceding par. (1) and substituted "such veteran" for "he" and "necessary hospital or nursing home care" for "necessary hospital care" in subpar. (B) of par. (1).

Subsec. (b)(1). Pub. L. 94–581, §210(a)(1)(C), substituted "such person" for "he".

Subsec. (b)(2). Pub. L. 94–581, §§202(d)(3), 210(a)(1)(B), substituted "a veteran who is in need of domiciliary care if such veteran" for "a veteran of any war or of service after January 31, 1955, who is in need of domiciliary care, if he".

Subsec. (c). Pub. L. 94–581, §210(a)(1)(B), substituted "for which such veteran is hospitalized" for "for which he is hospitalized".

Subsec. (d). Pub. L. 94–581, §202(d)(4), substituted "direct jurisdiction" for "direct and exclusive jurisdiction".

1973-Subsec. (a). Pub. L. 93–82, §102(1), (2), extended authority of the Administrator to furnish nursing home care, and in par. (1)(B), substituted "any veteran for a" for "a veteran of any war or of service after January 31, 1955, for".

Subsec. (c). Pub. L. 93–82, §102(3), expanded provision regarding medical services to include nursing home care and struck out requirement that the Administrator make a determination in each instance that the non-service-connected disability would be in the veteran's interest, would not prolong his hospitalization, and, would not interfere with the furnishing of hospital facilities to other veterans.

Subsec. (d). Pub. L. 93–82, §102(4), added subsec. (d).

1970-Subsec. (a). Pub. L. 91–500 added cl. (4).

1966-Pub. L. 89–358 inserted "or of service after January 31, 1955," after "veteran of any war" in subsecs. (a)(1)(B) and (b)(2).

Subsec. (c). Pub. L. 89–785 added subsec. (c).

1962-Subsec. (a)(1). Pub. L. 87–583 provided for hospital care to any veteran for a service-connected disability instead of to a veteran of any war for a service-connected disability incurred or aggravated during a period of war in subpar. (A) and incorporated existing provisions in subpar. (B).

Statutory Notes and Related Subsidiaries

Effective Date of 2022 Amendment

Pub. L. 117–328, div. U, title I, §101(b), Dec. 29, 2022, 136 Stat. 5408 , provided that: "The amendment made by subsection (a) [amending this section] shall take effect on March 31, 2023."

Pub. L. 117–168, title I, §111(e), Aug. 10, 2022, 136 Stat. 1766 , provided that: "This section [amending this section] and the amendments made by this section shall take effect on October 1, 2022."

Amendment by section 403(c) of Pub. L. 117–168 effective Aug. 10, 2022, with additional provisions for different applicability dates applying to various categories of veterans and claimants for compensation, see section 403(e) of Pub. L. 117–168, set out as a note under section 1116 of this title.

Effective Date of 2019 Amendment

Amendment by Pub. L. 116–23 effective Jan. 1, 2020, see section 2(g) of Pub. L. 116–23, set out as an Effective Date note under section 1116A of this title.

Effective Date of 2018 Amendment

Amendment by Pub. L. 115–232 effective Feb. 1, 2019, with provision for the coordination of amendments and special rule for certain redesignations, see section 800 of Pub. L. 115–232, set out as a note preceding section 3001 of Title 10, Armed Forces.

Effective Date of 2013 Amendment

Amendment by Pub. L. 113–37 effective Oct. 1, 2013, see section 4(a) of Pub. L. 113–37, set out as a note under section 322 of this title.

Effective Date of 2012 Amendment

Pub. L. 112–154, title I, §102(d), Aug. 6, 2012, 126 Stat. 1169 , provided that:

"(1) IN GENERAL.-The provisions of this section [enacting section 1787 of this title and amending this section] and the amendments made by this section shall take effect on the date of the enactment of this Act [Aug. 6, 2012].

"(2) APPLICABILITY.-Subparagraph (F) of section 1710(e)(1) of such title [probably means title 38, United States Code], as added by subsection (a), and section 1787 of title 38, United States Code, as added by subsection (b)(1), shall apply with respect to hospital care and medical services provided on or after the date of the enactment of this Act."

EFFECTIVE DATE OF 2006 AMENDMENT

Pub. L. 109–461, title II, §211(a)(5), Dec. 22, 2006, 120 Stat. 3419 , provided that: "The amendments made by this subsection [enacting section 1745 of this title and amending this section and sections 1741 and 1745 of this title] shall take effect 90 days after the date of the enactment of this Act [Dec. 22, 2006]."

EFFECTIVE DATE OF 2002 AMENDMENT

Amendment by section 202(b) of Pub. L. 107–135 effective Oct. 1, 2002, see section 202(c) of Pub. L. 107–135, set out as a note under section 1705 of this title.

EFFECTIVE DATE OF 1999 AMENDMENT

Amendment by section 101(f) of Pub. L. 106–117 effective Nov. 30, 1999, with provisions of subsec. (f) of this section not applicable to any day of nursing home care on or after the effective date of regulations under section 101(h)(2) of Pub. L. 106–117, see section 101(h) of Pub. L. 106–117, set out as an Effective Date note under section 1710B of this title.

Pub. L. 106–117, title II, §201(c), as added by Pub. L. 106–419, title II, §224(c), Nov. 1, 2000, 114 Stat. 1846 , provided that: "The amendments made by subsection (b) [amending this section] shall apply with respect to medical services furnished under section 1710(a) of title 38, United States Code, on or after the effective date of the regulations prescribed by the Secretary of Veterans Affairs to establish the amounts required to be established under paragraphs (1) and (2) of section 1710(g) of that title, as amended by subsection (b)."

EFFECTIVE DATE OF 1997 AMENDMENT

Pub. L. 105–33, title VIII, §8023(g), Aug. 5, 1997, 111 Stat. 668 , provided that:

"(1) Except as provided in paragraph (2), this section [enacting section 1729A of this title, amending this section and sections 712, 1722A, and 1729 of this title, and enacting provisions set out as notes under sections 1729 and 1729A of this title] and the amendments made by this section shall take effect on October 1, 1997.

"(2) The amendments made by subsection (d) [amending section 1729 of this title] shall take effect on the date of the enactment of this Act [Aug. 5, 1997]."

EFFECTIVE DATE OF 1996 AMENDMENT

Amendment by Pub. L. 104–275 effective Jan. 1, 1997, with no benefit to be paid or provided by reason of such amendment for any period before such date, see section 505(d) of Pub. L. 104–275, set out as a note under section 101 of this title.

EFFECTIVE DATE OF 1993 AMENDMENT

Pub. L. 103–210, §1(c)(1), Dec. 20, 1993, 107 Stat. 2497 , provided that: "The amendments made by subsections (a) and (b) [amending this section and section 1712 of this title] shall take effect as of August 2, 1990."

EFFECTIVE DATE OF 1990 AMENDMENTS

Pub. L. 102–145, §111, Oct. 28, 1991, 105 Stat. 970 , provided that: "Notwithstanding any other provision of this joint resolution or any other law, the amendments made by sections 8012 and 8013 of the Omnibus Budget Reconciliation Act of 1990 (Public Law 101–508) [enacting section 622A [now 1722A] of this title and amending this section and sections 612 [now 1712] and 622 [now 1722] of this title] shall remain in effect through the period covered by this joint resolution [see section 106 of Pub. L. 102–145, 105 Stat. 970 , as amended by Pub. L. 102–163, 105 Stat. 1048]."

Pub. L. 102–109, §111, Sept. 30, 1991, 105 Stat. 553 , provided that: "Notwithstanding any other provision of this joint resolution or any other law, the amendments made by sections 8012 and 8013 of the Omnibus Budget Reconciliation Act of 1990 (Public Law 101–508) [enacting section 622A [now 1722A] of this title and amending this section and sections 612 [now 1712] and 622 [now 1722] of this title] shall remain in effect through the period covered by this joint resolution [see section 106 of Pub. L. 102–109, 105 Stat. 553]."

Pub. L. 101–508, title VIII, §8013(d), (e), Nov. 5, 1990, 104 Stat. 1388–347 , as amended by Pub. L. 102–139, title V, §518(b), Oct. 28, 1991, 105 Stat. 779 ; Pub. L. 102–568, title VI, §606(b), Oct. 29, 1992, 106 Stat. 4343 ; Pub. L. 103–66, title XII, §12002(a), Aug. 10, 1993, 107 Stat. 414 ; Pub. L. 105–33, title VIII, §8021(a)(2), Aug. 5, 1997, 111 Stat. 665 , provided that:

"(d) EFFECTIVE DATE.-The amendments made by this section [amending this section and sections 612 and 622 [now 1712 and 1722] of this title] shall apply with respect to hospital care and medical services received after October 31, 1990, or the date of the enactment of this Act [Nov. 5, 1990], whichever is later.

"[(e) Repealed. Pub. L. 105–33, title VIII, §8021(a)(2), Aug. 5, 1997, 111 Stat. 665 .]"

EFFECTIVE DATE OF 1986 AMENDMENTS

Pub. L. 99–576, title II, §237(c), Oct. 28, 1986, 100 Stat. 3267 , provided that: "The amendments made by this section [amending this section and section 612 [now 1712] of this title] shall take effect as of April 7, 1986."

Pub. L. 99–272, title XIX, §19011(f), Apr. 7, 1986, 100 Stat. 380 , provided that:

"(1) Except as provided in paragraph (2), the amendments made by this section [amending this section and sections 525, 601, 612, 612A, 620, 622, and 663 [now 1525, 1701, 1712, 1712A, 1720, 1722, and 1763] of this title and enacting provisions set out as notes under this section and section 1722 of this title] shall apply to hospital care, nursing home care, and medical services furnished on or after July 1, 1986.

"(2)(A) The provisions of sections 610 and 622 [now 1710 and 1722] of title 38, United States Code, as in effect on the day before the date of the enactment of this Act [Apr. 7, 1986], shall apply with respect to hospital and nursing home care furnished on or after July 1, 1986, to veterans furnished such care or services on June 30, 1986, but only to the extent that such care is furnished with respect to the same episode of care for which it was furnished on June 30, 1986, as determined by the Administrator pursuant to regulations which the Administrator shall prescribe.

"(B) During the months of July and August 1986, the Administrator may, in order to continue a course of treatment begun before July 1, 1986, furnish medical services to a veteran on an ambulatory or outpatient basis without regard to the amendments made by this section.

"(C) For the purposes of this paragraph, the term 'episode of care' means a period of consecutive days-

"(i) beginning with the first day on which a veteran is furnished hospital or nursing home care; and

"(ii) ending on the day of the veteran's discharge from the hospital or nursing home facility, as the case may be."

EFFECTIVE DATE OF 1981 AMENDMENT

Pub. L. 97–37, §5(d), Aug. 14, 1981, 95 Stat. 937 , provided that: "The amendments made by this section [amending this section and section 612 [now 1712] of this title] shall take effect on October 1, 1981".

EFFECTIVE DATE OF 1979 AMENDMENT

Amendment by Pub. L. 96–22 effective Oct. 1, 1979, see section 107 of Pub. L. 96–22, set out as a note under section 1701 of this title.

EFFECTIVE DATE OF 1976 AMENDMENT

Amendment by Pub. L. 94–581 effective Oct. 21, 1976, see section 211 of Pub. L. 94–581, set out as a note under section 111 of this title.

EFFECTIVE DATE OF 1973 AMENDMENT

Amendment by Pub. L. 93–82 effective Sept. 1, 1973, see section 501 of Pub. L. 93–82, set out as a note under section 1701 of this title.

SAVINGS PROVISION

Pub. L. 104–262, title I, §102(b), Oct. 9, 1996, 110 Stat. 3182 , provided that: "The provisions of sections 1710(e) and 1712(a) of title 38, United States Code, as in effect on the day before the date of the enactment of this Act [Oct. 9, 1996], shall continue to apply on and after such date with respect to the furnishing of hospital care, nursing home care, and medical services for any veteran who was furnished such care or services before such date of enactment on the basis of presumed exposure to a substance or radiation under the authority of those provisions, but only for treatment for a disability for which such care or services were furnished before such date."

SAVINGS PROVISION FOR PUB. L. 100–322

Pub. L. 100–322, title I, §102(c), May 20, 1988, 102 Stat. 493 , provided that: "The amendment made by subsection (a) [amending this section] shall not limit or restrict the eligibility for domiciliary care of a

veteran who was a patient or a resident in a State home facility or a Veterans' Administration domiciliary facility during the period beginning on January 1, 1987, and ending on April 1, 1988."

Assessments of Implementation and Operation

Pub. L. 117–168, title I, §104, Aug. 10, 2022, 136 Stat. 1763 , provided that:

"(a) Initial Resource Assessment and Report.-Not later than 180 days after the date of the enactment of this Act [Aug. 10, 2022], the Secretary of Veterans Affairs shall-

"(1) complete an assessment to determine-

"(A) the personnel and material resources necessary to implement section 103 [amending this section] (including the amendments made by such section); and

"(B) the total number of covered veterans, as such term is defined in section 1119(c) of title 38, United States Code (as added by section 302), who receive hospital care or medical services furnished by the Secretary under chapter 17 of such title, disaggregated by priority group specified in section 1705(a) of such title; and

"(2) submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives a report containing the findings of the assessment completed under paragraph (1), including a specific determination as to whether the Department has the personnel and material resources necessary to implement section 103.

"(b) Information Systems.-Not later than October 1, 2024, the Secretary shall establish information systems to assess the implementation of section 103, including the amendments made by such section, and use the results of assessments under such systems to inform the reports under subsection (c).

"(c) Annual Reports.-

"(1) Reports.-Not later than October 1, 2025, and on an annual basis thereafter until October 1, 2033, the Secretary shall submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives a report on the following:

"(A) The effect of the implementation of, and the provision and management of care under, section 103 (including the amendments made by such section) on the demand by veterans described in subparagraphs (G), (H), and (I) of section 1710(e)(1) of title 38, United States Code (as added by such section 103) for health care services furnished by the Secretary.

"(B) Any differing patterns of demand for health care services by such veterans, disaggregated by factors such as the relative distance of the veteran from medical facilities of the Department and whether the veteran had previously received hospital care or medical services furnished by the Secretary under chapter 17 of such title.

"(C) The extent to which the Secretary has met such demand.

"(D) Any changes, during the year covered by the report, in the delivery patterns of health care furnished by the Secretary under chapter 17 of such title, and the fiscal impact of such changes.

"(2) Matters.-Each report under paragraph (1) shall include, with respect to the year covered by the report, detailed information on the following:

"(A) The total number of veterans enrolled in the patient enrollment system who, during such year, received hospital care or medical services furnished by the Secretary under chapter 17 of title 38, United States Code.

"(B) Of the veterans specified in subparagraph (A), the number of such veterans who, during the preceding three fiscal years, had not received such care or services.

"(C) With respect to the veterans specified in subparagraph (B), the cost of providing health care to such veterans during the year covered by the report, shown in total and disaggregated by-

"(i) the level of care; and

"(ii) whether the care was provided through the Veterans Community Care Program.

"(D) With respect to the number of veterans described in subparagraphs (G), (H), and (I) of section 1710(e)(1) of title 38, United States Code (as added by section 103), the following (shown in total and disaggregated by medical facility of the Department, as applicable):

"(i) The number of such veterans who, during the year covered by the report, enrolled in the patient enrollment system.

"(ii) The number of such veterans who applied for, but were denied, such enrollment.

"(iii) The number of such veterans who were denied hospital care or a medical service furnished by the Secretary that was considered to be medically necessary but not of an emergency nature.

"(E) The numbers and characteristics of, and the type and extent of health care furnished by the Secretary to, veterans enrolled in the patient enrollment system (shown in total and disaggregated by medical facility of the Department).

"(F) The numbers and characteristics of, and the type and extent of health care furnished by the Secretary to, veterans not enrolled in the patient enrollment system (disaggregated by each class

of eligibility for care under section 1710 of title 38, United States Code, and further shown as a total per class and disaggregated by medical facility of the Department).

"(G) The specific fiscal impact (shown in total and disaggregated by geographic health care delivery areas) of changes in the delivery patterns of health care furnished by the Secretary under chapter 17 of such title as a result of the implementation of section 103 (including the amendments made by such section).

"(d) DEFINITIONS.-In this section:

"(1) PATIENT ENROLLMENT SYSTEM.-The term 'patient enrollment system' means the patient enrollment system of the Department of Veterans Affairs established and operated under section 1705(a) of title 38, United States Code.

"(2) VETERANS COMMUNITY CARE PROGRAM.-The term 'Veterans Community Care Program' means the program established under section 1703 of title 38, United States Code."

CONTACT OF CERTAIN VETERANS TO ENCOURAGE RECEIPT OF COMPREHENSIVE MEDICAL EXAMINATIONS

Pub. L. 116–214, title II, §204, Dec. 5, 2020, 134 Stat. 1037 , provided that:

"(a) NOTICE.-Not later than 90 days after the date of the enactment of this Act [Dec. 5, 2020], the Under Secretary of Health of the Department of Veterans Affairs shall seek to contact each covered veteran by mail, telephone, or email to encourage each covered veteran to receive medical examinations including the following:

"(1) A comprehensive physical examination.

"(2) A comprehensive mental health examination.

"(3) A comprehensive eye examination if the covered veteran has not received such an examination in the year immediately preceding the date of such examination.

"(4) A comprehensive audiological examination if the covered veteran has not received such an examination in the year immediately preceding the date of such examination.

"(b) EXAMINATIONS.-

"(1) VA HEALTH CARE FACILITIES.-If a covered veteran elects to receive more than one examination described in subsection (a) at a health care facility of the Department of Veterans Affairs, the Under Secretary of Health shall seek to furnish all such scheduled examinations on the same day.

"(2) COMMUNITY CARE.-Pursuant to subsection (d) or (e) of section 1703 of title 38, United States Code, a covered veteran may receive an examination described in subsection (a) from a health care provider described in subsection (c) of that section.

"(c) TRANSPORTATION.-

"(1) BENEFICIARY TRAVEL PROGRAM.-Pursuant to section 111 of title 38, United States Code, the Secretary of Veterans Affairs may pay for a rural covered veteran to travel to a health care facility to receive an examination described in subsection (a).

"(2) SHUTTLE SERVICE.-The Under Secretary of Health shall seek to enter into agreements with non-profit organizations to provide shuttle service to rural covered veterans for examinations described in subsection (a).

"(d) REPORT REQUIRED.-Not later than 18 months after the date of the enactment of this Act, the Secretary of Veterans Affairs shall submit to Congress a report regarding how many covered veterans scheduled examinations described in subsection (a) after receiving a letter, telephone call, or email under that subsection.

"(e) DEFINITIONS.-In this section:

"(1) The term 'covered veteran' means a veteran who-

"(A) is enrolled in the patient enrollment system of the Department of Veterans Affairs under section 1705 of title 38, United States Code; and

"(B) has not received health care furnished or paid for by the Secretary of Veterans Affairs during the two years immediately preceding the date in subsection (a)(1).

"(2) The term 'rural covered veteran' means a covered veteran-

"(A) who lives in an area served by the Office of Rural Health of the Department of Veterans Affairs; and

"(B) whom [sic] the Under Secretary of Health determines requires assistance to travel to a health care facility to receive an examination described in subsection (a).

"(3) The term 'veteran' has the meaning given that term in section 101 of title 38, United States Code."

REPORT ON LOCATIONS WHERE WOMEN VETERANS ARE USING HEALTH CARE FROM DEPARTMENT OF VETERANS AFFAIRS

Pub. L. 116–214, title III, §302, Dec. 5, 2020, 134 Stat. 1039 , provided that:

"(a) REPORT.-Not later than 90 days after the date of the enactment of this Act [Dec. 5, 2020], and annually thereafter, the Secretary of Veterans Affairs shall submit to the Committees on Veterans' Affairs of the House of Representatives and the Senate a report on the use by women veterans of health care from the Department of Veterans Affairs.

"(b) ELEMENTS.-Each report required by subsection (a) shall include the following information:

"(1) The number of women veterans who reside in each State.

"(2) The number of women veterans in each State who are enrolled in the patient enrollment system of the Department under section 1705(a) of title 38, United States Code.

"(3) Of the women veterans who are so enrolled, the number who have received health care under the laws administered by the Secretary at least one time during the one-year period preceding the submission of the report.

"(4) The number of women veterans who have been seen at each medical facility of the Department during such year, disaggregated by facility.

"(5) The number of appointments that women veterans have had at a medical facility of the Department during such year, disaggregated by-

"(A) facility; and

"(B) appointments for-

"(i) primary care;

"(ii) specialty care; and

"(iii) mental health care.

"(6) For each appointment type specified in paragraph (5)(B), the number of appointments completed in-person and the number of appointments completed through the use of telehealth.

"(7) If known, an identification of the medical facility of the Department in each Veterans Integrated Service Network with the largest rate of increase in patient population of women veterans as measured by the increase in unique women veteran patient use.

"(8) If known, an identification of the medical facility of the Department in each Veterans Integrated Service Network with the largest rate of decrease in patient population of women veterans as measured by the decrease in unique women veterans patient use."

PILOT PROGRAM ON ASSISTANCE FOR CHILD CARE FOR CERTAIN VETERANS RECEIVING HEALTH CARE

Pub. L. 111–163, title II, §205, May 5, 2010, 124 Stat. 1144 , as amended by Pub. L. 113–37, §2(i), Sept. 30, 2013, 127 Stat. 525 ; Pub. L. 113–175, title I, §103, Sept. 26, 2014, 128 Stat. 1903 ; Pub. L. 114–58, title I, §105, Sept. 30, 2015, 129 Stat. 532 ; Pub. L. 114–228, title I, §105, Sept. 29, 2016, 130 Stat. 937 ; Pub. L. 115–62, title I, §105, Sept. 29, 2017, 131 Stat. 1161 ; Pub. L. 115–251, title I, §106, Sept. 29, 2018, 132 Stat. 3168 ; Pub. L. 116–159, div. E, title I, §5104, Oct. 1, 2020, 134 Stat. 748 ; Pub. L. 116–315, title V, §5107(a)(2), Jan. 5, 2021, 134 Stat. 5031 , provided that:

"(a) PILOT PROGRAM REQUIRED.-The Secretary of Veterans Affairs shall carry out a pilot program to assess the feasibility and advisability of providing, subject to subsection (b), assistance to qualified veterans described in subsection (c) to obtain child care so that such veterans can receive health care services described in subsection (c).

"(b) LIMITATION ON PERIOD OF PAYMENTS.-Assistance may only be provided to a qualified veteran under the pilot program for receipt of child care during the period that the qualified veteran-

"(1) receives the types of health care services described in subsection (c) at a facility of the Department; and

"(2) requires travel to and return from such facility for the receipt of such health care services.

"(c) QUALIFIED VETERANS.-For purposes of this section, a qualified veteran is a veteran who is-

"(1) the primary caretaker of a child or children; and

"(2)(A) receiving from the Department-

"(i) regular mental health care services;

"(ii) intensive mental health care services; or

"(iii) such other intensive health care services that the Secretary determines that provision of assistance to the veteran to obtain child care would improve access to such health care services by the veteran; or

"(B) in need of regular or intensive mental health care services from the Department, and but for lack of child care services, would receive such health care services from the Department.

"(d) LOCATIONS.-The Secretary shall carry out the pilot program in no fewer than three Veterans Integrated Service Networks selected by the Secretary for purposes of the pilot program.

"(e) TERMINATION.-The authority to carry out a pilot program under this section shall terminate on the date of the enactment of the Deborah Sampson Act of 2020 [Jan. 5, 2021].

"(f) FORMS OF CHILD CARE ASSISTANCE.-

"(1) IN GENERAL.-Child care assistance under this section may include the following:

"(A) Stipends for the payment of child care offered by licensed child care centers (either directly or through a voucher program) which shall be, to the extent practicable, modeled after the Department of Veterans Affairs Child Care Subsidy Program established pursuant to section 630 of the Treasury and General Government Appropriations Act, 2002 (Public Law 107–67; 115 Stat. 552) [now 40 U.S.C. 590(g)].

"(B) Direct provision of child care at an on-site facility of the Department of Veterans Affairs.

"(C) Payments to private child care agencies.

"(D) Collaboration with facilities or programs of other Federal departments or agencies.

"(E) Such other forms of assistance as the Secretary considers appropriate.

"(2) AMOUNTS OF STIPENDS.-In the case that child care assistance under this section is provided as a stipend under paragraph (1)(A), such stipend shall cover the full cost of such child care.

"(g) REPORT.-Not later than 6 months after the completion of the pilot program, the Secretary shall submit to Congress a report on the pilot program. The report shall include the findings and conclusions of the Secretary as a result of the pilot program, and shall include such recommendations for the continuation or expansion of the pilot program as the Secretary considers appropriate.

"(h) AUTHORIZATION OF APPROPRIATIONS.-There is authorized to be appropriated to the Secretary of Veterans Affairs to carry out the pilot program $1,500,000 for each of fiscal years 2010, 2015, 2016, 2017, 2018, 2019, 2020, 2021, and 2022."

[Pub. L. 116–315, §5107(a)(2), which directed amendment of section 205(e) of Pub. L. 111–163, set out above, by substituting "the date of the enactment of the Deborah Sampson Act of 2020" for "September 30, 2020", was executed by making the substitution for "September 30, 2022" to reflect the probable intent of Congress and the amendment by Pub. L. 116–159, which had substituted "September 30, 2022" for "September 30, 2020". For establishment of child care assistance program by Pub. L. 116–315, see section 1709C of this title.]

GRANTS FOR VETERANS SERVICE ORGANIZATIONS FOR TRANSPORTATION OF HIGHLY RURAL VETERANS

Pub. L. 111–163, title III, §307, May 5, 2010, 124 Stat. 1154 , as amended by Pub. L. 113–175, title I, §104, Sept. 26, 2014, 128 Stat. 1903 ; Pub. L. 114–58, title I, §106, Sept. 30, 2015, 129 Stat. 532 ; Pub. L. 114–228, title I, §106, Sept. 29, 2016, 130 Stat. 937 ; Pub. L. 115–62, title I, §106, Sept. 29, 2017, 131 Stat. 1161 ; Pub. L. 115–251, title I, §107, Sept. 29, 2018, 132 Stat. 3168 ; Pub. L. 116–159, div. E, title I, §5105, Oct. 1, 2020, 134 Stat. 748 , provided that:

"(a) GRANTS AUTHORIZED.-

"(1) IN GENERAL.-The Secretary of Veterans Affairs shall establish a grant program to provide innovative transportation options to veterans in highly rural areas.

"(2) ELIGIBLE RECIPIENTS.-The following may be awarded a grant under this section:

"(A) State veterans service agencies.

"(B) Veterans service organizations.

"(3) USE OF FUNDS.-A State veterans service agency or veterans service organization awarded a grant under this section may use the grant amount to-

"(A) assist veterans in highly rural areas to travel to Department of Veterans Affairs medical centers; and

"(B) otherwise assist in providing transportation in connection with the provision of medical care to veterans in highly rural areas.

"(4) MAXIMUM AMOUNT.-The amount of a grant under this section may not exceed $50,000.

"(5) NO MATCHING REQUIREMENT.-The recipient of a grant under this section shall not be required to provide matching funds as a condition for receiving such grant.

"(b) REGULATIONS.-The Secretary shall prescribe regulations for-

"(1) evaluating grant applications under this section; and

"(2) otherwise administering the program established by this section.

"(c) DEFINITIONS.-In this section:

"(1) HIGHLY RURAL.-The term 'highly rural', in the case of an area, means that the area consists of a county or counties having a population of less than seven persons per square mile.

"(2) VETERANS SERVICE ORGANIZATION.-The term 'veterans service organization' means any organization recognized by the Secretary of Veterans Affairs for the representation of veterans under section 5902 of title 38, United States Code.

"(d) AUTHORIZATION OF APPROPRIATIONS.-There is authorized to be appropriated $3,000,000 for each of fiscal years 2010 through 2022 to carry out this section."

CONTINUATION OF AUTHORITY

Pub. L. 110–92, §161, as added by Pub. L. 110–149, §2, Dec. 21, 2007, 121 Stat. 1819 , provided that: "Notwithstanding section 106 [121 Stat. 990], the authority to provide care and services under section 1710(e)(1)(E) of title 38, United States Code, shall continue in effect through September 30, 2008."

PERSONAL EMERGENCY RESPONSE SYSTEM FOR VETERANS WITH SERVICE-CONNECTED DISABILITIES

Pub. L. 107–135, title II, §210, Jan. 23, 2002, 115 Stat. 2464 , provided that:

"(a) EVALUATION AND STUDY.-The Secretary of Veterans Affairs shall carry out an evaluation and study of the feasibility and desirability of providing a personal emergency response system to veterans who have service-connected disabilities. The evaluation and study shall be commenced not later than 60 days after the date of the enactment of this Act [Jan. 23, 2002].

"(b) REPORT.-Not later than 180 days after the date of the enactment of this Act, the Secretary shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report on the evaluation and study under subsection (a). The Secretary shall include in the report the Secretary's findings resulting from the evaluation and study and the Secretary's conclusion as to whether the Department of Veterans Affairs should provide a personal emergency response system to veterans with service-connected disabilities.

"(c) AUTHORITY TO PROVIDE SYSTEM.-If the Secretary concludes in the report under subsection (b) that a personal emergency response system should be provided by the Department of Veterans Affairs to veterans with service-connected disabilities-

"(1) the Secretary may provide such a system, without charge, to any veteran with a service-connected disability who is enrolled under section 1705 of title 38, United States Code, and who submits an application for such a system under subsection (d); and

"(2) the Secretary may contract with one or more vendors to furnish such a system.

"(d) APPLICATION.-A personal emergency response system may be provided to a veteran under subsection (c)(1) only upon the submission by the veteran of an application for the system. Any such application shall be in such form and manner as the Secretary may require.

"(e) DEFINITION.-For purposes of this section, the term 'personal emergency response system' means a device-

"(1) that can be activated by an individual who is experiencing a medical emergency to notify appropriate emergency medical personnel that the individual is experiencing a medical emergency; and

"(2) that provides the individual's location through a Global Positioning System indicator."

CHIROPRACTIC TREATMENT

Pub. L. 107–135, title II, §204, Jan. 23, 2002, 115 Stat. 2459 , as amended by Pub. L. 115–141, div. J, title II, §245(a), Mar. 23, 2018, 132 Stat. 822 , provided that:

"(a) REQUIREMENT FOR PROGRAM.-Subject to the provisions of this section, the Secretary of Veterans Affairs shall carry out a program to provide chiropractic care and services to veterans through Department of Veterans Affairs medical centers and clinics.

"(b) ELIGIBLE VETERANS.-Veterans eligible to receive chiropractic care and services under the program are veterans who are enrolled in the system of patient enrollment under section 1705 of title 38, United States Code.

"(c) LOCATION OF PROGRAM.-(1) The program shall be carried out at sites designated by the Secretary for purposes of the program. The Secretary shall designate at least one site for such program in each geographic service area of the Veterans Health Administration. The sites so designated shall be medical centers and clinics located in urban areas and in rural areas.

"(2) The program shall be carried out at not fewer than two medical centers or clinics in each Veterans Integrated Service Network by not later than December 31, 2019, and at not fewer than 50 percent of all medical centers in each Veterans Integrated Service Network by not later than December 31, 2021.

"(d) CARE AND SERVICES AVAILABLE.-The chiropractic care and services available under the program shall include a variety of chiropractic care and services for neuro-musculoskeletal conditions, including subluxation complex.

"(e) OTHER ADMINISTRATIVE MATTERS.-(1) The Secretary shall carry out the program through personal service contracts and by appointment of licensed chiropractors in Department medical centers and clinics.

"(2) As part of the program, the Secretary shall provide training and materials relating to chiropractic care and services to Department health care providers assigned to primary care teams for the purpose of familiarizing such providers with the benefits of chiropractic care and services.

"(f) REGULATIONS.-The Secretary shall prescribe regulations to carry out this section.

"(g) CHIROPRACTIC ADVISORY COMMITTEE.-(1) The Secretary shall establish an advisory committee to provide direct assistance and advice to the Secretary in the development and implementation of the chiropractic health program.

"(2) The membership of the advisory committee shall include members of the chiropractic care profession and such other members as the Secretary considers appropriate.

"(3) Matters on which the advisory committee shall assist and advise the Secretary shall include the following:

"(A) Protocols governing referral to chiropractors.

"(B) Protocols governing direct access to chiropractic care.

"(C) Protocols governing scope of practice of chiropractic practitioners.

"(D) Definition of services to be provided.

"(E) Such other matters the Secretary determines to be appropriate.

"(4) The advisory committee shall cease to exist on December 31, 2004."

Pub. L. 106–117, title III, §303, Nov. 30, 1999, 113 Stat. 1572 , provided that:

"(a) ESTABLISHMENT OF PROGRAM.-Not later than 120 days after the date of the enactment of this Act [Nov. 30, 1999], the Under Secretary for Health of the Department of Veterans Affairs, after consultation with chiropractors, shall establish a policy for the Veterans Health Administration regarding the role of chiropractic treatment in the care of veterans under chapter 17 of title 38, United States Code.

"(b) DEFINITIONS.-For purposes of this section:

"(1) The term 'chiropractic treatment' means the manual manipulation of the spine performed by a chiropractor for the treatment of such musculo-skeletal conditions as the Secretary considers appropriate.

"(2) The term 'chiropractor' means an individual who-

"(A) is licensed to practice chiropractic in the State in which the individual performs chiropractic services; and

"(B) holds the degree of doctor of chiropractic from a chiropractic college accredited by the Council on Chiropractic Education."

IMPLEMENTATION REPORT

Pub. L. 105–368, title I, §102(b), Nov. 11, 1998, 112 Stat. 3322 , required the Secretary of Veterans Affairs, not later than Oct. 1, 1999, to submit to Congress a report on the Secretary's plan for establishing and operating the system for collection and analysis of information required by subsec. (e)(5) of this section.

DEMONSTRATION PROJECTS FOR TREATMENT OF PERSIAN GULF ILLNESS

Pub. L. 105–114, title II, §209(b), Nov. 21, 1997, 111 Stat. 2290 , provided that:

"(1) The Secretary of Veterans Affairs shall carry out a program of demonstration projects to test new approaches to treating, and improving the satisfaction with such treatment of, Persian Gulf veterans who suffer from undiagnosed and ill-defined disabilities. The program shall be established not later than July 1, 1998, and shall be carried out at up to 10 geographically dispersed medical centers of the Department of Veterans Affairs.

"(2) At least one of each of the following models shall be used at no less than two of the demonstration projects:

"(A) A specialized clinic which serves Persian Gulf veterans.

"(B) Multidisciplinary treatment aimed at managing symptoms.

"(C) Use of case managers.

"(3) A demonstration project under this subsection may be undertaken in conjunction with another funding entity, including agreements under section 8111 of title 38, United States Code.

"(4) The Secretary shall make available from appropriated funds (which have been retained for contingent funding) $5,000,000 to carry out the demonstration projects.

"(5) The Secretary may not approve a medical center as a location for a demonstration project under this subsection unless a peer review panel has determined that the proposal submitted by that medical center is among those proposals that have met the highest competitive standards of clinical merit and the Secretary has determined that the facility has the ability to-

"(A) attract the participation of clinicians of outstanding caliber and innovation to the project; and

"(B) effectively evaluate the activities of the project.

"(6) In determining which medical centers to select as locations for demonstration projects under this subsection, the Secretary shall give special priority to medical centers that have demonstrated a capability to compete successfully for extramural funding support for research into the effectiveness and cost-effectiveness of the care provided under the demonstration project."

PATIENT PRIVACY FOR WOMEN PATIENTS

Pub. L. 104–262, title III, §322, Oct. 9, 1996, 110 Stat. 3196 , provided that:

"(a) IDENTIFICATION OF DEFICIENCIES.-The Secretary of Veterans Affairs shall conduct a survey of each medical center under the jurisdiction of the Secretary to identify deficiencies relating to patient privacy afforded to women patients in the clinical areas at each such center which may interfere with appropriate treatment of such patients.

"(b) CORRECTION OF DEFICIENCIES.-The Secretary shall ensure that plans and, where appropriate, interim steps to correct the deficiencies identified in the survey conducted under subsection (a) are developed and are incorporated into the Department's construction planning processes and, in cases in which it is cost-effective to do so, are given a high priority.

"(c) REPORTS TO CONGRESS.-The Secretary shall compile an annual inventory, by medical center, of deficiencies identified under subsection (a) and of plans and, where appropriate, interim steps, to correct such deficiencies. The Secretary shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives, not later than October 1, 1997, and not later than October 1 each year thereafter through 1999 a report on such deficiencies. The Secretary shall include in such report the inventory compiled by the Secretary, the proposed corrective plans, and the status of such plans."

HOSPICE CARE STUDY

Pub. L. 104–262, title III, §341, Oct. 9, 1996, 110 Stat. 3205 , provided that:

"(a) STUDY REQUIRED.-The Secretary of Veterans Affairs shall conduct a research study to determine the desirability of the Secretary furnishing hospice care to terminally ill veterans and to evaluate the most cost-effective and efficient way to do so. The Secretary shall carry out the study using resources and personnel of the Department.

"(b) CONDUCT OF STUDY.-In carrying out the study required by subsection (a), the Secretary shall-

"(1) evaluate the programs, and the program models, through which the Secretary furnishes hospice care services within or through facilities of the Department of Veterans Affairs and the programs and program models through which non-Department facilities provide such services;

"(2) assess the satisfaction of patients, and family members of patients, in each of the program models covered by paragraph (1);

"(3) compare the costs (or range of costs) of providing care through each of the program models covered by paragraph (1); and

"(4) identify any barriers to providing, procuring, or coordinating hospice services through any of the program models covered by paragraph (1).

"(c) PROGRAM MODELS.-For purposes of subsection (b)(1), the Secretary shall evaluate a variety of types of models for delivery of hospice care, including the following:

"(1) Direct furnishing of full hospice care by the Secretary.

"(2) Direct furnishing of some hospice services by the Secretary.

"(3) Contracting by the Secretary for the furnishing of hospice care, with a commitment that the Secretary will provide any further required hospital care for the patient.

"(4) Contracting for all required care to be furnished outside the Department.

"(5) Referral of the patient for hospice care without a contract.

"(d) REPORT.-Not later than April 1, 1998, the Secretary shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report on the research study. The report shall set forth the Secretary's findings and recommendations. The Secretary shall include in the report information on the extent to which the Secretary advises veterans concerning their eligibility for hospice care and information on the number of veterans (as of the time of the report) who are in each model of hospice care described in subsection (c) and the average cost per patient of hospice care for each such model."

RATIFICATION OF ACTIONS DURING PERIOD OF EXPIRED AUTHORITY

Pub. L. 106–419, title II, §224(d), Nov. 1, 2000, 114 Stat. 1846 , provided that: "Any action taken by the Secretary of Veterans Affairs under section 1710(g) of title 38, United States Code, during the period beginning on November 30, 1999, and ending on the date of the enactment of this Act [Nov. 1, 2000] is hereby ratified."

Pub. L. 104–110, title I, §103, Feb. 13, 1996, 110 Stat. 769 , provided that: "Any action taken by the Secretary of Veterans Affairs before the date of the enactment of this Act [Feb. 13, 1996] under a provision of law amended by this title [amending this section, sections 1712, 1720A, 1720C, 3703, 3710, 3720, 3731, 3735, 7451, 7618, and 8169 of this title, sections 11448 and 11450 of Title 42, The Public Health and Welfare, and provisions set out as notes under sections 1712, 1718, and 7721 of this title] that was taken during the period beginning on the date on which the authority of the Secretary under that provision of law expired and ending on the date of the enactment of this Act shall be considered to have the same force and effect as if the amendment to that provision of law made by this title had been in effect at the time of that action."

Pub. L. 103–452, title I, §105, Nov. 2, 1994, 108 Stat. 4787 , provided that: "Any action of the Secretary of Veterans Affairs under section 1710(e) of title 38, United States Code, during the period beginning on July 1, 1994, and ending on the date of the enactment of this Act [Nov. 2, 1994] is hereby ratified."

Reimbursement for Hospital, Nursing Home or Outpatient Services Expenses

Pub. L. 103–210, §1(c)(2), Dec. 20, 1993, 107 Stat. 2497 , directed Secretary of Veterans Affairs, on request, to reimburse any veteran who paid the United States an amount under 38 U.S.C. 1710(f) or 1712(f) for hospital care, nursing home care, or outpatient services furnished by the Secretary to the veteran before Dec. 20, 1993, on the basis of a finding that the veteran may have been exposed to a toxic substance or environmental hazard during the Persian Gulf War, with amount of reimbursement to be amount that was paid by the veteran for such care or services.

Health Care Services for Women

Pub. L. 102–585, title I, §106, Nov. 4, 1992, 106 Stat. 4947 , provided that:

"(a) General Authority.-In furnishing hospital care and medical services under chapter 17 of title 38, United States Code, the Secretary of Veterans Affairs may provide to women the following health care services:

"(1) Papanicolaou tests (pap smears).

"(2) Breast examinations and mammography.

"(3) General reproductive health care, including the management of menopause, but not including under this section infertility services, abortions, or pregnancy care (including prenatal and delivery care), except for such care relating to a pregnancy that is complicated or in which the risks of complication are increased by a service-connected condition.

"(b) Responsibilities of Directors of Facilities.-The Secretary shall ensure that directors of medical facilities of the Department identify and assess opportunities under the authority provided in title II of this Act [38 U.S.C. 8111 note] to (1) expand the availability of, and access to, health care services for women veterans under sections 1710 and 1712 of title 38, United States Code, and (2) provide counseling, care, and services authorized by this title [see Short Title of 1992 Amendment note set out under section 101 of this title]."

Report on Health Care and Research

Pub. L. 102–585, title I, §107, Nov. 4, 1992, 106 Stat. 4947 , as amended by Pub. L. 104–262, title III, §324, Oct. 9, 1996, 110 Stat. 3197 , provided that:

"(a) In General.-Not later than January 1 of 1993 and each year thereafter through 1998, the Secretary of Veterans Affairs shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report on the provision of health care services and the conduct of research carried out by, or under the jurisdiction of, the Secretary relating to women veterans.

"(b) Contents.-The report under subsection (a) shall include the following information with respect to the most recent fiscal year before the date of the report:

"(1) The number of women veterans who have received services described in section 106 of this Act [set out as a note above] in facilities under the jurisdiction of the Secretary (or the Secretary of Defense), shown by reference to the Department facility which provided (or, in the case of Department of Defense facilities, arranged) those services;

"(2) A description of (A) the services provided at each such facility (including information on the number of inpatient stays and the number of outpatient visits through which such services were provided), and (B) the extent to which each such facility relies on contractual arrangements under section 1703 or 8153 of title 38, United States Code, to furnish care to women veterans in facilities which are not under the jurisdiction of the Secretary where the provision of such care is not furnished in a medical emergency.

"(3) The steps taken by each such facility to expand the provision of services at such facility (or under arrangements with a Department of Defense facility) to women veterans.

"(4) A description (as of October 1 of the year preceding the year in which the report is submitted) of the status of any research relating to women veterans being carried out by or under the jurisdiction of the Secretary, including research under section 109 of this Act [former 38 U.S.C. 7303 note].

"(5) A description of the actions taken by the Secretary to foster and encourage the expansion of such research."

Coordination of Women's Services

Pub. L. 102–585, title I, §108, Nov. 4, 1992, 106 Stat. 4948 , provided that: "The Secretary of Veterans Affairs shall ensure that an official in each regional office of the Veterans Health Administration shall serve

as a coordinator of women's services. The responsibilities of such official shall include the following:

"(1) Conducting periodic assessments of the needs for services of women veterans within such region.

"(2) Planning to meet such needs.

"(3) Assisting in carrying out the purposes of section 106(b) of this title [set out above].

"(4) Coordinating the training of women veterans coordinators who are assigned to Department facilities in the region under the jurisdiction of such regional coordinator.

"(5) Providing appropriate technical support and guidance to Department facilities in that region with respect to outreach activities to women veterans."

Population Study of Women Veterans

Pub. L. 102–585, title I, §110, Nov. 4, 1992, 106 Stat. 4948 , as amended by Pub. L. 103–452, title I, §102(c), Nov. 2, 1994, 108 Stat. 4786 , directed Secretary of Veterans Affairs, in consultation with Advisory Committee on Women Veterans, to conduct a study to determine needs of veterans who are women for health-care services, based on an appropriate sample of veterans who are women, and to submit to Congress, not later than 9 months after Nov. 4, 1992, an interim report describing information and advice obtained from Advisory Committee and status of study, and to submit, not later than Dec. 31, 1995, a final report describing results of study.

Demonstration Project To Evaluate Installation of Telephones for Patient Use at Department of Veterans Affairs Health-Care Facilities

Pub. L. 102–585, title V, §525, Nov. 4, 1992, 106 Stat. 4960 , directed Secretary of Veterans Affairs to carry out a demonstration project to evaluate feasibility and desirability of providing telephone service in patient rooms in Department of Veterans Affairs health-care facilities which do not currently provide such service, use of telephones by patients of such health-care facilities, and relative feasibility and cost-effectiveness of a variety of options for providing such service, and submit to Congress a report on the demonstration project not later than Sept. 30, 1994.

Reports on Furnishing of Health Care and Implementation of Changes in Eligibility

Pub. L. 99–272, title XIX, §19011(e), Apr. 7, 1986, 100 Stat. 379 , as amended by Pub. L. 100–527, §10(1), (2), Oct. 25, 1988, 102 Stat. 2640 , 2641; Pub. L. 101–237, title II, §201(d), Dec. 18, 1989, 103 Stat. 2066 ; Pub. L. 102–40, title III, §302, May 7, 1991, 105 Stat. 208 ; Pub. L. 102–83, §5(c)(2), Aug. 6, 1991, 105 Stat. 406 ; Pub. L. 102–291, §4, May 20, 1992, 106 Stat. 179 , directed Administrator of Veterans Affairs to submit to Congress a report for each fiscal year through fiscal year 1992 concerning implementation of the amendments made by section 19011 of Pub. L. 99–272, which amended this section and sections 1525, 1701, 1712, 1712A, 1720, 1722, and 1763 of this title and enacted provisions set out as notes under this section and section 1722 of this title, specified detailed information required to be submitted in each report, and provided that each report be submitted not later than the Feb. 1 following the end of the fiscal year for which it is submitted.

Chiropractic Services Pilot Program

Pub. L. 99–166, title I, §109, Dec. 3, 1985, 99 Stat. 948 , directed Administrator of Veterans' Affairs to conduct a pilot program to evaluate therapeutic benefits and cost-effectiveness of furnishing certain chiropractic services to veterans eligible for medical services under this chapter, provided that the pilot program be carried out during period beginning Jan. 1, 1986, and ending Dec. 31, 1988, and directed Administrator to submit to Committees on Veterans' Affairs of Senate and House of Representatives not later than Apr. 1, 1989, a report on implementation, operation, and results of the pilot program.

[1] *See References in Text note below.*

SEC. 106. HEALTH CARE SERVICES FOR WOMEN.

(a) GENERAL AUTHORITY.-In furnishing hospital care and medical services under chapter 17 of title 38, United States Code, the Secretary of Veterans Affairs may provide to women the following health care services:

(1) Papanicolaou tests (pap smears).

(2) Breast examinations and maromographf:

(3) General reproductive health care, including the management of menopause, but not including under this section infertility services, abortions, or pregnancy care (including prenatal and delivery care), except for such care relating to a pregnancy that is complicated or in which the risks of complication are increased by a service-connected condition.

(b) RESPONSIBILITIES OF DIRECTORS OF FACILITIES.-The Secretary shall ensure that directors of medical facilities of the Department identify and assess opportunities under the authority provided in title II of this Act to (1) expand the availability of, and access to, health care services for women veterans under sections 1710 and 1712 of title 38, United States Code, and (2) provide counseling, care, and services authorized by this title.

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or on the distribution of power and responsibilities between the Federal Government and Indian tribes.

E. Unfunded Mandates Reform Act

The Unfunded Mandates Reform Act of 1995 (2 U.S.C. 1531–1538) requires Federal agencies to assess the effects of their discretionary regulatory actions. In particular, the Act addresses actions that may result in the expenditure by a State, local, or tribal government, in the aggregate, or by the private sector of $100,000,000 (adjusted for inflation) or more in any one year. Though this rule will not result in such an expenditure, we do discuss the effects of this rule elsewhere in this preamble.

F. Environment

We have analyzed this rule under Department of Homeland Security Directive 023–01, Rev. 1, associated implementing instructions, and Environmental Planning COMDTINST 5090.1 (series), which guide the Coast Guard in complying with the National Environmental Policy Act of 1969 (42 U.S.C. 4321–4370f), and have determined that this action is one of a category of actions that do not individually or cumulatively have a significant effect on the human environment. This rule involves a safety zone lasting only 1 hour that will prohibit entry within a 500-foot radius of a fireworks display center in position 45°21′58.80″ N 85°01′54.38″ W in Bay Harbor, MI. It is categorically excluded from further review under paragraph L[60(a)] of Appendix A, Table 1 of DHS Instruction Manual 023–01–001–01, Rev. 1. A Record of Environmental Consideration supporting this determination is available in the docket. For instructions on locating the docket, see the **ADDRESSES** section of this preamble.

G. Protest Activities

The Coast Guard respects the First Amendment rights of protesters. Protesters are asked to call or email the person listed in the **FOR FURTHER INFORMATION CONTACT** section to coordinate protest activities so that your message can be received without jeopardizing the safety or security of people, places or vessels.

List of Subjects in 33 CFR Part 165

Harbors, Marine safety, Navigation (water), Reporting and record keeping requirements, Security measures, Waterways.

For the reasons discussed in the preamble, the Coast Guard amends 33 CFR part 165 as follows:

PART 165— REGULATED NAVIGATION AREAS AND LIMITED ACCESS AREAS

■ 1. The authority citation for part 165 continues to read as follows:

Authority: 46 U.S.C. 70034, 70051; 33 CFR 1.05–1, 6.04–1, 6.04–6, and 160.5; Department of Homeland Security Delegation No. 00170.1, Revision No. 01.3.

■ 2. Add § 165.T09–0671 to read as follows:

§ 165.T09–0671 Safety Zone; Steve Hemberger Wedding Fireworks, Bay Harbor, MI.

(a) *Location.* The following area is a safety zone: All navigable water within 500-feet of the fireworks launching location in position 45°21′58.80″ N 85°01′54.38″ W (NAD 83).

(b) *Definitions.* As used in this section, *designated representative* means a Coast Guard Patrol Commander, including a Coast Guard coxswain, petty officer, or other officer operating a Coast Guard vessel and a Federal, State, and local officer designated by or assisting the Captain of the Port Sault Sainte Marie (COTP) in the enforcement of the safety zone.

(c) *Regulations.* (1) In accordance with the general regulations in § 165.23, entry into, transiting, or anchoring within the safety zone described in paragraph (a) is prohibited unless authorized by the Captain of the Port, Sault Sainte Marie or his designated representative.

(2) Before a vessel operator may enter or operate within the safety zone, they must obtain permission from the Captain of the Port, Sault Sainte Marie, or his designated representative via VHF Channel 16 or telephone at (906) 635–3233. Vessel operators given permission to enter or operate in the safety zone must comply with all orders given to them by the Captain of the Port, Sault Sainte Marie or his designated representative.

(d) *Enforcement period.* This section will be enforced from 11 p.m. on October 1, 2022 until 12 a.m. on October 2, 2022.

Dated: September 1, 2022.

A.R. Jones,

Captain of the Port Sault Sainte Marie.

[FR Doc. 2022–19387 Filed 9–8–22; 8:45 am]

BILLING CODE 9110–04–P

DEPARTMENT OF VETERANS AFFAIRS

38 CFR Part 17

RIN 2900–AR57

Reproductive Health Services

AGENCY: Department of Veterans Affairs.

ACTION: Interim final rule with request for comments.

SUMMARY: The Department of Veterans Affairs (VA) amends its medical regulations to remove the exclusion on abortion counseling and establish exceptions to the exclusion on abortions in the medical benefits package for veterans who receive care set forth in that package, and to remove the exclusion on abortion counseling and expand the exceptions to the exclusion on abortions for Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) beneficiaries.

DATES:

Effective date: This interim final rule is September 9, 2022.

Comment date: Comments must be received on or before October 11, 2022.

ADDRESSES: Comments may be submitted through *www.regulations.gov*. Except as provided below, comments received before the close of the comment period will be available at *www.regulations.gov* for public viewing, inspection, or copying, including any personally identifiable or confidential business information that is included in a comment. We post the comments received before the close of the comment period on the following website as soon as possible after they have been received: *http://www.regulations.gov*. VA will not post on *Regulations.gov* public comments that make threats to individuals or institutions or suggest that the individual will take actions to harm the individual. VA encourages individuals not to submit duplicative comments. We will post acceptable comments from multiple unique commenters even if the content is identical or nearly identical to other comments.

FOR FURTHER INFORMATION CONTACT: Dr. Shereef Elnahal, Under Secretary for Health, Department of Veterans Affairs, 810 Vermont Avenue NW, Washington, DC 20420, (202) 461–7671.

SUPPLEMENTARY INFORMATION:

I. Background

A. Brief Summary of this Interim Final Rule

On June 24, 2022, the Supreme Court in *Dobbs* v. *Jackson Women's Health*

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Organization, 142 S. Ct. 2228 (2022), overruled *Roe* v. *Wade*, 410 U.S. 113 (1973), and *Planned Parenthood of Southeastern Pennsylvania* v. *Casey*, 505 U.S. 833 (1992). *Dobbs*, 142 S. Ct. at 2279. After *Dobbs*, certain States have begun to enforce existing abortion bans and restrictions on care, and are proposing and enacting new ones, creating urgent risks to the lives and health of pregnant veterans and CHAMPVA beneficiaries in these States. In response, VA is acting to help to ensnre that, irrespective of wbat laws or policies States may impose, veterans who receive the care set forth in the medical benefits package will be able to obtain abortions, if determined needed by a health care professional, wben the life or the health of the pregnant veteran would be endangered if the pregnancy were carried to term or the pregnancy is the result of an act of rape or incest. Similarly, VA is acting to ensure CHAMPVA beneficiaries will be able to obtain abortions, if determined medically necessary and appropriate, when the health of the pregnant CHAMPVA beneficiary wonld be endangered if the pregnancy were carried to term or the pregnancy is the result of an act of rape or incest.

VA is taking this action because it has determined that providing access to abortion-related medical services is needed to protect the lives and health of veterans. *See* section 1710 of title 38, United States Code (U.S.C.); § 17.38(b) of title 38, Code of Federal Rogulations (CFR). As abortion bans come into force across the country, veterans in many Statos are no longer assured access to abortion services in their commuuities, even when those services are needed. VA has determined that an abortion is "needed" pursuaut to 38 U.S.C. 1710, when sought by a veteran, if determined needed by a health care professional, 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 an act of rape or incest. Unless VA removes its existing prohibitions on abortion-related care and makos clear that needed abortion-related care is authorized, these veterans will face serious threats to their life and health.

Similarly, VA has determined that providing access to abortion-related medical services is medically necessary and appropriate to protect the health of CHAMPVA beneficiaries. *See* 38 U.S.C. 1781; 38 CFR 17.270(b) (defining "CHAMPVA-covered services and supplies" as "those medical services and supplies tbat are medically necessary and appropriate for the treatment of a condition and that are not specifically excluded under [38 CFR 17.272(a)(1)] through (84)"). CHAMPVA beneficiaries in many States are also no longer assured access to abortion services in their communities. Unless VA removes existing prohibitions on abortion-related care and makes clear that medically necessary and appropriate abortion-related care is authorized, these CHAMPVA beneficiaries will face serious threats to their health.

VA is therefore taking this action to avert imminent and future harm to the veterans and CHAMPVA beneficiaries whose interests Congress entrusted VA to serve.

B. VA Authority To Provide Abortions ond Abortion Counseling Under 38 U.S.C. 1710 (Medical Benefits Package)

Pursuant to VA's general treatment authority for veterans, VA "sball furnish" specified veterans with "hospital care and medical services which the Secretary determines to be needed." 38 U.S.C. 1710(a)(1)–(2). For veterans not described in paragraphs (1) and (2), the Secretary "may," subject to certain limitations, "furnish hospital care" and "medical services . . . which the Secretary determines to be needed." 38 U.S.C. 1710(a)(3). As relevant here, such "medical services" include "medical examination, treatment," "[s]urgical services," and "[p]reventive health services." 38 U.S.C. 1701(6).

VA implements its general treatment authority, and the Secretary determines what care is "needed," 38 U.S.C. 1710(a)(1)–(3), by regulation through VA's medical benefits package. 38 CFR 17.38. The medical benefits package consists of a wide range of basic and preventive care, including inpatient and ontpatient medical and surgical care, prescription drugs, emergency care (as authorized by statute and regulation), pregnancy and delivery services (to the extent authorized hy law),[1] aud periodic medical exams. 38 CFR 17.38(a). Care included in the medical benefits package is "provided to individuals only if it is determined by appropriate health care professionals that the care is needed to promote, preserve, or restore the health of the individual and is in accord with generally accepted standards of medical practico." 38 CFR 17.38(b).

Some care is specifically excluded from the medical benefits package because the Secretary has determined it is not "needed" within the meaning of 38 U.S.C. 1710(a)(1)–(3). 38 CFR 17.38(c); 64 FR 54207, 54210 (Oct. 6, 1999). Among other services, "[a]bortions and abortion counseling" are currently exclnded from the medical benefits package, witb no exceptions. 38 CFR 17.38(c)(1).

VA first established the medical benefits package in 1999. 64 FR 54217. The Veterans' Health Care Eligibility Reform Act of 1996, Public Law 104–262, 10 Stat. 3177, mandated that VA implement a national enrollment system to manage the delivery of health care services to eligible veterans. When VA developed regulations to implement this national enrollment system, VA recognized the need to also regulate the health care services it provided. 64 FR 54210. VA did not explain the rationale behind the exclusion of abortions and abortion counseling from the medical benefits package when it was established in 1999. At the time, *Roe* had been reaffirmed in relevant part by *Casey*, and VA was aware that veterans of reproductive age enrolled in its health care system could access abortion services in their communities.

After the *Dobbs* decision, however, veterans living in States that ban or restrict abortion services may no longer be able to receive such medical services in their communities, including in States that now restrict access to abortion even in cases of rape or incest or where the health of the pregnant individual is in danger. It is thus essential for the lives and health of our veterans that abortions be made available if determined needed by a health care professional when: (1) the life or health of the pregnant veteran would be endangered if the pregnancy were carried to term; or (2) the pregnancy is the result of an act of rape or incest. VA has also determined that abortion counseling is needed so that veterans can make informed decisions about their health care.

VA has determined that such medical care is "needed" within the meaning of VA's general treatment autbority, 38 U.S.C. 1710(a). This means that such care may be provided if an appropriate health care professional determines that such care is needed to promote, preserve, or restore the health of the individual and is in accord with generally accepted standards of medical practice. 38 CFR 17.38(b)(1)–(3). VA can therefore provide abortion counseling and covered abortions pursuant to 38 U.S.C. 1710 and 38 CFR 17.38.

The Veteraus Health Care Act of 1992, Public Law 102–585, 106 Stat. 4943 (VHCA), does not prohibit VA's amendment of its medical benefits package in this manner. When that law

[1] The language "to the extent authorized by law" in 38 CFR 17.38 means to the extent VA has legal authority to provido such services under 38 U.S.C.1710. 64 FR 54210 (Nov. 10, 1999).

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was enacted in 1992, prior to the 1996 enactment of the Veterans' Health Care Eligibility Reform Act, VA health care was subject to a patchwork of eligibility criteria, and care was largely linked only to service-connected conditions. *See* 38 U.S.C. 1710 (Supp. I 1994) (authority under which hospital and nursing home care were provided prior to 1996); 38 U.S.C. 1712 (Supp. I 1994) (authority under which medical services were provided prior to 1996). The VHCA, in relevant part, was designed to improve the health care services available to women veterans.[2] Section 106(a) of the VHCA stated that VA could provide "women" with "[p]apanicolaou tests (pap smears)," "[b]reast examinations and mammography," and "[g]eneral reproductive health care . . . , but not including under this section infertility services, abortions, or pregnancy care (including prenatal and delivery care), except for such care relating to a pregnancy that is complicated or in which the risks of complication are increased by a service-connected condition." Public Law 102–585, sec. 106(a).[3]

Section 106 did not limit VA's authority to provide care under any other provision of law. The "but not including" language in section 106 of the VHCA limited only the services provided "under this section," meaning that while section 106 barred the provision of any abortion or infertility service under section 106 of the VHCA, it did not limit VA's authority to provide such services under any other statutory provision such as 38 U.S.C. 1710 or 38 U.S.C. 1712. Public Law 102–585, sec. 106(a). Consequently, a veteran might have been eligible for infertility services for a service-connected disability under 38 U.S.C. 1712,[4] even though that veteran would have been ineligible for infertility services under section 106 because of that section's exclusions. VA has consistently interpreted section 106 in this fashion.[5]

In 1996, the Veterans' Health Care Eligibility Reform Act made major changes to eligibility for VA health care and, as noted above, directed VA to establish a system of patient enrollment to manage the provision of care. The purpose behind eligibility reform was to replace the old system with a system where an enrolled veteran could receive whatever medical care and services are deemed needed. *See* House of Representatives Report No. 104–690, at 4 (1996) ("[The Act] would substitute a single uniform eligibility standard for the complex array of standards governing access to VA hospital and outpatient care. While the new standard is a simple one, more importantly, it employed a clinically appropriate 'need for care' test, thereby ensuring that medical judgment rather than legal criteria will determine when care will be provided and the level at which that care will be furnished."); *id.* at 13 ("[The Act] would substitute a single, streamlined eligibility provision—based on clinical need for care—for the complex array of disparate rules currently governing veterans' eligibility for hospital and outpatient care."). The Veterans' Health Care Eligibility Reform Act effectively overtook section 106 of the VHCA.[6] For example, a veteran in 1992 was only eligible for pregnancy and delivery care under section 106 if the pregnancy was complicated or the risks of complication were increased by a service-connected condition. Public Law 102–585, sec. 106(a). In contrast, general pregnancy and delivery services were included in the medical benefits package when it was established in 1999 pursuant to VA's authority in 38 U.S.C. 1710. 64 FR 54210; 38 CFR 17.38(a)(1)(xiii). Moreover, while section 106 of the VHCA provided that infertility services could not be provided under that section, infertility services (with the exception of in vitro fertilization) were also included in the medical benefits package pursuant to VA's authority under 38 U.S.C. 1710. *Id.* Consequently, for decades, VA has offered general pregnancy care and certain infertility services under 38 U.S.C. 1710. *Id.* VA no longer relies on section 106 of the VHCA to provide such services or any other services.

Congress has ratified VA's interpretation that section 106 of the VHCA does not limit the medical care that the VA may provide pursuant to its authority under 38 U.S.C. 1710. Most recently, when Congress enacted the Deborah Sampson Act of 2020, Public Law 116–315, tit. V (2021), it created a central office to, inter alia, "monitor[ ] and encourag[e] the activities of the Veterans Health Administration with respect to the provision, evaluation, and improvement of health care services provided to women veterans by the Department." 38 U.S.C. 7310(b)(1). Congress defined "health care" for these purposes as "the health care and services included in the medical benefits package provided by the Department as in effect on the day before the date of the enactment of this Act [Jan. 5, 2021]." 38 U.S.C. 7310 note.[7] Given that VA's medical benefits package as of that date included services that were excluded from the coverage of Section 106 of the VHCA, Congress ratified VA's interpretation that it may provide for these services pursuant to its authority under 38 U.S.C. 1710, notwithstanding section 106. Indeed, the fact that the Deborah Sampson Act of 2020 did not reference section 106 of the VHCA and only referenced VA's medical benefits package shows that Congress did not interpret section 106 of the VHCA as a limitation on VA's authority to provide care to "women veterans."[8]

Furthermore, the fact that VA does not rely on section 106 of the VHCA and instead relies on 38 U.S.C. 1710(a)(1)–(3) to provide pap smears, breast exams and mammography, or general reproductive health services, pregnancy or infertility services confirms that

[2] 102 Cong. Rec. 32,367 (1992).

[3] Prior to the enactment of section 106(a), VA provided gynecology services, including mammograms and screening for cervical cancer, under the Department's authority to provide preventative health services pursuant to 38 U.S.C. 1762. General Accounting Office (GAO)/Human Resources Division (HRD)–92–23 *VA Health Care for Women: Despite Progress, Improvements needed* (January 1992) p. 3 (*https://www.gao.gov/assets/hrd-92-23.pdf*). However, the legislative history of the VHCA generally, and section 106 specifically, indicates that Congress sought to provide statutory support for the services VA already provided pursuant to its existing authority. Senate Report No. 102–409, p. 40 (1992) (discussing the intent behind S. 2973, section 201, *Well-women care services*, "The Committee expects that providing explicit authority to furnish cancer-screening procedures will lead VA to redouble its efforts in this critical area. The Committee believes that these services are not only vital to women veterans, but they are also in line with VA's goal to emphasize preventative health-care services within the system."); *see also* 102 Congressional Record 34,299 (1992) ("The measure also incorporates the exception to the bar on furnishing pregnancy care reflected in VA regulations (at 39 CFR 17.48(h) [sic]) associated with care relating to a complicated pregnancy, as well as the instance in which the risks of complication are increased by a service-connected condition.").

[4] 102 Congressional Record 34,299 (1992).

[5] Veterans Health Administration (VHA) Directive 10–93–151, December 6, 1993; Letter from Secretary Denis McDonough to Senator Jerry Moran, July 7, 2021.

[6] As detailed above, section 106 of the VHCA was intended to reinforce VA's existing authority to provide preventative health care services to women veterans. *See* 38 U.S.C. 1762; 38 CFR 17.30(m)(1); Public Law 102–585, sec. 513. The subsequent 1996 amendments to 38 U.S.C. 1710 and the 1999 rulemaking establishing the medical benefits package overtook VA's need to rely on section 106 to provide certain women's health care to women veterans.

[7] 38 U.S.C. 7310(b)(6) authorizes the Office of Women's Health to "promote the expansion and inclusion of clinical . . . activities of [VHA]." Additionally, subsection (b)(9) authorizes the Office to "carry out such other duties as the Under Secretary for Health may require." Thus, the Office of Women's Health can address health care and services that were not included in the medical benefits package on the day before the date of enactment of the Deborah Sampson Act of 2020.

[8] Letter to Denis McDonough from 24 U.S. Senators, July 28, 2022.

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section 106's prohibition on providing certain services "under this section" simply is no longer operative.

VA's authority under 38 U.S.C. 1710 is different from authorities governing the provision of health care by other Federal agencies. Pursuant to the 1996 amendment, by statute, VA "shall" (and, for some categories of veterans, "may") furnish care that "the Secretary determines to be needed" to veterans, with no exclusion for abortion. 38 U.S.C. 1710(a)(1)–(3). Other Federal agencies, by contrast, are subject to underlying statutory restrictions or restrictions in their appropriations acts concerning certain abortions. For instance, Federal funds available to the Departments of Labor, Health and Human Services, and Education are subject to an appropriations restriction known as the "Hyde Amendment." Congress has included the Hyde Amendment in those agencies' annual appropriations legislation for more than forty years. In its current form, the Hyde Amendment provides that no covered funds "shall be expended for any abortion" or "for health benefits coverage that includes coverage of abortion," except "if the pregnancy is the result of an act of rape or incest; or . . . in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed." Consolidated Appropriations Act, 2022, Public Law 117–103, Div. H, secs. 506–07, 136 Stat. 49. The breadth of the Hyde Amendment's exception has varied over the years, but since fiscal year 1994, the Hyde Amendment has included an exception for the life of the woman and for pregnancies resulting from acts of rape or incest. *See, e.g.*, Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 1994, Public Law 103–112, Sec. 509, 107 Stat. 1082, 1113 (1993). No similar statutory restriction applies to VA.

C. VA Authority To Provide Abortions and Abortion Counseling for CHAMPVA Beneficiaries

By statute, VA's "Secretary is authorized to provide" specified "medical care" to certain spouses, children, survivors, and caregivers of veterans who meet specific eligibility criteria. 38 U.S.C. 1781(a). This health benefits program is known as CHAMPVA. VA must provide "for medical care" under CHAMPVA "in the same or similar manner and subject to the same or similar limitations as medical care is" provided by the Department of Defense to active-duty family members, retired service members and their families, and others under the TRICARE (Select) program. 38 U.S.C. 1781(b); *see* 32 CFR 199.1(r), 199.17(a)(6)(ii)(D). VA has regulated services covered by CHAMPVA to mean those medical services that are medically necessary and appropriate for the treatment of a condition and that are not specifically excluded. 38 CFR 17.270(b).

The current CHAMPVA regulations exclude coverage for abortions, except when a physician certifies that the abortion was performed because the life of the woman would be endangered if the fetus were carried to term, 38 CFR 17.272(a)(64), and also exclude coverage for abortion counseling, 38 CFR 17.272(a)(65). The current CHAMPVA regulations do not include coverage for abortions when the pregnancy is the result of an act of rape or incest.

In contrast, TRICARE (Select) provides coverage for abortions when the pregnancy is the result of an act of rape or incest, or when a physician certifies that the life of the woman would be endangered if the fetus were carried to term, and it provides coverage for counseling for covered abortions.[9]

In this rule, VA amends its CHAMPVA regulations by removing the exclusion for abortion counseling and permitting abortions when the health of the pregnant beneficiary would be endangered if the pregnancy were carried to term, or when the pregnancy is the result of an act of rape or incest. This amendment will better align coverage under CHAMPVA with coverage under TRICARE (Select).

Coverage under CHAMPVA will deviate from coverage under TRICARE (Select) because CHAMPVA will cover abortions when the health of the CHAMPVA beneficiary is at risk and will cover abortion counseling for non-covered abortions. VA, however, has determined that, overall, the relevant care provided under CHAMPVA will still be sufficiently "similar" to that provided under TRICARE (Select). 38 U.S.C. 1781(b). Section 1781(b) does not require CHAMPVA and TRICARE (Select) to be administered identically. Rather, by referring to care that is "similar," the statute permits VA flexibility to administer the program for CHAMPVA beneficiaries. For this reason, not every aspect of CHAMPVA will find a corollary in TRICARE (Select).

VA has previously deviated from TRICARE (Select) in amending its CHAMPVA regulations to provide care that goes beyond the benefits offered by TRICARE (Select). Generally, VA determined that these deviations were necessary to best provide services to the CHAMPVA population while remaining "similar" to TRICARE (Select). For example, TRICARE (Select) does not include an annual physical exam benefit for all TRICARE (Select) beneficiaries; instead, that benefit is limited to certain circumstances.[10] VA has exercised its discretion to deviate from TRICARE (Select) and provide annual physical exams to all CHAMPVA beneficiaries. 38 CFR 17.272(30)(xiii). VA did not believe that limiting the provision of annual exams was appropriate from a clinical perspective. 83 FR 2396, 2401 (Jan. 17, 2018). Annual physical exams are beneficial for both CHAMPVA beneficiaries and VA because they may identify serious medical issues before they progress. *Id.* Additionally, TRICARE (Select) does not waive beneficiary costs associated with preventive services for TRICARE (Select) beneficiaries who are Medicare-eligible in cases in which those services are not covered by Medicare. VA's CHAMPVA regulations, however, do waive cost-sharing requirements for preventive services for Medicare-eligible beneficiaries. VA determined that enforcing cost-sharing requirements for Medicare-eligible beneficiaries for preventive services would unfairly disadvantage them as compared to CHAMPVA beneficiaries with other health insurance. 83 FR 2404.

Thus, VA has previously regulated to provide CHAMPVA benefits beyond those benefits offered by TRICARE (Select) if providing such health care would better promote the long-term health of CHAMPVA beneficiaries. In so doing, VA is still providing for health care in a manner similar to TRICARE (Select), but the care is being provided in a manner that best serves the CHAMPVA population. Similarly, here, VA is aligning CHAMPVA benefits with TRICARE (Select) benefits in certain ways, VA is also providing benefits beyond those offered by TRICARE (Select) in order to better promote the long-term health of CHAMPVA beneficiaries. For the reasons discussed further below, VA finds that allowing abortions for CHAMPVA beneficiaries when there is a risk to the CHAMPVA

[9] *Covered Services, Abortions*, TRICARE, *http://tricare.mil/CoveredServices/IsItCovered/Abortions* (last visited Aug. 22, 2022).

[10] *Covered Services, Physicals*, TRICARE, *http://tricare.mil/CoveredServices/IsItCovered/Physicals* (last visited Aug. 22, 2022).

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beneficiary's health and providing abortion counseling for both covered and noncovered abortions is both medically necessary and appropriate to promote the long-term health of CHAMPVA beneficiaries.

II. Abortions in Limited Circumstances Under 38 U.S.C. 1710 and 1781

A. Abortions When the Life or Health of the Pregnant Veteran Would Be Endangered if the Pregnancy Is Carried to Term Are Needed

VA has determined that access to abortions is "needed," 38 U.S.C. 1710(a)(1)–(3), and such care may be provided to veterans when an appropriate health care professional determines that such care "is needed to promote, preserve, or restore the health of the individual and is in accord with generally accepted standards of medical practice," 38 CFR 17.38(b), when the life or health of the pregnant veteran would be endangered if the pregnancy were carried to term. Abundant evidence supports VA's determination.

Research has shown that while most pregnancies progress without incident, pregnancy and childbirth in the United States can result in physical harm and even death for certain pregnant individuals. From 1998 to 2005, the U.S. mortality rate associated with live births was 8.8 deaths per 100,000 live births, and maternal mortality rates have increased staggeringly since then.[11] A 2019 study reviewed mortality data from 2007 to 2015 from the National Association for Public Health Statistics and Information Systems, which includes information on all deaths in the 50 States and the District of Columbia (DC). The data showed that, during this time, within 38 States and DC, the maternal mortality rate rose to 17.9 deaths of individuals per 100,000 live births. This study identified the factors that likely contributed to this rising maternal mortality rate, including reduced access to family planning and reproductive health services through abortion clinic closures and legislation restricting abortions based on gestational age.[12]

Individuals at risk of pregnancy complications who do not have access to contraception or abortion may experience conditions resulting from pregnancies that can leave them at risk for loss of future fertility, significant morbidity, or death. According to the American College of Obstetricians and Gynecologists (ACOG) and Physicians for Reproductive Health, there are situations when pregnancy termination, in the form of treatment that may be considered to be an abortion, is the only medical intervention that can preserve a patient's health or save their life.[13] Pregnancy poses significant physiological changes on an individual's body, which can exacerbate underlying or preexisting conditions, like renal or cardiac disease, and can severely compromise health or even cause death.[14] During pregnancies, individuals may suffer from life-threatening conditions such as severe preeclampsia, newly diagnosed cancer requiring prompt treatment, and intrauterine infections.[15] Preeclampsia is a disorder associated with new-onset hypertension that can result in blood pressure swings, liver issues, and seizures, among other conditions.[16]

Some pregnant veterans may be at heightened risk for other pregnancy complications including hemorrhage, placenta accreta spectrum, and peripartum hysterectomy, among others.[17] Notably, the need for peripartum hysterectomy in such instances would cause not only morbidity, but loss of future fertility. Pregnancy-related complications may endanger the pregnant veteran's life or health. Abortion may be needed to protect the life or health of the pregnant veteran in these and other circumstances.

Veterans of reproductive age, in particular, have high rates of chronic medical and mental health conditions that may increase the risks associated with pregnancy.[18] Such conditions include chronic post-traumatic stress disorder, severe hypertension, and chronic renal disease.[19] When a health care professional determines that these conditions (potentially in combination with other factors) render an abortion needed to preserve the health of a veteran, access to an abortion is essential health care.

For all of the reasons discussed above, research supports the conclusion that an abortion may be needed to save the life or preserve the health of a veteran. 38 CFR 17.38(b). Therefore, VA is revising the medical benefits package to allow the provision of abortions in such circumstances.

B. Abortions When the Health of the Pregnant CHAMPVA Beneficiary Would Be Endangered if the Pregnancy Is Carried to Term Are Medically Necessary and Appropriate

Currently, abortions for CHAMPVA beneficiaries are excluded "except when a physician certifies that the life of the mother would be endangered if the fetus were carried to term." 38 CFR 17.272(a)(64). VA has determined that when the health of the pregnant CHAMPVA beneficiary would be endangered if the pregnancy were carried to term, access to abortions is also medically necessary and appropriate and such abortions should be covered CHAMPVA services. As explained above, VA is required to provide medically necessary and appropriate care under CHAMPVA to certain spouses, children, survivors, and caregivers of veterans who meet specific eligibility criteria. 38 U.S.C. 1781(a); 38 CFR 17.270 *et seq.* While this care must be "in the same or similar manner and subject to the same or similar limitations as medical care is" provided by the Department of Defense under TRICARE (Select), 38 U.S.C. 1781(b), VA has consistently maintained that "similar" does not mean "identical." VA requires that such care be medically

[11] Elizabeth G. Raymond & David A. Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 Obstetrics & Gynecology 215, 216 (2012); see also Marian F. MacDorman et al., *Recent Increases in the U.S. Maternal Mortality Rate: Disentangling Trends from Measurement Issues*, 128 Obstetrics & Gynecology 447 (2016) (finding a 26.6 percent increase in maternal mortality rates between 2000 and 2014).

[12] Summer Sholburne Hawkins et al., *Impact of State-Level Changes on Maternal Mortality: A Population-Based, Quasi-Experimental Study*, Am. Journal of Preventive Medicine, 85(2): 165–74 (2019).

[13] *Abortion Can Be Medically Necessary*, Am. College of Obstetricians and Gynecologists, Sep. 25, 2019. *http://www.acog.org/news/news-releases/2019/09/abortion-can-be-medically-necessary* (last visited Aug. 22, 2022).

[14] Victoria L. Meah, et al., *Cardiac output and related haemodynamics during pregnancy: a series of meta-analyses*, Heart J., 102:518–526 (2016).

[15] *Abortions later in Pregnancy*, Kaiser Family Foundation, Dec. 5, 2019. *http://www.kff.org/womens-health-policy/fact-sheet/abortions-later-in-pregnancy/* (last visited Aug. 22, 2022).

[16] ACOG Practice Bulletin No. 222, *Gestational Hypertension and Preeclampsia*, Am. College of Obstetricians and Gynecologists (Dec. 2018).

[17] ACOG Practice Bulletin No. 183, *Postpartum Hemorrhage*, Am. College of Obstetricians and Gynecologists (Oct. 2017); ACOG Obstetric Care Consensus, Placenta Accreta Spectrum (July 2012, reaff'd 2021); ACOG Practice Bulletin No. 198, *Prevention and Management of Obstetric Lacerations at Vaginal Delivery*, Am. College of Obstetricians and Gynecologists (Sept. 2018); ACOG Clinical Consensus No. 1, *Pharmacologic Stepwise Multimodal Approach for Postpartum Pain Management*, Am. College of Obstetricians and Gynecologists (Sept. 2021).

[18] Joan L. Combellick, et al., *Severe Maternal Morbidity Among a Cohort of Post-9/11 Women Veterans*, J Women's Health, 29(4):577–84 (Apr. 2020).

[19] Jonathan Shaw, et al., *Post-traumatic Stress Disorder and Antepartum Complications: a Novel Risk Factor for Gestational Diabetes and Preeclampsia*, Paediatr Perinat Epidemiol. 31(3):165–194 (May 2017); David Jones & John P. Hayslett, *Outcome of pregnancy in women with moderate or severe renal insufficiency*, N Engl J Med. 25;335(4):226–32 (Jul. 1996).

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necessary and appropriate for the treatment of a condition and not be specifically excluded under the CHAMPVA regulations. *See* 38 CFR 17.270(b) (defining CHAMPVA-covered services and supplies).

As discussed in the prior section, an abortion may be medically necessary and appropriate to protect a pregnant individual's health. Pregnancy can exacerbate underlying or preexisting conditions, like renal or cardiac disease, in such a way as to severely compromise the health of an individual.[20] Additionally, pregnant individuals may have their health endangered due to severe preeclampsia, newly diagnosed cancer requiring prompt treatment, and intrauterine infections.[21] In those circumstances, an abortion may be the only treatment available to protect the health of the pregnant CHAMPVA beneficiary. Thus, there may be instances when an abortion may be medically necessary and appropriate to prevent a pregnant CHAMPVA beneficiary's health from being endangered if the pregnancy was carried to term, and VA finds it necessary to deviate from TRICARE (Select) to provide abortions in these circumstances.

Accordingly, consistent with VA's regulatory requirements in 38 CFR 17.270(b), VA is revising the CHAMPVA regulations to allow the provision of abortions in such circumstances.

C. Abortions for Veterans When the Pregnancy Is the Result of an Act of Rape or Incest Are Needed

VA has also determined that access to abortions is "needed," 38 U.S.C. 1710(a)(1)–(3), and such care may be provided in accordance with 38 CFR 17.38(b), when the pregnancy is the result of an act of rape or incest.

There are severe health consequences associated with being forced to carry a pregnancy that is the result of rape or incest to term, including constant exposure to the violation committed against the individual which can cause serious traumatic stress and a risk of long-lasting psychological conditions such as anxiety and depression.[22] Those mental health consequences have a unique impact on veterans, who report higher rates of sexual trauma compared to their civilian peers.[23] Moreover, veterans are also more likely to have preexisting mental health conditions that would be compounded by the mental health consequences of being forced to carry a pregnancy to term if that pregnancy is the result of rape or incest. Thus, abortion access is critical to protect the lives and health of pregnant veterans whose pregnancy is the result of an act of rape or incest.

As discussed above, even where Congress has restricted the circumstances in which other Federal agencies may provide abortions, Congress has allowed funding when the pregnancy is the result of an act of rape or incest. VA agrees that abortions for pregnancies resulting from rape or incest are, where sought by the pregnant veteran, needed to protect the life and the health of the veteran consistent with the terms of 38 U.S.C. 1710. VA further expects that, in all but the most unusual circumstances, an individual's access to abortion in cases of pregnancy resulting from rape or incest would be "needed to promote, preserve, or restore the health of the individual" and would be "in accord with generally accepted standards of medical practice." 38 CFR 17.38(b).

D. Abortions for CHAMPVA Beneficiaries When Pregnancy Is the Result of an Act of Rape or Incest Are Medically Necessary and Appropriate

For similar reasons as discussed above, VA has determined that access to abortion when the pregnancy is the result of an act of rape or incest is medically necessary and appropriate and must be available to CHAMPVA beneficiaries. Allowing abortions in these circumstances better aligns with TRICARE (Select), which also allows abortions when the pregnancy is the result of an act of rape or incest.[24]

VA has determined that this change will provide CHAMPVA beneficiaries with care that is medically necessary and appropriate.

III. Abortion Counseling Under 38 U.S.C. 1710 and 1781

A. Abortion Counseling Is Needed Care for Veterons

Through this rulemaking, VA will remove the exclusion on abortion counseling in the medical benefits package from 38 CFR 17.38(c)(1). 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. Abortion counseling has three purposes: (1) to aid a pregnant individual in making a decision about an unwanted pregnancy, (2) to help the pregnant individual implement the decision, and (3) to assist the pregnant individual in controlling their future fertility.[25]

Removing the exclusion on abortion counseling from 38 CFR 17.38(c)(1) will allow VA to provide abortion counseling services to veterans who receive the care set forth in the medical benefits package. Such counseling is essential to ensure that veterans may make informed decisions about their care. Studies have shown that individuals have limited knowledge about the safety and risks of abortion.[26] Providing veterans with accurate information about abortions is needed to ensure that they can make informed decisions about their health care. *See also* 38 U.S.C. 7331; 38 CFR 17.32.

Abortion counseling should no longer be excluded from the medical benefits package. The provision of abortion counseling will enable a pregnant veteran to make a fully informed health care decision, just as counseling is offered or covered by VA regarding any other health care decision. As such, abortion counseling will be provided as part of conversations a veteran has with their provider related to pregnancy options care, when appropriate.

B. Abortion Counseling Is Medicolly Necessary and Appropriate for CHAMPVA Beneficiaries

Through this rulemaking, VA will remove the exclusion of abortion counseling from 38 CFR 17.272(a)(65). This will authorize the provision of abortion counseling for both covered

[20] Victoria L. Meah, et al., *Cardiac output and related haemodynamics during pregnancy: a series of meta-analyses*, HEART J., 102:518–526 (2016).

[21] *Abortions later in Pregnancy*, Kaiser Family Foundation, Dec. 5, 2019. *http://www.kff.org/womens-health-policy/fact-sheet/abortions-later-in-pregnancy/* (last visited Aug. 22, 2022).

[22] *Concluding observations of the Committee against Torture*, United Nations Committee Against Torture, 47th Sess., Oct. 31, 2011–Nov. 25, 2011 CAT/C/PRY/CO/4–6; Paraguay, p. 9, paragraph 22. *https://www2.ohchr.org/english/bodies/cat/docs/CAT.C.PRY.CO.4-6_en.pdf.*

[23] Carey Pulverman & Suzannah Creech, *The Impact of Sexual Trauma on the Sexual Health of Women Veterans: A Comprehensive Review*, Trauma Violence Abuse. 22(4): 656–671 (Oct. 2021). doi: 10.1177/1524838019870912.

[24] *See Covered Services, Abortions*, TRICARE, *https://tricare.mil/CoveredServices/IsItCovered/Abortions* (last visited Aug. 22, 2022).; 38 U.S.C. 1781(b); and 32 CFR 199.1(r), 199.17(a)(6)(ii)(D).

[25] Asher, J.D., *Abortion counseling*. American Journal of Public Health,63(5):686–8 (May 1972). *https://pubmed.ncbi.nlm.nih.gov/5024296/.*

[26] Ellen Weibe., et al., *Knowledge and Attitudes about Contraception and Abortion in Canada, US, UK, France and Australia*, Gynecology & Obstetrics, 5(9) (2015), *http://www.longdom.org/open-access/knowledge-and-attitudes-about-contraception-and-abortion-in-canada-us-uk-france-and-australia-40135.html.*

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and noncovered abortions to CHAMPVA beneficiaries. We acknowledge that this is broader than the abortion counseling provided under TRICARE (Select). However, the relevant care provided under CHAMPVA will still be sufficiently "similar" to that provided under TRICARE (Select). 38 U.S.C. 1781(b). As explained previously, 38 U.S.C. 1781(b) does not require CHAMPVA and TRICARE (Select) to be administered identically. Rather, by referring to care that is "similar," the statute permits VA flexibility to administer the program for CHAMPVA beneficiaries. For this reason, not every aspect of CHAMPVA will find a corollary in TRICARE (Select).

Indeed, as addressed throughout this rule, VA has previously provided CHAMPVA beneficiaries with health care services that exceed those services offered by TRICARE (Select). As discussed in the section above, abortion counseling will enable a pregnant CHAMPVA beneficiary to make a fully informed health care decision, just as counseling is offered or covered by VA when medically necessary and appropriate to make any other health care decision. Because providing CHAMPVA beneficiaries with accurate information about abortions is medically necessary to ensure that they can make informed decisions about their health and the care will be similar to that provided under TRICARE (Select), we believe it is appropriate to revise the CHAMPVA regulations to authorize the provision of abortion counseling for both covered and noncovered abortions to CHAMPVA beneficiaries.

Thus, VA finds that abortion counseling is beneficial for all CHAMPVA beneficiaries to receive accurate information about abortions. Therefore, we are including abortion counseling as a covered medical service under CHAMPVA.

IV. These Changes Will Promote Clarity and Parity Across Federal Agencies

VA believes it is important to provide at least the same reproductive health care services that other Federal agencies provide their beneficiaries. Many veterans and VA beneficiaries previously received health care from other Federal agencies, such as the Department of Defense, and those beneficiaries should have the same or greater access to services that they had previously and came to expect under other agency policies. This is particularly true for our veteran patients who earned their VA health care benefits through their military service and sacrifice to this country. It is unconscionable that they would not have access to at least these same critical services following their transition to civilian life.

As a result of this rulemaking, VA will also provide abortions when the health of the pregnant veteran or CHAMPVA beneficiary is endangered in addition to when the pregnancy threatens their life. This difference is due to VA's particular statutory authority in 38 U.S.C. 1710 to provide needed health care for veterans and VA's flexibility in administering the CHAMPVA program under 38 U.S.C. 1781, as discussed throughout. In contrast, other Federal agencies have different statutory authorities and additional limitations concerning the services they provide, such as the Hyde Amendment discussed above.

In addition, some post-*Dobbs* State and local laws purport to impose criminal liability or threaten suspension of the medical licenses of providers who perform abortions without authorization.[27] In the absence of clarity as to exactly what care is covered, this may result in a chilling effect on the provision of care, including abortions, to veterans and CHAMPVA beneficiaries. Denial of care because of uncertainty about the scope of changing State laws has already been evidenced outside of the Federal health system in certain States.[28] ACOG warns that the full scope of abortion restrictions' effects includes how physicians' ethical obligations to their patients and to the practice of medicine may be reshaped, redirected, or even contradicted by the threat posed by laws not founded in science or based on evidence.[29]

Consequently, VA is revising its medical benefits package and CHAMPVA regulations to promote clarity.

V. Preemption and Related Principles

As previously described, as a result of *Dobbs*, States and localities have begun to enforce existing abortion bans and restrictions on care, and are proposing and enacting new bans or restrictions, creating urgent risks to the lives and health of pregnant veterans and the health of pregnant CHAMPVA beneficiaries in those States. Such State and local bans and restrictions on care chill the provision of needed care for veterans and medically necessary and appropriate care for CHAMPVA beneficiaries. For instance, the Texas Medical Association sent a letter to the Texas Medical Board, seeking clarity on the Texas abortion restrictions as it received complaints that in some health care settings, physicians have been prohibited from providing medically appropriate care to women with ectopic pregnancies and other complications.[30] As reported even before the *Dobbs* decision, there is a climate of fear created by these abortion restrictions that has resulted not only in patients not having access to needed care but also in patients receiving medically inappropriate care.[31]

Accordingly, 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. VA previously issued a regulation, 38 CFR 17.419, in which VA confirmed the ability of VA health care professionals to practice their health care profession consistent with the scope and requirements of their VA employment, notwithstanding any State license, registration, certification, or other requirements that unduly interfere with their practice. The regulation provides that, in order to "provide the same complete health care and hospital services to beneficiaries in all States . . . conflicting State laws, rules, regulations, or requirements pursuant to such laws are without any force or effect, and State governments have no legal authority to enforce them in relation to actions by health care professionals within the scope of their VA employment." 38 CFR 17.419(c). Consistent with § 17.419, VA has

[27] *See e.g.*, Ark. Code Ann. sec. 5–61–404 (making abortion an unclassified felony); Idaho Code Ann. sec. 18–622 (making abortion a felony and requiring suspension of medical license); La. Rev. Stat. Ann. sec. 40:1061 (making abortion a criminal act and basis for professional disciplinary action); Tenn. Code Ann. sec. 39–15–216 (2019) (making abortion a felony); Tex. Health & Safety Code Ann. sec. 170A.004–05 (making abortion a felony and subject to a civil penalty).

[28] See, *e.g.*, Pam Belluck, *They Had Miscarriages, and New Abortion Laws Obstructed Treatment*, N.Y. Times, July 21, 2022, *https://www.nytimes.com/2022/07/17/health/abortion-miscarriage-treatment.html* (last visited Aug. 23, 2022).

[29] *Breaking the Law or Breaking the Oath? How Abortion Bans Betray America's Patients and Physicians*, Am. College of Obstetricians and Gynecologists, *http://www.acog.org/education-and-events/webinars/acog-nyu-how-abortion-bans-betray-americas-patients-physicians* (last visited Aug. 22, 2022).

[30] Allie Morris, *Texas Hospitals Fearing Abortion Law Delay Pregnant Women's Care, Medical Association Says*, Dallas News, July 14, 2022, *http://www.dallasnews.com/news/politics/2022/07/14/texas-hospitals-fearing-abortion-law-delay-pregnant-womens-care-medical-association-says* (last visited Aug. 22, 2022).

[31] Whitney Arey, et al., *A Preview of the Dangerous Future of Abortion Bans—Texas Senate Bill 8*, N Engl J Med; 387:388–390 (2022), *http://www.nejm.org/doi/full/10.1056/NEJMp2207423* (last visited Aug 22, 2022).

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determined that State and local laws, rules, regulations, or requirements that restrict, limit, otherwise impede access to, or regulate the provision of health care provided by VA pursuant to Federal law, would "unduly interfere[] with VA health care professionals' practice within the scope of VA employment." 38 CFR 17.419(b)(1). Accordingly, consistent with § 17.419, this rulemaking confirms that a State or local civil or criminal law that restricts, limits, or otherwise impedes a VA professional's provision of care permitted by this regulation would be preempted.

In addition, "[t]he Constitution's Supremacy Clause generally immunizes the Federal Government from State laws that directly regulate or discriminate against it," unless federal law authorizes such State regulation. *United States* v. *Washington*, 142 S. Ct. 1976, 1982 (2022). Therefore, States generally may not impose criminal or civil liability on VA employees who perform their duties in a manner authorized by federal law. *See, e.g., In re Neagle*, 135 U.S. 1, 62 (1890). 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.

VI. Changes to 38 CFR 17.38(c)(1)

Based on the rationale described above, we remove the exclusion on abortion counseling from § 17.38(c)(1). We revise § 17.38(c)(1) by adding paragraphs (c)(1)(i) and (ii) to state that the medical benefits package includes abortions in certain circumstances.

Section 17.38(c)(1)(i) permits abortions when the life or health of the pregnant veteran would be endangered if the pregnancy is carried to term. Assessment of the conditions, injuries, illness, or diseases that will qualify for this care will be made by appropriate health care professionals on a case-by-case basis. As appropriate, VA may issue supplemental guidance to inform these decisions.

Section 17.38(c)(1)(ii) permits abortions when the pregnancy is the result of an act of rape or incest. We are not requiring a veteran to present particular evidence such as a police report to qualify for this care. This is consistent with longstanding VA policy to treat eligible individuals who experienced military sexual trauma without evidence of the trauma. This approach, similar to in the context of military sexual trauma, removes barriers to providing care. Therefore, the regulation will provide that self-reporting from the pregnant veteran constitutes sufficient evidence.

VII. Changes to 38 CFR 17.272

Based on the rationale described above, we amend the CHAMPVA regulations at 38 CFR 17.272. We remove § 17.272(a)(65) that excludes abortion counseling from the CHAMPVA program. We revise current § 17.272(a)(64), which excludes abortions except when a physician certifies that the life of the pregnant beneficiary would be endangered if the fetus were carried to term, and we add § 17.272(a)(64)(i) and (ii).

Section 17.272(a)(64)(i) permits abortions when the life or health of the CHAMPVA beneficiary would be endangered if the pregnancy is carried to term. Assessment of the conditions, injuries, illnesses, or diseases that will qualify for this care will be made by appropriate health care professionals on a case-by-case basis. As appropriate, VA may issue supplemental guidance to inform these decisions.

Section 17.272(a)(64)(ii) permits abortions when the pregnancy is the result of an act of rape or incest. We are not requiring the CHAMPVA beneficiary to present particular evidence such as a police report to qualify for this care. This approach, as discussed above, removes barriers to providing care. Therefore, the regulation will provide that self-reporting from the pregnant CHAMPVA beneficiary constitutes sufficient evidence.

VIII. Regulatory Requirements

A. Executive Order 13132, Federalism

Executive Order 13132 establishes principles for preemption of State laws when those laws are implicated in rulemaking or proposed legislation. The order provides that, where a Federal statute does not expressly preempt State law, agencies shall construe any authorization in the statute for the issuance of regulations as authorizing preemption of State law by rulemaking only when the exercise of State authority directly conflicts with the exercise of Federal authority or there is clear evidence to conclude that the Congress intended the agency to have the authority to preempt State law.

As discussed above, consistent with 38 CFR 17.419, State and local laws, rules, regulations, or requirements are preempted to the extent those laws unduly interfere with Federal operations and the performance of Federal duties. That includes laws that States and localities might attempt to enforce in civil, criminal, or administrative matters against VA health care professionals acting in the scope of their VA authority and employment and that would prevent those individuals from providing care authorized by 38 U.S.C. 1701, 1710, 1781, 1784A, 7301, and 7310, and VA's implementing regulations. State and local laws, rules, regulations, or requirements are therefore without any force or effect to the extent of the conflict with Federal law, and State and local governments have no legal authority to enforce them in relation to actions by VA employees acting within the scope of their VA authority and employment.

Because all State and local laws, rules, regulations, or requirements that unduly interfere with VA's provision of reproductive health care have no force or effect, there are no actual or possible violations of such laws related to VA programs, operations, facilities, contracts, or information technology systems that would necessitate mandatory reporting by VA employees. 38 CFR 1.201–1.205. This rulemaking confirms VA's authority and discretion to manage its employees concerning the services that will be provided pursuant to this rulemaking.

Next, Executive Order 13132 requires that any regulatory preemption of State law must be restricted to the minimum level necessary to achieve the objectives of the statute pursuant to which the regulations that are promulgated. Under VA's regulations, State and local laws, rules, regulations, or other requirements are preempted only to the extent they unduly interfere with the ability of VA employees to furnish reproductive health care while acting within the scope of their VA authority and employment. Therefore, VA believes that the rulemaking is restricted to the minimum level necessary to achieve the objectives of the Federal statutes.

B. Administrative Procedure Act

The Administrative Procedure Act (APA), codified in part at 5 U.S.C. 553, generally requires that agencies publish substantive rules in the **Federal Register** for notice and comment and provide a 30-day delay before the rules becomes effective. An agency may forgo notice if the agency for good cause finds that compliance would be impracticable, unnecessary, or contrary to the public interest. 5 U.S.C. 553(b)(B). An agency may also bypass the APA's 30-day delay requirement if good cause exists, 5

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U.S.C. 553(d)(3), or if the rule "recognizes an exemption or relieves a restriction," 5 U.S.C. 553(d)(1). The Secretary of Veterans Affairs finds that there is good cause under the provisions of 5 U.S.C. 553(b)(B) to publish this rule without prior opportunity for public comment because it would be impracticable and contrary to the public interest and finds that there is good cause under 5 U.S.C. 553(d)(3) to bypass the 30-day delay requirement. The Secretary also finds that the 30-day delay is inapplicable as this rule is removing restrictions on abortion, in certain, limited circumstances, and on abortion counseling, 5 U.S.C. 553(d)(1).

As discussed at length above, leaving veterans and CHAMPVA beneficiaries without access to abortions and abortion counseling puts their health and lives at risk. Pregnancy and childbirth in the United States can result in physical harm or death to certain pregnant individuals,[32] as pregnant individuals may suffer from life-threatening conditions such as severe preeclampsia, newly diagnosed cancer requiring prompt treatment, and intrauterine infections,[33] and may have pre-existing conditions exacerbated by continuing the pregnancy.[34] In such cases, an abortion may be the only treatment available to save the health or life of the pregnant individual.[35] This is especially relevant because VA serves a population that is particularly vulnerable to adverse pregnancy outcomes. Pregnant veterans and CHAMPVA beneficiaries may be at heightened risk for pregnancy complications including hemorrhage, placenta accreta spectrum, and peripartum hysterectomy, among others.[36] Veterans of reproductive age, in particular, have high rates of chronic medical and mental health conditions that may increase the risks associated with pregnancy.[37] As lack of access to abortions can result in loss of future fertility, significant morbidity, or death, it is critical that veterans and CHAMPVA beneficiaries have access to abortions that are needed to save their lives and preserve their health. 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 that their health care providers can and will take swift and decisive action to provide needed health care.

The ability of veterans and CHAMPVA beneficiaries to receive abortions through VA is especially critical following State attempts to further ban abortion, which put the health and lives of veterans and CHAMPVA beneficiaries at risk.

When VA implemented the exclusion on abortions in the medical benefits package in 1999, veterans and other CHAMPVA beneficiaries had access to abortions in their communities. However, in *Dobbs*, the Supreme Court overruled the constitutional protections recognized in *Roe* and *Casey*. *Dobbs* has had an immediate or near-immediate effect because several States had laws banning abortion that were triggered upon the overruling of *Roe*. *Dobbs* has also led States and localities to consider new restrictions on abortion. As of August 2022, many States appear to be enforcing bans on abortion that do not include, or have limited, exceptions for when the pregnancy is due to rape or incest. Other States have bans on abortions with limited exceptions that are poised to take effect imminently. Additional State legislatures are introducing bans on abortion with limited exceptions. While some State courts have temporarily blocked the implementation of abortion bans, litigation in those States remains ongoing and other State courts have declined to enjoin their State's abortion ban.[38] These developments have made it, and will likely continue to make it, very difficult for many veterans and CHAMPVA beneficiaries to receive needed abortions in their communities. Additionally, ongoing litigation challenging individual State abortion bans causes confusion about where abortion remains legally accessible.[39]

Thousands of veterans and CHAMPVA beneficiaries are or may be impacted by abortion bans and the state of confusion related to where abortion remains legal. 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.[40] VA estimates that over 155,000 veterans ages 18 through 49 are potentially capable of pregnancy, enrolled in VA health care, and live in States that have enacted abortion bans or restrictions. Additionally, VA estimates there are more veterans who may be capable of pregnancy who are eligible for, but are not currently enrolled in or using, VA health care who could also be impacted by current and future abortion bans and restrictions imposed by the State in which they live. Additionally, based on VA data, almost 50,000 CHAMPVA beneficiaries may similarly be impacted.

Thus, State bans and restrictions on abortion present a serious threat to the health and lives of over one hundred thousand veterans and CHAMPVA beneficiaries who currently rely, or may rely in the future, on VA health care. These State laws will have an immediate detrimental impact on the lives and health of veterans and CHAMPVA beneficiaries who are unable to receive the care that was available before State restrictions following the *Dobbs* decision. This detrimental impact is underscored by the potential harmful effects associated with being denied an abortion, when an abortion is needed to protect the life or

[32] Elizabeth G. Raymond & David A. Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 Obstetrics & Gynecology 215, 216 (2012); see also Marian F. MacDorman et al., *Recent Increases in the U.S. Maternal Mortality Rate: Disentangling Trends from Measurement Issues* 128 Obstetrics & Gynecology 447 (2016) (finding a 26.6 percent increase in maternal mortality rates between 2000 and 2014). Victoria L. Meah, et al., *Cardiac output and related haemodynamics during pregnancy: a series of meta-analyses*, Heart J., 102:518–526 (2016).

[33] *Abortions later in Pregnancy*, Kaiser Family Foundation, Dec. 5, 2019. *http://www.kff.org/womens-health-policy/fact-sheet/abortions-later-in-pregnancy/* (last visited Aug. 22, 2022).

[34] Victoria L. Meah, et al., *Cardiac output and related haemodynamics during pregnancy: a series of meta-analyses*, Heart J., 102:518–526 (2016).

[35] *Abortion Can Be Medically Necessary*, Am. College of Obstetricians and Gynecologists, Sep. 25, 2019. *http://www.acog.org/news/news-releases/2019/09/abortion-can-be-medically-necessary* (last visited Aug. 22, 2022).

[36] ACOG Practice Bulletin No. 183, *Postpartum Hemorrhage*, Am. College of Obstetricians and Gynecologists (Oct. 2017); ACOG Obstetric Care Consensus, Placenta Accreta Spectrum (July 2012, reaff'd 2021); ACOG Practice Bulletin No. 198, *Prevention and Management of Obstetric Lacerations at Vaginal Delivery*, Am. College of Obstetricians and Gynecologists (Sept. 2018); ACOG Clinical Consensus No. 1, *Pharmacologic Stepwise Multimodal Approach for Postpartum Pain Management*, Am. College of Obstetricians and Gynecologists (Sept. 2021).

[37] Joan L. Combellick, et al., *Severe Maternal Morbidity Among a Cohort of Post-9/11 Women Veterans*, J Women's Health, 29(4):577–84 (Apr. 2020).

[38] *See, e.g.*, Katie Shepherd, Rachel Roubein, and Caroline Kitchener, *1 in 3 American women have already lost abortion access. More restrictive laws are coming.*, Wash. Post (Aug. 22, 2022, 3:36 p.m.), *http://www.washingtonpost.com/nation/2022/08/22/more-trigger-bans-loom-1-3-women-lose-most-abortion-access-post-roe/*; *see also, e.g.*, Idaho Code Ann. sec. 18–622, 18–622(3)(a)(ii) (prohibiting abortion in all instances, only providing affirmative defenses in case of life or health of pregnant individual); La. Rev. Stat. Ann. sec. 40:1061 (providing limited exception for life or health to abortion prohibition).

[39] *See, e.g.*, Ava Sasani and Emily Cochrane, *'I'm Carrying This Baby Just to Bury It': The Struggle to Decode Abortion Laws*, N.Y. Times (Aug. 19, 2022), *http://www.nytimes.com/2022/08/19/us/politics/louisiana-abortion-law.html*.

[40] *Issue Brief: State Abortion Bans Could Harm Nearly 15 Million Women of Color* Nat'l Partnership for Women & Families (Jul. 2022), *http://www.nationalpartnership.org/our-work/economic-justice/reports/state-abortion-bans-harm-woc.html*.

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health of the pregnant individual, or in cases of rape or incest—as described in prior portions of this preamble.

It is critical that this rule be published and be made effective immediately to ensure pregnant veterans and CHAMPVA beneficiaries have access to this important care. Indeed, delaying the issuance of this rule would increase the risk to their health and lives and put care out of reach for some pregnant veterans and CHAMPVA beneficiaries entirely. Time is also of the essence because, after the *Dobbs* decision, many State laws have prompted providers to cease offering abortion services altogether; thus, many veterans and CHAMPVA beneficiaries would face delays (including travel and wait times) if they were required to obtain, outside the VA, the treatment permitted under this rule. Each day, pregnant patients in the United States, some of whom are veterans or CHAMPVA beneficiaries, find themselves in need of abortion services in accord with generally accepted standards of medical practice. Delaying that care for the time required for notice and comment rulemaking would result in substantial health deterioration and risk the lives of some pregnant veterans and CHAMPVA beneficiaries. Allowing even one preventable death of a veteran or CHAMPVA beneficiary by limiting access to abortions is unacceptable.

For these reasons, the Secretary has concluded that ordinary notice and comment procedures would be impracticable and contrary to the public interest and there is good cause to issue this interim final rule with an immediate effective date. Accordingly, VA is issuing this rule as an interim final rule with an immediate effective date. As noted above, this interim final rule will have a 30-day comment period, after which the Secretary will consider and address the comments received in a subsequent **Federal Register** document announcing a final rule incorporating any changes made in response to the public comments.

C. Executive Orders 12866 and 13563

Executive Orders 12866 (Regulatory Planning and Review) and 13563 (Improving Regulation and Regulatory Review) direct agencies to assess the costs and benefits of available regulatory alternatives and, when regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, and other advantages; distributive impacts; and equity). Executive Order 13563 emphasizes the importance of quantifying both costs and benefits, reducing costs, harmonizing rules, and promoting flexibility. The Office of Information and Regulatory Affairs has determined that this rule is a significant regulatory action under Executive Order 12866. The Regulatory Impact Analysis associated with this rulemaking can be found as a supporting document at *http://www.regulations.gov*.

D. Regulatory Flexibility Act

The Secretary hereby certifies that this rule will not have a significant economic impact on a substantial number of small entities as they are defined in the Regulatory Flexibility Act, 5 U.S.C. 601–12. This is because the rule does not directly regulate or impose costs on small entities and because any effects on small entities will be indirect. On this basis, the Secretary certifies that the adoption of this rule will not have a significant economic impact on a substantial number of small entities as they are defined in the Regulatory Flexibility Act. Therefore, pursuant to 5 U.S.C. 605(b), the initial and final regulatory flexibility analysis requirements of 5 U.S.C. 603 and 604 do not apply to this rule.

E. Unfunded Mandates

The Unfunded Mandates Reform Act of 1995, see 2 U.S.C. 1532, requires that agencies prepare an assessment of anticipated costs and benefits before issuing any rule that may result in the expenditure by State, local, and tribal governments, in the aggregate, or by the private sector, of $100 million or more (adjusted annually for inflation) in any one year. This rule will have no such effect on State, local, and tribal governmeuts, or on the private sector.

F. Paperwork Reductioa Act

This rule contains no provisions constituting a collection of information under the Paperwork Reduction Act of 1995, 44 U.S.C. 3501–21.

List of Subjects in 38 CFR Part 17

Administrative practice and procedure, Alcohol abuse, Alcoholism, Claims, Day care, Dental health, Drug abuse, Foreign relations, Government contracts, Grant programs—health, Grant programs—veterans, Health care, Health facilities, Health professions, Health records, Homeless, Medical and dental schools, Medical devices, Medical research, Mental health programs, Nursing homes, Philippines, Reporting and recordkeeping requirements, Scholarships and fellowships, Travel and transportation expenses, Veterans.

Signing Authority

Denis McDonough, Secretary of Veterans Affairs, approved this document on August 29, 2022, and authorized the undersigned to sign and submit the document to the Office of the Federal Register for publication electronically as an official document of the Department of Veterans Affairs.

Michael P. Shores,

Director, Office of Regulation Policy & Management, Office of General Counsel, Department of Veterans Affairs.

For the reasons stated in the preamble, the Department of Veterans Affairs amends 38 CFR part 17 as follows:

PART 17—MEDICAL

■ 1. The authority citatiou for part 17 continues to read as follows:

Authority: 38 U.S.C. 501, and as noted in specific sections.

■ 2. Amend § 17.38 by revising paragraph (c)(1) to read as follows:

§ 17.38 Medical benefits package.

* * * * *

(c) * * *

(1) Abortions, except when:

(i) The life or the health of the pregnant veteran would be endangered if the pregnancy were carried to term; or

(ii) The pregnancy is the result of an act of rape or incest. Self-reporting from the pregnant veteran constitutes sufficient evidence that an act of rape or incest occurred.

* * * * *

■ 3. Amend § 17.272 by:

■ a. Revising paragraph (a)(64).

■ b. Removing paragraph (a)(65).

■ c. Redesignating current paragraphs (a)(66) through (84) as paragraphs (a)(65) through (83).

The revision reads as follows:

§ 17.272 Benefits limitations/exclusions.

(a) * * *

(64) Abortious, except when:

(i) The life or the health of the pregnant beneficiary would be endangered if the pregnancy were carried to term; or

(ii) The pregnancy is the result of an act of rape or incest. Self-reporting from the pregnant beneficiary constitutes sufficient evidence that an act of rape or incest occurred.

* * * * *

[FR Doc. 2022–19239 Filed 9–8–22; 8:45 am]

BILLING CODE 8320–01–P

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This subsection is also amended to broaden the group of individuals who may act as Deputy Ethics Officials pursuant to delegations from the DAEO. Finally, 38 CFR 0.735–1(b)(2) is amended to include a citation to 5 CFR 2638.104(e) as the existing citation to 5 CFR 2638.204 is outdated.

Administrative Procedure Act

This final rule is a procedural rule that does not impose new rights, duties, or obligations on affected individuals but, rather, explains that the Secretary appoints Agency ethics officials and identifies the employees that may serve as Agency ethics officials. Therefore, it is exempt from the prior notice-and-comment and delayed-effective-date requirements of 5 U.S.C. 553. *See* 5 U.S.C. 553(b)(A) and (d)(3). This rule merely updates information regarding the delegation of Agency ethics officials, the employees who may serve in those roles, and the names of certain offices and employees in the Office of General Counsel.

Paperwork Reduction Act

This final rule contains no provisions constituting a collection of information under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501–3521).

Regulatory Flexibility Act

The initial and final regulatory flexibility analyses requirements of sections 603 and 604 of the Regulatory Flexibility Act, 5 U.S.C. 601–612, are not applicable to this rule because a notice of proposed rulemaking is not required for this rule. Even so, the Secretary hereby certifies that this final rule will not have a significant economic impact on a substantial number of small entities as they are defined in the Regulatory Flexibility Act. This rule will affect only: (1) Office of General Counsel (OGC) and VA employees who serve as Agency ethics officials, and (2) VA employees seeking ethics advice from these Agency ethics officials. Therefore, pursuant to 5 U.S.C. 605(b), the initial and final regulatory flexibility analysis requirements of 5 U.S.C. 603 and 604 do not apply.

Executive Orders 12866, 13563 and 14094

Executive Order 12866 (Regulatory Planning and Review) directs agencies to assess the costs and benefits of available regulatory alternatives and, when regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, and other advantages; distributive impacts; and equity). Executive Order 13563 (Improving Regulation and Regulatory Review) emphasizes the importance of quantifying both costs and benefits, reducing costs, harmonizing rules, and promoting flexibility. Executive Order 14094 (Executive Order on Modernizing Regulatory Review) supplements and reaffirms the principles, structures, and definitions governing contemporary regulatory review established in Executive Order 12866 of September 30, 1993 (Regulatory Planning and Review), and Executive Order 13563 of January 18, 2011 (Improving Regulation and Regulatory Review). The Office of Information and Regulatory Affairs has determined that this rulemaking is not a significant regulatory action under Executive Order 12866, as amended by Executive Order 14094. The Regulatory Impact Analysis associated with this rulemaking can be found as a supporting document at *www.regulations.gov*.

Assistance Listing

There are no Assistance Listing numbers and titles for the programs affected by this document.

Congressional Review Act

Pursuant to Subtitle E of the Small Business Regulatory Enforcement Fairness Act of 1996 (known as the Congressional Review Act) (5 U.S.C. 801 *et seq.*), the Office of Information and Regulatory Affairs designated this rule as not satisfying the criteria under 5 U.S.C. 804(2).

Unfunded Mandates

The Unfunded Mandates Reform Act of 1995 requires, at 2 U.S.C. 1532, that agencies prepare an assessment of anticipated costs and benefits before issuing any rule that may result in the expenditure by State, local, and tribal governments, in the aggregate, or by the private sector, of $100 million or more (adjusted annually for inflation) in any one year. This final rule will have no such effect on State, local, and tribal governments, or on the private sector.

List of Subjects in 38 CFR Part 0

Core Values, Characteristics and Customer Experience Principles of the Department, General Provisions, Standards of Ethical Conduct, and Related Responsibilities of Employees.

Signing Authority

Denis McDonough, Secretary of Veterans Affairs, approved this document on February 26, 2024, and authorized the undersigned to sign and submit the document to the Office of the Federal Register for publication electronically as an official document of the Department of Veterans Affairs.

Consuela Benjamin,

Regulations Development Coordinator, Office of Regulation Policy & Management, Office of General Counsel, Department of Veterans Affairs.

For the reasons set out in the preamble, the Department of Veterans Affairs amends 38 CFR part 0 as follows:

PART 0—VALUES, STANDARDS OF ETHICAL CONDUCT, AND RELATED RESPONSIBILITIES

■ 1. The authority citation for part 0 continues to read as follows:

Authority: 5 U.S.C. 301; 38 U.S.C. 501; see sections 201, 301, and 502(a) of E.O. 12674, 54 FR 15159, 3 CFR, 1989 Comp., p. 215 as modified by E.O. 12731, 55 FR 42547, 3 CFR, 1990 Comp., p. 306.

■ 2. Amend § 0.735–1 by revising paragraphs (a), (b)(1), and (b)(2) to read as follows:

§ 0.735–1 Agency ethics officials.

(a) *Designated Agency Ethics Official (DAEO).* The Secretary will designate attorneys from the Office of General Counsel to serve as the Designated Agency Ethics Official (DAEO) and Alternate Designated Agency Ethics Official (ADAEO).

(b) * * *

(1) The District Chief Counsels and attorneys on the Ethics Specialty Team are Deputy Ethics Officials. They have been delegated the authority to act for the DAEO pursuant to 5 CFR 2638.104(e).

(2) Other officials may also act as Deputy Ethics officials pursuant to delegations of one or more of the DAEO's duties from the DAEO.

[FR Doc. 2024–04442 Filed 3–1–24; 8:45 am]

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DEPARTMENT OF VETERANS AFFAIRS

38 CFR Part 17

RIN 2900–AR57

Reproductive Health Services

AGENCY: Department of Veterans Affairs.

ACTION: Final rule.

SUMMARY: The Department of Veterans Affairs (VA) is finalizing, without changes, an interim final rule that amended VA's medical regulations to remove the exclusion on abortion counseling in the medical benefits package; establish exceptions to the exclusion on abortions for veterans who

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receive care set forth in that package; and remove the exclusion on abortion counseling and expand the exceptions to the exclusion on abortions for Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) beneficiaries.

DATES: This rule is effective April 3, 2024.

FOR FURTHER INFORMATION CONTACT: Dr. Shereef Elnahal, Under Secretary for Health, Department of Veterans Affairs, 810 Vermont Avenue NW, Washington, DC 20420, (202) 461–0373.

SUPPLEMENTARY INFORMATION: In an interim final rule (IFR) published in the **Federal Register** (FR), VA amended its medical regulations to remove the exclusion on abortion counseling in the medical benefits package; establish exceptions to the exclusion on abortions for veterans who receive care set forth in that package; and remove the exclusion on abortion counseling and expand the exceptions to the exclusion on abortions for Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) beneficiaries. 87 FR 55287 (September 9, 2022).

VA provided a 30-day comment period on the IFR, which ended on October 11, 2022. VA received 57,901 comments, many of which were supportive of the IFR. The vast majority of the comments were a type of duplicated form response, where some requested clarifications or suggested changes to the IFR, and others merely expressed support or requested the IFR be rescinded without suggested clarifications or changes. VA summarizes and addresses all topics raised in relevant and significant comments below, but VA does not address any supportive comments below that did not also request clarifications or suggest substantive revisions.

I. Comments That Asserted VA Does Not Have Authority To Promulgate or Implement the IFR

Many commenters asserted that VA does not have the legal authority to promulgate or implement the IFR, most of which provided few details to explain their assertions. Other commenters cited to specific laws that they asserted conflicted with VA's provision of the health care services permitted by the IFR. VA addresses these comments below.

A. General Assertions of Lack of Authority

Many comments asserted that VA should rescind the IFR because VA has a longstanding policy regarding abortion and does not have the authority to impose the IFR in a manner that violates this policy. These comments generally assert that VA does not have authority to either promulgate or implement the IFR to remove the restriction on abortion counseling and create exceptions for abortions in certain circumstances in §§ 17.38 and 17.272 of title 38, Code of Federal Regulations (CFR).

VA does not make any changes to the rule and does not rescind the IFR based on these comments. As indicated in the IFR (see 87 FR 55288–55290), pursuant to VA's general treatment authority for veterans, VA "shall furnish" specified veterans with "hospital care and medical services which the Secretary determines to be needed." Section 1710(a)(1)–(2) of title 38, United States Code (U.S.C.). For veterans not described in paragraphs (1) and (2), the Secretary "may," subject to certain limitations, "furnish hospital care" and "medical services . . . which the Secretary determines to be needed," 38 U.S.C. 1710(a)(3). Such "medical services" include "medical examination, treatment," "[s]urgical services," and "[p]reventive health services." 38 U.S.C. 1701(6). VA implements its general treatment authority, and the Secretary determines what care is "needed," 38 U.S.C. 1710(a)(1)–(3), by regulation through VA's medical benefits package. 38 CFR 17.38. Care included in the medical benefits package is "provided to individuals only if it is determined by appropriate health care professionals that the care is needed to promote, preserve, or restore the health of the individual and is in accord with generally accepted standards of medical practice." 38 CFR 17.38(b). VA has determined that the health care services permitted under the IFR are "needed" within the meaning of VA's general treatment authority, 38 U.S.C. 1710, if an appropriate health care professional determines that such care is needed to promote, preserve, or restore the health of the individual and is in accord with generally accepted standards of medical practice. 38 CFR 17.38(b). Although VA previously did not have any exceptions to the exclusion on abortion in the medical benefits package, VA's authority as described above permits it to amend the medical benefits package through regulation. VA can therefore provide the health care services permitted under the IFR to veterans pursuant to 38 U.S.C. 1710 and 38 CFR 17.38. Similarly, VA has determined that providing access to such care is medically necessary and appropriate to protect the health of CHAMPVA beneficiaries. *See* 38 U.S.C. 1781; 38 CFR 17.270(b) (defining "CHAMPVA-covered services and supplies" as "those medical services and supplies that are medically necessary and appropriate for the treatment of a condition and that are not specifically excluded under [38 CFR 17.272(a)(1)] through (84)").

Several commenters suggested that the IFR usurps Congressional authority. Other commenters stated that VA is unable to provide the health care services permitted under the IFR because Congress has not funded them specifically, or that VA should not use taxpayer money to provide the health care services permitted under the IFR because VA does not have the legal right to do so, and it is contrary to the wishes of taxpayers. VA does not make changes to the rule based on these comments. The IFR did not usurp Congressional authority. VA, similar to other agencies in the Executive Branch, has the authority to promulgate regulations to interpret and implement laws passed by Congress, and such regulations may have the force and effect of law. In this instance, the IFR was promulgated and implemented pursuant to statute. 38 U.S.C. 1710, 1781; *see also id.* 501. VA does not receive separate appropriations for individual medical services, but instead receives appropriations generally for authorized services. While some taxpayers may disagree with this use of Federal funds, VA is authorized to provide and pay for care that is needed for veterans and medically necessary and appropriate for CHAMPVA beneficiaries.

B. Specific Assertions of Lack of Authority or Conflicting Authority

1. Lack of Authority Under 38 U.S.C. 1710

Commenters asserted that VA's interpretation of 38 U.S.C. 1710 to provide access to health care services permitted under the IFR was unsupported because the text of 38 U.S.C. 1710 does not expressly include these services and because VA has not previously invoked or construed 38 U.S.C. 1710 as authority for provision of these services. VA does not make changes to the rule based on these comments. The commenters' assertions regarding the text of 38 U.S.C. 1710 overlook that the terms "hospital care" and "medical services" as used in 38 U.S.C. 1710 are further defined in 38 U.S.C. 1701(5) and (6). As relevant here, "hospital care" is defined to include "medical services rendered in the

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course of hospitalization of any veteran'' and ''medical services'' is defined to include ''medical examination, treatment, and rehabilitative services,'' ''[s]urgical services,'' and ''[p]reventive health services'' (38 U.S.C. 1701(5) and (6)). The definitions of ''hospital care'' and ''medical services'' in 38 U.S.C. 1701(5) and (6) do not list more specific types of care or services. And, in describing categories of hospital care and medical services, 38 U.S.C. 1701 and 1710 do not enumerate every conceivable or commonly prescribed care or service, whether such care or service involves specific care or services such as abortion, prescription drugs, or completion of specific medical forms such as life insurance applications. Rather, such care and services are generally described in the VA medical benefits package codified in 38 CFR 17.38(a).

The medical benefits package consists of a wide range of basic and preventive care, including inpatient and outpatient medical and surgical care, prescription drugs, emergency care, pregnancy and delivery services, and periodic medical exams. 38 CFR 17.38(a). Whether hospital care or medical services under the medical benefits package are considered needed are determinations that 38 U.S.C. 1701 and 1710 leave to the Secretary's discretion. See 38 U.S.C. 1710(a)(1) (''The Secretary . . . shall furnish hospital care and medical services which the Secretary determines to be needed[.]''). The Secretary can include or exclude care in the medical benefits package based on whether the Secretary determines that care is ''needed'' within the meaning of 38 U.S.C. 1710(a)(1)–(3). 38 CFR 17.38(c).

After the Supreme Court issued its decision in *Dobbs* v. *Jackson Women's Health Organization*, 142 S. Ct. 2228 (2022), veterans living in States that ban or restrict abortions may no longer be able to receive needed medical services in their communities as a result of State restrictions. It is thus essential for the lives and health of our veterans that abortions be made available if determined needed by a health care professional when: (1) the life or health of the pregnant veteran would be endangered if the pregnancy were carried to term; or (2) the pregnancy is the result of an act of rape or incest.

Additionally, the commenters' assertions that VA has never previously invoked its authority under 38 U.S.C. 1710 to authorize the provision of abortions are incorrect. Before the regulatory promulgation of the medical benefits package in 1999, which excluded the health care services permitted under the IFR, VA policy authorized the provision of certain abortions. VHA Policy, Manual M–2, Professional Services Part XIV, Surgical Service, Change 27, paragraph 9.02a (July 26, 1977, partial rescission, expired on Jan. 7, 1999) (authorizing ''therapeutic . . . abortion as a proper treatment'' in some circumstances pursuant to the procedures described therein). This was permitted under VA's authority to provide hospital care and medical services under 38 U.S.C. 1710 and 38 U.S.C. 1712 (former medical services authority), respectively. As explained in the IFR, VA did not explain the rationale behind the exclusion of abortions and abortion counseling from the medical benefits package when it was established in 1999, but at the time, *Roe* v. *Wade*, 410 U.S. 113 (1973) had been reaffirmed in relevant part by *Casey*, and VA was aware that veterans could access abortions in their communities. 87 FR 55288. Following the *Dobbs* decision, States began to ban or restrict abortion services and veterans living in those States were losing access to such medical care. *Id.* Thus, VA explained in the IFR that this policy change was essential for the lives and health of the veterans that VA serves. *Id.*

VA makes no changes to the rule based on the assertions raised in these comments, as discussed above.

In support of the claim that 38 U.S.C. 1710 does not authorize VA's provision of the health care services permitted under the IFR, some commenters cited to testimony presented during a June 2022 legislative hearing before the House of Representatives Veterans Affairs Committee Subcommittee on Health and minutes from an August 2019 meeting of the Advisory Committee on Women Veterans. VA makes no changes to the rule based on this comment.

Neither the testimony presented during the June 2022 legislative hearing before the House of Representatives Veterans Affairs Committee Subcommittee on Health nor the minutes from the August 2019 meeting of the Advisory Committee on Women Veterans suggests that VA lacks authority under 38 U.S.C. 1710 to provide the health care services permitted under the IFR. The passage that the commenter cites from the Advisory Committee on Women Veterans meeting minutes refers to language from page 20 of the August 2019 Advisory Committee on Women Veterans meeting minutes, which refers to an update on the Committee's recommendation that VA pursue a regulatory change to remove the exclusion of abortions in cases of threat to the life of the mother, sexual assault, and incest from the medical benefits package. The minutes state:

> VA has declined the ACWV's recommendation and will not change the medical benefits package regulations to remove the exclusion of abortions and abortion counseling services. VA believes that Congress, as the representatives of the will of the American people, must take the lead on this sensitive and divisive issue. VA will take no further action on the matter without a legal mandate, and will work with the House Veterans Affairs Committee to provide technical assistance on related legislation.

VA has never indicated that it lacks statutory authority to include abortion counseling and abortions in its medical benefits package in a circumstance in which the VA Secretary determined that such care was needed. And notably, VA made this statement in response to ACWV's recommendations before the Supreme Court issued its decision in *Dobbs*.

In addition, during the June 2022 legislative hearing, VA was discussing a single, standalone bill, H.R. 345, that would have overridden VA's regulatory exclusion of abortion counseling by requiring the Department to provide this service to a veteran as appropriate. VA stated, ''[T]he bill would not authorize VA to provide abortions; it would only allow VA to provide patient education.'' This statement does not mean that VA otherwise lacks authority to provide abortions, merely that VA was providing testimony on a legislative measure that, if enacted, would have only overridden VA's then-exclusion of abortion counseling codified in VA regulations. VA also notes that such legislative discussions in 2022 do not provide a basis to narrowly construe the scope of VA's pre-existing statutory authority. *See, e.g., Bostock* v. *Clayton Cnty., Georgia*, 140 S. Ct. 1731, 1747 (2020) (''[S]peculation about why a later Congress declined to adopt new legislation offers a 'particularly dangerous' basis on which to rest an interpretation of an existing law a different and earlier Congress did adopt.'' (citing *Pension Benefit Guaranty Corporation* v. *LTV Corp.*, 496 U.S. 633, 650 (1990))).

One commenter, in further support of the assertion that VA did not have legal authority to issue the IFR, cited recent Supreme Court case law to argue that Federal agencies exceed their statutory authorities when they purport to find novel powers in long extant Federal statutes. *West Virginia* v. *Environmental Protection Agency*, 142 S. Ct. 2587 (2022); *National Federation of Independent Business* v. *Dept. of Labor*,

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142 S. Ct. 661 (2022). But those cases are inapposite because, as discussed, clear statutory authority supports this rulemaking. Pursuant to VA's general treatment authority provided by Congress, VA "shall furnish" specified veterans with "hospital care and medical services which the Secretary determines to be needed." 38 U.S.C. 1710(a)(1)–(2). For other veterans, the Secretary "may," subject to certain limitations, "furnish hospital care" and "medical services . . . which the Secretary determines to be needed." 38 U.S.C. 1710(a)(3). VA issued the IFR because the Secretary determined that it is "essential for the lives and health of our veterans that abortions be made available if determined needed by a health care professional when: (1) the life or health of the pregnant veteran would be endangered if the pregnancy were carried to term; or (2) the pregnancy is the result of an act of rape or incest." 87 FR 55288. The Secretary also determined that "abortion counseling is needed so that veterans can make informed decisions about their health care." *Id.* at 55292. The Secretary thus "determined that such medical care is 'needed' within the meaning of VA's general treatment authority," which "means that such care may be provided if an appropriate health care professional determines that such care is needed to promote, preserve, or restore the health of the individual and is in accord with generally accepted standards of medical practice." *Id.* at 55288. *See also* 38 U.S.C. 1781(a); 38 CFR 17.270(b); 87 FR 55290–92 (discussing the VA Secretary's authority and determinations regarding CHAMPVA beneficiaries).

The Secretary has previously exercised authority under 38 U.S.C. 1710 to amend 38 CFR 17.38 to add new services to the medical benefits package services. For example, VA added to the medical benefits package pregnancy and delivery services to the extent authorized by Federal law. See 64 FR 54217. VA also added newborn care as a service provided under the medical benefits package. See 76 FR 78569. Such care was authorized pursuant to 38 U.S.C. 1710 and 1786.

The decisions the commenter cites also are distinguishable because, as discussed above, this is not the first time that VA has relied on relevant statutory authority in this manner. As stated before, VA policy authorized the provision of certain abortions. VHA Policy, Manual M–2, Professional Services Part XIV, Surgical Service, Change 27, paragraph 9.02a. (July 26, 1977, partial rescission, expired on Jan. 7, 1999)) (authorizing "therapeutic . . . abortion as a proper treatment" in some circumstances pursuant to the procedures described therein).

The determination not to continue this medical service when the medical benefits package regulation was established in 1999 was based on a VA policy decision, not because VA's general treatment authority did not cover this medical service. Indeed, the fact that abortion was specifically excluded from the medical benefits package under 38 CFR 17.38(c) makes clear that VA has long held the position that abortion and abortion counseling is medical care that the Secretary is statutorily authorized, pursuant to his discretion, to include in the medical benefits package under § 17.38(a). Although VA maintained the exclusion on abortion care starting from the effective date of the medical benefits package in 1999 until 2022, as stated in the preamble to the IFR, Congress has authorized VA to amend its medical benefits package when the Secretary determines such change is warranted. Contrary to the commenter's assertion, VA's reading of 38 U.S.C. 1710 is not novel but supported by past readings of VA's medical care treatment authority; the commenter's cited case law is thus not applicable to this rulemaking. VA makes no changes to the rule based on this comment.

2. Conflict With Section 106 of the Veterans Health Care Act of 1992

Many commenters generally stated that the IFR violates section 106 of the Veterans Health Care Act of 1992 (VHCA), Public Law (Pub. L.) 102–585, 106 Stat. 4943, and that therefore VA should rescind the IFR. VA does not make any changes to the rule or rescind the IFR based on these comments. As explained in the preamble to the IFR, the VHCA barred the provision of abortion, infertility, and much of prenatal and delivery care but only under section 106 of the VHCA. It did not limit VA's authority to provide such services under any other statutory provision such as 38 U.S.C. 1710 or 38 U.S.C. 1712. Public Law 102–585, sec. 106(a). *See* 87 FR 55288–289. Moreover, in 1996, the Veterans' Health Care Eligibility Reform Act effectively overtook section 106 of the VHCA by enacting major changes to eligibility for VA health care, including by amending 38 U.S.C. 1710, and directing VA to establish a system of patient enrollment to manage the provision of care. *See* 87 FR 55289. The purpose behind eligibility reform was to replace the old system with a system where an enrolled veteran could receive whatever medical care and services are deemed needed. *See* House of Representatives Report No. 104–690, at 4 (1996). Consequently, for decades, VA has offered general pregnancy care and certain infertility services under 38 U.S.C. 1710, despite the VHCA's prohibition on providing such services under section 106. *Id.* VA has not relied on section 106 of the VHCA to provide such services or any other services.

Other commenters more specifically asserted that section 106 of the VHCA was still operable to prohibit abortion in VA health care programs, and provided more specific supporting rationale, as addressed below.

a. General Versus Specific Canon of Statutory Construction

Some commenters asserted that, under traditional rules of statutory construction, the more specific and targeted treatment of abortion in section 106 of the VHCA governs over the more general treatment of health care in the Veterans Health Care Eligibility Reform Act of 1996 and 38 U.S.C. 1710. As further explained below, this canon of construction is applicable when two statutory provisions are in conflict, but section 106 does not conflict with VA's authority to provide abortions under other statutory provisions such as 38 U.S.C. 1710 and 1712 (former medical services authority). Consequently, the focus of commenters on the general versus specific canon is mistaken, and VA does not make changes to the rule based on these comments.

By its plain terms, section 106 of the VHCA does not circumscribe the Secretary's authority to determine what hospital care and medical services are needed under 38 U.S.C. 1710. Section 106 affirmatively authorized VA to provide certain healthcare services to women, including "[g]eneral reproductive health care," but provided that this authorization for general reproductive health care did "not includ[e] *under this section* infertility services, abortions, or pregnancy care (including prenatal and delivery care), except for such care relating to a pregnancy that is complicated or in which the risks of complication are increased by a service-connected condition." (emphasis added). The phrase "under this section" means that while section 106 bars the provision of any abortion or infertility or general pregnancy services under section 106 of the VHCA, it does not limit VA's authority to provide such services under any other statutory provision, such as VA's general treatment authority, 38 U.S.C. 1710. *See, e.g., Intergovernmental Immunity for the Department of Veterans Affairs and Its Employees*

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When Providing Certain Abortion Services, 46 Op. O.L.C., , at *1, 7–8 (Sept. 21, 2022), *https://www.justice.gov/d9/2022-11/2022-09-21-va_iinmunity_for_abortian_services.pdf* (noting that the IFR represented a reasonable exercise of the VA Secretary's discretion to provide medical services).

Accordingly, the commenters' reliance on the ''general/specific canon'' is misplaced. Moreover, as the Supreme Court has acknowledged, the general/specific canon is not an absolute rule and can be overcome by textual indications that point to the general and specific provisions coexisting, rather than the specific governing the general. *See RadLAX Gateway Hotel* v. *Amalgamated Bank*, 566 U.S. 639, 646 (2012). In this case, section 106 specifies that abortions cannot be provided ''under this section'' of the VHCA, but it does not prohibit VA from providing abortions nnder other statutory provisions such as 38 U.S.C. 1710 and 1712 (former medical services anthority).

VA's interpretation of section 106 in this respect has been long-standing. VA has never interpreted section 106 to prohibit the Department from providing health care under other statutory authorities. For example, as discussed above, VA continued to provide certain abortions as well as therapeutic surgical sterilizations, a type of infertility treatment, after tbe passage of section 106 and until promulgation of the final rnle establishing VA's medical benefits package in October of 1999. *See* VHA Policy, Manual M–2, Professional Services Part XIV, Surgical Service, Change 27, paragraph 9.02a. (July 26, 1977, partial rescission, expired on Jan. 7, 1999) (authorizing ''therapentic . . . abortion as a proper treatment'' in some circumstances pursuant to the procedures described therein).

A VA policy published in 1993 also demonstrates this long-standing interpretation of section 106. With VA's increased focus on health services available for women veterans, VA published VHA Directive 10–93–151, Health Care Services for Women Including General Reproductive Health Care for Women Veterans under the Women Veterans Health Program Act of 1992 (Pub. L. 102–585) (dated Dec. 6, 1993, rescinded Dec. 29, 1994). In para. 2.b. of this 1993 policy, VA squarely addressed section 106's relation to other treatment laws. Specifically, VA explained that the exclusions from ''general reproductive healthcare'' (set forth in section 106(a)(3)) ''do not constitute a ban on the Secretary's authority to provide infertility or abortion services as otherwise authorized under 38 United States Code (U.S.C.) Chapter 17.'' It also explained how the authorities granted in section 106 ''are not new,'' as VA medical centers ''have provided cancer screening to women for some time,'' and it further described how ''general reprodnctive health care'' is ''within the purview of gynecology.'' To this point, when later issuing the medical benefits package, VA included, within covered basic care, infertility services (such as reverse voluntary sterilization and infertility services other than in vitro fertilization) becanse they meet the criteria for inclusion, *i.e.*, ''care that is determined by appropriate healthcare professionals to be needed to promote, preserve, or restore the health of the individual and to be in accord with generally accepted standards of medical practice.'' 64 FR 54207, 54210.

Similarly, VA has provided some infertility services (excluding in vitro fertilization (IVF) pnrsuant to 38 CFR 17.38(c)(2)) and pregnancy-related services under 38 U.S.C. 1710 for decades. See 87 FR 55289; see also 64 FR 54210; VHA Directive 10–93–151, December 6, 1993. Section 106 excludes ''infertility services'' and ''pregnancy care'' in addition to ''abortion'' from care provided under section 106. (We note that section 106 does not further define these terms.) Commenters' reliance on section 106 to object to VA's addition of abortion to care provided under 38 U.S.C. 1710 overlooks VA's longstanding provision of infertility services (exclnding IVF) and pregnancy-related services under 38 U.S.C. 1710, which shows that section 106 does not limit VA's other healthcare anthorities. And VA has long recognized that a veteran could be eligible for certain infertility services (excluding IVF) for a service-connected disability under (former) 38 U.S.C. 1712 (former anthority under which outpatient medical services were provided prior to 1996), even though that veteran would have been ineligible for infertility services under section 106 of the VHCA. 87 FR 55289.

The IFR explained that Congress enacted the VHCA at a time when ''VA health care was subject to a patchwork of eligibility criteria, and care was largely linked only to service-connected conditions,'' and how ''[t]he VHCA, in relevant part, was designed to improve the health care services available to women veterans.'' 87 FR 55288–89. Section 106 of the VHCA, however, was effectively overtaken by a subsequent statutory and regulatory overhaul of VA's medical benefits system, which extended eligibility for hospital care and medical services. The Veterans' Health Care Eligibility Reform Act of 1996 established a system in which an eligible veteran could receive whatever medical care and services the Secretary determines are ''needed.'' 38 U.S.C. 1710; *see, e.g.*, H.R. Rep. No. 104–690, at 4 (1996); *see also id.* (''While the new standard is a simple one, more importantly, it employed a clinically appropriate 'need for care' test, thereby ensuring that medical judgment rather than legal criteria will determine when care will be provided and the level at which that care will be furnished.''); *id.* at 13 (''[The Act] wonld substitute a single, streamlined eligibility provision—based on clinical need for care—for the complex array of disparate rules currently governing veterans' eligibility for hospital and outpatient care.''). As explained in the IFR, ''[t]he Veterans' Health Care Eligibility Reform Act effectively overtook section 106 of the VHCA,'' and ''section 106's prohibition on providing certain services 'under this section' simply is no longer operative.'' 87 FR 55289–90.

b. VA's Interpretation of the Phrase ''But Not Inclnding Under This Sectioo'' in Section 106 of VHCA

Some commenters further asserted that VA's interpretation of the phrase ''but not including under this section'' in section 106 of the VHCA, as reiterated in the lFR (87 FR 55289), was invalid, arguing that such language does not limit abortion restrictions to only that healthcare for women veterans that was provided nnder section 106. In support of this assertion, the commenters proffered that certain prefatory langnage in section 106(a) qualifies the ''under this section'' language in section 106(a)(3) such that the exclusion on abortions there must be read to apply to all hospital care and medical services under chapter 17 of title 38.

VA does not make changes to the rule based on these comments, which misunderstand VA's statutory authority. The VHCA, in relevant part, was designed to improve the health care services available to women veterans. 102 Cong. Rec. 32,367 (1992). Section 106(a) of the VHCA stated that ''[i]n furnishing hospital care and medical services under chapter 17 of title 38, United States Code,''—prefatory language applicable to all of section 106—VA could provide ''women'' with ''[p]apanicolaou tests (pap smears),'' ''[b]reast examinations and mammography,'' and ''[g]eneral reproductive health care . . . , but not including under this section infertility services, abortions, or pregnancy care

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(including prenatal and delivery care), except for such care relating to a pregnancy that is complicated or in which the risks of complication are increased by a service-connected condition.'' Public Law 102–585, sec. 106(a).

As explained above, the VHCA has heen effectively overtaken hy laws that Congress has subsequently enacted. But even taking section 106 on its own terms, the commenters' interpretation of section 106(a)'s prefatory language would render the important ''under this section'' qualifier in section 106(a)(3) a nullity, contrary to longstanding precedent. *Nat'l Ass'n af Mfrs.* v. *Dep't of Def.,* 583 U.S. 109, 128–29 (2018) (''As this Court has noted time and time again, the Court is 'obliged to give effect, if possible, to every word Congress used.' '' (quoting *Reiter* v. *Sonotone Corp.,* 442 U.S. 330, 339 (1979)). If section 106(a)'s prefatory language precluded VA from providing abortion care under its other statutory authorities, then section 106(a)(3)'s ''under this section'' qualifier would be ''a dead letter.'' *United States* v. *Atl. Rsch. Corp.,* 551 U.S. 128, 137 (2007). By contrast, VA's longstanding interpretation of section 106 faithfully reads the statute ''as a whole.'' *Id.* at 135 (quoting *King* v. *St. Vincent's Hospital,* 502 U.S. 215, 221 (1991)). In addition, VA finds support for this in the legislative history accompanying the enactment of section 106. See Joint Explanatory Statement on H.R. 5193, 1992 U.S.C.C.A.N. 4186, 4189–90 (noting ''[t]he inclusion of the phrase 'nnder this section' underscores the intent of the Committees not to limit such anthority as the Secretary may have to provide any infertility services under Chapter 17.''). As explained, moreover, the commenters' interpretation is inconsistent with the plain meaning (and VA's decades-long interpretation) of the phrase ''under this section.''

c. VA's Furnishing of In-Vitro Fertilization Services

Commenters asserted that section 106 of the VHCA remains in effect to prohibit VA from furnishing the health care services permitted under the IFR, citing as evidence the proposition that VA required a special amendment, the ''Mnrray Amendment,'' to carve out an exception from section 106 of the VHCA so that VA could provide IVF services. The Murray Amendment is a reference to section 260 of Public Law 114–223, Division A, title II, enacted on September 29, 2016, and renewed in subsequent fiscal years. Section 260(a)(1) of Public Law 114–223 provides, notwithstanding any other provision of law, that the amounts appropriated or otherwise made available to VA for the Medical Services account may be used to provide fertility counseling and treatment using assisted reproductive technology to a covered veteran or the spouse of a covered veteran, subject to certain statutory and regulatory limitations.

VA does not make changes to the rule based on these comments. VA disagrees with the commenters' assertion that independent authority to provide IVF care was needed to supersede section 106. The Murray Amendment established new authority to provide fertility connseling and treatment nsing assisted reproductive technology not only to a covered veteran but also to the spouse of a covered veteran. It was needed because 38 U.S.C. 1710 does not extend, and never has extended, to a veteran's spouse. See 38 U.S.C. 1710 (referring only to veterans) and 38 U.S.C. 1781 through 1789 (VA's statutory authorities to provide health care to persons other than veterans, which do not extend IVF care to non-veterans). Independent authority was needed to authorize VA to also include the spouses of covered veterans in the VA-furnished IVF episode of care. But the Murray Amendment was not necessary to enable VA to provide infertility services to the veterans themselves under 38 U.S.C. 1710. And as explained above, section 106 has no impact on VA's authority to provide medical services pursuant to section 1710 or any statutory authority other than section 106 itself. In short, the Murray Amendment did not and does not inplicate section 106 of the VHCA.

d. Effect of Deborah Sampson Act of 2020

Some commenters asserted that section 106 of the VHCA must prohibit VA from furnishing the health care services permitted under the IFR becanse the Deborah Sampson Act of 2020 (Pnb. L. 116–315, title V, subtitle A) defined ''health care'' as ''the health care and services included in the medical benefits package provided by the Department before January 5, 2021,'' sec. 5101 of Pnblic Law 116–315, and on January 4, 2021, the health care and services included in tho medical benefits package provided by the Department did not include abortion or abortion counseling. The commenters argued that Congress thus approved of the exclusion of abortion and abortion counseling.

VA does not make changes to the rule based on these comments. The IFR explained that the Deborah Sampson Act of 2020, Public Law 116–315, title V, section 5001 (2021) ''created a central office to, inter alia, 'monitor[ ] and encourag[e] the activities of the Veterans Health Administration with respect to the provision, evaluation, and improvement of health care services provided to women veterans by the Department.' '' 87 FR 55289 (quoting 38 U.S.C. 7310(b)(1)) (alterations in original). Congress defined ''health care'' for these purposes as ''the health care and services included in the medical benefits package provided by the Department as in effect on the day before the date of the enactment of this Act [Jan. 5, 2021].'' *Id.* (quoting 38 U.S.C. 7310 note). At the time, the medical benefits package included (and still includes) care that would have been excluded under the commenters' interpretation of section 106 of the VHCA, such as prenatal and delivery services.

The IFR stated that ''[gliven that VA's medical benefits package as of that date included services that were excluded from the coverage of Section 106 of the VHCA, Congress ratified VA's interpretation that it may provide for these services pursuant to its authority under 38 U.S.C. 1710, notwithstanding section 106. Indeed, the fact that the Deborah Sampson Act of 2020 did not reference section 106 of the VHCA and only referenced VA's medical benefits package shows that Congress did not interpret section 106 of the VHCA as a limitation on VA's authority to provide care to 'women veterans.' '' 87 FR 55289.

Contrary to the commenter's assertioo, the fact that VA had not, in its discretion, exercised its authority at the time of the Act to provide abortions or make exceptions to the regulatory exclusion on abortion does not mean that VA lacks statutory authority under 38 U.S.C. 1710 to determine that abortions in some cases constitute needed care and to accordingly amend its exclusion by regulation. As VA explained in the IFR, the Deborah Sampson Act of 2020 recognized 38 U.S.C. 1710 as a separate treatment authority unaffected and not limited by section 106. In fact, the terms of 38 U.S.C. 7310A(g)(2) as added by the Deborah Sampson Act of 2020 define, for purposes of VA's annual reporting requirement, gender-specific services to include: ''mammography, obstetric care, gynecological care, and such other services as the Secretary determines appropriate,'' some of which VA would not have authority to provide ''under the commenters' interpretation of section 106. *See also supra* I.B.2. Thns, section 106 and its limits on certain care under section 106 of Public Law 102–

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585 were clearly not seen by Congress in promulgating the Deborah Sampson Act of 2020 as having any effect on VA's exercise of authority under 38 U.S.C. 1710.

Nothing in the Deborah Sampson Act of 2020 prohibits VA from removing exclusions from the medical benefits package under 38 U.S.C. 1710. VA recognizes that 38 U.S.C. 7310, Note, (Pub. L. 116–315, title V, section 5101(b)(2)) provides that: "The references to health care and the references to services in sections 7310 and 7310A of title 38, United States Code, as added by paragraph (1), are references to the health care and services included in the medical benefits package provided by the Department as in effect on the day before the date of the enactment of this Act [Jan. 5, 2021]." Congress did not, through that language, freeze in place the types of medical services that VA is authorized to provide under its general treatment authorities. Section 7310 of title 38, U.S.C. relates to the establishment of the Office of Women's Health within VHA and its mission, and 38 U.S.C. 7310A relates to annual reports on Women's Health to be submitted to Congress. Nothing in either statute prohibits VA from expanding the medical benefits package or services or from providing additional information beyond what is required under 38 U.S.C. 7310 and 7310A. And these sections impose no limits on VA's general treatment authority in 38 U.S.C. 1710.

To the contrary, some of the functions of the Office of Women's Health set forth in 38 U.S.C. 7310(b) are to promote the expansion and improvement of clinical activities of VHA with respect to the health care of women veterans and to carry out such other duties as the Under Secretary for Health may require. On its face, the function of the Office to "expand and improve" clinical activities of VHA contemplates VA's authority to modify the medical benefits package to include additional services with respect to the health care of women veterans.

e. Repeal of Section 106 of the VHCA

Some commenters asserted that section 106 has not been expressly repealed and further that repeals by implication are not favored, citing *Branch* v. *Smith*, 538 U.S. 254, 273 (2003), and *Posadas* v. *National City Bank*, 296 U.S. 497 (1936). VA does not make any changes to the rule based on these comments.

At the outset, VA notes that this issue is immaterial because, even if section 106 remained in force, it would not constrain VA's authority to provide services (whether abortions, prenatal care, or other services) limited under section 106 but authorized under other statutory provisions such as 38 U.S.C. 1710 and former 38 U.S.C. 1712. Rather, the limitation in section 106 regarding care "under this section" applies only to section 106.

Regardless, VA disagrees with commenters that section 106 remains in force. As discussed above and in the preamble to the IFR, the Veterans' Health Care Eligibility Reform Act effectively overtook section 106 of the VHCA by establishing a new standard to focus on medical necessity as "the sole criterion of eligibility for VA hospital care and medical services." [1] The "need for care" test was meant to 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." [2] To the extent the commenters would construe section 106 of the VHCA to restrict VA's authority to provide a specific type of health care or service under separate statutory authorities, regardless of a finding of medical need, that restriction would irreconcilably conflict with VA's furnishing of any needed health care or services under 38 U.S.C. 1710. Indeed, for decades, VA has offered general pregnancy care and certain infertility services under 38 U.S.C. 1710 and has not relied on section 106 of the VHCA to provide such services or any other services.

3. Conflict With State Laws

Many commenters generally opined that the IFR violates State laws. VA does not make changes to the rule based on these comments.

The Supremacy Clause of the U.S. Constitution, U.S. Const. art. VI, cl. 2., generally prohibits States from interfering with or controlling the operations of the Federal government, and therefore immunizes the Federal government from State laws that directly regulate it. "[W]hen a federal agency 'perform[s] a federal function pursuant to a law validly enacted by Congress[,] . . . under the Supremacy Clause, the states may not prohibit or, by regulation, significantly burden the manner of its execution without the consent of the United States.'" *Intergovernmental Immunity for the Department of Veterans Affairs and Its Employees When Providing Certain Abortion Services,* 46 Op. O.L.C., __, at *4 (Sept. 21, 2022), *https://www.justice.gov/d9/2022-11/2022-09-21-va_immunity_for_abortion_services.pdf.* Applying this principle to VA's IFR, the Department of Justice's Office of Legal Counsel concluded that "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." *Id.* at *10.

Moreover, VA promulgated a regulation at 38 CFR 17.419 that explicitly preempts any State laws, rules, regulations, or requirements that conflict with a VA health care professional's practice within the scope of their VA employment. As explained in the IFR, consistent with § 17.419, VA has determined that State and local laws, rules, regulations, or requirements, to the extent those laws unduly interfere with Federal operations and the performance of Federal duties, are preempted. That includes laws that States and localities might attempt to enforce in civil, criminal, or administrative matters against VA employees. State and local governments lack legal authority to enforce such laws, rules, regulations, or requirements in relation to health care and medical services provided by VA employees acting within the scope of their VA authority and employment.

One commenter asserted that VA has no basis in Federal law to claim "blanket preemption" in States that prohibit or restrict abortion, and other commenters relatedly stated that VA must be specific with regards to its claim of Federal supremacy. Such comments noted specific kinds of State laws that they asserted VA must either adhere to or demonstrate are explicitly preempted. Other commenters stated that Federal agencies cannot preempt State law unless an explicit conflict exists.

VA does not make changes to the rule based on these comments. It is not clear what the commenter meant by "blanket preemption." VA has been specific as to the scope of preemption; as VA previously confirmed in 38 CFR 17.419, and reiterated in the IFR, VA health care professionals may practice their health care profession consistent with the scope and requirements of their VA employment, notwithstanding any State law or license, registration, certification, or other requirements that unduly interfere with their practice. VA's regulation provides that, in order to "provide the same complete health care and hospital service to beneficiaries in all States as required by 38 U.S.C. 7301, conflicting State laws, rules, regulations, or requirements pursuant to such laws are without any force or effect, and State governments have no legal authority to

[1] H.R. REP. NO. 104–690, at 11.

[2] Id. at 4.

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enforce them in relation to actions by health care professionals within the scope of their VA employment." 38 CFR 17.419. Consistent with the Supremacy Clause and § 17.419, the IFR further explainod that a Stato or local civil or criminal law that restricts, limits, or otherwise impedes a VA professional's provision of needed medical care within the scope of their VA employment, including the health care services permitted under the IFR, would be preempted. VA employees, including health care professionals who provide care and VA employees who facilitate that health care, such as VA employees in administrative positions who schedulo abortion procodures and VA employees who provide transportation to the veteran or CHAMPVA beneficiary to the VA facility for reproductive health care, may not he held liable undcr State or local law or regulation for reasonably performing their Federal duties.

In response to comments that raised specific State requirements related to abortion, and further suggested that VA must show whether such requirements are specifically preempted, we do not make changes. As a general matter, VA determines whether a State law "unduly interferes on a case-by-case basis." See Authority of VA Professionals to Practice Health Care, 85 FR 71838, 71842 (Nov. 12, 2020); Intergovernmental Immunity for the Department of Veterans Affairs and Its Employees When Providing Certain Abortion Services, 46 Op. O.L.C., __, at *10 (Sept. 21, 2022), *https://www.justice.gov/d9/2022-11/2022-09-21-va_immunity_for_abortion_services.pdf.* Accordingly, consistent with VA's existing regulations and the authorities discussed above, any State and local laws and regulations that VA determines would prevent or undnly interfere with VA health care professionals providing needed care as permitted by this rule, would be preempted.

Several commenters referenced a court case related to HHS's interpretation of the Emergency Medical Treatment and Labor Act (EMTALA), which VA believes meant to reference an injunction issued by the U.S. District Court for the Northern District of Texas, *Texas* v. *Becerra,* 623 F. Snpp. 3d 696 (N.D. Tex. 2022), *aff'd,* 89 F.4th 529 (5th Cir. 2024), where the district court was interpreting the specific language of this different statute that applies to certain hospitals that receive Medicare funding. The court was not interpreting VA's statutory authority, or related statutory language applicable here, and its decision and reasoning are not applicable to VA's IFR.

One commenter asserted, without any supporting authority, that VA is required to show a compelling interest to preempt State laws. As VA explained in tho IFR, pursuant to its authoritios in 38 U.S.C. 1710 and 1781, VA implemented the IFR to avert imminent and future harm to veterans and CHAMPVA beneficiaries whose interests Congress entrnsted VA to serve. As explained above, 38 CFR 17.419(c) preempts "conflicting State laws, rules, regulations, or requirements pursuant to such laws" to the extent the State law unduly interferes with VA's ability "provide the same complete health care and hospital services to beneficiarios in all Statos" including, but not limited to, abortion. VA takes no action based on this comment.

4. Conflict With the Holding in Dobbs and the Tenth Amendment

Some commenters stated that the *Dobbs* decision delegated abortion matters to States rather than the Federal government, and further that the Tenth Amendment of the United States Constitution limits VA's authority to proempt State law. VA takes no action based on these comments. The *Dobbs* decision overturned *Roe* v. *Wade,* 410 U.S. 113 (1973), and *Planned Parenthood of Southeastern Pennsylvania* v. *Casey,* 505 U.S. 833 (1992), and in no way affects VA's Federal statutory authority to develop regulations and policy related to the agency's own provision of needed medical care, including the health care services permitted nnder the IFR. VA furnishes hospital care and medical services determined to be needed pursuant to VA's general treatment authority for veterans (38 U.S.C. 1710), and pursuant to rogulation through VA's medical benefits package (38 CFR 17.38). VA has determined that the hcalth care services permitted by the IFR are needed. Similarly, VA has determined that providing access to such care is medically necessary and appropriate to protect the health of CHAMPVA beneficiaries. *See* 38 U.S.C. 1781; 38 CFR 17.270(b) (defining "CHAMPVA-covered services and supplies" as "those medical services and supplies that are medically necessary and appropriate for the treatment of a condition and that are not specifically excluded under [38 CFR 17.272(a)(1)] through (84)"). As explained above, the Supremacy Clause of the United States Constitution prohibits statcs from restricting Federal agencies and their employees acting within the scope of their Federal authority from providing abortion services. *See generally Intergovernmental Immunity for the Department of Veterons Affoirs and Its Employees When Providing Certain Abortion Services,* 46 Op. O.L.C., __, (Sept. 21, 2022), *https://www.justice.gov/d9/2022-11/2022-09-21-vo_immunity_for_abortion_services.pdf.*

The Tenth Amendment of the United States Constitution provides that the powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people. VA is a Federal health care system, the operations of which are governed by Federal law, consistent with title 38, United States Code. VA's authority to furnish health care to veterans and CHAMPVA beneficiaries has been granted by Federal statnte as described above. VA's issuing of the IFR does not encroach on any rights reserved to the States or to the people and is not a violation of the Tenth Amendment to the United States Constitution. The statement of preemption of conflicting State law under the IFR is consistent with 38 CFR 17.419(c) and lawful pursuant to the Supremacy Clause, U.S. Const. art. VI, cl. 2.

5. Conflict With Department of Defense Authorities

Commenters alleged that this rule violates 10 U.S.C. 1093 and that VA cannot or should not provide broader access to abortion counseling and abortions than DoD. Multiple of these commenters further asserted that it is hard to imagine that Congress intended for former members of the armed services and their dependents to have access to abortion under VA programs when current service members do not have such access under DoD programs, and one commenter incorrectly stated that VA Medical Centers are facilities within the control of DoD. VA does not make changes to the rule hased on these comments.

Section 1093 of title 10 of the U.S. Code establishes that DoD may not nse funds or facilities "to perform abortions except where the life of the mother would he endangered if the fetus were carried to term or in a case in which the prognancy is the rosnlt of an act of rape or incest." Section 1093 applies only to the use of DoD funds and facilities, not to VA funds and facilities. VA notes, however, that the terms of 10 U.S.C. 1093 conflict with the assertions made by some commenters that active-duty members of the armed services can never receive abortions under DoD programs.

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To the extent that some of these commenters raised the issue of dependents of service members having access to services in VA programs that they would not have under DoD programs for dependents, the statute governing VA's coverage for CHAMPVA beneficiaries specifically recognizes the possibility of differences in what care is covered under this VA program as opposed to the care covered under the similar DoD program, *i.e.*, TRICARE (Select). Congress did not require that VA furnish identical medical benefits to those not eligible for TRICARE (Select). Rather, the law directs VA to provide CHAMPVA beneficiaries with medical care "in the same *or similar* manner and subject to the same *or similar* limitations as medical care" furnished to DoD TRICARE Select beneficiaries. 38 U.S.C. 1781(b) (emphases added). Indeed, prior to the IFR, CHAMPVA was not identical to TRICARE (Select). *See, e.g.*, 87 FR 55290. For example, the former did not include access to abortions in cases of rape or incest, while the latter did. The IFR brought CHAMPVA more in line with TRICARE (Select) in this regard. The commenter does not address the statute's repeated use of the phrase "or similar." That text recognizes differences may exist between the two programs' respective beneficiary populations and their needs. As VA explained in the IFR, VA has previously regulated to provide CHAMPVA benefits beyond those benefits offered by TRICARE (Select) if providing such health care would better promote the long-term health of CHAMPVA beneficiaries. 87 FR 55290. Further, CHAMPVA beneficiaries (unlike TRICARE (Select) beneficiaries) include family caregivers of veterans, not just eligible dependents. 38 U.S.C. 1720G(a)(3)(A)(ii)(IV). Consistent with the statute's plain meaning, VA provides CHAMPVA beneficiaries certain care that is "similar," but not necessarily identical, to care provided to beneficiaries of TRICARE (Select). *See, e.g.*, 73 FR 65552 (November 4, 2008) (adding coverage for medically necessary prostheses because of significant conditions and removing exclusion of enuretic devices despite each not being covered by TRICARE (Select)); 87 FR 41594 (July 13, 2022) (providing coverage for annual physical exams, even though excluded in TRICARE (Select)).

6. Conflict With the Antideficiency Act

Commenters stated that VA is barred from providing or paying for abortion or abortion counseling pursuant to the Antideficiency Act. VA does not make changes to the rule based on these comments. The Antideficiency Act, 31 U.S.C. 1341(a), generally prohibits Federal agencies from making expenditures in excess of available appropriations or in advance of appropriations. Per 31 U.S.C. 1349(a) and 1350, there are penalties associated with violations of the Antideficiency Act.

In this case, the Antideficiency Act is not implicated because Congress appropriated funds to VA to perform authorized services. Per title II of division J of the Consolidated Appropriations Act, 2021 (Pub. L. 116–260), title II of division J of the Consolidated Appropriations Act, 2022 (Pub. L. 117–103) and title II of division J of the Consolidated Appropriations Act, 2023 (Pub. L. 117–328), funds appropriated for fiscal years 2022, 2023, and 2024 to the Medical Services appropriations account have been made available "[f]or necessary expenses for furnishing, as authorized by law, inpatient and outpatient care and treatment to beneficiaries of the Department of Veterans Affairs and veterans described in section 1705(a) of title 38, United States Code, including care and treatment in facilities not under the jurisdiction of the Department." The Medical Community Care appropriations account for fiscal years 2022, 2023, and 2024, has been made available "[f]or necessary expenses for furnishing health care to individuals pursuant to chapter 17 of title 38, United States Code, at non-Department facilities." Title II, Division J, Consolidated Appropriations Act, 2021 (Pub. L. 116–260); Title II, Division J, Consolidated Appropriations Act, 2022 (Pub. L. 117–103); Title II, Division J, Consolidated Appropriations Act, 2023 (Pub. L. 117–328). More specifically, the Medical Services appropriation is for necessary expenses of inpatient and outpatient VA beneficiary care provided by VA at VA facilities and Government facilities for which VA contracts. The Medical Community Care appropriation is for necessary expenses of providing healthcare to VA beneficiaries in the community—facilities other than VA facilities and Government facilities for which VA contracts.

As explained, an abortion is authorized care under 38 U.S.C. 1710, the IFR, and the medical benefits package when a health care professional determines it to be needed and in accord with generally accepted standards of medical practice and: (1) the life or the health of the pregnant veteran would be endangered if the pregnancy were carried to term; or (2) the pregnancy is the result of an act of rape or incest. Expenditures associated with such authorized care may be made from VA's Medical Services and—when appropriate—Medical Community Care accounts.

The IFR also authorizes the provision of medically necessary abortions and abortion counseling under VA's CHAMPVA program, 38 U.S.C. 1781, under the circumstances described in the rule. Medical Services and Medical Community Care account funds are used for the CHAMPVA program and may therefore be used for authorized counseling and care. Such expenditures are proper and do not violate VA's appropriations act or the Antideficiency Act.

7. Conflict With the Hyde Amendment

Some commenters stated that VA is barred from providing or paying for the health care services permitted under the IFR pursuant to what is referred to as the Hyde Amendment. VA does not make changes to the rule based on these comments.

VA is not subject to the Hyde Amendment, which addresses Federal funds available to the Departments of Labor, Health and Human Services, and Education in legislation on annual appropriations. Division H of Public Law 117–328; *see also* 87 FR 55290. Accordingly, VA is not barred by the Hyde Amendment from spending its funds to provide authorized health care services permitted by the IFR.

8. Couflict With the Assimilative Crimes Act aud VA-Related Regulation

Some commenters asserted that the IFR violates the Assimilative Crimes Act, 18 U.S.C. 13, which allows the Federal government to prosecute a State crime as a Federal offense in limited circumstances when such offense has been committed on an area within the jurisdiction of the United States known as a Federal enclave and is not otherwise a Federal offense. These commenters appeared to assert that if a State makes it a crime to perform an abortion, any abortion performed in that State, in the absence of a Federal law prohibiting such performing of an abortion, would be unlawful under 18 U.S.C. 13 if performed on Federal property. Relatedly, one commenter alleged that the rule conflicts with 38 CFR 1.218(c)(3), which states that nothing contained in the rules and regulations set forth under 38 CFR 1.218(a) shall be construed to abrogate any other Federal laws or regulations, including assimilated offenses under 18 U.S.C. 13, or any State or local laws and regulations applicable to the area in which the property is situated.

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VA does not make changes to the rule based on these comments. As some of these commenters acknowledged, the Department of Justice's Office of Legal Counsel (OLC) has examined whether the Assimilative Crimes Act would apply to Federal employees performing their duties in a manner authorized by Federal law, while on a Federal enclave, which may include VA hospitals. OLC concluded that Federal employees engaging in such conduct would not violate that statute and could not be prosecuted by the Federal government under that law. *Application of the Assimilative Crimes Act to Conduct of Federal Employees Authorized by Federal Law,* 46 Op. O.L.C. __ (Aug. 12, 2022), *https://www.justice.gov/olc/file/1527726/download.* The reasoning in that opinion applies to VA employees on Federal enclaves who are providing care in accordance with their Federal duties authorized under the IFR. The commenter did not provide any response to this analysis, other than to reiterate the commenter's view that Federal law "places significant limitations on abortions in VA programs." As explained, however, VA has statutory authority to provide the health care services permitted under the IFR.

Furthermore, the IFR is not in conflict with 38 CFR 1.218(c)(3), which provides, "Nothing contained in the rules and regulations set forth in paragraph (a) of this section shall be construed to abrogate any other Federal laws or regulations, including assimilated offenses under 18 U.S.C. 13 or any State or local laws and regulations applicable to the area in which the property is situated." Paragraph (a) of such section describes rules and regulations that apply at a property under the charge and control of VA, and to persons entering such property, including, for example, conduct related to gambling, use of service animals, creation of disturbances, and vehicular and pedestrian traffic. 38 CFR 1.218(a). This provision is unrelated to matters of medical practice or the provision of medical benefits. It does not subject VA and its employees to State or other local restrictions on any form of medical care that VA staff are authorized to furnish, including VA's provision of health care services permitted under the IFR. Additionally, because the Assimilative Crimes Act has no application to VA employees practicing within the scope of their VA practice, as explained above, the portion of 38 CFR 1.218(c)(3) referring to the Act has no application to care provided under the IFR.

9. Conflict With Interstate Prohibitions Under 18 U.S.C. 1461 and 1462

Commenters alleged that the IFR violates 18 U.S.C. 1461 and 1462. Section 1461, in pertinent part, prohibits the mailing of "[e]very article or thing designed, adapted, or intended for producing abortion, or for any indecent or immoral use" and "[e]very article, instrument, substance, drug, medicine, or thing which is advertised or described in a manner calculated to lead another to use or apply it for producing abortion, or for any indecent or immoral purpose." Section 1462, in pertinent part, prohibits the knowing use of "any express company or other common carrier or interactive computer service" for transportation across State lines of "any drug, medicine, article, or thing designed, adapted, or intended for producing abortion, or for any indecent or immoral use[.]" These commenters also alleged that violation of these laws then support offenses under 18 U.S.C. 1961(1)(B) and 18 U.S.C. 552 (prohibiting Federal employees from aiding and abetting persons engaged in violation of laws prohibiting dealing in, among other things, the means for procuring abortion).

VA does not make changes to the rule based on these comments because the IFR is consistent with 18 U.S.C. 1461. In December 2022, OLC concluded that 18 U.S.C. 1461 does not prohibit the mailing of certain drugs that can be used to perform abortions where the sender lacks the intent that the recipient of the drugs will use them unlawfully. Because there are manifold ways in which recipients in every State may lawfully use such drugs, the mere mailing of such drugs to a particular jurisdiction is an insufficient basis for concluding that the sender intends them to be used unlawfully. *See Application of the Comstock Act to the Mailing of Prescription Drugs That Can Be Used for Abortions,* 46 Op. O.L.C., __, at 1 (Dec. 23, 2022), *https://www.justice.gov/d9/opinions/attachments/2023/01/03/2022-12-23_-_comstock_act_1.pdf.* In support of this conclusion, the OLC opinion explains that there are uses of these medications that State law does not prohibit, including mailing of abortion medications intended, for example, to be used pursuant to Federal authorities. Federal agencies, including VA, provide lawful abortions pursuant to their Federal authorities; therefore the mailing of abortion medications intended to be used lawfully pursuant to those authorities would not violate 18 U.S.C. 1461. This opinion further explains that the same analysis is applicable to the cognate provision 18 U.S.C. 1462. *Id.* at 2 n.3. Because any mailing or other transporting across State lines of certain medications or items under the IFR would not violate 18 U.S.C. 1461 or 1462, there is no subsequent potential offense under 18 U.S.C. 1961(1)(B) and 18 U.S.C. 552.

10. Conflict With the Major Questions Doctrine

Commenters alleged that this rule violates the major questions doctrine, referencing *West Virginia* v. *Environmental Protection Agency,* 142 S. Ct. 2587 (2022). Under such doctrine, an agency must identify clear congressional authorization for its exercise of authority in " 'extraordinary cases' in which the 'history and the breadth of the authority that [the agency] has asserted,' and the 'economic and political significance' of that assertion, provide a 'reason to hesitate before concluding that Congress' meant to confer such authority." *Id.* at 2608 [alterations in original]. VA does not make changes to the rule based on these comments. As explained above, VA has not found "a newfound power" in an "ancillary provision" of the Veterans' Health Care Eligibility Reform Act of 1996, as the Supreme Court found the Environmental Protection Agency had done with the Clean Power Plan. *West Virginia,* 142 S. Ct. at 2602, 2610. Congress expressly delegated to the Secretary of Veterans Affairs the authority to "furnish hospital care [and] medical services . . . which the Secretary determines to be needed." 38 U.S.C. 1710(a)(1)–(3). Identifying the medical services "determine[d] to be needed" for veterans is clearly within VA's authority. As discussed above, prior to promulgation of the final rule establishing VA's medical benefits package in October of 1999, VHA Policy, Manual M–2, Professional Services Part XIV, Surgical Service, Change 27, paragraph 9.02a. (July 26, 1977, partial rescission, expired on Jan. 7, 1999), recognized the need for and authorized the provision of a "therapeutic . . . abortion as a proper treatment" in some circumstances pursuant to the procedures described therein. The IFR is thus a traditional exercise of VA's established authority to determine what medical services are "needed" and, therefore, to decide what specific medical services VA will cover or provide under the medical benefits package.

Additionally, Congress has directed VA to provide "for medical care" under CHAMPVA "in the same or similar manner and subject to the same or similar limitations as medical care is" provided under TRICARE (Select). As

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explained in the IFR, VA has previously deviated from TRICARE (Select) in amending its CHAMPVA regulations to provide services that best promote the long-term health of CHAMPVA beneficiaries while remaining sufficiently "similar" to TRICARE (Select). 87 FR 55290–55291. Thus, this IFR is also a traditional exercise of VA's authority to administer CHAMPVA and decide what medical services are medically necessary and appropriate for CHAMPVA coverage while remaining sufficiently "similar" to TRICARE (Select).

11. The Born Alive Infants Protection Act

One commenter inquired what VA will do to comply with its obligations under the Born Alive Infants Protection Act of 2002, and further stated that VA fails to explain what policies and procedures are in place to ensure that any children born alive after attempted abortions are given appropriate medical care in the same manner as other children born alive. The Born-Alive Infants Protection Act of 2002, Public Law 107–207, was enacted August 5, 2002, and is codified at 1 U.S.C. 8. The Act clarifies that, for purposes of any Act of Congress or any ruling, regulation, or interpretation of the various Federal agencies, the meaning of the words "person," "human being," "child," or "individual" "shall include any infant member of the species homo sapiens who is born alive at any stage of development." VA is subject to, and will continue to comply with, the provisions found in 1 U.S.C. 8. Additionally, VA is authorized to provide certain health care services to a newborn child of a woman veteran receiving care from VA. 38 U.S.C. 1784A and 1786. VA does not make changes to the rule based on this comment.

II. Comments That Raised Concerns With VA's Good Cause Analysis To Issue an IFR

VA issued an IFR, in which the changes to 38 CFR 17.38 and 17.272, were effective immediately upon publication, and the public comment period began on the date of publication. 87 FR 55287. VA found that good cause justified forgoing advance notice for public comment and a delayed effective date. 5 U.S.C. 553(b)(B), (d)(3). VA cited its urgent need to provide access to abortion counseling and to abortions in cases of rape or incest or where the life or health of the pregnant individual is in danger following *Dobbs*. After *Dobbs*, some States had begun to enforce existing abortion bans and restrictions on care and were proposing and enacting new bans and restrictions containing limited exceptions for medical necessity; some also included exceptions for pregnancy that is the result of rape or incest. These measures were creating urgent risks to the lives and health of pregnant veterans and CHAMPVA beneficiaries in those States. 87 FR 55294. VA received comments that opposed VA's issuance of an IFR based on general assertions that VA's good cause justification was insufficient, although only some of these comments directly addressed VA's good cause. VA notes at the outset that our request for comment in the IFR and issuance of this final rule have overtaken any assertions concerning a lack of good cause. In any event, VA addresses below the comments it received concerning VA's good cause for making the IFR effective immediately.

A. General Assertions Thot Good Cause Was Not Established

Some commenters asserted that VA's good cause justification was insufficient for general reasons unrelated to VA's rationales supporting good cause. Many of the duplicated form responses that VA received as comments asserted that the IFR violated the Administrative Procedure Act (APA) and stated that the APA requires that the public have an opportunity to provide comment on matters of public interest before a rule is effective. VA does not change course based on these comments. The APA, codified in part at 5 U.S.C. 553, generally requires that agencies publish substantive rules in the **Federal Register** for notice and comment and provide at least a 30-day delay before the rules become effective. 5 U.S.C. 553(b), (d). However, an agency may forgo prior notice if the agency for good cause finds that compliance would be impracticable, unnecessary, or contrary to the public interest (5 U.S.C. 553(b)(B)) and may also bypass the APA's 30-day delayed effective date requirement if good cause exists (5 U.S.C. 553(d)(3)), or if the rule "grants or recognizes an exemption or relieves a restriction" (5 U.S.C. 553(d)(1)). VA found good cause under 5 U.S.C. 553(b)(B), ((d)(3), and also explained that the IFR removed certain restrictions (*see* 87 FR 55294–96), and therefore did not violate the APA in issuing the IFR.

Other commenters asserted that although a Federal agency is allowed to publish an IFR, VA did not demonstrate that it had good cause to do so. Because these commenters did not specifically assert or explain why they believed VA did not demonstrate good cause, VA does not change course based on these comments. As VA explained in the IFR, VA had good cause to make the IFR effective immediately because delaying its effectiveness would leave many veterans and CHAMPVA beneficiaries without access to needed and medically necessary and appropriate health care—abortions and abortion counseling that VA is able to provide under the IFR—thus putting their health and lives at risk. 87 FR 55295–96. Immediate effectiveness was critical following State actions to further ban or restrict abortion post-*Dobbs*. *Id*. These State bans and restrictions on abortion presented a serious threat to the health and lives of over one hundred thousand veterans and CHAMPVA beneficiaries who relied, or may rely in the future, on VA health care. *Id*. VA determined that such bans and restrictions would have an immediate detrimental impact on the lives and health of veterans and CHAMPVA beneficiaries who are unable to receive the care that was available in the community before the *Dobbs* decision, especially as State laws prompted providers to cease offering abortion services altogether. 87 FR 55295–55296. This detrimental impact is underscored by the potential harmful effects associated with being denied an abortion when an abortion is needed to protect the life or health of the pregnant individual or when the pregnancy is the result of an act of rape or incest. *Id*. As noted in the IFR, it was estimated that up to 53 percent of veterans of reproductive age may be living in States that either had already banned abortions or were soon expected to ban abortions, following *Dobbs*. 87 FR 55295. VA also estimated that nearly 50,000 CHAMPVA beneficiaries could have been impacted by such those then-current or expected bans. *Id*.

Some commenters asserted that the substantive provisions of the IFR were generally not in the public interest or in States' interests (for those States that have instituted more stringent restrictions on abortions or more burdensome requirements on abortion counseling), and therefore VA could not have provided adequate good cause. These commenters did not offer specific reasons why VA did not have good cause to issue the IFR; rather, they seemed to assert that because they deemed a substantive provision of an IFR to generally be against the public or States' interests, then a good cause justification must necessarily fail. In invoking the public interest prong of the good cause exemption, the question is not whether a substantive provision of a rule, itself, would be contrary to public interest in the minds of some, but

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whether following "ordinary procedures—generally presumed to serve the public interest—would in fact harm that interest." *Mack Trucks, Inc.* v. *EPA*, 682 F.3d 87, 95 (D.C. Cir. 2012). For the reasons explained in the IFR, VA provided good cause for why providing advance notice and comment would be contrary to public interest. *See, e.g.*, 87 FR 55294–96.

B. Specific Assertions That Good Cause Was Not Established

Some commenters asserted that VA's good cause justification was insufficient for reasons more directly related to the reasons VA stated in finding good cause. These commenters did not agree with VA's statement of urgent need to provide access to the health care services permitted under the IFR following the ruling in *Dobbs*, which resulted in some States severely restricting and banning abortion. VA groups and summarizes such comments below.

Some commenters asserted that the IFR was not urgently needed because every, or nearly every, State that restricts abortion permits exceptions when the life of the pregnant individual would be endangered were the pregnancy carried to term, and further that some of those States also permit exceptions where the pregnancy was the result of rape or incest. These commenters generally seemed to assert that if many or enough of the States had similar exceptions for abortions as the IFR, then there could not be sufficient need among veterans to access the health care services permitted under the IFR from VA to support good cause.

VA does not change course based on these comments. The fact that some, but not all, States might permit similar access to care as VA is not sufficient to prevent endangerment to the life or health of pregnant individuals that VA serves. *See* 87 FR 55288 (concluding that care available under the IFR is needed and medically necessary and appropriate). In fact, even though some States may allow an abortion to prevent the endangerment to the life of a pregnant individual, they may not allow an abortion to prevent the endangerment to the health of a pregnant individual. When pregnant veterans and CHAMPVA beneficiaries face pregnancy-related complications that their VA health care providers have determined are putting their health or lives at risk or are pregnant due to an act of rape or incest, they must be confident that their providers can take the clinically necessary action to provide needed and medically necessary and appropriate health care. And even in States that restrict abortions subject to exceptions similar to VA's, abortion access is often subject to additional restrictions that VA, on the basis of its authorities and obligations, has not adopted, such as timeframe limitations, evidentiary requirements, or prerequisite procedures (such as mandatory waiting periods or required ultrasounds), which could delay delivery of care that is often time sensitive. VA must always ensure it can consistently meet the medical needs of veterans and CHAMPVA beneficiaries across its healthcare system. Even one State presents enough risk to the lives and health of veterans and CHAMPVA beneficiaries to support VA's good cause justification in the IFR. As the IFR states, "[a]llowing even one preventable death of a veteran or CHAMPVA beneficiary by limiting access to abortions is unacceptable." 87 FR at 55296.

Commenters further asserted that VA's statements of good cause were not substantiated because VA did not cite specific cases where needed and medically necessary and appropriate care would not be permitted. In so doing, commenters argued that VA must conduct a more thorough analysis to more specifically identify those individuals who cannot get the care VA has found to be needed and medically necessary and appropriate. Those commenters are incorrect. VA explained that "certain States have begun to enforce abortion bans and restrictions on care, and are proposing and enacting new ones." *Id.* at 55288; *see also id.* at 55293, 55295 (citing examples and describing the evolving legal landscape). VA also documented the pressing need to ensure that *all* of the veterans and CHAMPVA beneficiaries for which VA provides healthcare have access to needed and medically necessary and appropriate care. *Id.* at 55291–92.

Other commenters asserted that VA has not issued statements regarding, or otherwise does not have, a clear plan to implement the provisions of the IFR despite asserting an emergency to support good cause. These commenters seemed to argue that there can be no need to forgo notice and comment procedures and dispense with a delayed effective date if VA is not yet ready to implement the IFR on a large-scale level. That is incorrect: VA was prepared to offer health care services permitted under the IFR on the day the IFR was published.

To the extent commenters posit that abortion is harmful to patients or is never necessary—that abortions are, essentially, illegitimate medical services, thereby negating VA's good cause argument and grounds for publishing the IFR—the commenters failed to provide a rationale for, and to demonstrate the basis for, this position. The VA Secretary has determined that the health care services permitted under the IFR are needed pursuant to 38 U.S.C. 1710 and are medically necessary and appropriate pursuant to 38 U.S.C. 1781, as implemented by 38 CFR 17.270 *et seq.*, and VA has authority to provide these services under the terms of the IFR, as explained there. As non-exhaustive examples, the IFR identified conditions such as "severe preeclampsia, newly diagnosed cancer requiring prompt treatment, and intrauterine infections, and . . . pre-existing conditions exacerbated by continuing the pregnancy," for which pregnancy termination "may be the only treatment available to save the health or life of the pregnant individual." 87 FR 55295. In States that restrict access to abortion services, treatment delayed so VA could seek prior public comment would have been treatment denied.

Other commenters asserted that the timing of VA's publication of the IFR, being two months after publication of the *Dobbs* decision (and four montbs after such decision "leaked" as stated in the comments) was too late to justify VA's statement of need in support of its good cause. In support of this assertion, these commenters proffered that because VA was aware that the Supreme Court could overturn *Roe*, prior to the *Dobbs* decision, and because some States had taken anticipatory action prior to the *Dobbs* decision, VA would have issued the IFR sooner if there were an actual emergent need. VA does not change course based on these comments. The administrative process for VA to weigh policy, make decisions, draft a rulemaking, and have that rulemaking clear all required reviews prior to publication in the **Federal Register** can routinely take substantial effort and time. Indeed, the Supreme Court has found that an agency taking two months to prepare a 73-page rule did not constitute "delay" inconsistent with the Secretary's finding of good cause. *Missouri*, 142 S. Ct. at 654. Here, the publication of the IFR was completed at the earliest possible time and ensures that, irrespective of contrary State laws post-*Dobbs*, veterans and CHAMPVA beneficiaries can receive access to the needed and medically necessary and appropriate health care services permitted under the IFR.

One commenter opined that the IFR lacked good cause because VA has always provided care to pregnant individuals in life-threatening

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circumstances, including treatment for ectopic pregnancies or miscarriages, which were covered under VA's medical benefits package prior to the IFR. In support, the commenter cited to Veterans Health Administration (VHA) Directive 1330.03, titled Maternity Health Care and Coordination, dated November 3, 2020. The commenter further stated that providing such lifesaving care to a pregnant individual is not an abortion and is already allowed. This commenter seemed to assert that because VA provided some lifesaving treatment to manage certain complications associated with pregnancy prior to the IFR, that there could not have been an emergency to warrant VA's issuance of the IFR. While VA agrees that the care identified by the commenter has been lawfully provided, as discussed herein and in the IFR (for example, see 87 FR 55291), there are many life- and health-endangering complications of pregnancy other than ectopic pregnancies and miscarriages where abortion would be the needed or necessary treatment, and prior to the IFR, VA's medical benefits package did not provide access to care in such circumstances.

One commenter opined that the IFR did not have good cause since it undermines what the commenter described as the "pro-life policy stance" of Congress and further disregards governmental interests, including "interest in safeguarding preborn human life". VA disagrees with the commenter's assertion and implemented the IFR pursuant to the authority Congress granted VA to furnish eligible veterans and CHAMPVA beneficiaries with medical services that VA determines to be needed and medically necessary and appropriate. 38 U.S.C. 1710, 1781; 87 FR 55291–55293. The changes made by the IFR were within the scope of the authority Congress has provided to VA.

III. Comments Asserting That the IFR Is Too Broad

Commenters raised concerns with various aspects of the IFR being overly broad so as to allow for abortions for reasons beyond the circumstances stated in the IFR. VA summarizes and addresses those comments below.

A. Lack of Definition of Abortion

One commenter opined that the IFR avoided clarity by not defining abortion. VA does not make changes to the rule based on this comment. VA does not specifically define in its regulations the other various types of care provided under the medical benefits package or covered by CHAMPVA. As the medical field is constantly evolving, attempting to define medical terms in regulation could be arbitrary or outdated based on evolving standards of practice and thus could result in unintended limitations on the provision of life and health-saving care. Therefore, and consistent with other treatments listed in such regulations, VA does not find it appropriate to define the term abortion in regulation.

B. The Term "Health" Is Too Broad or Not Defined

Several commenters asserted that the term "health," in the context of the exception permitting abortion if a health care provider determines that the "health" of the pregnant individual would be endangered were the fetus carried to term, was too broad in scope. Some asserted that the lack of definition for the term "health" means VA will provide abortions in all circumstances, or, essentially, allow for "elective abortions." Other commenters more specifically asserted that the Supreme Court broadly defined "health" for purposes of abortion as "physical, emotional, psychological, familial, and the woman's age—relevant to the wellbeing of the patient. All these factors may relate to health." *Doe* v. *Bolton*, 410 U.S. 179, 192 (1973). These commenters argue that a rule permitting abortion for reasons of health without further qualification or limitation could be interpreted in a way that increases access to abortions beyond the scope stated in the IFR.

VA does not make changes to the term "health" or further define or characterize it in regulation based on these comments. VA has existing statutory and regulatory authorities that establish when needed care provided under the medical benefits package may be provided to an individual veteran and when medically necessary services are covered by CHAMPVA.

As explained in the IFR, VA's general treatment authority requires the Secretary to determine what "hospital care and medical services" are "needed." 38 U.S.C. 1710. Consistent with this authority and under the IFR, VA provides an abortion to a veteran only if an appropriate health care professional determines that such care is in accord with generally accepted standards of medical practice and is needed to promote, preserve, or restore the health of the individual, consistent with the definitions set forth by existing VA regulations. 38 CFR 17.38(b).

With respect to CHAMPVA, VA provides beneficiaries with medical services and supplies if the services and supplies are "medically necessary and appropriate for the treatment of a condition" and "not specifically excluded from program coverage." *See* 38 CFR 17.272(a). With respect to abortions, VA would provide or reimburse for the care only if the life or the health of the pregnant beneficiary would be endangered if the pregnancy were carried to term or if the pregnancy is the result of an act of rape or incest. See *id.* at § 17.272(a)(64).

Because determining whether a pregnant individual's health is endangered necessarily requires an individualized assessment by a health professional, VA does not believe it is appropriate to define the term "health" in regulation. Attempting to define every single condition, illness, and other circumstance (and combination of such circumstances) that could be included under such a definition would likely be arbitrary and incomplete and thus could result in veterans and CHAMPVA beneficiaries not receiving needed and medically necessary and appropriate care.

C. Breadth of Determinations by, or Quolifications of, Health Care Professionals

One commenter asserted "the phrase 'if determined to be needed by' a medical professional . . . allows abortion on demand" because it generally allows a provider to say such care is "needed for mental anguish or anxiety". VA does not make changes to the rule based on this comment. As stated above, the IFR does not allow for abortions in all circumstances; rather, it allows only those permitted under the circumstances described in the IFR when the life or health of the individual would be endangered if the pregnancy were carried to term or when the pregnancy is the result of rape or incest. The decision of whether a veteran's health is endangered is a clinical decision made on an individual, case-by-case basis using the standard provided in 38 CFR 17.38(b) for the provision of health care to veterans. VA health care professionals consider a veteran's health in terms of the veteran's whole health when determining if care is needed to promote, preserve, or restore the health of the individual and is also in accord with generally accepted standards of medical practice, pursuant to 38 CFR 17.38(b). As to CHAMPVA beneficiaries, a determination is likewise performed on a case-by-case basis, with the health care provider determining if the care is medically necessary and appropriate for the treatment of a condition and not specifically excluded from program coverage. *See* 38 CFR 17.272(a).

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Multiple commenters raised concerns that VA did not indicate in the IFR the qualifications or professional competence required for VA health care professionals to furnish the health care services permitted nnder the IFR. One commenter more specifically alleged that, to merely permit a "health care professional" (as that term was used in the preamble of the IFR) to determine the clinical need for an abortion would allow for personnel without any gynecological or obstetrical skill or experience to make such determination. One commenter more generally raised concerns about who determines whether the life of the pregnant individual is at risk and at what degree, and other commenters specifically requested that VA ensure only physician-led teams are making these clinical eligibility decisions.

VA does not make changes to the rule based on these comments. As a preliminary matter, VA regulations specify that care in the medical benefits package will only be provided if an "*appropriate* health care professional[ ]" determines that it is needed. 38 CFR 17.38(b) (emphasis added). VA health care professionals are not permitted to provide any medical care, including making determinations abont needed care, beyond the scope of their VA practice, training, expertise, and demonstrated skills and abilities. 38 U.S.C. 7402 and 38 CFR 17.419. Regarding the expressed concerns about the term "health care professional," or the lack of defined qualifications or occupations in the IFR to designate that a "health care professional" is permitted to determine whether an abortion is medically necessary, VA notes that the regulations revised by the IFR (38 CFR 17.38 and 38 CFR 17.272) only address the coverage of health care and not the provision of health care by a "health care professional" or the training or credentials they must possess. Therefore, this final rule will not specify particular occupations or qualifications for a VA health care professional to provide either abortion counseling or abortions under the circumstances identified through this rule. VA reiterates that only an appropriate health care professional can make determinations about what care is needed. A VA health care professional is not and will not be permitted to provide any medical care beyond the scope of their VA practice, training, expertise, and demonstrated skills and abilities in any context, including if providing either abortion counseling or abortions.

Regarding the comment that inquired about the degree of risk to life to be ascertained when determining whether an abortion is medically necessary, that determination is made by the appropriate health care professional on a case-by-case basis; VA will not establish a threshold degree of risk to life that is required before an individual is determined eligible for an abortion through VA because every case is clinically distinct. Regarding the requests that VA only permit decisions about the provision of abortions to be made by physician-led teams, VA restates from above that this final rule will not specify particular occupations or qualifications for a VA health care professional to provide either abortion counseling or abortions. VA does not intend for any occupation to perform clinical duties beyond their occupational training and expertise, and their practice will be consistent with generally accepted standards of care.

One commenter stated that the regulations were vague and can leave room for interpretation, and further suggested that VA have a service that would allow doctors or staff the ability to get a second opinion, feedback, and ability for quick determinations or assistance. VA does not make changes to the rule based on this comment. The IFR does not restrict VA health care professionals' ability to seek consultations for assistance with determinations of clinical necessity for any health care or service provided, to include the health care services permitted by the IFR.

D. Lack of Gestational Limits

Commenters raised concerns that the IFR did not establish gestational age limits beyond which an abortion would not be permitted, which they asserted will authorize VA to provide abortions for reasons beyond the circumstances permitted in the IFR. Most of these commenters did not offer specific support for this concern. Other commenters asserted that an abortion is only necessary up to a certain gestational age. One commenter specifically inquired about a gestational age limit for pregnancies that were the result of rape or incest, and relatedly other comments stated that some States that permit abortion in cases where the pregnancy is the result of rape or incest also have gestational age limits for such abortions. VA does not make changes to the rule based on these comments. As explained, the IFR does not permit the provision and coverage of abortions in all circumstances. The preamble to the IFR explains that VA has authority under 38 U.S.C. 1710 to furnish veterans with hospital care and medical services that the Secretary determines to be needed. 87 FR 55288. Consistent with this authority, VA would provide an abortion to a veteran only if determined needed by a health care professional when (1) the life or health of the pregnant veteran would be endangered if the pregnancy were carried to term; or (2) the pregnancy is the result of an act of rape or incest. This means that in either case such care may be provided only if an appropriate health care professional determines that such care is needed to promote, preserve, or restore the health of the individual and is in accord with generally accepted standards of medical practice. 38 CFR 17.38(b)(1)–(3).

Additionally, VA has authority under 38 U.S.C. 1781 to provide CHAMPVA beneficiaries with medical care. 87 FR 55290. Pursuant to 38 CFR 17.270(b), VA provides those medical services that are medically necessary and appropriate for the treatment of a condition and that are not specifically excluded. Consistent with these authorities, VA would provide an abortion to a CHAMPVA beneficiary only if such care is medically necessary and appropriate when (1) the life or health of the pregnant beneficiary would be endangered if the pregnancy were carried to term; or (2) the pregnancy is the result of an act of rape or incest. 38 CFR 17.272(a)(64).

The decision about whether a pregnancy endangers the veteran's or CHAMPVA beneficiary's life or health, and the needed care or medically necessary and appropriate treatment, must be made on a case-by-case basis by appropriate healthcare professionals consistent with 38 CFR 17.38 and 17.270(b). As life and health endangering pregnancy complications can arise throughout a pregnancy, imposing a time limit after which VA could not provide needed or medically necessary and appropriate care could be potentially dangerous to veterans and CHAMPVA beneficiaries and would bc inconsistent with VA's authority to provide needed health care to veterans and medically necessary and appropriate health care to CHAMPVA beneficiaries and contrary to VHA's primary function to provide a complete medical and hospital service for the medical care and treatment of veterans. 38 U.S.C. 1710, 38 CFR 17.38; 38 U.S.C. 7301(b); 38 U.S.C. 1781; 38 CFR 17.270(b). Each patient's situation is different, and the decision about whether to continue a pregnancy that endangers the veteran or CHAMPVA beneficiary's life or health must be made on a case-by-case basis by the pregnant patient in consultation with appropriate health care professionals based on the

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best medical evidence and accepted standards of medical practice. As to comments that specifically inquired about gestational age limits in cases where pregnancies are the result of rape or incest, we reiterate the statements above that establishing limits would be inconsistent with VA's authority to provide needed health care to veterans and medically necessary and appropriate health care to CHAMPVA beneficiaries and contrary to VHA's primary function to provide a complete medical and hospital service for the medical care and treatment of veterans. 38 U.S.C. 1710, 38 CFR 17.38, 38 U.S.C. 7301(b), 38 U.S.C. 1781, 38 CFR 17.270(b).

IV. Comments Related to the Exception for Abortion if the Life of the Pregnant Individual Would Be Endangered

The IFR revised 38 CFR 17.38(c)(1) to establish an exception for an abortion if the life of the pregnant veteran would be endangered if the pregnancy were carried to term. Below VA summarizes comments that specifically raised concerns with this exception, other than those already addressed in this rulemaking.

Commenters who opposed the IFR generally stated that it is rare that the life of a pregnant individual is truly threatened by pregnancy or delivery. VA does not make changes to the rule based on these comments as VA disagrees. Endangerment to even one veteran's life would be sufficient, and regardless, VA refers commenters to the discussion in the IFR that details how pregnant individuals may face life-threatening conditions, and abortion may be the only medical intervention available that can preserve their life. *See* 87 FR 55291. As noted in the IFR, while research has shown most pregnancies progress without incident, from 1998 to 2005, the U.S. maternal mortality rate associated with live births was 8.8 deaths per 100,000 live births, and maternal mortality rates have increased staggeringly since then. *Id.* A 2019 study reviewed mortality data from 2007 to 2015 from the National Association for Public Health Statistics and Information Systems, which includes information on all deaths in the 50 States and the District of Columbia (DC). *Id.* The data showed that, during this time, within 38 States and DC, the maternal mortality rate rose to 17.9 deaths of individuals per 100,000 live births. *Id.* Additionally, in 2020 and 2021, maternal mortality rates increased to 23.8 and 32.9 deaths per 100,000 live births, respectively. *Id.* The study identified abortion clinic closures and legislation restricting access to abortion as factors that likely contributed to this rise in maternal mortality rates. *Id.*

One commenter more specifically stated that the presence of underlying health conditions prior to pregnancy does not mean a patient's life is in danger when they are pregnant, and further asserted that such cases merely require more skill and attentiveness by a provider that specializes in obstetrics and gynecology. VA does not make changes to the rule based on this comment, which seems to be stating that a pregnancy can always be carried to term without the pregnant veteran's life ever being endangered by either preexisting health conditions or health conditions arising during pregnancy, if and when a correct approach is used by providers. This assertion is incorrect. As VA described in the IFR, there are circumstances in which abortion may be the only medical intervention available that can preserve a pregnant veteran's life. *See* 87 FR 55291. VA has amended the medical benefits package to allow VA to provide abortions in certain circumstances, including when an appropriate healthcare professional determines that such care is needed to save a pregnant veteran's life, which is critical now that some States are enforcing and enacting abortion restrictions that could result in the delay or denial of such life-saving treatment.

Relatedly, other commenters stated that the presence of health conditions (such as preeclampsia, as noted in one comment) in pregnant individuals are not life threatening as they can be resolved by the induction of labor or the performance of a c-section, and therefore an abortion is not necessary to preserve the pregnant individual's health or life. One commenter further asserted that a fetus is viable at approximately 24 weeks gestational age, and if the health of the pregnant patient was a concern, birth could be induced, or a cesarean section (c-section) performed, to save the life of both the pregnant patient and the child. VA does not make changes to the rule based on these comments. Similar to our response to related comments above, VA recognizes that there are circumstances in which abortion may be the only medical intervention available that can preserve a pregnant veteran's life, and the decision about the needed care or medically necessary treatment must be made on a case-by-case basis by appropriate healthcare professionals consistent with 38 CFR 17.38 and applying the applicable clinical standards discussed throughout this preamble.

V. Comments Related to the Exception for Abortion if the Health of the Pregnant Individual Would Be Endangered

Several commenters raised concerns about the exception for an abortion if the health of the pregnant individual would be endangered if the pregnancy were carried to term. Below VA summarizes comments that specifically raised concerns with this exception, other than as already addressed in this rulemaking.

One commenter suggested that VA revise the regulatory text in § 17.38(c)(1) to additionally include "wellbeing" because the addition of "wellbeing" would encompass mental and emotional health. This commenter raised concerns that the rule was not clear that mental health was included in the consideration of the "health" of the pregnant veteran as opposed to applying solely to physical health. Another commenter asked that VA acknowledge in the text of the rule that the exception for abortions for the health of the pregnant beneficiary includes mental health in addition to physical health. VA does not make any changes to the rule based on these comments. Both physical and mental health are included in the meaning of the term "health" under 38 CFR 17.38 and 38 CFR 17.272. *See also* 87 FR 55291 (explaining that both chronic medical and mental health conditions increase risks associated with pregnancy, and health care professionals may determine "that these conditions (potentially in combination with other factors) render an abortion needed to preserve the health of a veteran[.]"). VA therefore does not believe it is necessary to revise the regulatory text as the commenters suggest. *See also supra* Part III.B above.

One commenter asserted the IFR implied that all pregnancies threaten the health of the pregnant individual, and that abortions would be permitted in all circumstances based on the threat to the pregnant individual's health. The commenter states that authorizing abortions when there is a threat to health is an "ideological" statement and not a medical determination. The commenter further requests that VA enumerate these "threats to their health" in writing. VA makes no changes to the rule based on this comment. See Section III.B. above. VA has determined that abortions may be authorized when carrying the pregnancy to term endangers the health of the pregnant individual and VA has authority to provide these services under the terms of the IFR, as explained in the IFR and herein. Further, medical

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determinations regarding threats to health must be made by healthcare professionals on a case-by-case basis and be consistent with established standards of care.

VI. Comments Related to the Exception for Abortions in Cases of Rape or Incest

The IFR revised 38 CFR 17.38(c)(1) and 38 CFR 17.272(a) to establish an exception for an abortion if the pregnancy were the result of rape or incest. Below VA summarizes comments that specifically raised concerns with this exception other than as already addressed in this rulemaking.

A. Evidence of the Incident of Rape or Incest

Several commenters alleged that a person's statement that a pregnancy resulted from rape or incest is not sufficient evidence to support the provision of abortion, particularly as a provider has no obligation to confirm such statement.

VA does not make changes to the rule based on these comments. As VA explained in the IFR, the self-reporting from the pregnant veteran constitutes sufficient evidence, and the rule does not require a veteran or CHAMPVA beneficiary to present particular evidence such as a police report to qualify for this care. 87 FR 55294. This is consistent with longstanding VA policy to treat eligible individuals who experienced military sexual trauma without additional evidence of the trauma. *Id.* This approach is appropriate as it removes barriers to providing needed or medically necessary and appropriate care. *Id.* VA does not believe it is appropriate to require a provider to separately investigate or confirm the veteran or CHAMPVA beneficiary's self-reporting that an act of rape or incest occurred. Requiring such proof or confirmation could harm the provider-patient relationship, and it is unnecessary.

It is a part of routine practice for VA providers to take and rely on many types of patient-reported information (family, trauma, work, medical, legal, and other histories, for instance), as part of their clinical evaluations and assessments. For instance, VA providers make a clinical eligibility determination as to whether an individual is eligible for military sexual trauma-related treatment under 38 U.S.C. 1720D without requiring additional proof that this experience occurred, as already stated herein. See VHA Directive 1115(1), Military Sexual Trauma (MST) Program.

The comments misunderstand the function of the rape or incest exception. By operation of the IFR, patient self-reports of rape or incest constitute sufficient evidence for the VA provider to establish and document that this exception is met. 38 CFR 17.38(c)(1)(ii), 17.272(a)(64)(ii). There is no reason to treat these patient self-reports differently from self-reports supporting other sought-after medical care; nor do these comments provide any rationale for doing so. In any case where the rape or incest exception applies, the VA provider must still determine that an abortion meets the clinical standard set forth in 38 CFR 17.38(b) or 17.272(a), as applicable.

B. Assertions That Rape or Incest Exception Is Not Medically Necessary

One commenter opined that in the case of a pregnancy that is the result of rape or incest, an abortion can never be "needed" or "medically necessary and appropriate" and that patients who experience mental health issues following acts of rape or incest should be provided counseling and support, not abortions. VA does not make changes to the rule based on this comment. As VA explained in the IFR, VA has determined that abortions for pregnancies resulting from rape or incest, when sought by a pregnant veteran and clinically determined to be needed to promote, preserve, or restore the health of the veteran and in accord with generally accepted standards of medical practice, are needed consistent with the terms of 38 U.S.C. 1710. As noted in the IFR, there are severe health consequences associated with being forced to carry a pregnancy that is the result of rape or incest to term, including constant exposure to the violation committed against the individual which can cause serious traumatic stress and a risk of long-lasting psychological conditions. 87 FR 55292. Such consequences can have a particular impact on veterans, who report higher rates of sexual trauma compared with civilian peers. *Id.* In addition, veterans are more likely to have preexisting mental health conditions that would be compounded by the mental health consequences of being forced to carry a pregnancy to term if that pregnancy is the result of rape or incest. *Id.* In addition, for similar reasons to those discussed above and in the IFR, and because it is "similar" to the care offered under TRICARE (Select), *see* 38 U.S.C. 1781(b), VA has also determined, for purposes of 38 CFR 17.272(a), that access to abortion when the pregnancy is the result of an act of rape or incest is medically necessary and appropriate and so must be available to CHAMPVA beneficiaries. 87 FR 55292.

C. Investigation or Reporting

Commenters raised concerns about whether evidence of sexual abuse will be investigated or reported. To the extent these commenters might want VA to regulate such investigation or reporting for purposes of providing the health care services permitted under the IFR, VA does not make changes to the rule. For the reasons already explained herein, self-reports are sufficient to establish that an act of rape or incest occurred. Further, this approach is similar to how VA providers, who are not investigators, consider other types of patient self-reported information such as military sexual trauma; other trauma; and medical, personal, health information and history. VA will investigate claims of rape or incest to the extent they occurred on VA property or involved a VA employee, consistent with VHA Directive 5019.02, which relates to reporting of harassment, sexual assault, and other public safety incidents in VHA. Additionally, consistent with VHA Directive 1199(2), VA providers will report claims of abuse, as necessary and required by Federal law.

VII. Availability of the Health Care Services Permitted Under the IFR to Non-Veterans and Non-CHAMPVA Beneficiaries

A. Spina Bifida Health Care Benefits Program

One commenter inquired into whether the health care services permitted under the IFR will be available to beneficiaries in VA's Spina Bifida Health Care Benefits Program. VA considers this comment outside the scope of the rulemaking as VA did not amend the regulations for such program; only the regulations for the medical benefits package and CHAMPVA were amended by the IFR. VA makes no changes to the rule based on this comment.

B. Nonveterans

This same commenter inquired into whether the health care services permitted under the IFR will be available to nonveterans for emergency services on a humanitarian basis. VA is authorized to provide humanitarian care under 38 U.S.C. 1784 and medical screening and stabilization for an emergency medical condition under 38 U.S.C. 1784A, but VA considers this comment to be outside the scope of the rulemaking as VA only amended the regulations for the medical benefits

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package and CHAMPVA, which determine care for veterans and CHAMPVA beneficiaries, respectively. VA makes no changes to the rule based on this comment.

C. "Wives of Military Members"

Another commenter inquired whether "wives of military members" will be eligible for the health care services permitted under the IFR. To the extent such individuals have veteran status and are receiving their medical care through VA (specifically care included in tbe medical benefits package), or else are CHAMPVA beneficiaries, then they would be eligible for health care services in the circumstances permitted by the IFR. However, to the extent the commenter is referring to individuals who do not have veteran status or are not CHAMPVA beneficiaries, these individuals are not covered by the amendments made by the IFR. VA makes no changes to the rule based on this comment.

VIII. Comments That Stated Abortion Was Not Health Care or Is Otherwise Harmful

Many commenters stated that abortion is not health care. Some of these commenters did not provide any supporting rationale for this statement, while others asserted that abortion could not be health care because the practice of medicine is supposed to preserve life, not end life. VA does not make changes to the rule based on these comments. As VA explained in the IFR and herein, abortions are health care and may be needed to preserve the life or health of a pregnant individual. Pregnant individuals may face life and health-threatening conditions, where abortion may be the only medical intervention available that can preserve their health or life.[3] *See* 87 FR 55291.

Many commenters opposed VA providing access to abortions because they asserted that abortions can be harmful to pregnant individuals. Some commenters stated that abortions can result in emotional harm or complications for pregnant individuals but did not offer support, evidence, or a rationale for such assertions. Some commenters asserted similar opinions but posited distinct harms and cited certain literature. VA does not make changes to the rule based on these comments.

All medical care may pose a risk of complications to some patients. In every instance of care, medical practice requires practitioners to balance the risks of providing needed or medically necessary and appropriate care with the risks of not doing so, a calculation guided by clinical standards and informed by reliable data. The patient must then also balance the risks of receiving needed or medically necessary and appropriate care with the risks of not doing so, and VA obtains informed consent for any medical care pursuant to its existing informed consent requirements set forth in 38 CFR 17.32 (implementing 38 U.S.C. 7331). As explained in the IFR (87 FR 55291) and herein, research has shown that while most pregnancies progress without incident, pregnancy and childbirth in the United States can result in physical harm and even death for pregnant individuals.[4] Without access to comprehensive reproductive health care, including abortion, such individuals may experience conditions resulting from their pregnancy that can leave tbem at risk for loss of future fertility, significant morbidity, or death. In such instances, an abortion may be the only medical intervention that can preserve that individual's health or save their life.[5]

The health care profession understands that abortions are safe medical interventions.[6] A study available to the public and cited in the IFR addressed the rate of abortion complications and concluded that, contrary to the unsupported assertion by commenters, the most common type of complications from abortions are minor and treatable.[7] The scientific evidence also shows that the risk of complication or mortality from abortion is less than the risk of complication or mortality from other common clinical procedures.[8]

A 2018 consensus study report from the National Academy of Medicine (National Academies of Sciences, Engineering, and Medicine (NASEM)) reviewed the then available evidence on the safety and quality of legal abortions in the United States and concluded that having an abortion does not increase an individual's risk of secondary infertility, pregnancy-related hypertensive disorders, abnormal placentation, preterm birth, or breast cancer.[9] This review by NASEM also found that having an abortion does not increase a person's risk of depression, anxiety, or posttraumatic stress disorder.[10]

One commenter opined that allowing access to abortion counseling or abortions via telehealth is harmful. The commenter provides no evidence or rationale for this assertion. VA makes no changes to the rule based on this comment. Telehealth is widely implemented at VA to provide high-quality care to veterans and eligible beneficiaries, enhancing access to care in appropriate cases. *See* 38 U.S.C. 1730C. Abortion counseling as well as some abortions can be provided through telehealth in accord with generally accepted standards of medical practice. VA will only provide medical care, whether in-person or through telehealth, that is consistent with generally accepted standards of care.

Commenters also raised concerns that the rule did not include informed consent or standards for medical evaluations to ensure that an abortion would not lead to further medical complications or harm for women. VA does not make changes to the rule based on these comments. In determining whether to recommend *any* treatment or procedure, VA providers take into consideration all relevant clinical factors, that is, they conduct a medical evaluation based on a number of clinical factors. Decisions as to which treatment or procedures to recommend are clinical judgments made in accord with generally accepted standards of care. Informed consent is not required as part of the provider's individual undertaking of a differential diagnosis or decision process as to available and recommended treatment options. These clinical evaluation steps occur before the provider's professional recommendation is decided. Informed consent only applies to the receipt of

[3] Martha B. Kole, Jennifer Villavicencio, and Erika G. Werner, *Reproductive services for the patient at increased risk for morbidity and mortality during the second trimester.* Semin Perinatol, 44 (5), 151270 (2020).

[4] Elizabeth G Raymond & David A Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States,* 119 Obstetrics & Gynecology 215, 216 (2012); see also Marian F. MacDorman et al., *Recent Increases in the U.S. Maternal Mortality Rate: Disentangling Trends from Measurement Issues,* 128 Obstetrics & Gynecology 447 (2016) (finding a 26.6 percent increase in maternal mortality rates between 2000 and 2014).

[5] *Abortion Can Be Medically Necessary,* Am. College of Obstetricians and Gynecologists, Sep. 25, 2019. *http://www.acog.org/news/news-releases/2019/09/abortion-can-be-medically-necessary* (last visited Aug. 22, 2022).

[6] *Abortion Access Fact Sheet.* The American College of Obstetrics and Gynecology. 2023. *https://www.acog.org/advocacy/abortion-is-essential/come-prepared/abortion-access-fact-sheet* (last visited May 15, 2023).

[7] Desai Upadhyay, et al. *Incidence of emergency department visits and complications after abortion,* Obstet Gynecol; 125(1):175–183 (2105).

[8] *Abortion Access Fact Sheet.* The American College of Obstetrics and Gynecology. 2023. *https://www.acog.org/advocacy/abortion-is-essential/come-prepared/abortion-access-fact-sheet* (last visited May 15, 2023).

[9] *The Safety and Quality of Abortion Care in the United States.* National Academies of Sciences, Engineering, and Medicine (Mar. 2018), *https://nap.nationalacademies.org/catalog/24950/the-safety-and-quality-of-abortion-care-in-the-united-states.*

[10] Id.

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VA recommended treatment or procedures, which the patient can then decide to reject or accept. No medical treatment or procedure may be performed without the prior, voluntary, and fully informed consent of the patient. 38 CFR 17.32(b). 38 U.S.C. 7331; 38 CFR 17.32. As part of informed consent discussion, the practitioner must explain in plain language understandable to the patient the nature of the proposed procedure or treatment; expected benefits; reasonably foreseeable associated risks, complications, side effects; reasonable and available alternatives; and anticipated result if nothing is done, among other information. *See* 38 CFR 17.32(c)(2).

IX. Comments Related to Employee Rights and Protections and Rights of the Public

Commenters raised concerns related to employees' religious and conscience-based protections, including under the First Amendment, the Religious Freedom Restoration Act, the Public Health Service Act (including the Coats-Snowe Amendment), and Title VII of the Civil Rights Act of 1964. Commenters further asserted that VA is forcing VA employees to provide abortions that may be criminal offenses under State or local law, and one commenter specifically inquired whether any or all VA employees will be responsible for assisting with "emergency abortions." VA does not make any changes to the rule based on these comments. In implementing the IFR and this rule, VA adheres to all applicable Federal laws relating to employee rights and protections, including protections based on an employee's religious or conscience-based objection to abortion. VA has a policy in place for reasonable accommodation requests, where employees may request to be excused from providing, participating in, or facilitating an aspect of clinical care, including reproductive health clinical care authorized by this rule. See, AUSHO Memorandum, *Processing Employee Requests to be Excused from Aspects of the Provision of Reproductive Health Care within the Veterans Health Administration* (Jan. 6, 2023). Pursuant to that policy, VA health care professionals that object to furnishing the care covered by this rulemaking to veterans or CHAMPVA beneficiaries may request to be excused from that care and such requests will be individually assessed under the applicable Federal law. If excusal is requested, supervisors should grant interim excusal for employees from duties or training regarding reproductive health care while requests are being processed.

Commenters also raised concerns regarding whether those providing the health care services permitted under the IFR, including VA employees and non-VA providers, would be protected by VA against State action, such as potential enforcement of State criminal, civil, or administrative penalties related to the provision of the health care services permitted under the IFR. To the extent a VA employee provides the health care services permitted under the IFR within the scope of their VA employment as authorized by Federal law, they could not legally be subject to adverse State actions. As described above, State and local laws, rules, regulations, and requirements that unduly interfere with health care professionals' practice will have no force or effect when such professionals are practicing health care while working within the scope of their VA employment. 38 CFR 17.419.

Moreover, as further described above, in circumstances where there is a conflict between Federal and State law, Federal law would prevail in accordance with the Supremacy Clause under Article VI, clause 2, of the U.S. Constitution. The Department of Justice's Office of Legal Counsel has issued an opinion confirming that States may not impose criminal or civil liability on VA employees who provide or facilitate abortions or related services in a manner authorized by Federal law, including this rule. *See* 46 Op. O.L.C. __ (Sept. 21, 2022); *www.justice.gov/olc/opinion/intergovernmental-immunity-department-veterans-affairs-and-its-employees-when-providing*. If States attempt to subject VA employees to legal action for appropriately carrying out their Federal duties the Department of Justice will support and provide representation to those employees.

Several commenters additionally asserted that performing an abortion would violate a VA health care professional's Hippocratic oath, where some of these comments further noted that this oath requires individuals who take it to "do no harm" in the practice of medicine. VA does not make changes to the rule based on these comments. An abortion would be provided pursuant to the rule to veterans only when determined by appropriate healthcare professionals to be needed to promote, preserve, or restore the health of the individual and to be in accord with generally accepted standards of medical practice; and to CHAMPVA beneficiaries when medically necessary and appropriate.

Some commenters appeared to allege that the IFR violates their First Amendment rights and religious freedoms as members of the public, without providing rationale or support for such statements. Unlike the comments above that raised specific First Amendment and religious freedom concerns for VA health care professionals, these comments did not assert or explain why they believed the IFR violated their First Amendment rights or religious freedoms as members of the public. VA's IFR authorizes the provision of abortions and abortion counseling to veterans and CHAMPVA beneficiaries in certain circumstances. It does not limit the First Amendment rights or religious freedoms of the public.

X. Comments Specifically Concerning Abortion Counseling

The IFR revised 38 CFR 17.38(c)(1) and 17.272(a) to remove a prohibition on VA providing access to abortion counseling. Below VA summarizes comments that specifically raised concerns with this revision, other than as already addressed in this rulemaking.

A. Provision of Abortion Counseling

Multiple commenters raised various concerns about VA's provision of abortion counseling. The commenters stated that abortion counseling should be unbiased, and that VA should not "direct" pregnant individuals to have an abortion. The commenters further suggested that abortion counseling should include discussion of options other than abortion and should also include information about the negative effects of abortion. One commenter further implied that VA is not providing counseling about options other than abortion specifically for victims of rape or incest.

VA does not make changes to the rule based on these comments. Prior to the IFR, VA could not discuss abortion as an option with pregnant patients, but VA has always provided counseling to pregnant patients about pregnancy options such as carrying the pregnancy to term and adoption. Under the IFR, VA now provides the full range of pregnancy options counseling to individuals who are pregnant, which includes all options related to that individual's pregnancy and is not limited to discussing only the option of abortion. This is consistent with Centers for Disease Control and Prevention guidance.[11] As explained in the IFR,

[11] *Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs*. Centers for Disease Control and

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abortion counseling is part of pregnancy options counseling and is a component of comprehensive, patient-centered, high-quality reproductive health care, and is needed care for veterans, and medically necessary and appropriate for CHAMPVA beneficiaries, because such counseling will enable a pregnant individual to make a fully informed health care decision, just as counseling offered or covered by VA regarding other health care treatments enables the patient to make an informed decision. *See* 87 FR 55292–93. Such pregnancy options counseling is provided in a neutral, non-directive, and unbiased manner to ensure patients receive the most complete and accurate information regarding available treatment options. VA does not direct a patient towards a specific option when it conducts pregnancy options counseling. The rule also makes clear that VA's determinations that such counseling is needed care (as to veterans) and medically necessary and appropriate (as to CHAMPVA beneficiaries)—and the accompanying regulatory amendments—were not limited to instances in which the pregnancy is the result of rape or incest. *See, e.g., id* at 55293–94.

B. Post-Abortion Counseling

Another commenter suggested VA provide post-abortion counseling and support for the pregnant individual and their spouse. VA does not make changes to the rule based on this comment. To the extent a veteran requests counseling or mental health support from VA after an abortion or any other type of medical service, such care is available to veterans as part of the medical benefits package. VA would also cover such counseling and mental health support for CHAMPVA beneficiaries. However, and as explained herein, VA does not have authority to provide such counseling under the medical benefits package or CHAMPVA to non-veterans and non-VA beneficiaries, respectively.

XI. Comments Specific to CHAMPVA

Prior to the IFR, the CHAMPVA program at 38 CFR 17.272(a)(64) covered abortions for beneficiaries when the life of the beneficiary would be endangered if the pregnancy were carried to term. The IFR revised § 17.272(a)(64) to: (i) expand the exception on the exclusion of abortion to cover cases where the health of the pregnant CHAMPVA beneficiary would be endangered if the pregnancy were carried to term; and (ii) to establish an exception to the exclusion of abortion to cover cases where the pregnancy of the CHAMPVA beneficiary is the result of an act of rape or incest. Below VA addresses comments that specifically raised concerns with these changes to CHAMPVA, other than as already addressed in this rulemaking.

A. CHAMPVA and TRICARE

One commenter stated that VA does not have authority to provide medical care under the CHAMPVA program in the same manner as under the TRICARE program because TRICARE and CHAMPVA are separate programs and CHAMPVA covers medical care only to those specifically identified at 38 U.S.C. 1781(a). The commenter further stated that VA does not effectively argue that CHAMPVA and TRICARE coverage should be aligned. VA does not make any changes to the rule based on this comment. It appears that the commenter may misunderstand the CHAMPVA authority. VA has authority to furnish medical care to CHAMPVA beneficiaries pursuant to 38 U.S.C. 1781. Section 1781(b) establishes that VA must provide such care "in the same or similar manner and subject to the same or similar limitations as medical care" is provided by DoD under the TRICARE program.

Other commenters asserted that the IFR's changes to the CHAMPVA regulations were not the same or similar to what is permitted under TRICARE. Specifically, these comments noted that the exclusion to provide abortions if the health of an individual were endangered, as well as furnishing abortion counseling for any reason (and not just in those cases for which abortions would be covered by TRICARE), were too broad to be considered the same or similar to what is permitted under TRICARE. Notably, these comments also incorrectly argued that the CHAMPVA exception to protect the health of the pregnant individual without further qualification or limitation could be interpreted in a way that increases access to abortion services beyond the scope stated in the IFR.

VA does not make changes to the rule based on these comments. As explained in the IFR and herein, TRICARE (Select) provides coverage for abortions when the pregnancy is the result of an act of rape or incest, or when a physician certifies that the life of the woman would be endangered if the pregnancy were carried to term. 87 FR 55290. CHAMPVA regulations previously allowed for abortions only when a physician certifies that the abortion was performed because the life of the woman would be endangered if the pregnancy were carried to term. *See* 38 CFR 17.272(a)(64); 87 FR 55290. Pursuant to VA's authority in 38 U.S.C. 1781, VA amended the CHAMPVA regulations to better align coverage under CHAMPVA with coverage under TRICARE (Select). In this regard, VA amended its regulations to additionally provide coverage of abortions when the pregnancy is the result of an act of rape or incest. Although VA also revised the regulations to cover abortions when the health of the CHAMPVA beneficiary would be endangered if the pregnancy were carried to term, in contrast with coverage under TRICARE (Select), coverage under CHAMPVA must be provided in the "same or similar" manner and subject to the "same or similar" limitations as TRICARE (Select). 38 U.S.C. 1781(b); *see* 87 FR 55290. By referring to care that is "similar," the statute permits VA flexibility to administer the program for CHAMPVA beneficiaries. If Congress had intended for VA to administer the program for CHAMPVA beneficiaries in a manner equivalent to TRICARE (Select), 38 U.S.C. 1781(b) simply could have required VA provide "the same" care in "the same" manner as TRICARE (Select); however, the statute recognizes that there will be differences in how VA administers CHAMPVA. VA determined that the care provided under this rule is similar to that provided by DOD under TRICARE (Select), which covers abortions to beneficiaries when there is a medical risk to the pregnant individual if the pregnancy were carried to term or if the pregnancy is the result of an act of rape or incest. *Id.* The flexibility to administer CHAMPVA in a manner "similar" to TRICARE (Select) also recognizes that VA serves a different population than TRICARE under a different authority. Section 1781(b) of 38 U.S.C. authorizes VA to provide care directly to CHAMPVA beneficiaries through VA facilities, and beneficiaries who receive care at a VA facility are eligible for the same medical services as a veteran. In exercising our discretion to provide care in a "similar" manner to TRICARE (Select), we have concluded it lies within our discretion to determine that abortions in the circumstances authorized by the IFR should be made available to all CHAMPVA beneficiaries, not just those who receive their care through VA facilities. As explained, it is important to provide medically necessary and appropriate abortion care when the health of the pregnant individual is endangered, as determined by an appropriate medical professional under

Prevention. April 25, 2014. *https://www.cdc.gov/mmwr/preview/mmwrhtml/rr6304a1.htm?s_cid=rr6304a1_w* (last visited December 6, 2023).

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generally accepted standards of care, to better promote the long-term health of CHAMPVA beneficiaries, which is consistent with VA's past practices related to implementing CHAMPVA.

Regarding the portion of these comments related to VA furnishing abortion counseling under CHAMPVA for any beneficiary and not just in those cases for which an abortion would be covered hy TRICARE, we reiterate from above that VA finds this more comprehensive abortion counseling to be sufficiently similar to that under TRICARE (Select). VA's broader coverage may deviate for purposes of promoting the long-term health of CHAMPVA beneficiaries by covering the most complete and accurate information available regarding various pregnancy and health care options, regardless of whether CHAMPVA would cover any such abortion the beneficiary receives. *See also* 87 FR 55292–93.

B. CHAMPVA Care at VA Facilities

One commenter stated that 38 U.S.C. 1781 authorizes, but does not mandate, the provision of CHAMPVA care at VA facilities through the CHAMPVA In-House Treatment Initiative (CITI). The commenter suggested that VA ensure that VA facilities provide access to abortion to CHAMPVA beneficiaries through the CITI program, particularly in localities where abortions are banned or restricted. VA does not make changes to the rule based on this comment. The provision of CHAMPVA care at VA facilities through the CITI program is permissible under 38 U.S.C. 1781(b), which provides that those VA medical facilities that are equipped to provide CHAMPVA beneficiaries care may do so only to the extent they are not being utilized for the care of eligible veterans. Because the capacity, projected demands, and care needs of veterans at each VA Medical Center can fluctuate, VA cannot ensure that a certain number of VA facilities or facilities in any particular State or region will participate in the CITI program at any given time. However, where a VA facility operates a CITI program, it will provide the health care services permitted by the IFR to CHAMPVA beneficiaries who are eligible to receive care through CITI consistent with the IFR and to the extent that facility's resources are not being utilized for the care of eligible veterans. Further, it remains the case that the CITI program may expand to additional VA facilities if such facilities are equipped to provide the care and treatment and are not being utilized for the care of eligible veterans, without any revisions to VA regulations.

C. Provision of Abortions and Abortion Counseling to Those Under Age 18

One commenter asserted that VA should clarify that it is not requiring its health care professionals to perform any abortions on those under the age of 18, and that parental notification and consent is required for any abortion. Another commenter similarly stated that it was unclear what protocols will be put in place to ensure that children of veterans who may be eligible to receive abortions through the VA have received proper parental consent. VA makes no changes to the rule based on these comments.

In accordance with VHA Directive 1004.01, dated December 12, 2023, it is VA policy that if a patient is considered a minor under State law in the jurisdiction where the VA facility is located, then that patient is not presumed to have decision-making capacity for giving informed consent. As a result, for patients considered minors, consent would be obtained from the patient's parent or legal guardian, except as otherwise provided by law. And as also consistent with this VA policy, if the patient is not considered a minor under State law, for example, by virtue of a State court order awarding emancipation to the minor or automatic emancipation under State law based on certain events, parental notification and consent would not be required.

XII. Comments Related to Fatal Fetal Anomalies

One commenter recommends VA revise the rule to include an exception to allow abortions for fatal fetal anomalies. VA makes no changes based on this comment. The commenter provides no rationale for the proposal that abortions be provided absent the circumstances identified in the rule, or for a finding that the proposed expansion would constitute needed care (for veterans) or medically necessary and appropriate care (for CHAMPVA beneficiaries) under 38 U.S.C. 1710 and 1781. As explained herein and in the IFR, VA has determined that abortions are needed or medically necessary and appropriate care, as required under VA's statutory authorities, when the life or health of the pregnant veteran or CHAMPVA beneficiary would be endangered if the pregnancy were carried to term or when the pregnancy is the result of an act of rape or incest. It is up to the provider to determine if the specific clinical facts of the individual case establish that the carrying to term of a fetus with a fatal fetal anomaly would endanger the life or health of a pregnant veteran or CHAMPVA beneficiary. That is, it would be up to the provider to make the necessary clinical determination.

XIII. Comments Related to VA Mission and Funding

Several commenters opined that VA should not use its limited resources for abortion as VA facilities are for veteran care. These commenters expressed concerns regarding the impact of the health care services permitted under the IFR on VA's provision of other needed care. VA makes no changes to the rule based on these comments. As explained in the IFR and throughout this final rule, abortions can also be needed health care for veterans and medically necessary and appropriate for CHAMPVA beneficiaries. Pursuant to authorized appropriations, detailed above, VA receives and uses funding to furnish medical care authorized under the medical benefits package, which now includes abortions in certain circumstances and abortion counseling. VA's provision of the health care services permitted under the IFR does not impact or preclude VA's provision of all other needed health care.

XIV. Comments That VA Should Expand Access to Abortion

Several commenters opined that VA should permit access to abortions for any reason, not just in the circumstances identified in the IFR. One of these commenters asserted that VA's statutory authority permits abortion care in all circumstances, not just in cases where the life or health of the pregnant patient would be endangered if the pregnancy were carried to term, or when the pregnancy is the result of rape or incest. Consistent with its authorities, and as discussed throughout this rule and the IFR, VA has removed exclusions for certain care that VA has, at this time, determined to be "needed" (for veterans) and "medically necessary and appropriate" (for CHAMPVA beneficiaries). We decline to change course based on these comments.

Some commenters supported a legislative change to permit VA to provide access to abortions for any reason. Those comments regarding Congress's ability to amend VA's statutory authority are outside the scope of this rulemaking.

Some commenters otherwise asserted that the IFR's framing of VA's regulatory changes as prohibitions on abortion with exceptions could be confusing, perhaps to the detriment of veterans or CHAMPVA beneficiaries. As discussed, given VA's statutory authorities and regulations concerning determinations that care is "needed" or "medically

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necessary and appropriate''—as well as a preexisting prohibition with ''exceptions'' for abortion care nnder VA's implementing regulations for CHAMPVA (38 CFR 17.272)—it was appropriate to regulate in this consistent manner. VA has and will continue to issue appropriate guidance to ensure that VA health care professionals understand that abortion is permitted under the exceptions as outlined in the IFR, and again directs veterans, CHAMPVA heneficiaries, and external stakeholders to VA's public-facing websites for clarifying information: *www.womenshealth.va.gov/WOMENSHEALTH/topics/abortion-services.asp.*

XV. Comments Outside the Scope of the IFR

Many commenters raised concerns that were outside the scope of the rulemaking, in addition to those noted above. VA has hriefly summarized those concerns below; VA does not make any changes to the rule based on them.

A. Mandated Provision of Abortion or Any Related Reproductive Health Services

One commenter suggested VA clarify that ''the rule cannot mandate coverage for abortion or situationally for any related reproductive health services.'' To the extent the comment was simply asking VA to clarify this point, we reiterate that the covered health care and services permitted under the IFR are available to veterans and CHAMPVA beneficiaries when their health care provider determines they are needed or medically necessary and appropriate. The decision to pursue a particular course of treatment is the pregnant individual's decision, made in consultation with a provider, VA does not make that decision for the individual.

B. VA's Implementation of the IFR

Multiple commenters made statements or asked questions abont VA's implementation plan(s) related to the IFR. VA finds comments related to VA's implementation beyond the scope of the IFR as these are administrative matters not controlled by the regulations that were revised by the IFR. Nonetheless, VA provides summaries and responses below for the purposes of transparency and as appropriate.

One commenter opined that VA must make explicit its plan to implement the rule. VA has made relevant information available on its website. *See www.womenshealth.va.gov/WOMENSHEALTH/topics/abortion-services.asp.* As stated there, VA is taking steps to guarantee veterans and CHAMPVA beneficiaries have access to abortion-related care, as anthorized by this rule, anywhere in the conntry.

One commenter stated that a VHA website related to community care provisions (*https://www.va.gov/communitycare/programs/veterans/general_care.asp*) provided that VA facilities do not provide maternity care which suggests that veterans can only receive medical care related to pregnancy (and therefore abortions) through VA's community care providers. The commenter raised a concern about how eligible veterans would be able to access the health care services permitted under the IFR if they were solely available in the community and those community providers would be required to adhere to State law requirements. Relatedly, another commenter inquired whether VA will be providing the health care services permitted under the IFR within its VA medical facilities or referring individuals out to the community in other States.

VA does provide some maternity care services to veterans in VA medical facilities, and to the extent that VA can furnish the health care services permitted by the IFR directly, it will do so. Since the IFR published and became effective, VA has made efforts to ensure it has adequate capacity to provide abortion care at VA facilities, including abortion counseling. Regarding needed health care services permitted hy the IFR that cannot he furnished in VA facilities (due to lack of resources such as staff or equipment, for instance), VA may refer such care to VA community care providers where that health care is available, consistent with existing VA regulations (see, for instance, 38 CFR 17.4000 *et seq.*).

Several commenters raised concerns that the IFR does not explain the types of abortion methods that will be permitted or prohibited by VA. As noted above, VA does not generally find it appropriate to regulate the types of methods of care or procedures that are permitted or prohibited. Doing so could unnecessarily restrict the provision of care, including abortions, and result in negative impact or harm to our patients. The type of abortion provided will vary on a case-to-case basis, and appropriate VA medical professionals must be able to determine, in accord with generally accepted standards of medical practice, how best to treat all individuals.

One commenter opined that VA should clarify in guidance that no additional administrative barriers should delay or impede access to the health care services permitted under the IFR determined to be appropriate by a health care professional. Neither the IFR nor this final rnle adds administrative barriers to delay or impede access to the health care services permitted under the IFR. VA will ensure its health care professionals furnish this care consistent with the manner in which they furnish all other authorized health care.

One commenter inquired as to whether VA will have funding for the provision of this care, if VA will provide medication abortion, and if VA will have necessary providers available to provide this care. VA is using and will continue to nse its current funding for the provision of health care authorized under 38 U.S.C. 1710 and 1781 to provide health care services in the circumstances permitted under the IFR. VA will ensure that experienced and trained VA providers are available to provide abortions, including medication abortion. Another commenter relatedly recommended that VA equip its pharmacists with the authority and infrastructure to support mail dispensary of medication abortion drugs. VA pharmacists do have the authority to mail medications.

Another commenter urged VA to include virtual counseling and medication abortion as part of the care authorized under the IFR. As explained previously in this rule, abortion counseling may he provided virtually through telehealth in accord with generally accepted standards of care. VA will provide medication abortious when needed and medically appropriate and in a manner consistent with Federal law.

Another commenter suggested that VA clarify that sexual assault survivors can receive the full range of health care without barriers, especially as the majority of sexual assaults are not reported, and survivors may distrust the police or fear retaliation from a known perpetrator. Veterans who are eligihle for VA health care and CHAMPVA beneficiaries are able to receive the full range of health care authorized under the medical benefits package and CHAMPVA, respectively, regardless of whether they are a sexual assault survivor. VA notes that it has military sexual trauma coordinators at every VA medical facility that can further assist eligible individuals in accessing needed military sexual trauma care. For additional information, please see *www.va.gov/health-care/health-needs-conditions/military-sexual-trauma/.*

One commeuter appeared to support VA's training of medical students and residents to provide the health care services permitted under the IFR.

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Similar to the provision of all other health care provided by VA, medical students and residents may receive training from VA regarding the provision of the health care services permitted under the IFR. Such training would be conducted pursuant to an affiliation agreement between an educational institution and a VA facility, and under the clinical supervision of an appropriate health care professional.

One commenter stated that not all VA facilities are located on exclusive Federal property, and therefore it would seem necessary to alert individuals seeking an abortion at such a VA facility that VA cannot guarantee that such individuals would not be prosecuted under State law even though the VA medical provider would appear to be protected. The commenter further stated that a better option would be to have VA authorize transport at government expense of such an individual to a VA facility in a State that does not criminalize abortion. Relatedly, commenters inquired how VA will address State action concerns because not all veterans live in areas that permit abortion counseling or services and that there should be measures to ensure travel across State lines if necessary, and generally noted that VA needs to ensure that veterans feel safe in accessing abortion care.

For the portions of these comments that assert or question VA's jurisdiction or control of its facilities, any care or services furnished by VA in a manner authorized by Federal law, including by this rule, would preempt conflicting State law that would penalize VA employees for performing their Federal functions, regardless of any specific land ownership or leasing arrangements (for instance, such as if a VA facility is co-located to a State-sponsored academic institution).

To the extent these comments may raise concerns that needed abortion counseling or abortions cannot be furnished in VA facilities (due to lack of resources such as staff or equipment, for instance), VA reiterates from earlier in this discussion that VA may refer such care to VA community care providers where available.

Insofar as some comments concerned potential travel needed to obtain the health care services permitted under the IFR, veterans would have access to both Beneficiary Travel and Veterans Transportation Program benefits if so eligible under VA regulations at 38 CFR part 70.

Finally, insofar as commenters suggested that VA alert certain individuals seeking abortions that VA cannot guarantee that such individuals would not be prosecuted under State law, VA is a health care provider, and VA attorneys have no authority to provide any legal advice to veterans or CHAMPVA beneficiaries.

C. Suggested Alternatives to VA Providing Access to Abortion

Commenters asserted that instead of access to the health care services permitted under the IFR they believed pregnant individuals should be given the option of emotional and physical support throughout their pregnancies and post-partum experiences, specifically including prenatal medical attention. Other commenters similarly indicated that instead of providing access to abortions, VA should direct pregnant individuals to support groups that are available and, if such individuals do not wish to keep a child after giving birth, to help them through the adoption process. As with all comments discussed in this section, VA finds these comments to be beyond the scope of the IFR.

These commenters seem to assert that abortion would not be necessary if pregnant individuals were given more support during prenatal, pregnancy, or postpartum stages, or offered choices beyond abortion, which seems to assume that VA is providing access to abortion procedures for reasons other than medical necessity. However, the IFR permits abortions to be provided only when the life or health of the pregnant individual would be endangered if the pregnancy were carried to term or when the pregnancy is the result of an act of rape or incest. VA provides care to veterans when such care is determined by an appropriate health care professional to be needed to promote, preserve, or restore the health of the veteran and is in accord with generally accepted standards of medical practice, and provides care for CHAMPVA beneficiaries that is medically necessary and appropriate. The need for health care services permitted under the IFR would not be prevented by increased access to support groups or to a particular level of maternity care services. Moreover, VA's pregnancy options counseling, discussed above, includes abortion counseling and all other pregnancy options. The course of treatment is the pregnant individual's decision, made in consultation with a provider, and nothing in the IFR changes this.

To the extent the commenters might be expressing that lack of maternity care services could endanger a pregnant individual's life or health if the pregnancy were carried to term, maternity care services provided by VA include comprehensive pre- and post-partum care and services. VA will continue to provide comprehensive maternity care in addition to the health care services permitted by the IFR in the circumstances stated in the rule.

Regarding the request in the comments that VA assist pregnant individuals with the adoption process if they did not want to keep a child after giving birth, VA does provide pregnancy options counseling as part of its furnishing of maternity care services, and this pregnancy options counseling includes providing information on adoption.

Severability

The purpose of this section is to clarify VA's intent with respect to the severability of provisions of this rule. Each provision and portion of this rule is capable of operating independently. If any provision or portion of this rule is determined by judicial review or operation of law to be invalid, that partial invalidation will not render the remainder of this rule invalid. As explained in the IFR and above, VA amended its regulations because it determined that providing access to abortion-related medical care is needed to protect the lives and health of veterans and is medically necessary and appropriate care for CHAMPVA beneficiaries. For those same reasons, VA intends each aspect of the rule to operate and ensure that such care is available, even if one portion of the rule is invalidated. For example, if a provision of the rule concerning benefits for CHAMPVA beneficiaries were held invalid, other provisions concerning CHAMPVA beneficiaries, and provisions concerning the care available to Veterans under the medical benefits package, could and should continue to operate independently. The provisions authorizing abortions in cases where the life or health of the pregnant veteran or CHAMPVA beneficiary would be endangered if the pregnancy were carried to term could operate independently should the provision authorizing abortions in cases where the pregnancy is due to an act of rape or incest be held invalid, and vice versa. The provisions authorizing VA to provide abortions could continue to operate should the provisions authorizing VA to provide abortion counseling be held invalid. We emphasize that this is a non-exhaustive list of examples. Likewise, if the application of any portion of this rule to a particular circumstance is determined to be invalid, the agency intends that

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the rule remain applicable to all other circumstances.

Administrative Procedure Act

VA has considered all relevant input and information contained in the comments submitted in response to the IFR (87 FR 55287) and, for the reasons set forth in the foregoing responses to those comments, has concluded that changes to the IFR are not warranted. Accordingly, based upon the authorities and reasons set forth in issuing the IFR (87 FR 55287), as supplemented by the additional reasons provided in this document in response to comments received, VA is adopting the provisions of the IFR as a final rule without changes.

Executive Order 13132, Federalism

Executive Order 13132 establishes principles for preemption of State laws when those laws are implicated in rulemaking or proposed legislation. The order provides that, where a Federal statute does not expressly preempt State law, agencies shall construe any authorization in the statute for the issuance of regulations as authorizing preemption of State law by rulemaking only when the exercise of State authority directly conflicts with the exercise of Federal authority or there is clear evidence to conclude that the Congress intended the agency to have the authority to preempt State law.

As discussed in the IFR, consistent with 38 CFR 17.419, State and local laws, rules, regulations, or requirements are preempted to the extent those laws unduly interfere with Federal operations or the performance of Federal duties. 87 FR 55293–55294. That includes laws that States and localities might attempt to enforce in civil, criminal, or administrative matters against VA health care professionals acting in the scope of their VA authority and employment and that would prevent those individuals from providing care authorized by 38 U.S.C. 1701, 1710, 1781, 1784A, 7301, and 7310, and VA's implementing regulations. State and local laws, rules, regulations, or requirements are therefore without any force or effect to the extent of the conflict with Federal law, and State and local governments have no legal authority to enforce them in relation to actions by VA employees acting within the scope of their VA authority and employment.

Because all State and local laws, rules, regulations, or requirements have no force or effect to the extent that they unduly interfere with the ability of VA employees to furnish reproductive health care while acting within the scope of their VA authority and employment, there are no actual or possible violations of such laws related to VA programs, operations, facilities, contracts, or information technology systems that would necessitate mandatory reporting by VA employees. 38 CFR 1.201–1.205. This rulemaking confirms VA's authority and discretion to manage its employees concerning the services that will be provided pursuant to this rulemaking.

Next, Executive Order 13132 requires that any regulatory preemption of State law must be restricted to the minimum level necessary to achieve the objectives of the statute pursuant to which the regulations are promulgated. Under VA's regulations, State and local laws, rules, regulations, or other requirements are preempted only to the extent they unduly interfere with the ability of VA employees to furnish needed or medically necessary and appropriate health care to veterans and CHAMPVA beneficiaries while acting within the scope of their VA authority and employment. Therefore, VA believes that the rulemaking is restricted to the minimum level necessary to achieve the objectives of the Federal statutes.

Executive Orders 12866, 13563, and 14094

Executive Order 12866 (Regulatory Planning and Review) directs agencies to assess the costs and benefits of available regulatory alternatives and, when regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, and other advantages; distributive impacts; and equity). Executive Order 13563 (Improving Regulation and Regulatory Review) emphasizes the importance of quantifying both costs and benefits, reducing costs, harmonizing rules, and promoting flexibility. Executive Order 14094 (Executive order on Modernizing Regulatory Review) supplements and reaffirms the principles, structures, and definitions governing contemporary regulatory review established in Executive Order 12866 of September 30, 1993 (Regulatory Planning and Review), and Executive Order 13563 of January 18, 2011 (Improving Regulation and Regulatory Review). The Office of Information and Regulatory Affairs has determined that this rule is a significant regulatory action under Executive Order 12866, as amended by Executive Order 14094. The Regulatory Impact Analysis associated with this rulemaking can be found as a supporting document at *https://www.regulations.gov*.

Regulatory Flexibility Act

The Secretary hereby certifies that this final rule will not have a significant economic impact on a substantial number of small entities as they are defined in the Regulatory Flexibility Act (5 U.S.C. 601–612). This final rule will not have a significant impact on a substantial number of small entities because the final rule does not directly regulate or impose costs on small entities and any effects will be indirect. Therefore, pursuant to 5 U.S.C. 605(b), the initial and final regulatory flexibility analysis requirements of 5 U.S.C. 603 and 604 do not apply.

Unfunded Mandates

The Unfunded Mandates Reform Act of 1995, see 2 U.S.C. 1532, requires that agencies prepare an assessment of anticipated costs and benefits before issuing any rule that may result in the expenditure by State, local, and tribal governments, in the aggregate, or by the private sector, of $100 million or more (adjusted annually for inflation) in any one year. This rule will have no such effect on State, local, and tribal governments, or on the private sector.

Paperwork Reduction Act

This rule contains no provisions constituting a collection of information under the Paperwork Reduction Act of 1995, 44 U.S.C. 3501–21.

Congressional Review Act

Pursuant to the Subtitle E of the Small Business Regulatory Enforcement Fairness Act of 1996 (known as the Congressional Review Act) (5 U.S.C. 801 *et seq.*), the Office of Information and Regulatory Affairs designated this rule as not satisfying the criteria under 5 U.S.C. 804(2).

List of Subjects in 38 CFR Part 17

Administrative practice and procedure, Claims, Health care, Health facilities, Health professions, Health records, Medical devices, Medical research, Mental health programs, Veterans.

■ For the reasons stated in the preamble, the interim final rule amending 38 CFR part 17, which was published at 87 FR 55287 on September 9, 2022, is adopted as final.

Signing Authority

Denis McDonough, Secretary of Veterans Affairs, approved and signed this document on February 26, 2024, and authorized the undersigned to sign and submit the document to the Office of the Federal Register for publication

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electronically as an official document of the Department of Veterans Affairs.

Michael P. Shores,

Director, Office of Regulation Policy & Management, Office of General Counsel, Department of Veterans Affairs.

[FR Doc. 2024–04275 Filed 3–1–24; 8:45 am]

BILLING CODE 8320–01–P

POSTAL SERVICE

39 CFR Part 20

International Mail Manual; Incorporation by Reference

AGENCY: Postal Service™.

ACTION: Final rule.

SUMMARY: The Postal Service announces the issuance of the *Mailing Standards of the United States Postal Service, International Mail Manual* (IMM®) dated January 21, 2024, and its incorporation by reference in the *Code of Federal Regulations.*

DATES: This rule is effective March 4, 2024. The incorporation by reference of certain material listed in this rule is approved by the Director of the Federal Register as of March 4, 2024.

FOR FURTHER INFORMATION CONTACT: Dale Kennedy, (202) 268–6592.

SUPPLEMENTARY INFORMATION: The *International Mail Manual* (IMM) provides our standards for all international mailing services and references for the applicable prices. It was issued on January 21, 2024, and was updated with *Postal Bulletin* revisions through December 28, 2023. It replaces all previous editions.

The IMM continues to enable the Postal Service to fulfill its long-standing mission of providing affordable, universal mail service. It continues to: (1) increase the user's ability to find information; (2) increase the user's confidence that he or she has found the information they need; and (3) reduce the need to consult multiple sources to locate necessary information. The provisions throughout this issue support the standards and mail preparation changes implemented since the version of July 10, 2022. The *International Mail Manual* is available to the public on the Postal Explorer® internet site at *https://pe.usps.com.*

List of Subjects in 39 CFR Part 20

Administrative practice and procedure, Foreign relations, Incorporation by reference.

In view of the considerations discussed above, the Postal Service hereby amends 39 CFR part 20 as follows:

PART 20—INTERNATIONAL POSTAL SERVICE

■ 1. The authority citation for part 20 continues to read as follows:

Authority: 5 U.S.C. 552(a); 13 U.S.C. 301–307; 18 U.S.C. 1692–1737; 39 U.S.C. 101, 401, 403, 404, 407, 414, 416, 3001–3011, 3201–3219, 3403–3406, 3621, 3622, 3626, 3632, 3633, and 5001.

■ 2. Amend § 20.1 by revising paragraphs (a)(3) and (b) to read as follows:

§ 20.1 Incorporation by reference; Mailing Standards of the United States Postal Service, International Mail Manual.

(a) * * *

(3) *Inspection—NARA.* You may view this material at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, visit *www.archives.gov/federal-register/cfr/ibr-locations* or email *fr.inspection@nara.gov.*

(b) The Director of the Federal Register approved the IMM, updated January 21, 2024, for incorporation by reference as of March 4, 2024.

■ 3. Revise § 20.2 to read as follows:

§ 20.2 Effective date of the International Mail Manual.

The provisions of the *International Mail Manual* issued January 21, 2024 (incorporated by reference, see § 20.1), are applicable with respect to the international mail services of the Postal Service.

■ 4. Amend § 20.4 by adding an entry for "IMM" at the end of table 1 to read as follows:

§ 20.4 Amendments to the International Mail Manual.

* * * * *

TABLE 1 TO § 20.4—INTERNATIONAL MAIL MANUAL

International mail manual	Date of issuance
* * * * *	
IMM	January 21, 2024.

Sarah E. Sullivan,

Attorney, Ethics and Legal Compliance.

[FR Doc. 2024–04420 Filed 3–1–24; 8:45 am]

BILLING CODE 7710–12–P

POSTAL SERVICE

39 CFR Part 111

Domestic Mail Manual; Incorporation by Reference

AGENCY: Postal Service™.

ACTION: Final rule.

SUMMARY: The Postal Service announces the issuance of the *Mailing Standards of the United States Postal Service, Domestic Mail Manual* (DMM®) dated January 21, 2024, and its incorporation by reference in the *Code of Federal Regulations.*

DATES: This rule is effective March 4, 2024. The incorporation by reference of certain material listed in this rule is approved by the Director of the Federal Register as of March 4, 2024.

FOR FURTHER INFORMATION CONTACT: Dale Kennedy (202) 268–6592.

SUPPLEMENTARY INFORMATION: The *Mailing Standards of the United States Postal Service, Domestic Mail Manual* (DMM) provides the United States Postal Service's official prices and standards for all domestic mailing services. The most recent issue of the DMM is dated January 21, 2024. This issue of the DMM contains all Postal Service domestic mailing standards and continues to: (1) increase the user's ability to find information; (2) increase confidence that users have found all the information they need; and (3) reduce the need to consult multiple chapters of the Manual to locate necessary information. The issue dated January 21, 2024, sets forth specific changes, including new standards throughout the DMM to support the standards and mail preparation changes implemented since the version issued on July 10, 2022.

Changes to mailing standards will continue to be published through **Federal Register** documents and the *Postal Bulletin* and will appear in the next online version available via the Postal Explorer® website at: *https://pe.usps.com.*

List of Subjects in 39 CFR Part 111

Administrative practice and procedure, Incorporation by reference.

In view of the considerations discussed above, the Postal Service hereby amends 39 CFR part 111 as follows:

PART 111—GENERAL INFORMATION ON POSTAL SERVICE

■ 1. The authority citation for 39 CFR part 111 continues to read as follows:

Authority: 5 U.S.C. 552(a); 13 U.S.C. 301–307; 18 U.S.C. 1692–1737; 39 U.S.C. 101,

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This subsection is also amended to broaden the group of individuals who may act as Deputy Ethics Officials pursuant to delegations from the DAEO. Finally, 38 CFR 0.735–1(b)(2) is amended to include a citation to 5 CFR 2638.104(e) as the existing citation to 5 CFR 2638.204 is outdated.

Administrative Procedure Act

This final rule is a procedural rule that does not impose new rights, duties, or obligations on affected individuals but, rather, explains that the Secretary appoints Agency ethics officials and identifies the employees that may serve as Agency ethics officials. Therefore, it is exempt from the prior notice-and-comment and delayed-effective-date requirements of 5 U.S.C. 553. *See* 5 U.S.C. 553(b)(A) and (d)(3). This rule merely updates information regarding the delegation of Agency ethics officials, the employees who may serve in those roles, and the names of certain offices and employees in the Office of General Counsel.

Paperwork Reduction Act

This final rule contains no provisions constituting a collection of information under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501–3521).

Regulatory Flexibility Act

The initial and final regulatory flexibility analyses requirements of sections 603 and 604 of the Regulatory Flexibility Act, 5 U.S.C. 601–612, are not applicable to this rule because a notice of proposed rulemaking is not required for this rule. Even so, the Secretary hereby certifies that this final rule will not have a significant economic impact on a substantial number of small entities as they are defined in the Regulatory Flexibility Act. This rule will affect only: (1) Office of General Counsel (OGC) and VA employees who serve as Agency ethics officials, and (2) VA employees seeking ethics advice from these Agency ethics officials. Therefore, pursuant to 5 U.S.C. 605(b), the initial and final regulatory flexibility analysis requirements of 5 U.S.C. 603 and 604 do not apply.

Executive Orders 12866, 13563 and 14094

Executive Order 12866 (Regulatory Planning and Review) directs agencies to assess the costs and benefits of available regulatory alternatives and, when regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, and other advantages; distributive impacts; and equity). Executive Order 13563 (Improving Regulation and Regulatory Review) emphasizes the importance of quantifying both costs and benefits, reducing costs, harmonizing rules, and promoting flexibility. Executive Order 14094 (Executive Order on Modernizing Regulatory Review) supplements and reaffirms the principles, structures, and definitions governing contemporary regulatory review established in Executive Order 12866 of September 30, 1993 (Regulatory Planning and Review), and Executive Order 13563 of January 18, 2011 (Improving Regulation and Regulatory Review). The Office of Information and Regulatory Affairs has determined that this rulemaking is not a significant regulatory action under Executive Order 12866, as amended by Executive Order 14094. The Regulatory Impact Analysis associated with this rulemaking can be found as a supporting document at *www.regulations.gov*.

Assistance Listing

There are no Assistance Listing numbers and titles for the programs affected by this document.

Congressional Review Act

Pursuant to Subtitle E of the Small Business Regulatory Enforcement Fairness Act of 1996 (known as the Congressional Review Act) (5 U.S.C. 801 *et seq.*), the Office of Information and Regulatory Affairs designated this rule as not satisfying the criteria under 5 U.S.C. 804(2).

Unfunded Mandates

The Unfunded Mandates Reform Act of 1995 requires, at 2 U.S.C. 1532, that agencies prepare an assessment of anticipated costs and benefits before issuing any rule that may result in the expenditure by State, local, and tribal governments, in the aggregate, or by the private sector, of $100 million or more (adjusted annually for inflation) in any one year. This final rule will have no such effect on State, local, and tribal governments, or on the private sector.

List of Subjects in 38 CFR Part 0

Core Values, Characteristics and Customer Experience Principles of the Department, General Provisions, Standards of Ethical Conduct, and Related Responsibilities of Employees.

Signing Authority

Denis McDonough, Secretary of Veterans Affairs, approved this document on February 26, 2024, and authorized the undersigned to sign and submit the document to the Office of the Federal Register for publication electronically as an official document of the Department of Veterans Affairs.

Consuela Benjamin,

Regulations Development Coordinator, Office of Regulation Policy & Management, Office of General Counsel, Department of Veterans Affairs.

For the reasons set out in the preamble, the Department of Veterans Affairs amends 38 CFR part 0 as follows:

PART 0—VALUES, STANDARDS OF ETHICAL CONDUCT, AND RELATED RESPONSIBILITIES

■ 1. The authority citation for part 0 continues to read as follows:

Authority: 5 U.S.C. 301; 38 U.S.C. 501; see sections 201, 301, and 502(a) of E.O. 12674, 54 FR 15159, 3 CFR, 1989 Comp., p. 215 as modified by E.O. 12731, 55 FR 42547, 3 CFR, 1990 Comp., p. 306.

■ 2. Amend § 0.735–1 by revising paragraphs (a), (b)(1), and (b)(2) to read as follows:

§ 0.735–1 Agency ethics officials.

(a) *Designated Agency Ethics Official (DAEO).* The Secretary will designate attorneys from the Office of General Counsel to serve as the Designated Agency Ethics Official (DAEO) and Alternate Designated Agency Ethics Official (ADAEO).

(b) * * *

(1) The District Chief Counsels and attorneys on the Ethics Specialty Team are Deputy Ethics Officials. They have been delegated the authority to act for the DAEO pursuant to 5 CFR 2638.104(e).

(2) Other officials may also act as Deputy Ethics officials pursuant to delegations of one or more of the DAEO's duties from the DAEO.

[FR Doc. 2024–04442 Filed 3–1–24; 8:45 am]

BILLING CODE 8320–01–P

DEPARTMENT OF VETERANS AFFAIRS

38 CFR Part 17

RIN 2900–AR57

Reproductive Health Services

AGENCY: Department of Veterans Affairs.

ACTION: Final rule.

SUMMARY: The Department of Veterans Affairs (VA) is finalizing, without changes, an interim final rule that amended VA's medical regulations to remove the exclusion on abortion counseling in the medical benefits package; establish exceptions to the exclusion on abortions for veterans who

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receive care set forth in that package; and remove the exclusion on abortion counseling and expand the exceptions to the exclusion on abortions for Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) beneficiaries.

DATES: This rule is effective April 3, 2024.

FOR FURTHER INFORMATION CONTACT: Dr. Shereef Elnahal, Under Secretary for Health, Department of Veterans Affairs, 810 Vermont Avenue NW, Washington, DC 20420, (202) 461–0373.

SUPPLEMENTARY INFORMATION: In an interim final rule (IFR) published in the **Federal Register** (FR), VA amended its medical regulations to remove the exclusion on abortion counseling in the medical benefits package; establish exceptions to the exclusion on abortions for veterans who receive care set forth in that package; and remove the exclusion on abortion counseling and expand the exceptions to the exclusion on abortions for Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) beneficiaries. 87 FR 55287 (September 9, 2022).

VA provided a 30-day comment period on the IFR, which ended on October 11, 2022. VA received 57,901 comments, many of which were supportive of the IFR. The vast majority of the comments were a type of duplicated form response, where some requested clarifications or suggested changes to the IFR, and others merely expressed support or requested the IFR be rescinded without suggested clarifications or changes. VA summarizes and addresses all topics raised in relevant and significant comments below, but VA does not address any supportive comments below that did not also request clarifications or suggest substantive revisions.

I. Comments That Asserted VA Does Not Have Authority To Promulgate or Implement the IFR

Many commenters asserted that VA does not have the legal authority to promulgate or implement the IFR, most of which provided few details to explain their assertions. Other commenters cited to specific laws that they asserted conflicted with VA's provision of the health care services permitted by the IFR. VA addresses these comments below.

A. General Assertions of Lack of Authority

Many comments asserted that VA should rescind the IFR because VA has a longstanding policy regarding abortion and does not have the authority to impose the IFR in a manner that violates this policy. These comments generally assert that VA does not have authority to either promulgate or implement the IFR to remove the restriction on abortion counseling and create exceptions for abortions in certain circumstances in §§ 17.38 and 17.272 of title 38, Code of Federal Regulations (CFR).

VA does not make any changes to the rule and does not rescind the IFR based on these comments. As indicated in the IFR (see 87 FR 55288–55290), pursuant to VA's general treatment authority for veterans, VA "shall furnish" specified veterans with "hospital care and medical services which the Secretary determines to be needed." Section 1710(a)(1)–(2) of title 38, United States Code (U.S.C.). For veterans not described in paragraphs (1) and (2), the Secretary "may," subject to certain limitations, "furnish hospital care" and "medical services . . . which the Secretary determines to be needed," 38 U.S.C. 1710(a)(3). Such "medical services" include "medical examination, treatment," "[s]urgical services," and "[p]reventive health services." 38 U.S.C. 1701(6). VA implements its general treatment authority, and the Secretary determines what care is "needed," 38 U.S.C. 1710(a)(1)–(3), by regulation through VA's medical benefits package. 38 CFR 17.38. Care included in the medical benefits package is "provided to individuals only if it is determined by appropriate health care professionals that the care is needed to promote, preserve, or restore the health of the individual and is in accord with generally accepted standards of medical practice." 38 CFR 17.38(b). VA has determined that the health care services permitted under the IFR are "needed" within the meaning of VA's general treatment authority, 38 U.S.C. 1710, if an appropriate health care professional determines that such care is needed to promote, preserve, or restore the health of the individual and is in accord with generally accepted standards of medical practice. 38 CFR 17.38(b). Although VA previously did not have any exceptions to the exclusion on abortion in the medical benefits package, VA's authority as described above permits it to amend the medical benefits package through regulation. VA can therefore provide the health care services permitted under the IFR to veterans pursuant to 38 U.S.C. 1710 and 38 CFR 17.38. Similarly, VA has determined that providing access to such care is medically necessary and appropriate to protect the health of CHAMPVA beneficiaries. *See* 38 U.S.C. 1781; 38 CFR 17.270(b) (defining "CHAMPVA-covered services and supplies" as "those medical services and supplies that are medically necessary and appropriate for the treatment of a condition and that are not specifically excluded under [38 CFR 17.272(a)(1)] through (84)").

Several commenters suggested that the IFR usurps Congressional authority. Other commenters stated that VA is unable to provide the health care services permitted under the IFR because Congress has not funded them specifically, or that VA should not use taxpayer money to provide the health care services permitted under the IFR because VA does not have the legal right to do so, and it is contrary to the wishes of taxpayers. VA does not make changes to the rule based on these comments. The IFR did not usurp Congressional authority. VA, similar to other agencies in the Executive Branch, has the authority to promulgate regulations to interpret and implement laws passed by Congress, and such regulations may have the force and effect of law. In this instance, the IFR was promulgated and implemented pursuant to statute. 38 U.S.C. 1710, 1781; *see also id.* 501. VA does not receive separate appropriations for individual medical services, but instead receives appropriations generally for authorized services. While some taxpayers may disagree with this use of Federal funds, VA is authorized to provide and pay for care that is needed for veterans and medically necessary and appropriate for CHAMPVA beneficiaries.

B. Specific Assertions of Lack of Authority or Conflicting Authority

1. Lack of Authority Under 38 U.S.C. 1710

Commenters asserted that VA's interpretation of 38 U.S.C. 1710 to provide access to health care services permitted under the IFR was unsupported because the text of 38 U.S.C. 1710 does not expressly include these services and because VA has not previously invoked or construed 38 U.S.C. 1710 as authority for provision of these services. VA does not make changes to the rule based on these comments. The commenters' assertions regarding the text of 38 U.S.C. 1710 overlook that the terms "hospital care" and "medical services" as used in 38 U.S.C. 1710 are further defined in 38 U.S.C. 1701(5) and (6). As relevant here, "hospital care" is defined to include "medical services rendered in the

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course of hospitalization of any veteran'' and ''medical services'' is defined to include ''medical examination, treatment, and rehabilitative services,'' ''[s]urgical services,'' and ''[p]reventive health services'' (38 U.S.C. 1701(5) and (6)). The definitions of ''hospital care'' and ''medical services'' in 38 U.S.C. 1701(5) and (6) do not list more specific types of care or services. And, in describing categories of hospital care and medical services, 38 U.S.C. 1701 and 1710 do not ennmerate every conceivable or commonly prescribed care or service, whether such care or service involves specific care or services such as abortion, prescription drugs, or completion of specific medical forms snch as life insurance applications. Rather, such care and services are generally described in tbe VA medical benefits package codified in 38 CFR 17.38(a).

The medical benefits package consists of a wide range of hasic and preventive care, including inpatient and ontpatient medical and surgical care, prescription drugs, emergency care, pregnancy and delivery services, and periodic medical exams. 38 CFR 17.38(a). Whether hospital care or medical services under the medical benefits package are considered needed are determinations that 38 U.S.C. 1701 and 1710 leave to the Secretary's discretion. See 38 U.S.C. 1710(a)(1) (''The Secretary . . . shall furnish hospital care and medical services which the Secretary determines to bo needed[.]''). The Secretary can include or exclude care in the medical benefits package based on whether the Secretary determinos that care is ''needed'' within the meaning of 38 U.S.C. 1710(a)(1)–(3). 38 CFR 17.38(c).

After the Supreme Court issued its decision in *Dobbs* v. *Jackson Women's Health Organization*, 142 S. Ct. 2228 (2022), veterans living in States that han or restrict abortions may no longer be able to receive needed medical services in their communities as a result of State restrictions. It is thus essential for the lives and health of our veterans that abortions be made available if determined needed by a health care professional when: (1) the life or health of tho pregnant veteran would be endangered if the pregnancy were carried to tern; or (2) the pregnancy is the resnlt of an act of rape or incest.

Additionally, the comnenters' assertions that VA has never previously invoked its authority under 38 U.S.C. 1710 to authorize the provision of abortions are incorrect. Before the regulatory promulgation of the medical benefits package in 1999, which excluded the health care services permitted under the IFR, VA policy authorized the provision of certain abortions. VHA Policy, Manual M–2, Professional Services Part XIV, Surgical Service, Change 27, paragraph 9.02a (July 26, 1977, partial rescission, expired on Jan. 7, 1999) (authorizing ''therapeutic . . . abortion as a proper treatment'' in some circumstances pursuant to the procedures described therein). This was permitted under VA's authority to provide hospital care and medical services under 38 U.S.C. 1710 and 38 U.S.C. 1712 (former medical services authority), respectively. As explained in the IFR, VA did not explain the rationale behind the exclusion of abortions and abortion counseling from the medical benefits package when it was established in 1999, but at the time, *Roe* v. *Wade*, 410 U.S. 113 (1973) had been reaffirmed in relevant part by *Casey*, and VA was aware that veterans could access abortions in their communities. 87 FR 55288. Following the *Dobbs* decision, States began to ban or restrict abortion services and veterans living in those States were losing access to such medical care. *Id.* Thus, VA explained in the IFR that this policy change was essential for the lives and health of the veterans that VA serves. *Id.*

VA makes no changes to the rule based on the assertions raised in these comments, as discussed above.

In support of the claim that 38 U.S.C. 1710 does not authorize VA's provision of tho health care services permitted under the IFR, some commenters cited to testimony presented during a June 2022 legislative hearing before the House of Representatives Veterans Affairs Committee Subcommittee on Health and minutes from an August 2019 meeting of the Advisory Committee on Women Veterans. VA makes no changes to the rule based on this comment.

Neither the testimony presented during the June 2022 legislative hearing before the House of Representatives Veterans Affairs Committee Snbcommittee on Hoalth nor the minutes from the August 2019 meeting of the Advisory Committee on Women Veterans suggests that VA lacks authority under 38 U.S.C. 1710 to provide the health care services permitted under the IFR. The passage that the commenter cites from the Advisory Committee on Women Veterans meeting minntes refers to language from page 20 of the August 2019 Advisory Committee on Women Veterans meeting minutes, which refers to an update on the Committee's recommendation that VA pursue a regulatory change to remove the exclusion of abortions in cases of threat to the life of the mother, sexual assault, and incest from the medical benefits package. The minutes state:

> VA has declined the ACWV's recommendation and will not change the medical benefits package regulations to remove the exclusion of abortions and abortion counseling services. VA believes that Congress, as the representatives of the will of the American people, must take the lead on this sensitive and divisive issue. VA will take no further action on the matter without a legal mandate, and will work with the House Veterans Affairs Comnittee to provide technical assistance on related legislation.

VA has never indicated that it lacks statutory authority to include abortion counseling and abortions in its medical benefits package in a circumstance in which the VA Secretary determined that such care was needed. And notably, VA made this statement in response to ACWV's recommendations before the Supreme Court issued its decision in *Dobbs*.

In addition, during the June 2022 legislative hearing, VA was discussing a single, standalone bill, H.R. 345, that would have overridden VA's regulatory exclusion of abortion counseling by requiring the Department to provide this service to a veteran as appropriate. VA stated, ''[T]he bill would not authorize VA to provide abortions; it would only allow VA to provide patient education.'' This statement does not mean that VA otherwise lacks authority to provide abortions, merely that VA was providing testimony on a legislative measure that, if enacted, would have only overridden VA's then-exclusion of abortion counseling codified in VA regulations. VA also notes that such legislative discussions in 2022 do not provide a basis to narrowly construe the scope of VA's pre-existing statutory authority. *See, e.g., Bostock* v. *Clayton Cnty., Georgia*, 140 S. Ct. 1731, 1747 (2020) (''[S]peculation about why a later Congress declined to adopt new legislation offers a 'particularly dangerous' basis on which to rest an interpretation of an existing law a different and earlier Congress did adopt.'' (citing *Pension Benefit Guaranty Corporation* v. *LTV Corp.*, 496 U.S. 633, 650 (1990))).

One commenter, in further support of the assertion that VA did not have legal authority to issue the IFR, cited recent Supreme Court case law to argue that Federal agencies exceed their statutory authorities when they purport to find novel powers in long extant Federal statutes. *West Virginia* v. *Environmental Protection Agency*, 142 S. Ct. 2587 (2022); *National Federation of Independent Business* v. *Dept. of Labor*,

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142 S. Ct. 661 (2022). But those cases are inapposite because, as discussed, clear statutory authority supports this rulemaking. Pursuant to VA's general treatment authority provided by Congress, VA ''shall furnish'' specified veterans with ''hospital care and medical services which the Secretary determines to be needed.'' 38 U.S.C. 1710(a)(1)–(2). For other veterans, the Secretary ''may,'' subject to certain limitations, ''furnish hospital care'' and ''medical services . . . which the Secretary determines to be needed.'' 38 U.S.C. 1710(a)(3). VA issued the IFR because the Secretary determined that it is ''essential for the lives and health of our veterans that abortions be made available if determined needed by a health care professional when: (1) the life or health of the pregnant veteran would be endangered if the pregnancy were carried to term; or (2) the pregnancy is the result of an act of rape or incest.'' 87 FR 55288. The Secretary also determined that ''abortion counseling is needed so that veterans can make informed decisions about their health care.'' *Id.* at 55292. The Secretary thus ''determined that such medical care is 'needed' within the meaning of VA's general treatment authority,'' which ''means that such care may be provided if an appropriate health care professional determines that such care is needed to promote, preserve, or restore the health of the individual and is in accord with generally accepted standards of medical practice.'' *Id.* at 55288. *See also* 38 U.S.C. 1781(a); 38 CFR 17.270(b); 87 FR 55290–92 (discussing the VA Secretary's authority and determinations regarding CHAMPVA beneficiaries).

The Secretary has previously exercised authority under 38 U.S.C. 1710 to amend 38 CFR 17.38 to add new services to the medical benefits package services. For example, VA added to the medical benefits package pregnancy and delivery services to the extent authorized by Federal law. See 64 FR 54217. VA also added newborn care as a service provided under the medical benefits package. See 76 FR 78569. Such care was authorized pursuant to 38 U.S.C. 1710 and 1786.

The decisions the commenter cites also are distinguishable because, as discussed above, this is not the first time that VA has relied on relevant statutory authority in this manner. As stated before, VA policy authorized the provision of certain abortions. VHA Policy, Manual M–2, Professional Services Part XIV, Surgical Service, Change 27, paragraph 9.02a. (July 26, 1977, partial rescission, expired on Jan. 7, 1999)) (authorizing ''therapeutic . . . abortion as a proper treatment'' in some circumstances pursuant to the procedures described therein).

The determination not to continue this medical service when the medical benefits package regulation was established in 1999 was based on a VA policy decision, not because VA's general treatment authority did not cover this medical service. Indeed, the fact that abortion was specifically excluded from the medical benefits package under 38 CFR 17.38(c) makes clear that VA has long held the position that abortion and abortion counseling is medical care that the Secretary is statutorily authorized, pursuant to his discretion, to include in the medical benefits package under § 17.38(a). Although VA maintained the exclusion on abortion care starting from the effective date of the medical benefits package in 1999 until 2022, as stated in the preamble to the IFR, Congress has authorized VA to amend its medical benefits package when the Secretary determines such change is warranted. Contrary to the commenter's assertion, VA's reading of 38 U.S.C. 1710 is not novel but supported by past readings of VA's medical care treatment authority; the commenter's cited case law is thus not applicable to this rulemaking. VA makes no changes to the rule based on this comment.

2. Conflict With Section 106 of the Veterans Health Care Act of 1992

Many commenters generally stated that the IFR violates section 106 of the Veterans Health Care Act of 1992 (VHCA), Public Law (Pub. L.) 102–585, 106 Stat. 4943, and that therefore VA should rescind the IFR. VA does not make any changes to the rule or rescind the IFR based on these comments. As explained in the preamble to the IFR, the VHCA barred the provision of abortion, infertility, and much of prenatal and delivery care but only under section 106 of the VHCA. It did not limit VA's authority to provide such services under any other statutory provision such as 38 U.S.C. 1710 or 38 U.S.C. 1712. Public Law 102–585, sec. 106(a). *See* 87 FR 55288–289. Moreover, in 1996, the Veterans' Health Care Eligibility Reform Act effectively overtook section 106 of the VHCA by enacting major changes to eligibility for VA health care, including by amending 38 U.S.C. 1710, and directing VA to establish a system of patient enrollment to manage the provision of care. *See* 87 FR 55289. The purpose behind eligibility reform was to replace the old system with a system where an enrolled veteran could receive whatever medical care and services are deemed needed. *See* House of Representatives Report No. 104–690, at 4 (1996). Consequently, for decades, VA has offered general pregnancy care and certain infertility services under 38 U.S.C. 1710, despite the VHCA's prohibition on providing such services under section 106. *Id.* VA has not relied on section 106 of the VHCA to provide such services or any other services.

Other commenters more specifically asserted that section 106 of the VHCA was still operable to prohibit abortion in VA health care programs, and provided more specific supporting rationale, as addressed below.

a. General Versus Specific Canon of Statutory Construction

Some commenters asserted that, under traditional rules of statutory construction, the more specific and targeted treatment of abortion in section 106 of the VHCA governs over the more general treatment of health care in the Veterans Health Care Eligibility Reform Act of 1996 and 38 U.S.C. 1710. As further explained below, this canon of construction is applicable when two statutory provisions are in conflict, but section 106 does not conflict with VA's authority to provide abortions under other statutory provisions such as 38 U.S.C. 1710 and 1712 (former medical services authority). Consequently, the focus of commenters on the general versus specific canon is mistaken, and VA does not make changes to the rule based on these comments.

By its plain terms, section 106 of the VHCA does not circumscribe the Secretary's authority to determine what hospital care and medical services are needed under 38 U.S.C. 1710. Section 106 affirmatively authorized VA to provide certain healthcare services to women, including ''[g]eneral reproductive health care,'' but provided that this authorization for general reproductive health care did ''not includ[e] *under this section* infertility services, abortions, or pregnancy care (including prenatal and delivery care), except for such care relating to a pregnancy that is complicated or in which the risks of complication are increased by a service-connected condition.'' (emphasis added). The phrase ''under this section'' means that while section 106 bars the provision of any abortion or infertility or general pregnancy services under section 106 of the VHCA, it does not limit VA's authority to provide such services under any other statutory provision, such as VA's general treatment authority, 38 U.S.C. 1710. *See, e.g., Intergovernmental Immunity for the Department of Veterans Affairs and Its Employees*

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When Providing Certain Abortion Services, 46 Op. O.L.C., , at *1, 7–8 (Sept. 21, 2022), *https://www.justice.gov/d9/2022-11/2022-09-21-va_iinmunity_for_abortian_services.pdf* (noting that the IFR represented a reasonable exercise of the VA Secretary's discretion to provide medical services).

Accordingly, the commenters' reliance on the ''general/specific canon'' is misplaced. Moreover, as the Supreme Court has acknowledged, the general/specific canon is not an absolute rule and can be overcome by textual indications that point to the general and specific provisions coexisting, rather than the specific governing the general. *See RadLAX Gateway Hotel* v. *Amalgamated Bank*, 566 U.S. 639, 646 (2012). In this case, section 106 specifies that abortions cannot be provided ''under this section'' of the VHCA, but it does not prohibit VA from providing abortions nnder other statutory provisions such as 38 U.S.C. 1710 and 1712 (former medical services anthority).

VA's interpretation of section 106 in this respect has been long-standing. VA has never interpreted section 106 to prohibit the Department from providing health care under other statutory authorities. For example, as discussed above, VA continued to provide certain abortions as well as therapeutic surgical sterilizations, a type of infertility treatment, after tbe passage of section 106 and until promulgation of the final rnle establishing VA's medical benefits package in October of 1999. *See* VHA Policy, Manual M–2, Professional Services Part XIV, Surgical Service, Change 27, paragraph 9.02a. (July 26, 1977, partial rescission, expired on Jan. 7, 1999) (authorizing ''therapentic . . . abortion as a proper treatment'' in some circumstances pursuant to the procedures described therein).

A VA policy published in 1993 also demonstrates this long-standing interpretation of section 106. With VA's increased focus on health services available for women veterans, VA published VHA Directive 10–93–151, Health Care Services for Women Including General Reproductive Health Care for Women Veterans under the Women Veterans Health Program Act of 1992 (Pub. L. 102–585) (dated Dec. 6, 1993, rescinded Dec. 29, 1994). In para. 2.b. of this 1993 policy, VA squarely addressed section 106's relation to other treatment laws. Specifically, VA explained that the exclusions from ''general reproductive healthcare'' (set forth in section 106(a)(3)) ''do not constitute a ban on the Secretary's authority to provide infertility or abortion services as otherwise authorized under 38 United States Code (U.S.C.) Chapter 17.'' It also explained how the authorities granted in section 106 ''are not new,'' as VA medical centers ''have provided cancer screening to women for some time,'' and it further described how ''general reprodnctive health care'' is ''within the purview of gynecology.'' To this point, when later issuing the medical benefits package, VA included, within covered basic care, infertility services (such as reverse voluntary sterilization and infertility services other than in vitro fertilization) becanse they meet the criteria for inclusion, *i.e.*, ''care that is determined by appropriate healthcare professionals to be needed to promote, preserve, or restore the health of the individual and to be in accord with generally accepted standards of medical practice.'' 64 FR 54207, 54210.

Similarly, VA has provided some infertility services (excluding in vitro fertilization (IVF) pnrsuant to 38 CFR 17.38(c)(2)) and pregnancy-related services under 38 U.S.C. 1710 for decades. See 87 FR 55289; see also 64 FR 54210; VHA Directive 10–93–151, December 6, 1993. Section 106 excludes ''infertility services'' and ''pregnancy care'' in addition to ''abortion'' from care provided under section 106. (We note that section 106 does not further define these terms.) Commenters' reliance on section 106 to object to VA's addition of abortion to care provided under 38 U.S.C. 1710 overlooks VA's longstanding provision of infertility services (exclnding IVF) and pregnancy-related services under 38 U.S.C. 1710, which shows that section 106 does not limit VA's other healthcare anthorities. And VA has long recognized that a veteran could be eligible for certain infertility services (excluding IVF) for a service-connected disability under (former) 38 U.S.C. 1712 (former anthority under which outpatient medical services were provided prior to 1996), even though that veteran would have been ineligible for infertility services under section 106 of the VHCA. 87 FR 55289.

The IFR explained that Congress enacted the VHCA at a time when ''VA health care was subject to a patchwork of eligibility criteria, and care was largely linked only to service-connected conditions,'' and how ''[t]he VHCA, in relevant part, was designed to improve the health care services available to women veterans.'' 87 FR 55288–89. Section 106 of the VHCA, however, was effectively overtaken by a subsequent statutory and regulatory overhaul of VA's medical benefits system, which extended eligibility for hospital care and medical services. The Veterans' Health Care Eligibility Reform Act of 1996 established a system in which an eligible veteran could receive whatever medical care and services the Secretary determines are ''needed.'' 38 U.S.C. 1710; *see, e.g.*, H.R. Rep. No. 104–690, at 4 (1996); *see also id.* (''While the new standard is a simple one, more importantly, it employed a clinically appropriate 'need for care' test, thereby ensuring that medical judgment rather than legal criteria will determine when care will be provided and the level at which that care will be furnished.''); *id.* at 13 (''[The Act] wonld substitute a single, streamlined eligibility provision—based on clinical need for care—for the complex array of disparate rules currently governing veterans' eligibility for hospital and outpatient care.''). As explained in the IFR, ''[t]he Veterans' Health Care Eligibility Reform Act effectively overtook section 106 of the VHCA,'' and ''section 106's prohibition on providing certain services 'under this section' simply is no longer operative.'' 87 FR 55289–90.

b. VA's Interpretation of the Phrase ''But Not Inclnding Under This Sectioo'' in Section 106 of VHCA

Some commenters further asserted that VA's interpretation of the phrase ''but not including under this section'' in section 106 of the VHCA, as reiterated in the lFR (87 FR 55289), was invalid, arguing that such language does not limit abortion restrictions to only that healthcare for women veterans that was provided nnder section 106. In support of this assertion, the commenters proffered that certain prefatory langnage in section 106(a) qualifies the ''under this section'' language in section 106(a)(3) such that the exclusion on abortions there must be read to apply to all hospital care and medical services under chapter 17 of title 38.

VA does not make changes to the rule based on these comments, which misunderstand VA's statutory authority. The VHCA, in relevant part, was designed to improve the health care services available to women veterans. 102 Cong. Rec. 32,367 (1992). Section 106(a) of the VHCA stated that ''[i]n furnishing hospital care and medical services under chapter 17 of title 38, United States Code,''—prefatory language applicable to all of section 106—VA could provide ''women'' with ''[p]apanicolaou tests (pap smears),'' ''[b]reast examinations and mammography,'' and ''[g]eneral reproductive health care . . . , but not including under this section infertility services, abortions, or pregnancy care

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(including prenatal and delivery care), except for such care relating to a pregnancy that is complicated or in which the risks of complication are increased by a service-connected condition.'' Public Law 102–585, sec. 106(a).

As explained above, the VHCA has heen effectively overtaken hy laws that Congress has subsequently enacted. But even taking section 106 on its own terms, the commenters' interpretation of section 106(a)'s prefatory language would render the important ''under this section'' qualifier in section 106(a)(3) a nullity, contrary to longstanding precedent. *Nat'l Ass'n af Mfrs.* v. *Dep't of Def.*, 583 U.S. 109, 128–29 (2018) (''As this Court has noted time and time again, the Court is 'obliged to give effect, if possible, to every word Congress used.' '' (quoting *Reiter* v. *Sonotone Corp.*, 442 U.S. 330, 339 (1979)). If section 106(a)'s prefatory language precluded VA from providing abortion care under its other statutory authorities, then section 106(a)(3)'s ''under this section'' qualifier would be ''a dead letter.'' *United States* v. *Atl. Rsch. Corp.*, 551 U.S. 128, 137 (2007). By contrast, VA's longstanding interpretation of section 106 faithfully reads the statute ''as a whole.'' *Id.* at 135 (quoting *King* v. *St. Vincent's Hospital*, 502 U.S. 215, 221 (1991)). In addition, VA finds support for this in the legislative history accompanying the enactment of section 106. See Joint Explanatory Statement on H.R. 5193, 1992 U.S.C.C.A.N. 4186, 4189–90 (noting ''[t]he inclusion of the phrase 'nnder this section' underscores the intent of the Committees not to limit such anthority as the Secretary may have to provide any infertility services under Chapter 17.''). As explained, moreover, the commenters' interpretation is inconsistent with the plain meaning (and VA's decades-long interpretation) of the phrase ''under this section.''

c. VA's Furnishing of In-Vitro Fertilization Services

Commenters asserted that section 106 of the VHCA remains in effect to prohibit VA from furnishing the health care services permitted under the IFR, citing as evidence the proposition that VA required a special amendment, the ''Mnrray Amendment,'' to carve out an exception from section 106 of the VHCA so that VA could provide IVF services. The Murray Amendment is a reference to section 260 of Public Law 114–223, Division A, title II, enacted on September 29, 2016, and renewed in subsequent fiscal years. Section 260(a)(1) of Public Law 114–223 provides, notwithstanding any other provision of law, that the amounts appropriated or otherwise made available to VA for the Medical Services account may be used to provide fertility counseling and treatment using assisted reproductive technology to a covered veteran or the spouse of a covered veteran, subject to certain statutory and regulatory limitations.

VA does not make changes to the rule based on these comments. VA disagrees with the commenters' assertion that independent authority to provide IVF care was needed to supersede section 106. The Murray Amendment established new authority to provide fertility connseling and treatment nsing assisted reproductive technology not only to a covered veteran but also to the spouse of a covered veteran. It was needed because 38 U.S.C. 1710 does not extend, and never has extended, to a veteran's spouse. See 38 U.S.C. 1710 (referring only to veterans) and 38 U.S.C. 1781 through 1789 (VA's statutory authorities to provide health care to persons other than veterans, which do not extend IVF care to non-veterans). Independent authority was needed to authorize VA to also include the spouses of covered veterans in the VA-furnished IVF episode of care. But the Murray Amendment was not necessary to enable VA to provide infertility services to the veterans themselves under 38 U.S.C. 1710. And as explained above, section 106 has no impact on VA's authority to provide medical services pursuant to section 1710 or any statutory authority other than section 106 itself. In short, the Murray Amendment did not and does not inplicate section 106 of the VHCA.

d. Effect of Deborah Sampson Act of 2020

Some commenters asserted that section 106 of the VHCA must prohibit VA from furnishing the health care services permitted under the IFR becanse the Deborah Sampson Act of 2020 (Pnb. L. 116–315, title V, subtitle A) defined ''health care'' as ''the health care and services included in the medical benefits package provided by the Department before January 5, 2021,'' sec. 5101 of Pnblic Law 116–315, and on January 4, 2021, the health care and services included in tho medical benefits package provided by the Department did not include abortion or abortion counseling. The commenters argued that Congress thus approved of the exclusion of abortion and abortion counseling.

VA does not make changes to the rule based on these comments. The IFR explained that the Deborah Sampson Act of 2020, Public Law 116–315, title V, section 5001 (2021) ''created a central office to, inter alia, 'monitor[ ] and encourag[e] the activities of the Veterans Health Administration with respect to the provision, evaluation, and improvement of health care services provided to women veterans by the Department.' '' 87 FR 55289 (quoting 38 U.S.C. 7310(b)(1)) (alterations in original). Congress defined ''health care'' for these purposes as ''the health care and services included in the medical benefits package provided by the Department as in effect on the day before the date of the enactment of this Act [Jan. 5, 2021].'' *Id.* (quoting 38 U.S.C. 7310 note). At the time, the medical benefits package included (and still includes) care that would have been excluded under the commenters' interpretation of section 106 of the VHCA, such as prenatal and delivery services.

The IFR stated that ''[gliven that VA's medical benefits package as of that date included services that were excluded from the coverage of Section 106 of the VHCA, Congress ratified VA's interpretation that it may provide for these services pursuant to its authority under 38 U.S.C. 1710, notwithstanding section 106. Indeed, the fact that the Deborah Sampson Act of 2020 did not reference section 106 of the VHCA and only referenced VA's medical benefits package shows that Congress did not interpret section 106 of the VHCA as a limitation on VA's authority to provide care to 'women veterans.' '' 87 FR 55289.

Contrary to the commenter's assertioo, the fact that VA had not, in its discretion, exercised its authority at the time of the Act to provide abortions or make exceptions to the regulatory exclusion on abortion does not mean that VA lacks statutory authority under 38 U.S.C. 1710 to determine that abortions in some cases constitute needed care and to accordingly amend its exclusion by regulation. As VA explained in the IFR, the Deborah Sampson Act of 2020 recognized 38 U.S.C. 1710 as a separate treatment authority unaffected and not limited by section 106. In fact, the terms of 38 U.S.C. 7310A(g)(2) as added by the Deborah Sampson Act of 2020 define, for purposes of VA's annual reporting requirement, gender-specific services to include: ''mammography, obstetric care, gynecological care, and such other services as the Secretary determines appropriate,'' some of which VA would not have authority to provide ''under the commenters' interpretation of section 106. *See also supra* I.B.2. Thns, section 106 and its limits on certain care under section 106 of Public Law 102–

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585 were clearly not seen by Congress in promulgating the Deborah Sampson Act of 2020 as having any effect on VA's exercise of authority under 38 U.S.C. 1710.

Nothing in the Deborah Sampson Act of 2020 prohibits VA from removing exclusions from the medical benefits package under 38 U.S.C. 1710. VA recognizes that 38 U.S.C. 7310, Note, (Pub. L. 116–315, title V, section 5101(b)(2)) provides that: "The references to health care and the references to services in sections 7310 and 7310A of title 38, United States Code, as added by paragraph (1), are references to the health care and services included in the medical benefits package provided by the Department as in effect on the day before the date of the enactment of this Act [Jan. 5, 2021]." Congress did not, through that language, freeze in place the types of medical services that VA is authorized to provide under its general treatment authorities. Section 7310 of title 38, U.S.C. relates to the establishment of the Office of Women's Health within VHA and its mission, and 38 U.S.C. 7310A relates to annual reports on Women's Health to be submitted to Congress. Nothing in either statute prohibits VA from expanding the medical benefits package or services or from providing additional information beyond what is required under 38 U.S.C. 7310 and 7310A. And these sections impose no limits on VA's general treatment authority in 38 U.S.C. 1710.

To the contrary, some of the functions of the Office of Women's Health set forth in 38 U.S.C. 7310(b) are to promote the expansion and improvement of clinical activities of VHA with respect to the health care of women veterans and to carry out such other duties as the Under Secretary for Health may require. On its face, the function of the Office to "expand and improve" clinical activities of VHA contemplates VA's authority to modify the medical benefits package to include additional services with respect to the health care of women veterans.

e. Repeal of Section 106 of the VHCA

Some commenters asserted that section 106 has not been expressly repealed and further that repeals by implication are not favored, citing *Branch* v. *Smith*, 538 U.S. 254, 273 (2003), and *Posadas* v. *National City Bank*, 296 U.S. 497 (1936). VA does not make any changes to the rule based on these comments.

At the outset, VA notes that this issue is immaterial because, even if section 106 remained in force, it would not constrain VA's authority to provide services (whether abortions, prenatal care, or other services) limited under section 106 but authorized under other statutory provisions such as 38 U.S.C. 1710 and former 38 U.S.C. 1712. Rather, the limitation in section 106 regarding care "under this section" applies only to section 106.

Regardless, VA disagrees with commenters that section 106 remains in force. As discussed above and in the preamble to the IFR, the Veterans' Health Care Eligibility Reform Act effectively overtook section 106 of the VHCA by establishing a new standard to focus on medical necessity as "the sole criterion of eligibility for VA hospital care and medical services." [1] The "need for care" test was meant to 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." [2] To the extent the commenters would construe section 106 of the VHCA to restrict VA's authority to provide a specific type of health care or service under separate statutory authorities, regardless of a finding of medical need, that restriction would irreconcilably conflict with VA's furnishing of any needed health care or services under 38 U.S.C. 1710. Indeed, for decades, VA has offered general pregnancy care and certain infertility services under 38 U.S.C. 1710 and has not relied on section 106 of the VHCA to provide such services or any other services.

3. Conflict With State Laws

Many commenters generally opined that the IFR violates State laws. VA does not make changes to the rule based on these comments.

The Supremacy Clause of the U.S. Constitution, U.S. Const. art. VI, cl. 2., generally prohibits States from interfering with or controlling the operations of the Federal government, and therefore immunizes the Federal government from State laws that directly regulate it. "[W]hen a federal agency 'perform[s] a federal function pursuant to a law validly enacted by Congress[,] . . . under the Supremacy Clause, the states may not prohibit or, by regulation, significantly burden the manner of its execution without the consent of the United States.'" *Intergovernmental Immunity for the Department of Veterans Affairs and Its Employees When Providing Certain Abortion Services*, 46 Op. O.L.C., __, at *4 (Sept. 21, 2022), *https://www.justice.gov/d9/2022-11/2022-09-21-va_immunity_for_abortion_services.pdf*. Applying this principle to VA's IFR, the Department of Justice's Office of Legal Counsel concluded that "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." *Id.* at *10.

Moreover, VA promulgated a regulation at 38 CFR 17.419 that explicitly preempts any State laws, rules, regulations, or requirements that conflict with a VA health care professional's practice within the scope of their VA employment. As explained in the IFR, consistent with § 17.419, VA has determined that State and local laws, rules, regulations, or requirements, to the extent those laws unduly interfere with Federal operations and the performance of Federal duties, are preempted. That includes laws that States and localities might attempt to enforce in civil, criminal, or administrative matters against VA employees. State and local governments lack legal authority to enforce such laws, rules, regulations, or requirements in relation to health care and medical services provided by VA employees acting within the scope of their VA authority and employment.

One commenter asserted that VA has no basis in Federal law to claim "blanket preemption" in States that prohibit or restrict abortion, and other commenters relatedly stated that VA must be specific with regards to its claim of Federal supremacy. Such comments noted specific kinds of State laws that they asserted VA must either adhere to or demonstrate are explicitly preempted. Other commenters stated that Federal agencies cannot preempt State law unless an explicit conflict exists.

VA does not make changes to the rule based on these comments. It is not clear what the commenter meant by "blanket preemption." VA has been specific as to the scope of preemption; as VA previously confirmed in 38 CFR 17.419, and reiterated in the IFR, VA health care professionals may practice their health care profession consistent with the scope and requirements of their VA employment, notwithstanding any State law or license, registration, certification, or other requirements that unduly interfere with their practice. VA's regulation provides that, in order to "provide the same complete health care and hospital service to beneficiaries in all States as required by 38 U.S.C. 7301, conflicting State laws, rules, regulations, or requirements pursuant to such laws are without any force or effect, and State governments have no legal authority to

[1] H.R. REP. NO. 104–690, at 11.

[2] Id. at 4.

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enforce them in relation to actions by health care professionals within the scope of their VA employment." 38 CFR 17.419. Consistent with the Supremacy Clause and § 17.419, the IFR further explained that a State or local civil or criminal law that restricts, limits, or otherwise impedes a VA professional's provision of needed medical care within the scope of their VA employment, including the health care services permitted under the IFR, would be preempted. VA employees, including health care professionals who provide care and VA employees who facilitate that health care, such as VA employees in administrative positions who 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.

In response to comments that raised specific State requirements related to abortion, and further suggested that VA must show whether such requirements are specifically preempted, we do not make changes. As a general matter, VA determines whether a State law "unduly interferes on a case-by-case basis." See Authority of VA Professionals to Practice Health Care, 85 FR 71838, 71842 (Nov. 12, 2020); Intergovernmental Immunity for the Department of Veterans Affairs and Its Employees When Providing Certain Abortion Services, 46 Op. O.L.C., __, at *10 (Sept. 21, 2022), *https://www.justice.gov/d9/2022-11/2022-09-21-va_immunity_for_abortion_services.pdf.* Accordingly, consistent with VA's existing regulations and the authorities discussed above, any State and local laws and regulations that VA determines would prevent or unduly interfere with VA health care professionals providing needed care as permitted by this rule, would be preempted.

Several commenters referenced a court case related to HHS's interpretation of the Emergency Medical Treatment and Labor Act (EMTALA), which VA believes meant to reference an injunction issued by the U.S. District Court for the Northern District of Texas, *Texas* v. *Becerra,* 623 F. Supp. 3d 696 (N.D. Tex. 2022), *aff'd,* 89 F.4th 529 (5th Cir. 2024), where the district court was interpreting the specific language of this different statute that applies to certain hospitals that receive Medicare funding. The court was not interpreting VA's statutory authority, or related statutory language applicable here, and its decision and reasoning are not applicable to VA's IFR.

One commenter asserted, without any supporting authority, that VA is required to show a compelling interest to preempt State laws. As VA explained in the IFR, pursuant to its authorities in 38 U.S.C. 1710 and 1781, VA implemented the IFR to avert imminent and future harm to veterans and CHAMPVA beneficiaries whose interests Congress entrusted VA to serve. As explained above, 38 CFR 17.419(c) preempts "conflicting State laws, rules, regulations, or requirements pursuant to such laws" to the extent the State law unduly interferes with VA's ability "provide the same complete health care and hospital services to beneficiaries in all States" including, but not limited to, abortion. VA takes no action based on this comment.

4. Conflict With the Holding in Dobbs and the Tenth Amendment

Some commenters stated that the *Dobbs* decision delegated abortion matters to States rather than the Federal government, and further that the Tenth Amendment of the United States Constitution limits VA's authority to preempt State law. VA takes no action based on these comments. The *Dobbs* decision overturned *Roe* v. *Wade,* 410 U.S. 113 (1973), and *Planned Parenthood of Southeastern Pennsylvania* v. *Casey,* 505 U.S. 833 (1992), and in no way affects VA's Federal statutory authority to develop regulations and policy related to the agency's own provision of needed medical care, including the health care services permitted under the IFR. VA furnishes hospital care and medical services determined to be needed pursuant to VA's general treatment authority for veterans (38 U.S.C. 1710), and pursuant to regulation through VA's medical benefits package (38 CFR 17.38). VA has determined that the health care services permitted by the IFR are needed. Similarly, VA has determined that providing access to such care is medically necessary and appropriate to protect the health of CHAMPVA beneficiaries. *See* 38 U.S.C. 1781; 38 CFR 17.270(b) (defining "CHAMPVA-covered services and supplies" as "those medical services and supplies that are medically necessary and appropriate for the treatment of a condition and that are not specifically excluded under [38 CFR 17.272(a)(1)] through (84)"). As explained above, the Supremacy Clause of the United States Constitution prohibits states from restricting Federal agencies and their employees acting within the scope of their Federal authority from providing abortion services. *See generally Intergovernmental Immunity for the Department of Veterans Affairs and Its Employees When Providing Certain Abortion Services,* 46 Op. O.L.C., __, (Sept. 21, 2022), *https://www.justice.gov/d9/2022-11/2022-09-21-va_immunity_for_abortion_services.pdf.*

The Tenth Amendment of the United States Constitution provides that the powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people. VA is a Federal health care system, the operations of which are governed by Federal law, consistent with title 38, United States Code. VA's authority to furnish health care to veterans and CHAMPVA beneficiaries has been granted by Federal statute as described above. VA's issuing of the IFR does not encroach on any rights reserved to the States or to the people and is not a violation of the Tenth Amendment to the United States Constitution. The statement of preemption of conflicting State law under the IFR is consistent with 38 CFR 17.419(c) and lawful pursuant to the Supremacy Clause, U.S. Const. art. VI, cl. 2.

5. Conflict With Department of Defense Authorities

Commenters alleged that this rule violates 10 U.S.C. 1093 and that VA cannot or should not provide broader access to abortion counseling and abortions than DoD. Multiple of these commenters further asserted that it is hard to imagine that Congress intended for former members of the armed services and their dependents to have access to abortion under VA programs when current service members do not have such access under DoD programs, and one commenter incorrectly stated that VA Medical Centers are facilities within the control of DoD. VA does not make changes to the rule based on these comments.

Section 1093 of title 10 of the U.S. Code establishes that DoD may not use funds or facilities "to perform abortions except where the life of the mother would be endangered if the fetus were carried to term or in a case in which the pregnancy is the result of an act of rape or incest." Section 1093 applies only to the use of DoD funds and facilities, not to VA funds and facilities. VA notes, however, that the terms of 10 U.S.C. 1093 conflict with the assertions made by some commenters that active-duty members of the armed services can never receive abortions under DoD programs.

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To the extent that some of these commenters raised the issue of dependents of service members having access to services in VA programs that they would not have under DoD programs for dependents, the statute governing VA's coverage for CHAMPVA beneficiaries specifically recognizes the possibility of differences in what care is covered under this VA program as opposed to the care covered under the similar DoD program, *i.e.*, TRICARE (Select). Congress did not require that VA furnish identical medical benefits to those not eligible for TRICARE (Select). Rather, the law directs VA to provide CHAMPVA beneficiaries with medical care "in the same *or similar* manner and subject to the same *or similar* limitations as medical care" furnished to DoD TRICARE Select beneficiaries. 38 U.S.C. 1781(b) (emphases added). Indeed, prior to the IFR, CHAMPVA was not identical to TRICARE (Select). *See, e.g.*, 87 FR 55290. For example, the former did not include access to abortions in cases of rape or incest, while the latter did. The IFR brought CHAMPVA more in line with TRICARE (Select) in this regard. The commenter does not address the statute's repeated use of the phrase "or similar." That text recognizes differences may exist between the two programs' respective beneficiary populations and their needs. As VA explained in the IFR, VA has previously regulated to provide CHAMPVA benefits beyond those benefits offered by TRICARE (Select) if providing such health care would better promote the long-term health of CHAMPVA beneficiaries. 87 FR 55290. Further, CHAMPVA beneficiaries (unlike TRICARE (Select) beneficiaries) include family caregivers of veterans, not just eligible dependents. 38 U.S.C. 1720G(a)(3)(A)(ii)(IV). Consistent with the statute's plain meaning, VA provides CHAMPVA beneficiaries certain care that is "similar," but not necessarily identical, to care provided to beneficiaries of TRICARE (Select). *See, e.g.*, 73 FR 65552 (November 4, 2008) (adding coverage for medically necessary prostheses because of significant conditions and removing exclusion of enuretic devices despite each not being covered by TRICARE (Select)); 87 FR 41594 (July 13, 2022) (providing coverage for annual physical exams, even though excluded in TRICARE (Select)).

6. Conflict With the Antideficiency Act

Commenters stated that VA is barred from providing or paying for abortion or abortion counseling pursuant to the Antideficiency Act. VA does not make changes to the rule based on these comments. The Antideficiency Act, 31 U.S.C. 1341(a), generally prohibits Federal agencies from making expenditures in excess of available appropriations or in advance of appropriations. Per 31 U.S.C. 1349(a) and 1350, there are penalties associated with violations of the Antideficiency Act.

In this case, the Antideficiency Act is not implicated because Congress appropriated funds to VA to perform authorized services. Per title II of division J of the Consolidated Appropriations Act, 2021 (Pub. L. 116–260), title II of division J of the Consolidated Appropriations Act, 2022 (Pub. L. 117–103) and title II of division J of the Consolidated Appropriations Act, 2023 (Pub. L. 117–328), funds appropriated for fiscal years 2022, 2023, and 2024 to the Medical Services appropriations account have been made available "[f]or necessary expenses for furnishing, as authorized by law, inpatient and outpatient care and treatment to beneficiaries of the Department of Veterans Affairs and veterans described in section 1705(a) of title 38, United States Code, including care and treatment in facilities not under the jurisdiction of the Department." The Medical Community Care appropriations account for fiscal years 2022, 2023, and 2024, has been made available "[f]or necessary expenses for furnishing health care to individuals pursuant to chapter 17 of title 38, United States Code, at non-Department facilities." Title II, Division J, Consolidated Appropriations Act, 2021 (Pub. L. 116–260); Title II, Division J, Consolidated Appropriations Act, 2022 (Pub. L. 117–103); Title II, Division J, Consolidated Appropriations Act, 2023 (Pub. L. 117–328). More specifically, the Medical Services appropriation is for necessary expenses of inpatient and outpatient VA beneficiary care provided by VA at VA facilities and Government facilities for which VA contracts. The Medical Community Care appropriation is for necessary expenses of providing healthcare to VA beneficiaries in the community—facilities other than VA facilities and Government facilities for which VA contracts.

As explained, an abortion is authorized care under 38 U.S.C. 1710, the IFR, and the medical benefits package when a health care professional determines it to be needed and in accord with generally accepted standards of medical practice and: (1) the life or the health of the pregnant veteran would be endangered if the pregnancy were carried to term; or (2) the pregnancy is the result of an act of rape or incest. Expenditures associated with such authorized care may be made from VA's Medical Services and—when appropriate—Medical Community Care accounts.

The IFR also authorizes the provision of medically necessary abortions and abortion counseling under VA's CHAMPVA program, 38 U.S.C. 1781, under the circumstances described in the rule. Medical Services and Medical Community Care account funds are used for the CHAMPVA program and may therefore be used for authorized counseling and care. Such expenditures are proper and do not violate VA's appropriations act or the Antideficiency Act.

7. Conflict With the Hyde Amendment

Some commenters stated that VA is barred from providing or paying for the health care services permitted under the IFR pursuant to what is referred to as the Hyde Amendment. VA does not make changes to the rule based on these comments.

VA is not subject to the Hyde Amendment, which addresses Federal funds available to the Departments of Labor, Health and Human Services, and Education in legislation on annual appropriations. Division H of Public Law 117–328; *see also* 87 FR 55290. Accordingly, VA is not barred by the Hyde Amendment from spending its funds to provide authorized health care services permitted by the IFR.

8. Couflict With the Assimilative Crimes Act aud VA-Related Regulation

Some commenters asserted that the IFR violates the Assimilative Crimes Act, 18 U.S.C. 13, which allows the Federal government to prosecute a State crime as a Federal offense in limited circumstances when such offense has been committed on an area within the jurisdiction of the United States known as a Federal enclave and is not otherwise a Federal offense. These commenters appeared to assert that if a State makes it a crime to perform an abortion, any abortion performed in that State, in the absence of a Federal law prohibiting such performing of an abortion, would be unlawful under 18 U.S.C. 13 if performed on Federal property. Relatedly, one commenter alleged that the rule conflicts with 38 CFR 1.218(c)(3), which states that nothing contained in the rules and regulations set forth under 38 CFR 1.218(a) shall be construed to abrogate any other Federal laws or regulations, including assimilated offenses under 18 U.S.C. 13, or any State or local laws and regulations applicable to the area in which the property is situated.

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VA does not make changes to the rule based on these comments. As some of these commenters acknowledged, the Department of Justice's Office of Legal Counsel (OLC) has examined whether the Assimilative Crimes Act would apply to Federal employees performing their duties in a manner authorized by Federal law, while on a Federal enclave, which may include VA hospitals. OLC concluded that Federal employees engaging in such conduct would not violate that statute and could not be prosecuted by the Federal government under that law. *Application of the Assimilative Crimes Act to Conduct of Federal Employees Authorized by Federal Law,* 46 Op. O.L.C. __ (Aug. 12, 2022), *https://www.justice.gov/olc/file/1527726/download.* The reasoning in that opinion applies to VA employees on Federal enclaves who are providing care in accordance with their Federal duties authorized under the IFR. The commenter did not provide any response to this analysis, other than to reiterate the commenter's view that Federal law "places significant limitations on abortions in VA programs." As explained, however, VA has statutory authority to provide the health care services permitted under the IFR.

Furthermore, the IFR is not in conflict with 38 CFR 1.218(c)(3), which provides, "Nothing contained in the rules and regulations set forth in paragraph (a) of this section shall be construed to abrogate any other Federal laws or regulations, including assimilated offenses under 18 U.S.C. 13 or any State or local laws and regulations applicable to the area in which the property is situated." Paragraph (a) of such section describes rules and regulations that apply at a property under the charge and control of VA, and to persons entering such property, including, for example, conduct related to gambling, use of service animals, creation of disturbances, and vehicular and pedestrian traffic. 38 CFR 1.218(a). This provision is unrelated to matters of medical practice or the provision of medical benefits. It does not subject VA and its employees to State or other local restrictions on any form of medical care that VA staff are authorized to furnish, including VA's provision of health care services permitted under the IFR. Additionally, because the Assimilative Crimes Act has no application to VA employees practicing within the scope of their VA practice, as explained above, the portion of 38 CFR 1.218(c)(3) referring to the Act has no application to care provided under the IFR.

9. Conflict With Interstate Prohibitions Under 18 U.S.C. 1461 and 1462

Commenters alleged that the IFR violates 18 U.S.C. 1461 and 1462. Section 1461, in pertinent part, prohibits the mailing of "[e]very article or thing designed, adapted, or intended for producing abortion, or for any indecent or immoral use" and "[e]very article, instrument, substance, drug, medicine, or thing which is advertised or described in a manner calculated to lead another to use or apply it for producing abortion, or for any indecent or immoral purpose." Section 1462, in pertinent part, prohibits the knowing use of "any express company or other common carrier or interactive computer service" for transportation across State lines of "any drug, medicine, article, or thing designed, adapted, or intended for producing abortion, or for any indecent or immoral use[.]" These commenters also alleged that violation of these laws then support offenses under 18 U.S.C. 1961(1)(B) and 18 U.S.C. 552 (prohibiting Federal employees from aiding and abetting persons engaged in violation of laws prohibiting dealing in, among other things, the means for procuring abortion).

VA does not make changes to the rule based on these comments because the IFR is consistent with 18 U.S.C. 1461. In December 2022, OLC concluded that 18 U.S.C. 1461 does not prohibit the mailing of certain drugs that can be used to perform abortions where the sender lacks the intent that the recipient of the drugs will use them unlawfully. Because there are manifold ways in which recipients in every State may lawfully use such drugs, the mere mailing of such drugs to a particular jurisdiction is an insufficient basis for concluding that the sender intends them to be used unlawfully. *See Application of the Comstock Act to the Mailing of Prescription Drugs That Can Be Used for Abortions,* 46 Op. O.L.C., __, at 1 (Dec. 23, 2022), *https://www.justice.gov/d9/opinions/attachments/2023/01/03/2022-12-23_-_comstock_act_1.pdf.* In support of this conclusion, the OLC opinion explains that there are uses of these medications that State law does not prohibit, including mailing of abortion medications intended, for example, to be used pursuant to Federal authorities. Federal agencies, including VA, provide lawful abortions pursuant to their Federal authorities; therefore the mailing of abortion medications intended to be used lawfully pursuant to those authorities would not violate 18 U.S.C. 1461. This opinion further explains that the same analysis is applicable to the cognate provision 18 U.S.C. 1462. *Id.* at 2 n.3. Because any mailing or other transporting across State lines of certain medications or items under the IFR would not violate 18 U.S.C. 1461 or 1462, there is no subsequent potential offense under 18 U.S.C. 1961(1)(B) and 18 U.S.C. 552.

10. Conflict With the Major Questions Doctrine

Commenters alleged that this rule violates the major questions doctrine, referencing *West Virginia* v. *Environmental Protection Agency,* 142 S. Ct. 2587 (2022). Under such doctrine, an agency must identify clear congressional authorization for its exercise of authority in " 'extraordinary cases' in which the 'history and the breadth of the authority that [the agency] has asserted,' and the 'economic and political significance' of that assertion, provide a 'reason to hesitate before concluding that Congress' meant to confer such authority." *Id.* at 2608 [alterations in original]. VA does not make changes to the rule based on these comments. As explained above, VA has not found "a newfound power" in an "ancillary provision" of the Veterans' Health Care Eligibility Reform Act of 1996, as the Supreme Court found the Environmental Protection Agency had done with the Clean Power Plan. *West Virginia,* 142 S. Ct. at 2602, 2610. Congress expressly delegated to the Secretary of Veterans Affairs the authority to "furnish hospital care [and] medical services . . . which the Secretary determines to be needed." 38 U.S.C. 1710(a)(1)–(3). Identifying the medical services "determine[d] to be needed" for veterans is clearly within VA's authority. As discussed above, prior to promulgation of the final rule establishing VA's medical benefits package in October of 1999, VHA Policy, Manual M–2, Professional Services Part XIV, Surgical Service, Change 27, paragraph 9.02a. (July 26, 1977, partial rescission, expired on Jan. 7, 1999), recognized the need for and authorized the provision of a "therapeutic . . . abortion as a proper treatment" in some circumstances pursuant to the procedures described therein. The IFR is thus a traditional exercise of VA's established authority to determine what medical services are "needed" and, therefore, to decide what specific medical services VA will cover or provide under the medical benefits package.

Additionally, Congress has directed VA to provide "for medical care" under CHAMPVA "in the same or similar manner and subject to the same or similar limitations as medical care is" provided under TRICARE (Select). As

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explained in the IFR, VA has previously deviated from TRICARE (Select) in amending its CHAMPVA regulations to provide services that best promote the long-term health of CHAMPVA beneficiaries while remaining sufficiently "similar" to TRICARE (Select). 87 FR 55290–55291. Thus, this IFR is also a traditional exercise of VA's authority to administer CHAMPVA and decide what medical services are medically necessary and appropriate for CHAMPVA coverage while remaining sufficiently "similar" to TRICARE (Select).

11. The Born Alive Infants Protection Act

One commenter inquired what VA will do to comply with its obligations under the Born Alive Infants Protection Act of 2002, and further stated that VA fails to explain what policies and procedures are in place to ensure that any children born alive after attempted abortions are given appropriate medical care in the same manner as other children born alive. The Born-Alive Infants Protection Act of 2002, Public Law 107–207, was enacted August 5, 2002, and is codified at 1 U.S.C. 8. The Act clarifies that, for purposes of any Act of Congress or any ruling, regulation, or interpretation of the various Federal agencies, the meaning of the words "person," "human being," "child," or "individual" "shall include any infant member of the species homo sapiens who is born alive at any stage of development." VA is subject to, and will continue to comply with, the provisions found in 1 U.S.C. 8. Additionally, VA is authorized to provide certain health care services to a newborn child of a woman veteran receiving care from VA. 38 U.S.C. 1784A and 1786. VA does not make changes to the rule based on this comment.

II. Comments That Raised Concerns With VA's Good Cause Analysis To Issue an IFR

VA issued an IFR, in which the changes to 38 CFR 17.38 and 17.272, were effective immediately upon publication, and the public comment period began on the date of publication. 87 FR 55287. VA found that good cause justified forgoing advance notice for public comment and a delayed effective date. 5 U.S.C. 553(b)(B), (d)(3). VA cited its urgent need to provide access to abortion counseling and to abortions in cases of rape or incest or where the life or health of the pregnant individual is in danger following *Dobbs*. After *Dobbs*, some States had begun to enforce existing abortion bans and restrictions on care and were proposing and enacting new bans and restrictions containing limited exceptions for medical necessity; some also included exceptions for pregnancy that is the result of rape or incest. These measures were creating urgent risks to the lives and health of pregnant veterans and CHAMPVA beneficiaries in those States. 87 FR 55294. VA received comments that opposed VA's issuance of an IFR based on general assertions that VA's good cause justification was insufficient, although only some of these comments directly addressed VA's good cause. VA notes at the outset that our request for comment in the IFR and issuance of this final rule have overtaken any assertions concerning a lack of good cause. In any event, VA addresses below the comments it received concerning VA's good cause for making the IFR effective immediately.

A. General Assertions Thot Good Cause Was Not Established

Some commenters asserted that VA's good cause justification was insufficient for general reasons unrelated to VA's rationales supporting good cause. Many of the duplicated form responses that VA received as comments asserted that the IFR violated the Administrative Procedure Act (APA) and stated that the APA requires that the public have an opportunity to provide comment on matters of public interest before a rule is effective. VA does not change course based on these comments. The APA, codified in part at 5 U.S.C. 553, generally requires that agencies publish substantive rules in the **Federal Register** for notice and comment and provide at least a 30-day delay before the rules become effective. 5 U.S.C. 553(b), (d). However, an agency may forgo prior notice if the agency for good cause finds that compliance would be impracticable, unnecessary, or contrary to the public interest (5 U.S.C. 553(b)(B)) and may also bypass the APA's 30-day delayed effective date requirement if good cause exists (5 U.S.C. 553(d)(3)), or if the rule "grants or recognizes an exemption or relieves a restriction" (5 U.S.C. 553(d)(1)). VA found good cause under 5 U.S.C. 553(b)(B), ((d)(3), and also explained that the IFR removed certain restrictions (*see* 87 FR 55294–96), and therefore did not violate the APA in issuing the IFR.

Other commenters asserted that although a Federal agency is allowed to publish an IFR, VA did not demonstrate that it had good cause to do so. Because these commenters did not specifically assert or explain why they believed VA did not demonstrate good cause, VA does not change course based on these comments. As VA explained in the IFR, VA had good cause to make the IFR effective immediately because delaying its effectiveness would leave many veterans and CHAMPVA beneficiaries without access to needed and medically necessary and appropriate health care—abortions and abortion counseling that VA is able to provide under the IFR—thus putting their health and lives at risk. 87 FR 55295–96. Immediate effectiveness was critical following State actions to further ban or restrict abortion post-*Dobbs*. *Id*. These State bans and restrictions on abortion presented a serious threat to the health and lives of over one hundred thousand veterans and CHAMPVA beneficiaries who relied, or may rely in the future, on VA health care. *Id*. VA determined that such bans and restrictions would have an immediate detrimental impact on the lives and health of veterans and CHAMPVA beneficiaries who are unable to receive the care that was available in the community before the *Dobbs* decision, especially as State laws prompted providers to cease offering abortion services altogether. 87 FR 55295–55296. This detrimental impact is underscored by the potential harmful effects associated with being denied an abortion when an abortion is needed to protect the life or health of the pregnant individual or when the pregnancy is the result of an act of rape or incest. *Id*. As noted in the IFR, it was estimated that up to 53 percent of veterans of reproductive age may be living in States that either had already banned abortions or were soon expected to ban abortions, following *Dobbs*. 87 FR 55295. VA also estimated that nearly 50,000 CHAMPVA beneficiaries could have been impacted by such those then-current or expected bans. *Id*.

Some commenters asserted that the substantive provisions of the IFR were generally not in the public interest or in States' interests (for those States that have instituted more stringent restrictions on abortions or more burdensome requirements on abortion counseling), and therefore VA could not have provided adequate good cause. These commenters did not offer specific reasons why VA did not have good cause to issue the IFR; rather, they seemed to assert that because they deemed a substantive provision of an IFR to generally be against the public or States' interests, then a good cause justification must necessarily fail. In invoking the public interest prong of the good cause exemption, the question is not whether a substantive provision of a rule, itself, would be contrary to public interest in the minds of some, but

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whether following "ordinary procedures—generally presumed to serve the public interest—would in fact harm that interest." *Mack Trucks, Inc.* v. *EPA*, 682 F.3d 87, 95 (D.C. Cir. 2012). For the reasons explained in the IFR, VA provided good cause for why providing advance notice and comment would be contrary to public interest. *See, e.g.*, 87 FR 55294–96.

B. Specific Assertions That Good Cause Was Not Established

Some commenters asserted that VA's good cause justification was insufficient for reasons more directly related to the reasons VA stated in finding good cause. These commenters did not agree with VA's statement of urgent need to provide access to the health care services permitted under the IFR following the ruling in *Dobbs*, which resulted in some States severely restricting and banning abortion. VA groups and summarizes such comments below.

Some commenters asserted that the IFR was not urgently needed because every, or nearly every, State that restricts abortion permits exceptions when the life of the pregnant individual would be endangered were the pregnancy carried to term, and further that some of those States also permit exceptions where the pregnancy was the result of rape or incest. These commenters generally seemed to assert that if many or enough of the States had similar exceptions for abortions as the IFR, then there could not be sufficient need among veterans to access the health care services permitted under the IFR from VA to support good cause.

VA does not change course based on these comments. The fact that some, but not all, States might permit similar access to care as VA is not sufficient to prevent endangerment to the life or health of pregnant individuals that VA serves. *See* 87 FR 55288 (concluding that care available under the IFR is needed and medically necessary and appropriate). In fact, even though some States may allow an abortion to prevent the endangerment to the life of a pregnant individual, they may not allow an abortion to prevent the endangerment to the health of a pregnant individual. When pregnant veterans and CHAMPVA beneficiaries face pregnancy-related complications that their VA health care providers have determined are putting their health or lives at risk or are pregnant due to an act of rape or incest, they must be confident that their providers can take the clinically necessary action to provide needed and medically necessary and appropriate health care. And even in States that restrict abortions subject to exceptions similar to VA's, abortion access is often subject to additional restrictions that VA, on the basis of its authorities and obligations, has not adopted, such as timeframe limitations, evidentiary requirements, or prerequisite procedures (such as mandatory waiting periods or required ultrasounds), which could delay delivery of care that is often time sensitive. VA must always ensure it can consistently meet the medical needs of veterans and CHAMPVA beneficiaries across its healthcare system. Even one State presents enough risk to the lives and health of veterans and CHAMPVA beneficiaries to support VA's good cause justification in the IFR. As the IFR states, "[a]llowing even one preventable death of a veteran or CHAMPVA beneficiary by limiting access to abortions is unacceptable." 87 FR at 55296.

Commenters further asserted that VA's statements of good cause were not substantiated because VA did not cite specific cases where needed and medically necessary and appropriate care would not be permitted. In so doing, commenters argued that VA must conduct a more thorough analysis to more specifically identify those individuals who cannot get the care VA has found to be needed and medically necessary and appropriate. Those commenters are incorrect. VA explained that "certain States have begun to enforce abortion bans and restrictions on care, and are proposing and enacting new ones." *Id.* at 55288; *see also id.* at 55293, 55295 (citing examples and describing the evolving legal landscape). VA also documented the pressing need to ensure that *all* of the veterans and CHAMPVA beneficiaries for which VA provides healthcare have access to needed and medically necessary and appropriate care. *Id.* at 55291–92.

Other commenters asserted that VA has not issued statements regarding, or otherwise does not have, a clear plan to implement the provisions of the IFR despite asserting an emergency to support good cause. These commenters seemed to argue that there can be no need to forgo notice and comment procedures and dispense with a delayed effective date if VA is not yet ready to implement the IFR on a large-scale level. That is incorrect: VA was prepared to offer health care services permitted under the IFR on the day the IFR was published.

To the extent commenters posit that abortion is harmful to patients or is never necessary—that abortions are, essentially, illegitimate medical services, thereby negating VA's good cause argument and grounds for publishing the IFR—the commenters failed to provide a rationale for, and to demonstrate the basis for, this position. The VA Secretary has determined that the health care services permitted under the IFR are needed pursuant to 38 U.S.C. 1710 and are medically necessary and appropriate pursuant to 38 U.S.C. 1781, as implemented by 38 CFR 17.270 *et seq.*, and VA has authority to provide these services under the terms of the IFR, as explained there. As non-exhaustive examples, the IFR identified conditions such as "severe preeclampsia, newly diagnosed cancer requiring prompt treatment, and intrauterine infections, and . . . pre-existing conditions exacerbated by continuing the pregnancy," for which pregnancy termination "may be the only treatment available to save the health or life of the pregnant individual." 87 FR 55295. In States that restrict access to abortion services, treatment delayed so VA could seek prior public comment would have been treatment denied.

Other commenters asserted that the timing of VA's publication of the IFR, being two months after publication of the *Dobbs* decision (and four montbs after such decision "leaked" as stated in the comments) was too late to justify VA's statement of need in support of its good cause. In support of this assertion, these commenters proffered that because VA was aware that the Supreme Court could overturn *Roe*, prior to the *Dobbs* decision, and because some States had taken anticipatory action prior to the *Dobbs* decision, VA would have issued the IFR sooner if there were an actual emergent need. VA does not change course based on these comments. The administrative process for VA to weigh policy, make decisions, draft a rulemaking, and have that rulemaking clear all required reviews prior to publication in the **Federal Register** can routinely take substantial effort and time. Indeed, the Supreme Court has found that an agency taking two months to prepare a 73-page rule did not constitute "delay" inconsistent with the Secretary's finding of good cause. *Missouri*, 142 S. Ct. at 654. Here, the publication of the IFR was completed at the earliest possible time and ensures that, irrespective of contrary State laws post-*Dobbs*, veterans and CHAMPVA beneficiaries can receive access to the needed and medically necessary and appropriate health care services permitted under the IFR.

One commenter opined that the IFR lacked good cause because VA has always provided care to pregnant individuals in life-threatening

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circumstances, including treatment for ectopic pregnancies or miscarriages, which were covered under VA's medical benefits package prior to the IFR. In support, the commenter cited to Veterans Health Administration (VHA) Directive 1330.03, titled Maternity Health Care and Coordination, dated November 3, 2020. The commenter further stated that providing such lifesaving care to a pregnant individual is not an abortion and is already allowed. This commenter seemed to assert that because VA provided some lifesaving treatment to manage certain complications associated with pregnancy prior to the IFR, that there could not have been an emergency to warrant VA's issuance of the IFR. While VA agrees that the care identified by the commenter has been lawfully provided, as discussed herein and in the IFR (for example, see 87 FR 55291), there are many life- and health-endangering complications of pregnancy other than ectopic pregnancies and miscarriages where abortion would be the needed or necessary treatment, and prior to the IFR, VA's medical benefits package did not provide access to care in such circumstances.

One commenter opined that the IFR did not have good cause since it undermines what the commenter described as the "pro-life policy stance" of Congress and further disregards governmental interests, including "interest in safeguarding preborn human life". VA disagrees with the commenter's assertion and implemented the IFR pursuant to the authority Congress granted VA to furnish eligible veterans and CHAMPVA beneficiaries with medical services that VA determines to be needed and medically necessary and appropriate. 38 U.S.C. 1710, 1781; 87 FR 55291–55293. The changes made by the IFR were within the scope of the authority Congress has provided to VA.

III. Comments Asserting That the IFR Is Too Broad

Commenters raised concerns with various aspects of the IFR being overly broad so as to allow for abortions for reasons beyond the circumstances stated in the IFR. VA summarizes and addresses those comments below.

A. Lack of Definition of Abortion

One commenter opined that the IFR avoided clarity by not defining abortion. VA does not make changes to the rule based on this comment. VA does not specifically define in its regulations the other various types of care provided under the medical benefits package or covered by CHAMPVA. As the medical field is constantly evolving, attempting to define medical terms in regulation could be arbitrary or outdated based on evolving standards of practice and thus could result in unintended limitations on the provision of life and health-saving care. Therefore, and consistent with other treatments listed in such regulations, VA does not find it appropriate to define the term abortion in regulation.

B. The Term "Health" Is Too Broad or Not Defined

Several commenters asserted that the term "health," in the context of the exception permitting abortion if a health care provider determines that the "health" of the pregnant individual would be endangered were the fetus carried to term, was too broad in scope. Some asserted that the lack of definition for the term "health" means VA will provide abortions in all circumstances, or, essentially, allow for "elective abortions." Other commenters more specifically asserted that the Supreme Court broadly defined "health" for purposes of abortion as "physical, emotional, psychological, familial, and the woman's age—relevant to the wellbeing of the patient. All these factors may relate to health." *Doe* v. *Bolton*, 410 U.S. 179, 192 (1973). These commenters argue that a rule permitting abortion for reasons of health without further qualification or limitation could be interpreted in a way that increases access to abortions beyond the scope stated in the IFR.

VA does not make changes to the term "health" or further define or characterize it in regulation based on these comments. VA has existing statutory and regulatory authorities that establish when needed care provided under the medical benefits package may be provided to an individual veteran and when medically necessary services are covered by CHAMPVA.

As explained in the IFR, VA's general treatment authority requires the Secretary to determine what "hospital care and medical services" are "needed." 38 U.S.C. 1710. Consistent with this authority and under the IFR, VA provides an abortion to a veteran only if an appropriate health care professional determines that such care is in accord with generally accepted standards of medical practice and is needed to promote, preserve, or restore the health of the individual, consistent with the definitions set forth by existing VA regulations. 38 CFR 17.38(b).

With respect to CHAMPVA, VA provides beneficiaries with medical services and supplies if the services and supplies are "medically necessary and appropriate for the treatment of a condition" and "not specifically excluded from program coverage." *See* 38 CFR 17.272(a). With respect to abortions, VA would provide or reimburse for the care only if the life or the health of the pregnant beneficiary would be endangered if the pregnancy were carried to term or if the pregnancy is the result of an act of rape or incest. See *id.* at § 17.272(a)(64).

Because determining whether a pregnant individual's health is endangered necessarily requires an individualized assessment by a health professional, VA does not believe it is appropriate to define the term "health" in regulation. Attempting to define every single condition, illness, and other circumstance (and combination of such circumstances) that could be included under such a definition would likely be arbitrary and incomplete and thus could result in veterans and CHAMPVA beneficiaries not receiving needed and medically necessary and appropriate care.

C. Breadth of Determinations by, or Quolifications of, Health Care Professionals

One commenter asserted "the phrase 'if determined to be needed by' a medical professional . . . allows abortion on demand" because it generally allows a provider to say such care is "needed for mental anguish or anxiety". VA does not make changes to the rule based on this comment. As stated above, the IFR does not allow for abortions in all circumstances; rather, it allows only those permitted under the circumstances described in the IFR when the life or health of the individual would be endangered if the pregnancy were carried to term or when the pregnancy is the result of rape or incest. The decision of whether a veteran's health is endangered is a clinical decision made on an individual, case-by-case basis using the standard provided in 38 CFR 17.38(b) for the provision of health care to veterans. VA health care professionals consider a veteran's health in terms of the veteran's whole health when determining if care is needed to promote, preserve, or restore the health of the individual and is also in accord with generally accepted standards of medical practice, pursuant to 38 CFR 17.38(b). As to CHAMPVA beneficiaries, a determination is likewise performed on a case-by-case basis, with the health care provider determining if the care is medically necessary and appropriate for the treatment of a condition and not specifically excluded from program coverage. *See* 38 CFR 17.272(a).

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Multiple commenters raised concerns that VA did not indicate in the IFR the qualifications or professional competence required for VA health care professionals to furnish the health care services permitted nnder the IFR. One commenter more specifically alleged that, to merely permit a "health care professional" (as that term was used in the preamble of the IFR) to determine the clinical need for an abortion would allow for personnel without any gynecological or obstetrical skill or experience to make such determination. One commenter more generally raised concerns about who determines whether the life of the pregnant individual is at risk and at what degree, and other commenters specifically requested that VA ensure only physician-led teams are making these clinical eligibility decisions.

VA does not make changes to the rule based on these comments. As a preliminary matter, VA regulations specify that care in the medical benefits package will only be provided if an "*appropriate* health care professional[ ]" determines that it is needed. 38 CFR 17.38(b) (emphasis added). VA health care professionals are not permitted to provide any medical care, including making determinations abont needed care, beyond the scope of their VA practice, training, expertise, and demonstrated skills and abilities. 38 U.S.C. 7402 and 38 CFR 17.419. Regarding the expressed concerns about the term "health care professional," or the lack of defined qualifications or occupations in the IFR to designate that a "health care professional" is permitted to determine whether an abortion is medically necessary, VA notes that the regulations revised by the IFR (38 CFR 17.38 and 38 CFR 17.272) only address the coverage of health care and not the provision of health care by a "health care professional" or the training or credentials they must possess. Therefore, this final rule will not specify particular occupations or qualifications for a VA health care professional to provide either abortion counseling or abortions under the circumstances identified through this rule. VA reiterates that only an appropriate health care professional can make determinations about what care is needed. A VA health care professional is not and will not be permitted to provide any medical care beyond the scope of their VA practice, training, expertise, and demonstrated skills and abilities in any context, including if providing either abortion counseling or abortions.

Regarding the comment that inquired about the degree of risk to life to be ascertained when determining whether an abortion is medically necessary, that determination is made by the appropriate health care professional on a case-by-case basis; VA will not establish a threshold degree of risk to life that is required before an individual is determined eligible for an abortion through VA because every case is clinically distinct. Regarding the requests that VA only permit decisions about the provision of abortions to be made by physician-led teams, VA restates from above that this final rule will not specify particular occupations or qualifications for a VA health care professional to provide either abortion counseling or abortions. VA does not intend for any occupation to perform clinical duties beyond their occupational training and expertise, and their practice will be consistent with generally accepted standards of care.

One commenter stated that the regulations were vague and can leave room for interpretation, and further suggested that VA have a service that would allow doctors or staff the ability to get a second opinion, feedback, and ability for quick determinations or assistance. VA does not make changes to the rule based on this comment. The IFR does not restrict VA health care professionals' ability to seek consultations for assistance with determinations of clinical necessity for any health care or service provided, to include the health care services permitted by the IFR.

D. Lack of Gestational Limits

Commenters raised concerns that the IFR did not establish gestational age limits beyond which an abortion would not be permitted, which they asserted will authorize VA to provide abortions for reasons beyond the circumstances permitted in the IFR. Most of these commenters did not offer specific support for this concern. Other commenters asserted that an abortion is only necessary up to a certain gestational age. One commenter specifically inquired about a gestational age limit for pregnancies that were the result of rape or incest, and relatedly other comments stated that some States that permit abortion in cases where the pregnancy is the result of rape or incest also have gestational age limits for such abortions. VA does not make changes to the rule based on these comments. As explained, the IFR does not permit the provision and coverage of abortions in all circumstances. The preamble to the IFR explains that VA has authority under 38 U.S.C. 1710 to furnish veterans with hospital care and medical services that the Secretary determines to be needed. 87 FR 55288. Consistent with this authority, VA would provide an abortion to a veteran only if determined needed by a health care professional when (1) the life or health of the pregnant veteran would be endangered if the pregnancy were carried to term; or (2) the pregnancy is the result of an act of rape or incest. This means that in either case such care may be provided only if an appropriate health care professional determines that such care is needed to promote, preserve, or restore the health of the individual and is in accord with generally accepted standards of medical practice. 38 CFR 17.38(b)(1)–(3).

Additionally, VA has authority under 38 U.S.C. 1781 to provide CHAMPVA beneficiaries with medical care. 87 FR 55290. Pursuant to 38 CFR 17.270(b), VA provides those medical services that are medically necessary and appropriate for the treatment of a condition and that are not specifically excluded. Consistent with these authorities, VA would provide an abortion to a CHAMPVA beneficiary only if such care is medically necessary and appropriate when (1) the life or health of the pregnant beneficiary would be endangered if the pregnancy were carried to term; or (2) the pregnancy is the result of an act of rape or incest. 38 CFR 17.272(a)(64).

The decision about whether a pregnancy endangers the veteran's or CHAMPVA beneficiary's life or health, and the needed care or medically necessary and appropriate treatment, must be made on a case-by-case basis by appropriate healthcare professionals consistent with 38 CFR 17.38 and 17.270(b). As life and health endangering pregnancy complications can arise throughout a pregnancy, imposing a time limit after which VA could not provide needed or medically necessary and appropriate care could be potentially dangerous to veterans and CHAMPVA beneficiaries and would bc inconsistent with VA's authority to provide needed health care to veterans and medically necessary and appropriate health care to CHAMPVA beneficiaries and contrary to VHA's primary function to provide a complete medical and hospital service for the medical care and treatment of veterans. 38 U.S.C. 1710, 38 CFR 17.38; 38 U.S.C. 7301(b); 38 U.S.C. 1781; 38 CFR 17.270(b). Each patient's situation is different, and the decision about whether to continue a pregnancy that endangers the veteran or CHAMPVA beneficiary's life or health must be made on a case-by-case basis by the pregnant patient in consultation with appropriate health care professionals based on the

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best medical evidence and accepted standards of medical practice. As to comments that specifically inquired about gestational age limits in cases where pregnancies are the result of rape or incest, we reiterate the statements above that establishing limits would be inconsistent with VA's authority to provide needed health care to veterans and medically necessary and appropriate health care to CHAMPVA beneficiaries and contrary to VHA's primary function to provide a complete medical and hospital service for the medical care and treatment of veterans. 38 U.S.C. 1710, 38 CFR 17.38, 38 U.S.C. 7301(b), 38 U.S.C. 1781, 38 CFR 17.270(b).

IV. Comments Related to the Exception for Abortion if the Life of the Pregnant Individual Would Be Endangered

The IFR revised 38 CFR 17.38(c)(1) to establish an exception for an abortion if the life of the pregnant veteran would be endangered if the pregnancy were carried to term. Below VA summarizes comments that specifically raised concerns with this exception, other than those already addressed in this rulemaking.

Commenters who opposed the IFR generally stated that it is rare that the life of a pregnant individual is truly threatened by pregnancy or delivery. VA does not make changes to the rule based on these comments as VA disagrees. Endangerment to even one veteran's life would be sufficient, and regardless, VA refers commenters to the discussion in the IFR that details how pregnant individuals may face life-threatening conditions, and abortion may be the only medical intervention available that can preserve their life. *See* 87 FR 55291. As noted in the IFR, while research has shown most pregnancies progress without incident, from 1998 to 2005, the U.S. maternal mortality rate associated with live births was 8.8 deaths per 100,000 live births, and maternal mortality rates have increased staggeringly since then. *Id.* A 2019 study reviewed mortality data from 2007 to 2015 from the National Association for Public Health Statistics and Information Systems, which includes information on all deaths in the 50 States and the District of Columbia (DC). *Id.* The data showed that, during this time, within 38 States and DC, the maternal mortality rate rose to 17.9 deaths of individuals per 100,000 live births. *Id.* Additionally, in 2020 and 2021, maternal mortality rates increased to 23.8 and 32.9 deaths per 100,000 live births, respectively. *Id.* The study identified abortion clinic closures and legislation restricting access to abortion as factors that likely contributed to this rise in maternal mortality rates. *Id.*

One commenter more specifically stated that the presence of underlying health conditions prior to pregnancy does not mean a patient's life is in danger when they are pregnant, and further asserted that such cases merely require more skill and attentiveness by a provider that specializes in obstetrics and gynecology. VA does not make changes to the rule based on this comment, which seems to be stating that a pregnancy can always be carried to term without the pregnant veteran's life ever being endangered by either preexisting health conditions or health conditions arising during pregnancy, if and when a correct approach is used by providers. This assertion is incorrect. As VA described in the IFR, there are circumstances in which abortion may be the only medical intervention available that can preserve a pregnant veteran's life. *See* 87 FR 55291. VA has amended the medical benefits package to allow VA to provide abortions in certain circumstances, including when an appropriate healthcare professional determines that such care is needed to save a pregnant veteran's life, which is critical now that some States are enforcing and enacting abortion restrictions that could result in the delay or denial of such life-saving treatment.

Relatedly, other commenters stated that the presence of health conditions (such as preeclampsia, as noted in one comment) in pregnant individuals are not life threatening as they can be resolved by the induction of labor or the performance of a c-section, and therefore an abortion is not necessary to preserve the pregnant individual's health or life. One commenter further asserted that a fetus is viable at approximately 24 weeks gestational age, and if the health of the pregnant patient was a concern, birth could be induced, or a cesarean section (c-section) performed, to save the life of both the pregnant patient and the child. VA does not make changes to the rule based on these comments. Similar to our response to related comments above, VA recognizes that there are circumstances in which abortion may be the only medical intervention available that can preserve a pregnant veteran's life, and the decision about the needed care or medically necessary treatment must be made on a case-by-case basis by appropriate healthcare professionals consistent with 38 CFR 17.38 and applying the applicable clinical standards discussed throughout this preamble.

V. Comments Related to the Exception for Abortion if the Health of the Pregnant Individual Would Be Endangered

Several commenters raised concerns about the exception for an abortion if the health of the pregnant individual would be endangered if the pregnancy were carried to term. Below VA summarizes comments that specifically raised concerns with this exception, other than as already addressed in this rulemaking.

One commenter suggested that VA revise the regulatory text in § 17.38(c)(1) to additionally include "wellbeing" because the addition of "wellbeing" would encompass mental and emotional health. This commenter raised concerns that the rule was not clear that mental health was included in the consideration of the "health" of the pregnant veteran as opposed to applying solely to physical health. Another commenter asked that VA acknowledge in the text of the rule that the exception for abortions for the health of the pregnant beneficiary includes mental health in addition to physical health. VA does not make any changes to the rule based on these comments. Both physical and mental health are included in the meaning of the term "health" under 38 CFR 17.38 and 38 CFR 17.272. *See also* 87 FR 55291 (explaining that both chronic medical and mental health conditions increase risks associated with pregnancy, and health care professionals may determine "that these conditions (potentially in combination with other factors) render an abortion needed to preserve the health of a veteran[.]"). VA therefore does not believe it is necessary to revise the regulatory text as the commenters suggest. *See also supra* Part III.B above.

One commenter asserted the IFR implied that all pregnancies threaten the health of the pregnant individual, and that abortions would be permitted in all circumstances based on the threat to the pregnant individual's health. The commenter states that authorizing abortions when there is a threat to health is an "ideological" statement and not a medical determination. The commenter further requests that VA enumerate these "threats to their health" in writing. VA makes no changes to the rule based on this comment. See Section III.B. above. VA has determined that abortions may be authorized when carrying the pregnancy to term endangers the health of the pregnant individual and VA has authority to provide these services under the terms of the IFR, as explained in the IFR and herein. Further, medical

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determinations regarding threats to health must be made by healthcare professionals on a case-by-case basis and be consistent with established standards of care.

VI. Comments Related to the Exception for Abortions in Cases of Rape or Incest

The IFR revised 38 CFR 17.38(c)(1) and 38 CFR 17.272(a) to establish an exception for an abortion if the pregnancy were the result of rape or incest. Below VA summarizes comments that specifically raised concerns with this exception other than as already addressed in this rulemaking.

A. Evidence of the Incident of Rape or Incest

Several commenters alleged that a person's statement that a pregnancy resulted from rape or incest is not sufficient evidence to support the provision of abortion, particularly as a provider has no obligation to confirm such statement.

VA does not make changes to the rule based on these comments. As VA explained in the IFR, the self-reporting from the pregnant veteran constitutes sufficient evidence, and the rule does not require a veteran or CHAMPVA beneficiary to present particular evidence such as a police report to qualify for this care. 87 FR 55294. This is consistent with longstanding VA policy to treat eligible individuals who experienced military sexual trauma without additional evidence of the trauma. *Id.* This approach is appropriate as it removes barriers to providing needed or medically necessary and appropriate care. *Id.* VA does not believe it is appropriate to require a provider to separately investigate or confirm the veteran or CHAMPVA beneficiary's self-reporting that an act of rape or incest occurred. Requiring such proof or confirmation could harm the provider-patient relationship, and it is unnecessary.

It is a part of routine practice for VA providers to take and rely on many types of patient-reported information (family, trauma, work, medical, legal, and other histories, for instance), as part of their clinical evaluations and assessments. For instance, VA providers make a clinical eligibility determination as to whether an individual is eligible for military sexual trauma-related treatment under 38 U.S.C. 1720D without requiring additional proof that this experience occurred, as already stated herein. See VHA Directive 1115(1), Military Sexual Trauma (MST) Program.

The comments misunderstand the function of the rape or incest exception. By operation of the IFR, patient self-reports of rape or incest constitute sufficient evidence for the VA provider to establish and document that this exception is met. 38 CFR 17.38(c)(1)(ii), 17.272(a)(64)(ii). There is no reason to treat these patient self-reports differently from self-reports supporting other sought-after medical care; nor do these comments provide any rationale for doing so. In any case where the rape or incest exception applies, the VA provider must still determine that an abortion meets the clinical standard set forth in 38 CFR 17.38(b) or 17.272(a), as applicable.

B. Assertions That Rape or Incest Exception Is Not Medically Necessary

One commenter opined that in the case of a pregnancy that is the result of rape or incest, an abortion can never be "needed" or "medically necessary and appropriate" and that patients who experience mental health issues following acts of rape or incest should be provided counseling and support, not abortions. VA does not make changes to the rule based on this comment. As VA explained in the IFR, VA has determined that abortions for pregnancies resulting from rape or incest, when sought by a pregnant veteran and clinically determined to be needed to promote, preserve, or restore the health of the veteran and in accord with generally accepted standards of medical practice, are needed consistent with the terms of 38 U.S.C. 1710. As noted in the IFR, there are severe health consequences associated with being forced to carry a pregnancy that is the result of rape or incest to term, including constant exposure to the violation committed against the individual which can cause serious traumatic stress and a risk of long-lasting psychological conditions. 87 FR 55292. Such consequences can have a particular impact on veterans, who report higher rates of sexual trauma compared with civilian peers. *Id.* In addition, veterans are more likely to have preexisting mental health conditions that would be compounded by the mental health consequences of being forced to carry a pregnancy to term if that pregnancy is the result of rape or incest. *Id.* In addition, for similar reasons to those discussed above and in the IFR, and because it is "similar" to the care offered under TRICARE (Select), *see* 38 U.S.C. 1781(b), VA has also determined, for purposes of 38 CFR 17.272(a), that access to abortion when the pregnancy is the result of an act of rape or incest is medically necessary and appropriate and so must be available to CHAMPVA beneficiaries. 87 FR 55292.

C. Investigation or Reporting

Commenters raised concerns about whether evidence of sexual abuse will be investigated or reported. To the extent these commenters might want VA to regulate such investigation or reporting for purposes of providing the health care services permitted under the IFR, VA does not make changes to the rule. For the reasons already explained herein, self-reports are sufficient to establish that an act of rape or incest occurred. Further, this approach is similar to how VA providers, who are not investigators, consider other types of patient self-reported information such as military sexual trauma; other trauma; and medical, personal, health information and history. VA will investigate claims of rape or incest to the extent they occurred on VA property or involved a VA employee, consistent with VHA Directive 5019.02, which relates to reporting of harassment, sexual assault, and other public safety incidents in VHA. Additionally, consistent with VHA Directive 1199(2), VA providers will report claims of abuse, as necessary and required by Federal law.

VII. Availability of the Health Care Services Permitted Under the IFR to Non-Veterans and Non-CHAMPVA Beneficiaries

A. Spina Bifida Health Care Benefits Program

One commenter inquired into whether the health care services permitted under the IFR will be available to beneficiaries in VA's Spina Bifida Health Care Benefits Program. VA considers this comment outside the scope of the rulemaking as VA did not amend the regulations for such program; only the regulations for the medical benefits package and CHAMPVA were amended by the IFR. VA makes no changes to the rule based on this comment.

B. Nonveterans

This same commenter inquired into whether the health care services permitted under the IFR will be available to nonveterans for emergency services on a humanitarian basis. VA is authorized to provide humanitarian care under 38 U.S.C. 1784 and medical screening and stabilization for an emergency medical condition under 38 U.S.C. 1784A, but VA considers this comment to be outside the scope of the rulemaking as VA only amended the regulations for the medical benefits

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package and CHAMPVA, which determine care for veterans and CHAMPVA beneficiaries, respectively. VA makes no changes to the rule based on this comment.

C. "Wives of Military Members"

Another commenter inquired whether "wives of military members" will be eligible for the health care services permitted under the IFR. To the extent such individuals have veteran status and are receiving their medical care through VA (specifically care included in the medical benefits package), or else are CHAMPVA beneficiaries, then they would be eligible for health care services in the circumstances permitted by the IFR. However, to the extent the commenter is referring to individuals who do not have veteran status or are not CHAMPVA beneficiaries, these individuals are not covered by the amendments made by the IFR. VA makes no changes to the rule based on this comment.

VIII. Comments That Stated Abortion Was Not Health Care or Is Otherwise Harmful

Many commenters stated that abortion is not health care. Some of these commenters did not provide any supporting rationale for this statement, while others asserted that abortion could not be health care because the practice of medicine is supposed to preserve life, not end life. VA does not make changes to the rule based on these comments. As VA explained in the IFR and herein, abortions are health care and may be needed to preserve the life or health of a pregnant individual. Pregnant individuals may face life and health-threatening conditions, where abortion may be the only medical intervention available that can preserve their health or life.[3] *See* 87 FR 55291.

Many commenters opposed VA providing access to abortions because they asserted that abortions can be harmful to pregnant individuals. Some commenters stated that abortions can result in emotional harm or complications for pregnant individuals but did not offer support, evidence, or a rationale for such assertions. Some commenters asserted similar opinions but posited distinct harms and cited certain literature. VA does not make changes to the rule based on these comments.

All medical care may pose a risk of complications to some patients. In every instance of care, medical practice requires practitioners to balance the risks of providing needed or medically necessary and appropriate care with the risks of not doing so, a calculation guided by clinical standards and informed by reliable data. The patient must then also balance the risks of receiving needed or medically necessary and appropriate care with the risks of not doing so, and VA obtains informed consent for any medical care pursuant to its existing informed consent requirements set forth in 38 CFR 17.32 (implementing 38 U.S.C. 7331). As explained in the IFR (87 FR 55291) and herein, research has shown that while most pregnancies progress without incident, pregnancy and childbirth in the United States can result in physical harm and even death for pregnant individuals.[4] Without access to comprehensive reproductive health care, including abortion, such individuals may experience conditions resulting from their pregnancy that can leave them at risk for loss of future fertility, significant morbidity, or death. In such instances, an abortion may be the only medical intervention that can preserve that individual's health or save their life.[5]

The health care profession understands that abortions are safe medical interventions.[6] A study available to the public and cited in the IFR addressed the rate of abortion complications and concluded that, contrary to the unsupported assertion by commenters, the most common type of complications from abortions are minor and treatable.[7] The scientific evidence also shows that the risk of complication or mortality from abortion is less than the risk of complication or mortality from other common clinical procedures.[8]

A 2018 consensus study report from the National Academy of Medicine (National Academies of Sciences, Engineering, and Medicine (NASEM)) reviewed the then available evidence on the safety and quality of legal abortions in the United States and concluded that having an abortion does not increase an individual's risk of secondary infertility, pregnancy-related hypertensive disorders, abnormal placentation, preterm birth, or breast cancer.[9] This review by NASEM also found that having an abortion does not increase a person's risk of depression, anxiety, or posttraumatic stress disorder.[10]

One commenter opined that allowing access to abortion counseling or abortions via telehealth is harmful. The commenter provides no evidence or rationale for this assertion. VA makes no changes to the rule based on this comment. Telehealth is widely implemented at VA to provide high-quality care to veterans and eligible beneficiaries, enhancing access to care in appropriate cases. *See* 38 U.S.C. 1730C. Abortion counseling as well as some abortions can be provided through telehealth in accord with generally accepted standards of medical practice. VA will only provide medical care, whether in-person or through telehealth, that is consistent with generally accepted standards of care.

Commenters also raised concerns that the rule did not include informed consent or standards for medical evaluations to ensure that an abortion would not lead to further medical complications or harm for women. VA does not make changes to the rule based on these comments. In determining whether to recommend *any* treatment or procedure, VA providers take into consideration all relevant clinical factors, that is, they conduct a medical evaluation based on a number of clinical factors. Decisions as to which treatment or procedures to recommend are clinical judgments made in accord with generally accepted standards of care. Informed consent is not required as part of the provider's individual undertaking of a differential diagnosis or decision process as to available and recommended treatment options. These clinical evaluation steps occur before the provider's professional recommendation is decided. Informed consent only applies to the receipt of

[3] Martha B. Kole, Jennifer Villavicencio, and Erika G. Werner. *Reproductive services for the patient at increased risk for morbidity and mortality during the second trimester.* Semin Perinatol, 44 (5), 151270 (2020).

[4] Elizabeth G Raymond & David A Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States,* 119 Obstetrics & Gynecology 215, 216 (2012); see also Marian F. MacDorman et al., *Recent Increases in the U.S. Maternal Mortality Rate: Disentangling Trends from Measurement Issues.* 128 Obstetrics & Gynecology 447 (2016) (finding a 26.6 percent increase in maternal mortality rates between 2000 and 2014).

[5] *Abortion Can Be Medically Necessary,* Am. College of Obstetricians and Gynecologists, Sep. 25, 2019. *http://www.acog.org/news/news-releases/2019/09/abortion-can-be-medically-necessary* (last visited Aug. 22, 2022).

[6] *Abortion Access Fact Sheet.* The American College of Obstetrics and Gynecology. 2023. *https://www.acog.org/advocacy/abortion-is-essential/come-prepared/abortion-access-fact-sheet* (last visited May 15, 2023).

[7] Desai Upadhyay, et al. *Incidence of emergency department visits and complications after abortion,* Obstet Gynecol; 125(1):175–183 (2105).

[8] *Abortion Access Fact Sheet.* The American College of Obstetrics and Gynecology. 2023. *https://www.acog.org/advocacy/abortion-is-essential/come-prepared/abortion-access-fact-sheet* (last visited May 15, 2023).

[9] *The Safety and Quality of Abortion Care in the United States.* National Academies of Sciences, Engineering, and Medicine (Mar. 2018). *https://nap.nationalacademies.org/catalog/24950/the-safety-and-quality-of-abortion-care-in-the-united-states.*

[10] Id.

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VA recommended treatment or procedures, which the patient can then decide to reject or accept. No medical treatment or procedure may be performed without the prior, voluntary, and fully informed consent of the patient. 38 CFR 17.32(b). 38 U.S.C. 7331; 38 CFR 17.32. As part of informed consent discussion, the practitioner must explain in plain language understandable to the patient the nature of the proposed procedure or treatment; expected benefits; reasonably foreseeable associated risks, complications, side effects; reasonable and available alternatives; and anticipated result if nothing is done, among other information. *See* 38 CFR 17.32(c)(2).

IX. Comments Related to Employee Rights and Protections and Rights of the Public

Commenters raised concerns related to employees' religious and conscience-based protections, including under the First Amendment, the Religious Freedom Restoration Act, the Public Health Service Act (including the Coats-Snowe Amendment), and Title VII of the Civil Rights Act of 1964. Commenters further asserted that VA is forcing VA employees to provide abortions that may be criminal offenses under State or local law, and one commenter specifically inquired whether any or all VA employees will be responsible for assisting with "emergency abortions." VA does not make any changes to the rule based on these comments. In implementing the IFR and this rule, VA adheres to all applicable Federal laws relating to employee rights and protections, including protections based on an employee's religious or conscience-based objection to abortion. VA has a policy in place for reasonable accommodation requests, where employees may request to be excused from providing, participating in, or facilitating an aspect of clinical care, including reproductive health clinical care authorized by this rule. See, AUSHO Memorandum, *Processing Employee Requests to be Excused from Aspects of the Provision of Reproductive Health Care within the Veterans Health Administration* (Jan. 6, 2023). Pursuant to that policy, VA health care professionals that object to furnishing the care covered by this rulemaking to veterans or CHAMPVA beneficiaries may request to be excused from that care and such requests will be individually assessed under the applicable Federal law. If excusal is requested, supervisors should grant interim excusal for employees from duties or training regarding reproductive health care while requests are being processed.

Commenters also raised concerns regarding whether those providing the health care services permitted under the IFR, including VA employees and non-VA providers, would be protected by VA against State action, such as potential enforcement of State criminal, civil, or administrative penalties related to the provision of the health care services permitted under the IFR. To the extent a VA employee provides the health care services permitted under the IFR within the scope of their VA employment as authorized by Federal law, they could not legally be subject to adverse State actions. As described above, State and local laws, rules, regulations, and requirements that unduly interfere with health care professionals' practice will have no force or effect when such professionals are practicing health care while working within the scope of their VA employment. 38 CFR 17.419.

Moreover, as further described above, in circumstances where there is a conflict between Federal and State law, Federal law would prevail in accordance with the Supremacy Clause under Article VI, clause 2, of the U.S. Constitution. The Department of Justice's Office of Legal Counsel has issued an opinion confirming that States may not impose criminal or civil liability on VA employees who provide or facilitate abortions or related services in a manner authorized by Federal law, including this rule. *See* 46 Op. O.L.C. __ (Sept. 21, 2022); *www.justice.gov/olc/opinion/intergovernmental-immunity-department-veterans-affairs-and-its-employees-when-providing*. If States attempt to subject VA employees to legal action for appropriately carrying out their Federal duties the Department of Justice will support and provide representation to those employees.

Several commenters additionally asserted that performing an abortion would violate a VA health care professional's Hippocratic oath, where some of these comments further noted that this oath requires individuals who take it to "do no harm" in the practice of medicine. VA does not make changes to the rule based on these comments. An abortion would be provided pursuant to the rule to veterans only when determined by appropriate healthcare professionals to be needed to promote, preserve, or restore the health of the individual and to be in accord with generally accepted standards of medical practice; and to CHAMPVA beneficiaries when medically necessary and appropriate.

Some commenters appeared to allege that the IFR violates their First Amendment rights and religious freedoms as members of the public, without providing rationale or support for such statements. Unlike the comments above that raised specific First Amendment and religious freedom concerns for VA health care professionals, these comments did not assert or explain why they believed the IFR violated their First Amendment rights or religious freedoms as members of the public. VA's IFR authorizes the provision of abortions and abortion counseling to veterans and CHAMPVA beneficiaries in certain circumstances. It does not limit the First Amendment rights or religious freedoms of the public.

X. Comments Specifically Concerning Abortion Counseling

The IFR revised 38 CFR 17.38(c)(1) and 17.272(a) to remove a prohibition on VA providing access to abortion counseling. Below VA summarizes comments that specifically raised concerns with this revision, other than as already addressed in this rulemaking.

A. Provision of Abortion Counseling

Multiple commenters raised various concerns about VA's provision of abortion counseling. The commenters stated that abortion counseling should be unbiased, and that VA should not "direct" pregnant individuals to have an abortion. The commenters further suggested that abortion counseling should include discussion of options other than abortion and should also include information about the negative effects of abortion. One commenter further implied that VA is not providing counseling about options other than abortion specifically for victims of rape or incest.

VA does not make changes to the rule based on these comments. Prior to the IFR, VA could not discuss abortion as an option with pregnant patients, but VA has always provided counseling to pregnant patients about pregnancy options such as carrying the pregnancy to term and adoption. Under the IFR, VA now provides the full range of pregnancy options counseling to individuals who are pregnant, which includes all options related to that individual's pregnancy and is not limited to discussing only the option of abortion. This is consistent with Centers for Disease Control and Prevention guidance.[11] As explained in the IFR,

[11] *Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs*. Centers for Disease Control and

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abortion counseling is part of pregnancy options counseling and is a component of comprehensive, patient-centered, high-quality reproductive health care, and is needed care for veterans, and medically necessary and appropriate for CHAMPVA beneficiaries, because such counseling will enable a pregnant individual to make a fully informed health care decision, just as counseling offered or covered by VA regarding other health care treatments enables the patient to make an informed decision. *See* 87 FR 55292–93. Such pregnancy options counseling is provided in a neutral, non-directive, and unbiased manner to ensure patients receive the most complete and accurate information regarding available treatment options. VA does not direct a patient towards a specific option when it conducts pregnancy options counseling. The rule also makes clear that VA's determinations that such counseling is needed care (as to veterans) and medically necessary and appropriate (as to CHAMPVA beneficiaries)—and the accompanying regulatory amendments—were not limited to instances in which the pregnancy is the result of rape or incest. *See, e.g., id* at 55293–94.

B. Post-Abortion Counseling

Another commenter suggested VA provide post-abortion counseling and support for the pregnant individual and their spouse. VA does not make changes to the rule based on this comment. To the extent a veteran requests counseling or mental health support from VA after an abortion or any other type of medical service, such care is available to veterans as part of the medical benefits package. VA would also cover such counseling and mental health support for CHAMPVA beneficiaries. However, and as explained herein, VA does not have authority to provide such counseling under the medical benefits package or CHAMPVA to non-veterans and non-VA beneficiaries, respectively.

XI. Comments Specific to CHAMPVA

Prior to the IFR, the CHAMPVA program at 38 CFR 17.272(a)(64) covered abortions for beneficiaries when the life of the beneficiary would be endangered if the pregnancy were carried to term. The IFR revised § 17.272(a)(64) to: (i) expand the exception on the exclusion of abortion to cover cases where the health of the pregnant CHAMPVA beneficiary would be endangered if the pregnancy were carried to term; and (ii) to establish an exception to the exclusion of abortion to cover cases where the pregnancy of the CHAMPVA beneficiary is the result of an act of rape or incest. Below VA addresses comments that specifically raised concerns with these changes to CHAMPVA, other than as already addressed in this rulemaking.

A. CHAMPVA and TRICARE

One commenter stated that VA does not have authority to provide medical care under the CHAMPVA program in the same manner as under the TRICARE program because TRICARE and CHAMPVA are separate programs and CHAMPVA covers medical care only to those specifically identified at 38 U.S.C. 1781(a). The commenter further stated that VA does not effectively argue that CHAMPVA and TRICARE coverage should be aligned. VA does not make any changes to the rule based on this comment. It appears that the commenter may misunderstand the CHAMPVA authority. VA has authority to furnish medical care to CHAMPVA beneficiaries pursuant to 38 U.S.C. 1781. Section 1781(b) establishes that VA must provide such care "in the same or similar manner and subject to the same or similar limitations as medical care" is provided by DoD under the TRICARE program.

Other commenters asserted that the IFR's changes to the CHAMPVA regulations were not the same or similar to what is permitted under TRICARE. Specifically, these comments noted that the exclusion to provide abortions if the health of an individual were endangered, as well as furnishing abortion counseling for any reason (and not just in those cases for which abortions would be covered by TRICARE), were too broad to be considered the same or similar to what is permitted under TRICARE. Notably, these comments also incorrectly argued that the CHAMPVA exception to protect the health of the pregnant individual without further qualification or limitation could be interpreted in a way that increases access to abortion services beyond the scope stated in the IFR.

VA does not make changes to the rule based on these comments. As explained in the IFR and herein, TRICARE (Select) provides coverage for abortions when the pregnancy is the result of an act of rape or incest, or when a physician certifies that the life of the woman would be endangered if the pregnancy were carried to term. 87 FR 55290. CHAMPVA regulations previously allowed for abortions only when a physician certifies that the abortion was performed because the life of the woman would be endangered if the pregnancy were carried to term. *See* 38 CFR 17.272(a)(64); 87 FR 55290. Pursuant to VA's authority in 38 U.S.C. 1781, VA amended the CHAMPVA regulations to better align coverage under CHAMPVA with coverage under TRICARE (Select). In this regard, VA amended its regulations to additionally provide coverage of abortions when the pregnancy is the result of an act of rape or incest. Although VA also revised the regulations to cover abortions when the health of the CHAMPVA beneficiary would be endangered if the pregnancy were carried to term, in contrast with coverage under TRICARE (Select), coverage under CHAMPVA must be provided in the "same or similar" manner and subject to the "same or similar" limitations as TRICARE (Select). 38 U.S.C. 1781(b); *see* 87 FR 55290. By referring to care that is "similar," the statute permits VA flexibility to administer the program for CHAMPVA beneficiaries. If Congress had intended for VA to administer the program for CHAMPVA beneficiaries in a manner equivalent to TRICARE (Select), 38 U.S.C. 1781(b) simply could have required VA provide "the same" care in "the same" manner as TRICARE (Select); however, the statute recognizes that there will be differences in how VA administers CHAMPVA. VA determined that the care provided under this rule is similar to that provided by DOD under TRICARE (Select), which covers abortions to beneficiaries when there is a medical risk to the pregnant individual if the pregnancy were carried to term or if the pregnancy is the result of an act of rape or incest. *Id.* The flexibility to administer CHAMPVA in a manner "similar" to TRICARE (Select) also recognizes that VA serves a different population than TRICARE under a different authority. Section 1781(b) of 38 U.S.C. authorizes VA to provide care directly to CHAMPVA beneficiaries through VA facilities, and beneficiaries who receive care at a VA facility are eligible for the same medical services as a veteran. In exercising our discretion to provide care in a "similar" manner to TRICARE (Select), we have concluded it lies within our discretion to determine that abortions in the circumstances authorized by the IFR should be made available to all CHAMPVA beneficiaries, not just those who receive their care through VA facilities. As explained, it is important to provide medically necessary and appropriate abortion care when the health of the pregnant individual is endangered, as determined by an appropriate medical professional under

Prevention. April 25, 2014. *https://www.cdc.gov/mmwr/preview/mmwrhtml/rr6304a1.htm?s_cid=rr6304a1_w* (last visited December 6, 2023).

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generally accepted standards of care, to better promote the long-term health of CHAMPVA beneficiaries, which is consistent with VA's past practices related to implementing CHAMPVA.

Regarding the portion of these comments related to VA furnishing abortion counseling under CHAMPVA for any beneficiary and not just in those cases for which an abortion would be covered hy TRICARE, we reiterate from above that VA finds this more comprehensive abortion counseling to be sufficiently similar to that under TRICARE (Select). VA's broader coverage may deviate for purposes of promoting the long-term health of CHAMPVA beneficiaries by covering the most complete and accurate information available regarding various pregnancy and health care options, regardless of whether CHAMPVA would cover any such abortion the beneficiary receives. *See also* 87 FR 55292–93.

B. CHAMPVA Care at VA Facilities

One commenter stated that 38 U.S.C. 1781 authorizes, but does not mandate, the provision of CHAMPVA care at VA facilities through the CHAMPVA In-House Treatment Initiative (CITI). The commenter suggested that VA ensure that VA facilities provide access to abortion to CHAMPVA beneficiaries through the CITI program, particularly in localities where abortions are banned or restricted. VA does not make changes to the rule based on this comment. The provision of CHAMPVA care at VA facilities through the CITI program is permissible under 38 U.S.C. 1781(b), which provides that those VA medical facilities that are equipped to provide CHAMPVA beneficiaries care may do so only to the extent they are not being utilized for the care of eligible veterans. Because the capacity, projected demands, and care needs of veterans at each VA Medical Center can fluctuate, VA cannot ensure that a certain number of VA facilities or facilities in any particular State or region will participate in the CITI program at any given time. However, where a VA facility operates a CITI program, it will provide the health care services permitted by the IFR to CHAMPVA beneficiaries who are eligible to receive care through CITI consistent with the IFR and to the extent that facility's resources are not being utilized for the care of eligible veterans. Further, it remains the case that the CITI program may expand to additional VA facilities if such facilities are equipped to provide the care and treatment and are not being utilized for the care of eligible veterans, without any revisions to VA regulations.

C. Provision of Abortions and Abortion Counseling to Those Under Age 18

One commenter asserted that VA should clarify that it is not requiring its health care professionals to perform any abortions on those under the age of 18, and that parental notification and consent is required for any abortion. Another commenter similarly stated that it was unclear what protocols will be put in place to ensure that children of veterans who may be eligible to receive abortions through the VA have received proper parental consent. VA makes no changes to the rule based on these comments.

In accordance with VHA Directive 1004.01, dated December 12, 2023, it is VA policy that if a patient is considered a minor under State law in the jurisdiction where the VA facility is located, then that patient is not presumed to have decision-making capacity for giving informed consent. As a result, for patients considered minors, consent would be obtained from the patient's parent or legal guardian, except as otherwise provided by law. And as also consistent with this VA policy, if the patient is not considered a minor under State law, for example, by virtue of a State court order awarding emancipation to the minor or automatic emancipation under State law based on certain events, parental notification and consent would not be required.

XII. Comments Related to Fatal Fetal Anomalies

One commenter recommends VA revise the rule to include an exception to allow abortions for fatal fetal anomalies. VA makes no changes based on this comment. The commenter provides no rationale for the proposal that abortions be provided absent the circumstances identified in the rule, or for a finding that the proposed expansion would constitute needed care (for veterans) or medically necessary and appropriate care (for CHAMPVA beneficiaries) under 38 U.S.C. 1710 and 1781. As explained herein and in the IFR, VA has determined that abortions are needed or medically necessary and appropriate care, as required under VA's statutory authorities, when the life or health of the pregnant veteran or CHAMPVA beneficiary would be endangered if the pregnancy were carried to term or when the pregnancy is the result of an act of rape or incest. It is up to the provider to determine if the specific clinical facts of the individual case establish that the carrying to term of a fetus with a fatal fetal anomaly would endanger the life or health of a pregnant veteran or CHAMPVA beneficiary. That is, it would be up to the provider to make the necessary clinical determination.

XIII. Comments Related to VA Mission and Funding

Several commenters opined that VA should not use its limited resources for abortion as VA facilities are for veteran care. These commenters expressed concerns regarding the impact of the health care services permitted under the IFR on VA's provision of other needed care. VA makes no changes to the rule based on these comments. As explained in the IFR and throughout this final rule, abortions can also be needed health care for veterans and medically necessary and appropriate for CHAMPVA beneficiaries. Pursuant to authorized appropriations, detailed above, VA receives and uses funding to furnish medical care authorized under the medical benefits package, which now includes abortions in certain circumstances and abortion counseling. VA's provision of the health care services permitted under the IFR does not impact or preclude VA's provision of all other needed health care.

XIV. Comments That VA Should Expand Access to Abortion

Several commenters opined that VA should permit access to abortions for any reason, not just in the circumstances identified in the IFR. One of these commenters asserted that VA's statutory authority permits abortion care in all circumstances, not just in cases where the life or health of the pregnant patient would be endangered if the pregnancy were carried to term, or when the pregnancy is the result of rape or incest. Consistent with its authorities, and as discussed throughout this rule and the IFR, VA has removed exclusions for certain care that VA has, at this time, determined to be "needed" (for veterans) and "medically necessary and appropriate" (for CHAMPVA beneficiaries). We decline to change course based on these comments.

Some commenters supported a legislative change to permit VA to provide access to abortions for any reason. Those comments regarding Congress's ability to amend VA's statutory authority are outside the scope of this rulemaking.

Some commenters otherwise asserted that the IFR's framing of VA's regulatory changes as prohibitions on abortion with exceptions could be confusing, perhaps to the detriment of veterans or CHAMPVA beneficiaries. As discussed, given VA's statutory authorities and regulations concerning determinations that care is "needed" or "medically

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necessary and appropriate''—as well as a preexisting prohibition with ''exceptions'' for abortion care nnder VA's implementing regulations for CHAMPVA (38 CFR 17.272)—it was appropriate to regulate in this consistent manner. VA has and will continue to issue appropriate gnidance to ensure that VA health care professionals understand that abortion is permitted under the exceptions as outlined in the IFR, and again directs veterans, CHAMPVA beneficiaries, and external stakeholders to VA's public-facing websites for clarifying information: *www.womenshealth.va.gov/WOMENSHEALTH/topics/abortion-services.asp.*

XV. Comments Outside the Scope of the IFR

Many commenters raised concerns that were outside the scope of the rulemaking, in addition to those noted above. VA has briefly summarized those concerns below; VA does not make any changes to the rule based on them.

A. Mandated Provision of Abortion or Any Related Reproductive Health Services

One commenter suggested VA clarify that ''the rule cannot mandate coverage for abortion or situationally for any related reproductive health services.'' To the extent the comment was simply asking VA to clarify this point, we reiterate that the covered health care and services permitted under the IFR are available to veterans and CHAMPVA beneficiaries when their health care provider determines they are needed or medically necessary and appropriate. The decision to pursue a particular course of treatment is the pregnant individual's decision, made in consultation with a provider, VA does not make that decision for the individual.

B. VA's Implementation of the IFR

Multiple commenters made statements or asked questions about VA's implementation plan(s) related to the IFR. VA finds comments related to VA's implementation beyond the scope of the IFR as these are administrative matters not controlled by the regulations that were revised by the IFR. Nonetheless, VA provides summaries and responses below for the purposes of transparency and as appropriate.

One commenter opined that VA must make explicit its plan to implement the rule. VA has made relevant information available on its website. *See www.womenshealth.va.gov/WOMENSHEALTH/topics/abortion-services.asp.* As stated there, VA is taking steps to guarantee veterans and CHAMPVA beneficiaries have access to abortion-related care, as authorized by this rule, anywhere in the country.

One commenter stated that a VHA website related to community care provisions (*https://www.va.gov/communitycare/programs/veterans/general_care.asp*) provided that VA facilities do not provide maternity care which suggests that veterans can only receive medical care related to pregnancy (and therefore abortions) through VA's community care providers. The commenter raised a concern about how eligible veterans would be able to access the health care services permitted under the IFR if they were solely available in the community and those community providers would be required to adhere to State law requirements. Relatedly, another commenter inquired whether VA will be providing the health care services permitted nnder the IFR within its VA medical facilities or referring individuals out to the community in other States.

VA does provide some maternity care services to veterans in VA medical facilities, and to the extent that VA can furnish the health care services permitted by the IFR directly, it will do so. Since the IFR published and became effective, VA has made efforts to ensure it has adequate capacity to provide abortion care at VA facilities, including abortion counseling. Regarding needed health care services permitted by the IFR that cannot be furnished in VA facilities (due to lack of resources such as staff or equipment, for instance), VA may refer such care to VA community care providers where that health care is available, consistent with existing VA regulations (see, for instance, 38 CFR 17.4000 *et seq.*).

Several commenters raised concerns that the IFR does not explain the types of abortion methods that will be permitted or prohibited by VA. As noted above, VA does not generally find it appropriate to regulate the types of methods of care or procedures that are permitted or prohibited. Doing so could unnecessarily restrict the provision of care, including abortions, and result in negative impact or harm to our patients. The type of abortion provided will vary on a case-to-case basis, and appropriate VA medical professionals must be able to determine, in accord with generally accepted standards of medical practice, how best to treat all individuals.

One commenter opined that VA should clarify in guidance that no additional administrative barriers should delay or impede access to the health care services permitted under the IFR determined to be appropriate by a health care professional. Neither the IFR nor this final rule adds administrative barriers to delay or impede access to the health care services permitted under the IFR. VA will ensure its health care professionals furnish this care consistent with the manner in which they furnish all other authorized health care.

One commenter inquired as to whether VA will have funding for the provision of this care, if VA will provide medication abortion, and if VA will have necessary providers available to provide this care. VA is using and will continue to use its current funding for the provision of health care authorized under 38 U.S.C. 1710 and 1781 to provide health care services in the circumstances permitted under the IFR. VA will ensure that experienced and trained VA providers are available to provide abortions, including medication abortion. Another commenter relatedly recommended that VA equip its pharmacists with the authority and infrastructure to support mail dispensary of medication abortion drugs. VA pharmacists do have the authority to mail medications.

Another commenter urged VA to include virtual counseling and medication abortion as part of the care authorized under the IFR. As explained previously in this rule, abortion counseling may be provided virtually through telehealth in accord with generally accepted standards of care. VA will provide medication abortions when needed and medically appropriate and in a manner consistent with Federal law.

Another commenter suggested that VA clarify that sexual assault survivors can receive the full range of health care without barriers, especially as the majority of sexual assaults are not reported, and survivors may distrust the police or fear retaliation from a known perpetrator. Veterans who are eligible for VA health care and CHAMPVA beneficiaries are able to receive the full range of health care authorized under the medical benefits package and CHAMPVA, respectively, regardless of whether they are a sexual assault survivor. VA notes that it has military sexual trauma coordinators at every VA medical facility that can further assist eligible individuals in accessing needed military sexual trauma care. For additional information, please see *www.va.gov/health-care/health-needs-conditions/military-sexual-trauma/.*

One commenter appeared to support VA's training of medical students and residents to provide the health care services permitted under the IFR.

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Similar to the provision of all other health care provided by VA, medical students and residents may receive training from VA regarding the provision of the health care services permitted under the IFR. Such training would be conducted pursuant to an affiliation agreement between an educational institution and a VA facility, and under the clinical supervision of an appropriate health care professional.

One commenter stated that not all VA facilities are located on exclusive Federal property, and therefore it would seem necessary to alert individuals seeking an abortion at such a VA facility that VA cannot guarantee that such individuals would not be prosecuted under State law even though the VA medical provider would appear to be protected. The commenter further stated that a better option would be to have VA authorize transport at government expense of such an individual to a VA facility in a State that does not criminalize abortion. Relatedly, commenters inquired how VA will address State action concerns because not all veterans live in areas that permit abortion counseling or services and that there should be measures to ensure travel across State lines if necessary, and generally noted that VA needs to ensure that veterans feel safe in accessing abortion care.

For the portions of these comments that assert or question VA's jurisdiction or control of its facilities, any care or services furnished by VA in a manner authorized by Federal law, including by this rule, would preempt conflicting State law that would penalize VA employees for performing their Federal functions, regardless of any specific land ownership or leasing arrangements (for instance, such as if a VA facility is co-located to a State-sponsored academic institution).

To the extent these comments may raise concerns that needed abortion counseling or abortions cannot be furnished in VA facilities (due to lack of resources such as staff or equipment, for instance), VA reiterates from earlier in this discussion that VA may refer such care to VA community care providers where available.

Insofar as some comments concerned potential travel needed to obtain the health care services permitted under the IFR, veterans would have access to both Beneficiary Travel and Veterans Transportation Program benefits if so eligible under VA regulations at 38 CFR part 70.

Finally, insofar as commenters suggested that VA alert certain individuals seeking abortions that VA cannot guarantee that such individuals would not be prosecuted under State law, VA is a health care provider, and VA attorneys have no authority to provide any legal advice to veterans or CHAMPVA beneficiaries.

C. Suggested Alternatives to VA Providing Access to Abortion

Commenters asserted that instead of access to the health care services permitted under the IFR they believed pregnant individuals should be given the option of emotional and physical support throughout their pregnancies and post-partum experiences, specifically including prenatal medical attention. Other commenters similarly indicated that instead of providing access to abortions, VA should direct pregnant individuals to support groups that are available and, if such individuals do not wish to keep a child after giving birth, to help them through the adoption process. As with all comments discussed in this section, VA finds these comments to be beyond the scope of the IFR.

These commenters seem to assert that abortion would not be necessary if pregnant individuals were given more support during prenatal, pregnancy, or postpartum stages, or offered choices beyond abortion, which seems to assume that VA is providing access to abortion procedures for reasons other than medical necessity. However, the IFR permits abortions to be provided only when the life or health of the pregnant individual would be endangered if the pregnancy were carried to term or when the pregnancy is the result of an act of rape or incest. VA provides care to veterans when such care is determined by an appropriate health care professional to be needed to promote, preserve, or restore the health of the veteran and is in accord with generally accepted standards of medical practice, and provides care for CHAMPVA beneficiaries that is medically necessary and appropriate. The need for health care services permitted under the IFR would not be prevented by increased access to support groups or to a particular level of maternity care services. Moreover, VA's pregnancy options counseling, discussed above, includes abortion counseling and all other pregnancy options. The course of treatment is the pregnant individual's decision, made in consultation with a provider, and nothing in the IFR changes this.

To the extent the commenters might be expressing that lack of maternity care services could endanger a pregnant individual's life or health if the pregnancy were carried to term, maternity care services provided by VA include comprehensive pre- and post-partum care and services. VA will continue to provide comprehensive maternity care in addition to the health care services permitted by the IFR in the circumstances stated in the rule.

Regarding the request in the comments that VA assist pregnant individuals with the adoption process if they did not want to keep a child after giving birth, VA does provide pregnancy options counseling as part of its furnishing of maternity care services, and this pregnancy options counseling includes providing information on adoption.

Severability

The purpose of this section is to clarify VA's intent with respect to the severability of provisions of this rule. Each provision and portion of this rule is capable of operating independently. If any provision or portion of this rule is determined by judicial review or operation of law to be invalid, that partial invalidation will not render the remainder of this rule invalid. As explained in the IFR and above, VA amended its regulations because it determined that providing access to abortion-related medical care is needed to protect the lives and health of veterans and is medically necessary and appropriate care for CHAMPVA beneficiaries. For those same reasons, VA intends each aspect of the rule to operate and ensure that such care is available, even if one portion of the rule is invalidated. For example, if a provision of the rule concerning benefits for CHAMPVA beneficiaries were held invalid, other provisions concerning CHAMPVA beneficiaries, and provisions concerning the care available to Veterans under the medical benefits package, could and should continue to operate independently. The provisions authorizing abortions in cases where the life or health of the pregnant veteran or CHAMPVA beneficiary would be endangered if the pregnancy were carried to term could operate independently should the provision authorizing abortions in cases where the pregnancy is due to an act of rape or incest be held invalid, and vice versa. The provisions authorizing VA to provide abortions could continue to operate should the provisions authorizing VA to provide abortion counseling be held invalid. We emphasize that this is a non-exhaustive list of examples. Likewise, if the application of any portion of this rule to a particular circumstance is determined to be invalid, the agency intends that

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the rule remain applicable to all other circumstances.

Administrative Procedure Act

VA has considered all relevant input and information contained in the comments submitted in response to the IFR (87 FR 55287) and, for the reasons set forth in the foregoing responses to those comments, has concluded that changes to the IFR are not warranted. Accordingly, based upon the authorities and reasons set forth in issuing the IFR (87 FR 55287), as supplemented by the additional reasons provided in this document in response to comments received, VA is adopting the provisions of the IFR as a final rule without changes.

Executive Order 13132, Federalism

Executive Order 13132 establishes principles for preemption of State laws when those laws are implicated in rulemaking or proposed legislation. The order provides that, where a Federal statute does not expressly preempt State law, agencies shall construe any authorization in the statute for the issuance of regulations as authorizing preemption of State law by rulemaking only when the exercise of State authority directly conflicts with the exercise of Federal authority or there is clear evidence to conclude that the Congress intended the agency to have the authority to preempt State law.

As discussed in the IFR, consistent with 38 CFR 17.419, State and local laws, rules, regulations, or requirements are preempted to the extent those laws unduly interfere with Federal operations or the performance of Federal duties. 87 FR 55293–55294. That includes laws that States and localities might attempt to enforce in civil, criminal, or administrative matters against VA health care professionals acting in the scope of their VA authority and employment and that would prevent those individuals from providing care authorized by 38 U.S.C. 1701, 1710, 1781, 1784A, 7301, and 7310, and VA's implementing regulations. State and local laws, rules, regulations, or requirements are therefore without any force or effect to the extent of the conflict with Federal law, and State and local governments have no legal authority to enforce them in relation to actions by VA employees acting within the scope of their VA authority and employment.

Because all State and local laws, rules, regulations, or requirements have no force or effect to the extent that they unduly interfere with the ability of VA employees to furnish reproductive health care while acting within the scope of their VA authority and employment, there are no actual or possible violations of such laws related to VA programs, operations, facilities, contracts, or information technology systems that would necessitate mandatory reporting by VA employees. 38 CFR 1.201–1.205. This rulemaking confirms VA's authority and discretion to manage its employees concerning the services that will be provided pursuant to this rulemaking.

Next, Executive Order 13132 requires that any regulatory preemption of State law must be restricted to the minimum level necessary to achieve the objectives of the statute pursuant to which the regulations are promulgated. Under VA's regulations, State and local laws, rules, regulations, or other requirements are preempted only to the extent they unduly interfere with the ability of VA employees to furnish needed or medically necessary and appropriate health care to veterans and CHAMPVA beneficiaries while acting within the scope of their VA authority and employment. Therefore, VA believes that the rulemaking is restricted to the minimum level necessary to achieve the objectives of the Federal statutes.

Executive Orders 12866, 13563, and 14094

Executive Order 12866 (Regulatory Planning and Review) directs agencies to assess the costs and benefits of available regulatory alternatives and, when regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, and other advantages; distributive impacts; and equity). Executive Order 13563 (Improving Regulation and Regulatory Review) emphasizes the importance of quantifying both costs and benefits, reducing costs, harmonizing rules, and promoting flexibility. Executive Order 14094 (Executive order on Modernizing Regulatory Review) supplements and reaffirms the principles, structures, and definitions governing contemporary regulatory review established in Executive Order 12866 of September 30, 1993 (Regulatory Planning and Review), and Executive Order 13563 of January 18, 2011 (Improving Regulation and Regulatory Review). The Office of Information and Regulatory Affairs has determined that this rule is a significant regulatory action under Executive Order 12866, as amended by Executive Order 14094. The Regulatory Impact Analysis associated with this rulemaking can be found as a supporting document at *https://www.regulations.gov*.

Regulatory Flexibility Act

The Secretary hereby certifies that this final rule will not have a significant economic impact on a substantial number of small entities as they are defined in the Regulatory Flexibility Act (5 U.S.C. 601–612). This final rule will not have a significant impact on a substantial number of small entities because the final rule does not directly regulate or impose costs on small entities and any effects will be indirect. Therefore, pursuant to 5 U.S.C. 605(b), the initial and final regulatory flexibility analysis requirements of 5 U.S.C. 603 and 604 do not apply.

Unfunded Mandates

The Unfunded Mandates Reform Act of 1995, see 2 U.S.C. 1532, requires that agencies prepare an assessment of anticipated costs and benefits before issuing any rule that may result in the expenditure by State, local, and tribal governments, in the aggregate, or by the private sector, of $100 million or more (adjusted annually for inflation) in any one year. This rule will have no such effect on State, local, and tribal governments, or on the private sector.

Paperwork Reduction Act

This rule contains no provisions constituting a collection of information under the Paperwork Reduction Act of 1995, 44 U.S.C. 3501–21.

Congressional Review Act

Pursuant to the Subtitle E of the Small Business Regulatory Enforcement Fairness Act of 1996 (known as the Congressional Review Act) (5 U.S.C. 801 *et seq.*), the Office of Information and Regulatory Affairs designated this rule as not satisfying the criteria under 5 U.S.C. 804(2).

List of Subjects in 38 CFR Part 17

Administrative practice and procedure, Claims, Health care, Health facilities, Health professions, Health records, Medical devices, Medical research, Mental health programs, Veterans.

■ For the reasons stated in the preamble, the interim final rule amending 38 CFR part 17, which was published at 87 FR 55287 on September 9, 2022, is adopted as final.

Signing Authority

Denis McDonough, Secretary of Veterans Affairs, approved and signed this document on February 26, 2024, and authorized the undersigned to sign and submit the document to the Office of the Federal Register for publication

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electronically as an official document of the Department of Veterans Affairs.

Michael P. Shores,

Director, Office of Regulation Policy & Management, Office of General Counsel, Department of Veterans Affairs.

[FR Doc. 2024–04275 Filed 3–1–24; 8:45 am]

BILLING CODE 8320–01–P

POSTAL SERVICE

39 CFR Part 20

International Mail Manual; Incorporation by Reference

AGENCY: Postal Service™.

ACTION: Final rule.

SUMMARY: The Postal Service announces the issuance of the *Mailing Standards of the United States Postal Service, International Mail Manual* (IMM®) dated January 21, 2024, and its incorporation by reference in the *Code of Federal Regulations.*

DATES: This rule is effective March 4, 2024. The incorporation by reference of certain material listed in this rule is approved by the Director of the Federal Register as of March 4, 2024.

FOR FURTHER INFORMATION CONTACT: Dale Kennedy, (202) 268–6592.

SUPPLEMENTARY INFORMATION: The *International Mail Manual* (IMM) provides our standards for all international mailing services and references for the applicable prices. It was issued on January 21, 2024, and was updated with *Postal Bulletin* revisions through December 28, 2023. It replaces all previous editions.

The IMM continues to enable the Postal Service to fulfill its long-standing mission of providing affordable, universal mail service. It continues to: (1) increase the user's ability to find information; (2) increase the user's confidence that he or she has found the information they need; and (3) reduce the need to consult multiple sources to locate necessary information. The provisions throughout this issue support the standards and mail preparation changes implemented since the version of July 10, 2022. The *International Mail Manual* is available to the public on the Postal Explorer® internet site at *https://pe.usps.com.*

List of Subjects in 39 CFR Part 20

Administrative practice and procedure, Foreign relations, Incorporation by reference.

In view of the considerations discussed above, the Postal Service hereby amends 39 CFR part 20 as follows:

PART 20—INTERNATIONAL POSTAL SERVICE

■ 1. The authority citation for part 20 continues to read as follows:

Authority: 5 U.S.C. 552(a); 13 U.S.C. 301–307; 18 U.S.C. 1692–1737; 39 U.S.C. 101, 401, 403, 404, 407, 414, 416, 3001–3011, 3201–3219, 3403–3406, 3621, 3622, 3626, 3632, 3633, and 5001.

■ 2. Amend § 20.1 by revising paragraphs (a)(3) and (b) to read as follows:

§ 20.1 Incorporation by reference; Mailing Standards of the United States Postal Service, International Mail Manual.

(a) * * *

(3) *Inspection—NARA.* You may view this material at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, visit *www.archives.gov/federal-register/cfr/ibr-locations* or email *fr.inspection@nara.gov.*

(b) The Director of the Federal Register approved the IMM, updated January 21, 2024, for incorporation by reference as of March 4, 2024.

■ 3. Revise § 20.2 to read as follows:

§ 20.2 Effective date of the International Mail Manual.

The provisions of the *International Mail Manual* issued January 21, 2024 (incorporated by reference, see § 20.1), are applicable with respect to the international mail services of the Postal Service.

■ 4. Amend § 20.4 by adding an entry for "IMM" at the end of table 1 to read as follows:

§ 20.4 Amendments to the International Mail Manual.

* * * * *

TABLE 1 TO § 20.4—INTERNATIONAL MAIL MANUAL

International mail manual	Date of issuance
* * * * *	
IMM	January 21, 2024.

Sarah E. Sullivan,

Attorney, Ethics and Legal Compliance.

[FR Doc. 2024–04420 Filed 3–1–24; 8:45 am]

BILLING CODE 7710–12–P

POSTAL SERVICE

39 CFR Part 111

Domestic Mail Manual; Incorporation by Reference

AGENCY: Postal Service™.

ACTION: Final rule.

SUMMARY: The Postal Service announces the issuance of the *Mailing Standards of the United States Postal Service, Domestic Mail Manual* (DMM®) dated January 21, 2024, and its incorporation by reference in the *Code of Federal Regulations.*

DATES: This rule is effective March 4, 2024. The incorporation by reference of certain material listed in this rule is approved by the Director of the Federal Register as of March 4, 2024.

FOR FURTHER INFORMATION CONTACT: Dale Kennedy (202) 268–6592.

SUPPLEMENTARY INFORMATION: The *Mailing Standards of the United States Postal Service, Domestic Mail Manual* (DMM) provides the United States Postal Service's official prices and standards for all domestic mailing services. The most recent issue of the DMM is dated January 21, 2024. This issue of the DMM contains all Postal Service domestic mailing standards and continues to: (1) increase the user's ability to find information; (2) increase confidence that users have found all the information they need; and (3) reduce the need to consult multiple chapters of the Manual to locate necessary information. The issue dated January 21, 2024, sets forth specific changes, including new standards throughout the DMM to support the standards and mail preparation changes implemented since the version issued on July 10, 2022.

Changes to mailing standards will continue to be published through **Federal Register** documents and the *Postal Bulletin* and will appear in the next online version available via the Postal Explorer® website at: *https://pe.usps.com.*

List of Subjects in 39 CFR Part 111

Administrative practice and procedure, Incorporation by reference.

In view of the considerations discussed above, the Postal Service hereby amends 39 CFR part 111 as follows:

PART 111—GENERAL INFORMATION ON POSTAL SERVICE

■ 1. The authority citation for 39 CFR part 111 continues to read as follows:

Authority: 5 U.S.C. 552(a); 13 U.S.C. 301–307; 18 U.S.C. 1692–1737; 39 U.S.C. 101,

This content is from the eCFR and is authoritative but unofficial.

Displaying the eCFR in effect on 7/26/2022.

Title 38 - Pensions, Bonuses, and Veterans' Relief
Chapter I - Department of Veterans Affairs
Part 17 - Medical
Enrollment Provisions and Medical Benefits Package

§ 17.38 Medical benefits package.

(a) Subject to paragraphs (b) and (c) of this section, the following hospital, outpatient, and extended care services constitute the "medical benefits package" (basic care and preventive care):

(1) Basic care.

(i) Outpatient medical, surgical, and mental healthcare, including care for substance abuse.

(ii) Inpatient hospital, medical, surgical, and mental healthcare, including care for substance abuse.

(iii) Prescription drugs, including over-the-counter drugs and medical and surgical supplies available under the VA national formulary system.

(iv) Emergency care in VA facilities; and emergency care in non-VA facilities in accordance with sharing contracts or if authorized by§ 17.52(a)(3), § 17.53, § 17.54, §§ 17.120 through 17.132, or §§ 17.4000 through 17.4040.

(v) Bereavement counseling as authorized in § 17.98.

(vi) Comprehensive rehabilitative services other than vocational services provided under 38 U.S.C. chapter 31.

(vii) Consultation, professional counseling, marriage and family counseling, training, and mental health services for the members of the immediate family or legal guardian of the veteran or the individual in whose household the veteran certifies an intention to live, as necessary and appropriate, in connection with the veteran's treatment as authorized under 38 CFR 71.50.

(viii) Prosthetic and rehabilitative items and services as authorized under §§ 17.3200 through 17.3250, and eyeglasses and hearing aids as authorized under § 17.149.

(ix) Home health services authorized under 38 U.S.C. 1717 and 1720C.

(x) Reconstructive (plastic) surgery required as a result of disease or trauma, but not including cosmetic surgery that is not medically necessary.

(xi)

(A) Hospice care, palliative care, and institutional respite care; and

(B) Noninstitutional extended care services, including but not limited to noninstitutional geriatric evaluation, noninstitutional adult day health care, and noninstitutional respite care.

(xii) Payment of beneficiary travel as authorized under 38 CFR part 70.

(xiii) Pregnancy and delivery services, to the extent authorized by law.

(xiv) Newborn care, post delivery, for a newborn child for the date of birth plus seven calendar days after the birth of the child when the birth mother is a woman veteran enrolled in VA health care and receiving maternity care furnished by VA or under authorization from VA and the child is delivered either in a VA facility, or in another facility pursuant to a VA authorization for maternity care at VA expense.

(xv) Completion of forms (e.g., Family Medical Leave forms, life insurance applications, Department of Education forms for loan repayment exemptions based on disability, non-VA disability program forms) by healthcare professionals based on an examination or knowledge of the veteran's condition,

but not including the completion of forms for examinations if a third party customarily will pay health care practitioners for the examination but will not pay VA.

(2) Preventive care, as defined in 38 U.S.C. 1701(9), which includes:

(i) Periodic medical exams.

(ii) Health education, including nutrition education.

(iii) Maintenance of drug-use profiles, drug monitoring, and drug use education.

(iv) Mental health and substance abuse preventive services.

(v) Immunizations against infectious disease.

(vi) Prevention of musculoskeletal deformity or other gradually developing disabilities of a metabolic or degenerative nature.

(vii) Genetic counseling concerning inheritance of genetically determined diseases.

(viii) Routine vision testing and eye-care services.

(ix) Periodic reexamination of members of high-risk groups for selected diseases and for functional decline of sensory organs, and the services to treat these diseases and functional declines.

(b) ***Provision of the "medical benefits package".*** Care referred to in the "medical benefits package" will be provided to individuals only if it is determined by appropriate health care professionals that the care is needed to promote, preserve, or restore the health of the individual and is in accord with generally accepted standards of medical practice.

(1) ***Promote health.*** Care is deemed to promote health if the care will enhance the quality of life or daily functional level of the veteran, identify a predisposition for development of a condition or early onset of disease which can be partly or totally ameliorated by monitoring or early diagnosis and treatment, and prevent future disease.

(2) ***Preserve health.*** Care is deemed to preserve health if the care will maintain the current quality of life or daily functional level of the veteran, prevent the progression of disease, cure disease, or extend life span.

(3) ***Restoring health.*** Care is deemed to restore health if the care will restore the quality of life or daily functional level that has been lost due to illness or injury.

(c) In addition to the care specifically excluded from the "medical benefits package" under paragraphs (a) and (b) of this section, the "medical benefits package" does not include the following:

(1) Abortions and abortion counseling.

(2) In vitro fertilization. Note: See § 17.380.

(3) Drugs, biologicals, and medical devices not approved by the Food and Drug Administration unless the treating medical facility is conducting formal clinical trials under an Investigational Device Exemption (IDE) or an Investigational New Drug (IND) application, or the drugs, biologicals, or medical devices are prescribed under a compassionate use exemption.

(4) Gender alterations.

(5) Hospital and outpatient care for a veteran who is either a patient or inmate in an institution of another government agency if that agency has a duty to give the care or services. This exclusion does not apply to veterans who are released from incarceration in a prison or jail into a temporary housing program (such as a community residential re-entry center or halfway house).

(6) Membership in spas and health clubs.

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This content is from the eCFR and is authoritative but unofficial.

Title 38 —Pensions, Bonuses, and Veterans' Relief
Chapter I —Department of Veterans Affairs
Part 17 —Medical
Enrollment Provisions and Medical Benefits Package

Authority: 38 U.S.C. 501, and as noted in specific sections. Section 17.30 also issued under 38 U.S.C. 1701. Section 17.32 also issued under 38 U.S.C. 7331-7334. *See Part 17 for more*

§ 17.38 Medical benefits package.

(a) Subject to paragraphs (b) and (c) of this section, the following hospital, outpatient, and extended care services constitute the "medical benefits package" (basic care and preventive care):

(1) Basic care.

(i) Outpatient medical, surgical, and mental healthcare, including care for substance abuse.

(ii) Inpatient hospital, medical, surgical, and mental healthcare, including care for substance abuse.

(iii) Prescription drugs, including over-the-counter drugs and medical and surgical supplies available under the VA national formulary system.

(iv) Emergency care in VA facilities; and emergency care in non-VA facilities in accordance with sharing contracts or if authorized by§ 17.52(a)(3), § 17.53, § 17.54, §§ 17.120 through 17.132, or §§ 17.4000 through 17.4040.

(v) Bereavement counseling as authorized in § 17.98.

(vi) Comprehensive rehabilitative services other than vocational services provided under 38 U.S.C. chapter 31.

(vii) Consultation, professional counseling, marriage and family counseling, training, and mental health services for the members of the immediate family or legal guardian of the veteran or the individual in whose household the veteran certifies an intention to live, as necessary and appropriate, in connection with the veteran's treatment as authorized under 38 CFR 71.50.

(viii) Prosthetic and rehabilitative items and services as authorized under §§ 17.3200 through 17.3250, and eyeglasses and hearing aids as authorized under § 17.149.

(ix) Home health services authorized under 38 U.S.C. 1717 and 1720C.

(x) Reconstructive (plastic) surgery required as a result of disease or trauma, but not including cosmetic surgery that is not medically necessary.

(xi)

(A) Hospice care, palliative care, and institutional respite care; and

(B) Noninstitutional extended care services, including but not limited to noninstitutional geriatric evaluation, noninstitutional adult day health care, and noninstitutional respite care.

(xii) Payment of beneficiary travel as authorized under 38 CFR part 70.

(xiii) Pregnancy and delivery services, to the extent authorized by law.

(xiv) Newborn care, post delivery, for a newborn child for the date of birth plus seven calendar days after the birth of the child when the birth mother is a woman veteran enrolled in VA health care and receiving maternity care furnished by VA or under authorization from VA and the child is delivered either in a VA facility, or in another facility pursuant to a VA authorization for maternity care at VA expense.

(xv) Completion of forms (e.g., Family Medical Leave forms, life insurance applications, Department of Education forms for loan repayment exemptions based on disability, non-VA disability program forms) by healthcare professionals based on an examination or knowledge of the veteran's condition, but not including the completion of forms for examinations if a third party customarily will pay health care practitioners for the examination but will not pay VA.

(2) Preventive care, as defined in 38 U.S.C. 1701(9), which includes:

(i) Periodic medical exams.

(ii) Health education, including nutrition education.

(iii) Maintenance of drug-use profiles, drug monitoring, and drug use education.

(iv) Mental health and substance abuse preventive services.

(v) Immunizations against infectious disease.

(vi) Prevention of musculoskeletal deformity or other gradually developing disabilities of a metabolic or degenerative nature.

(vii) Genetic counseling concerning inheritance of genetically determined diseases.

(viii) Routine vision testing and eye-care services.

(ix) Periodic reexamination of members of high-risk groups for selected diseases and for functional decline of sensory organs, and the services to treat these diseases and functional declines.

(x) Chiropractic services.

(b) ***Provision of the "medical benefits package".*** Care referred to in the "medical benefits package" will be provided to individuals only if it is determined by appropriate health care professionals that the care is needed to promote, preserve, or restore the health of the individual and is in accord with generally accepted standards of medical practice.

(1) ***Promote health.*** Care is deemed to promote health if the care will enhance the quality of life or daily functional level of the veteran, identify a predisposition for development of a condition or early onset of disease which can be partly or totally ameliorated by monitoring or early diagnosis and treatment, and prevent future disease.

(2) ***Preserve health.*** Care is deemed to preserve health if the care will maintain the current quality of life or daily functional level of the veteran, prevent the progression of disease, cure disease, or extend life span.

(3) ***Restoring health.*** Care is deemed to restore health if the care will restore the quality of life or daily functional level that has been lost due to illness or injury.

(c) In addition to the care specifically excluded from the "medical benefits package" under paragraphs (a) and (b) of this section, the "medical benefits package" does not include the following:

(1) Abortions, except when:

(i) The life or the health of the pregnant veteran would be endangered if the pregnancy were carried to term; or

(ii) The pregnancy is the result of an act of rape or incest. Self-reporting from the pregnant veteran constitutes sufficient evidence that an act of rape or incest occurred.

(2) In vitro fertilization. Note: See § 17.380.

(3) Drugs, biologicals, and medical devices not approved by the Food and Drug Administration unless the treating medical facility is conducting formal clinical trials under an Investigational Device Exemption (IDE) or an Investigational New Drug (IND) application, or the drugs, biologicals, or medical devices are prescribed under a compassionate use exemption.

(4) Gender alterations.

(5) Hospital and outpatient care for a veteran who is either a patient or inmate in an institution of another government agency if that agency has a duty to give the care or services. This exclusion does not apply to veterans who are released from incarceration in a prison or jail into a temporary housing program (such as a community residential re-entry center or halfway house).

(6) Membership in spas and health clubs.

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38 USC 1710: Eligibility for hospital, nursing home, and domiciliary care
Text contains those laws in effect on February 12, 2025

From Title 38-VETERANS' BENEFITS
PART II-GENERAL BENEFITS
CHAPTER 17-HOSPITAL, NURSING HOME, DOMICILIARY, AND MEDICAL CARE
SUBCHAPTER II-HOSPITAL, NURSING HOME, OR DOMICILIARY CARE AND MEDICAL TREATMENT

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§1710. Eligibility for hospital, nursing home, and domiciliary care

(a)(1) The Secretary (subject to paragraph (4)) shall furnish hospital care and medical services which the Secretary determines to be needed-

(A) to any veteran for a service-connected disability; and

(B) to any veteran who has a service-connected disability rated at 50 percent or more.

(2) The Secretary (subject to paragraph (4)) shall furnish hospital care and medical services, and may furnish nursing home care, which the Secretary determines to be needed to any veteran-

(A) who has a compensable service-connected disability rated less than 50 percent or, with respect to nursing home care during any period during which the provisions of section 1710A(a) of this title are in effect, a compensable service-connected disability rated less than 70 percent;

(B) whose discharge or release from active military, naval, air, or space service was for a disability that was incurred or aggravated in the line of duty;

(C) who is in receipt of, or who, but for a suspension pursuant to section 1151 of this title (or both a suspension and the receipt of retired pay), would be entitled to disability compensation, but only to the extent that such veteran's continuing eligibility for such care is provided for in the judgment or settlement provided for in such section;

(D) who is a former prisoner of war, who was awarded the medal of honor under section 7271, 8291, or 9271 of title 10 or section 491 [1] of title 14, or who was awarded the Purple Heart;

(E) who is a veteran of-

(i) the Mexican border period;

(ii) World War I; or

(iii) World War II;

(F) who is a toxic-exposed veteran, in accordance with subsection (e); or

(G) who is unable to defray the expenses of necessary care as determined under section 1722(a) of this title.

(3) In the case of a veteran who is not described in paragraphs (1) and (2), the Secretary may, to the extent resources and facilities are available and subject to the provisions of subsections (f) and (g), furnish hospital care, medical services, and nursing home care which the Secretary determines to be needed.

(4) The requirement in paragraphs (1) and (2) that the Secretary furnish hospital care and medical services, the requirement in section 1710A(a) of this title that the Secretary provide nursing home care, the requirement in section 1710B of this title that the Secretary provide a program of extended care services, and the requirement in section 1745 of this title to provide nursing home care and prescription medicines to veterans with service-connected disabilities in State homes shall be effective in any fiscal year only to the extent and in the amount provided in advance in appropriations Acts for such purposes.

(5) During any period during which the provisions of section 1710A(a) of this title are not in effect, the Secretary may furnish nursing home care which the Secretary determines is needed to any veteran described in paragraph (1), with the priority for such care on the same basis as if provided under that paragraph.

(b)(1) The Secretary may furnish to a veteran described in paragraph (2) of this subsection such domiciliary care as the Secretary determines is needed for the purpose of the furnishing of medical services to the veteran.

(2) This subsection applies in the case of the following veterans:

(A) Any veteran whose annual income (as determined under section 1503 of this title) does not exceed the maximum annual rate of pension that would be applicable to the veteran if the veteran were eligible for pension

under section 1521(d) of this title.

(B) Any veteran who the Secretary determines has no adequate means of support.

(c) While any veteran is receiving hospital care or nursing home care in any Department facility, the Secretary may, within the limits of Department facilities, furnish medical services to correct or treat any non-service-connected disability of such veteran, in addition to treatment incident to the disability for which such veteran is hospitalized, if the veteran is willing, and the Secretary finds such services to be reasonably necessary to protect the health of such veteran. The Secretary may furnish dental services and treatment, and related dental appliances, under this subsection for a non-service-connected dental condition or disability of a veteran only (1) to the extent that the Secretary determines that the dental facilities of the Department to be used to furnish such services, treatment, or appliances are not needed to furnish services, treatment, or appliances for dental conditions or disabilities described in section 1712(a) of this title, or (2) if (A) such non-service-connected dental condition or disability is associated with or aggravating a disability for which such veteran is receiving hospital care, or (B) a compelling medical reason or a dental emergency requires furnishing dental services, treatment, or appliances (excluding the furnishing of such services, treatment, or appliances of a routine nature) to such veteran during the period of hospitalization under this section.

(d) In no case may nursing home care be furnished in a hospital not under the direct jurisdiction of the Secretary except as provided in section 1720 of this title.

(e)(1)(A) A Vietnam-era herbicide-exposed veteran is eligible (subject to paragraph (2)) for hospital care, medical services, and nursing home care under subsection (a)(2)(F) for any disability, notwithstanding that there is insufficient medical evidence to conclude that such disability may be associated with such exposure.

(B) A radiation-exposed veteran is eligible for hospital care, medical services, and nursing home care under subsection (a)(2)(F) for any disease suffered by the veteran that is-

(i) a disease listed in section 1112(c)(2) of this title; or

(ii) any other disease for which the Secretary, based on the advice of the Advisory Committee on Environmental Hazards, determines that there is credible evidence of a positive association between occurrence of the disease in humans and exposure to ionizing radiation.

(C) Subject to paragraph (2) of this subsection, a veteran who served on active duty between August 2, 1990, and November 11, 1998, in the Southwest Asia theater of operations during the Persian Gulf War is eligible for hospital care, medical services, and nursing home care under subsection (a)(2)(F) for any disability, notwithstanding that there is insufficient medical evidence to conclude that such disability may be associated with such service.

(D) Subject to paragraphs (2) and (3), a veteran who served on active duty in a theater of combat operations (as determined by the Secretary in consultation with the Secretary of Defense) during a period of war after the Persian Gulf War (including any veteran who, in connection with service during such period, received the Armed Forces Expeditionary Medal, Service Specific Expeditionary Medal, Combat Era Specific Expeditionary Medal, Campaign Specific Medal, or any other combat theater award established by a Federal statute or an Executive order), or in combat against a hostile force during a period of hostilities after November 11, 1998, is eligible for hospital care, medical services, and nursing home care under subsection (a)(2)(F) for any illness, notwithstanding that there is insufficient medical evidence to conclude that such condition is attributable to such service.

(E) Subject to paragraph (2), a veteran who participated in a test conducted by the Department of Defense Deseret Test Center as part of a program for chemical and biological warfare testing from 1962 through 1973 (including the program designated as "Project Shipboard Hazard and Defense (SHAD)" and related land-based tests) is eligible for hospital care, medical services, and nursing home care under subsection (a)(2)(F) for any illness, notwithstanding that there is insufficient medical evidence to conclude that such illness is attributable to such testing.

(F) Subject to paragraph (2), a veteran who served on active duty in the Armed Forces at Camp Lejeune, North Carolina, for not fewer than 30 days during the period beginning on August 1, 1953, and ending on December 31, 1987, is eligible for hospital care and medical services under subsection (a)(2)(F) for any of the following illnesses or conditions, notwithstanding that there is insufficient medical evidence to conclude that such illnesses or conditions are attributable to such service:

(i) Esophageal cancer.
(ii) Lung cancer.
(iii) Breast cancer.
(iv) Bladder cancer.
(v) Kidney cancer.
(vi) Leukemia.
(vii) Multiple myeloma.
(viii) Myelodysplastic syndromes.
(ix) Renal toxicity.
(x) Hepatic steatosis.
(xi) Female infertility.
(xii) Miscarriage.
(xiii) Scleroderma.
(xiv) Neurobehavioral effects.
(xv) Non-Hodgkin's lymphoma.

(G) Beginning not later than the applicable date specified in paragraph (6), and subject to paragraph (2), a veteran who participated in a toxic exposure risk activity while serving on active duty, active duty for training, or inactive duty training is eligible for hospital care (including mental health services and counseling), medical services, and nursing home care under subsection (a)(2)(F) for any illness.

(H) Beginning not later than the applicable date specified in paragraph (6), and subject to paragraph (2), a covered veteran (as defined in section 1119(c) of this title) is eligible for hospital care (including mental health services and counseling), medical services, and nursing home care under subsection (a)(2)(F) for any illness.

(I)(i) Beginning not later than the applicable date specified in paragraph (6), and subject to paragraph (2), a veteran who deployed in support of a contingency operation specified in clause (ii) is eligible for hospital care (including mental health services and counseling), medical services, and nursing home care under subsection (a)(2)(F) for any illness.

(ii) A contingency operation specified in this clause is any of the following:

(I) Operation Enduring Freedom.

(II) Operation Freedom's Sentinel.

(III) Operation Iraqi Freedom.

(IV) Operation New Dawn.

(V) Operation Inherent Resolve.

(VI) Resolute Support Mission.

(2)(A) In the case of a veteran described in paragraph (1)(A), hospital care, medical services, and nursing home care may not be provided under subsection (a)(2)(F) with respect to-

(i) a disability that is found, in accordance with guidelines issued by the Under Secretary for Health, to have resulted from a cause other than an exposure described in paragraph (4)(A)(ii); or

(ii) a disease for which the National Academy of Sciences, in a report issued in accordance with section 3 of the Agent Orange Act of 1991, has determined that there is limited or suggestive evidence of the lack of a positive association between occurrence of the disease in humans and exposure to a herbicide agent.

(B) In the case of a veteran described in subparagraph (C), (D), (E), (F), (G), (H), or (I) of paragraph (1), hospital care, medical services, and nursing home care may not be provided under subsection (a)(2)(F) with respect to a disability that is found, in accordance with guidelines issued by the Under Secretary for Health, to have resulted from a cause other than the service, testing, or activity described in such subparagraph.

(3) In the case of care for a veteran described in paragraph (1)(D), hospital care, medical services, and nursing home care may be provided under or by virtue of subsection (a)(2)(F) only during the following periods:

(A) Except as provided by subparagraph (B), with respect to a veteran described in paragraph (1)(D) who is discharged or released from the active military, naval, air, or space service after September 11, 2001, the 10-year period beginning on the date of such discharge or release.

(B) With respect to a veteran described in paragraph (1)(D) who was discharged or released from the active military, naval, air, or space service after September 11, 2001, and before October 1, 2013, but did not enroll to receive such hospital care, medical services, or nursing home care under such paragraph pursuant to subparagraph (A) before October 1, 2022, the one-year period beginning on October 1, 2022.

(4) For purposes of this subsection-

(A) The term "Vietnam-era herbicide-exposed veteran" means a veteran who-

(i) performed covered service, as defined in section 1116(d) of this title; or

(ii) the Secretary finds may have been exposed during active military, naval, air, or space service to dioxin during the Vietnam era, regardless of the geographic area of such service, or was exposed during such service to a toxic substance found in a herbicide or defoliant used for military purposes during such era, regardless of the geographic area of such service.

(B) The term "radiation-exposed veteran" has the meaning given that term in section 1112(c)(3) of this title.

(C) The term "toxic exposure risk activity" means any activity-

(i) that requires a corresponding entry in an exposure tracking record system (as defined in section 1119(c) of this title) for the veteran who carried out the activity; or

(ii) that the Secretary determines qualifies for purposes of this subsection when taking into account what is reasonably prudent to protect the health of veterans.

(5) When the Secretary first provides care for veterans using the authority provided in paragraph (1)(D), the Secretary shall establish a system for collection and analysis of information on the general health status and health care utilization patterns of veterans receiving care under that paragraph. Not later than 18 months after first providing care under such authority, the Secretary shall submit to Congress a report on the experience under that authority. The Secretary shall include in the report any recommendations of the Secretary for extension of that authority.

(6)(A) The Secretary shall determine the dates in subparagraphs (G), (H), and (I) of paragraph (1) as follows:

(i) October 1, 2024, with respect to a veteran described in such subparagraph (G) or (H) who was discharged or released from the active military, naval, air, or space service during the period beginning on August 2, 1990, and

ending on September 11, 2001.

(ii) October 1, 2026, with respect to a veteran described in such subparagraph (G) or (H) who was discharged or released from the active military, naval, air, or space service during the period beginning on September 12, 2001, and ending on December 31, 2006.

(iii) October 1, 2028, with respect to a veteran described in such subparagraph (G) or (H) who was discharged or released from the active military, naval, air, or space service during the period beginning on January 1, 2007, and ending on December 31, 2012.

(iv) October 1, 2030, with respect to a veteran described in such subparagraph (G) or (H) who was discharged or released from the active military, naval, air, or space service during the period beginning on January 1, 2013, and ending on December 31, 2018.

(v) October 1, 2032, with respect to a veteran described in such subparagraph (I).

(B)(i) The Secretary may modify a date specified in subparagraph (A) to an earlier date, as the Secretary determines appropriate based on the number of veterans receiving hospital care, medical services, and nursing home care under subparagraphs (G), (H), and (I) of paragraph (1) and the resources available to the Secretary.

(ii) If the Secretary determines to modify a date under clause (i), the Secretary shall-

(I) notify the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives of the proposed modification; and

(II) publish such modified date in the Federal Register.

(f)(1) The Secretary may not furnish hospital care or nursing home care (except if such care constitutes hospice care) under this section to a veteran who is eligible for such care under subsection (a)(3) of this section unless the veteran agrees to pay to the United States the applicable amount determined under paragraph (2) or (4) of this subsection.

(2) A veteran who is furnished hospital care or nursing home care under this section and who is required under paragraph (1) of this subsection to agree to pay an amount to the United States in order to be furnished such care shall be liable to the United States for an amount equal to-

(A) the lesser of-

(i) the cost of furnishing such care, as determined by the Secretary; or

(ii) the amount determined under paragraph (3) of this subsection; and

(B) before September 30, 2025, an amount equal to $10 for every day the veteran receives hospital care and $5 for every day the veteran receives nursing home care.

(3)(A) In the case of hospital care furnished during any 365-day period, the amount referred to in paragraph (2)(A)(ii) of this subsection is-

(i) the amount of the inpatient Medicare deductible, plus

(ii) one-half of such amount for each 90 days of care (or fraction thereof) after the first 90 days of such care during such 365-day period.

(B) In the case of nursing home care furnished during any 365-day period, the amount referred to in paragraph (2)(A)(ii) of this subsection is the amount of the inpatient Medicare deductible for each 90 days of such care (or fraction thereof) during such 365-day period.

(C)(i) Except as provided in clause (ii) of this subparagraph, in the case of a veteran who is admitted for nursing home care under this section after being furnished, during the preceding 365-day period, hospital care for which the veteran has paid the amount of the inpatient Medicare deductible under this subsection and who has not been furnished 90 days of hospital care in connection with such payment, the veteran shall not incur any liability under paragraph (2) of this subsection with respect to such nursing home care until-

(I) the veteran has been furnished, beginning with the first day of such hospital care furnished in connection with such payment, a total of 90 days of hospital care and nursing home care; or

(II) the end of the 365-day period applicable to the hospital care for which payment was made,

whichever occurs first.

(ii) In the case of a veteran who is admitted for nursing home care under this section after being furnished, during any 365-day period, hospital care for which the veteran has paid an amount under subparagraph (A)(ii) of this paragraph and who has not been furnished 90 days of hospital care in connection with such payment, the amount of the liability of the veteran under paragraph (2) of this subsection with respect to the number of days of such nursing home care which, when added to the number of days of such hospital care, is 90 or less, is the difference between the inpatient Medicare deductible and the amount paid under such subparagraph until-

(I) the veteran has been furnished, beginning with the first day of such hospital care furnished in connection with such payment, a total of 90 days of hospital care and nursing home care; or

(II) the end of the 365-day period applicable to the hospital care for which payment was made,

whichever occurs first.

(D) In the case of a veteran who is admitted for hospital care under this section after having been furnished, during the preceding 365-day period, nursing home care for which the veteran has paid the amount of the inpatient Medicare deductible under this subsection and who has not been furnished 90 days of nursing home care in connection with such payment, the veteran shall not incur any liability under paragraph (2) of this subsection with respect to such hospital care until-

(i) the veteran has been furnished, beginning with the first day of such nursing home care furnished in connection with such payment, a total of 90 days of nursing home care and hospital care; or

(ii) the end of the 365-day period applicable to the nursing home care for which payment was made,

whichever occurs first.

(E) A veteran may not be required to make a payment under this subsection for hospital care or nursing home care furnished under this section during any 90-day period in which the veteran is furnished medical services under paragraph (3) of subsection (a) to the extent that such payment would cause the total amount paid by the veteran under this subsection for hospital care and nursing home care furnished during that period and under subsection (g) for medical services furnished during that period to exceed the amount of the inpatient Medicare deductible in effect on the first day of such period.

(F) A veteran may not be required to make a payment under this subsection or subsection (g) for any days of care in excess of 360 days of care during any 365-calendar-day period.

(4) In the case of a veteran covered by this subsection who is also described by section 1705(a)(7) of this title, the amount for which the veteran shall be liable to the United States for hospital care under this subsection shall be an amount equal to 20 percent of the total amount for which the veteran would otherwise be liable for such care under subparagraphs (2)(B) and (3)(A) but for this paragraph.

(5) For the purposes of this subsection, the term "inpatient Medicare deductible" means the amount of the inpatient hospital deductible in effect under section 1813(b) of the Social Security Act (42 U.S.C. 1395e(b)) on the first day of the 365-day period applicable under paragraph (3) of this subsection.

(g)(1) The Secretary may not furnish medical services (except if such care constitutes hospice care) under subsection (a) of this section (including home health services under section 1717 of this title) to a veteran who is eligible for hospital care under this chapter by reason of subsection (a)(3) of this section unless the veteran agrees to pay to the United States in the case of each outpatient visit the applicable amount or amounts established by the Secretary by regulation.

(2) A veteran who is furnished medical services under subsection (a) of this section and who is required under paragraph (1) of this subsection to agree to pay an amount to the United States in order to be furnished such services shall be liable to the United States, in the case of each visit in which such services are furnished to the veteran, for an amount which the Secretary shall establish by regulation.

(3) This subsection does not apply with respect to the following:

(A) Home health services under section 1717 of this title to the extent that such services are for improvements and structural alterations.

(B) Education on the use of opioid antagonists to reverse the effects of overdoses of specific medications or substances.

(h) Nothing in this section requires the Secretary to furnish care to a veteran to whom another agency of Federal, State, or local government has a duty under law to provide care in an institution of such government.

(Pub. L. 85–857, Sept. 2, 1958, 72 Stat. 1141 , §610; Pub. L. 87–583, §1, Aug. 14, 1962, 76 Stat. 381 ; Pub. L. 89–358, §8, Mar. 3, 1966, 80 Stat. 27 ; Pub. L. 89–785, title III, §304, Nov. 7, 1966, 80 Stat. 1377 ; Pub. L. 91–500, §4, Oct. 22, 1970, 84 Stat. 1096 ; Pub. L. 93–82, title I, §102, Aug. 2, 1973, 87 Stat. 180 ; Pub. L. 94–581, title II, §§202(d), 210(a)(1), Oct. 21, 1976, 90 Stat. 2855 , 2862; Pub. L. 96–22, title I, §102(a), June 13, 1979, 93 Stat. 47 ; Pub. L. 97–37, §5(a), Aug. 14, 1981, 95 Stat. 936 ; Pub. L. 97–72, title I, §102(a), Nov. 3, 1981, 95 Stat. 1047 ; Pub. L. 98–160, title VII, §701, Nov. 21, 1983, 97 Stat. 1008 ; Pub. L. 99–166, title I, §103, Dec. 3, 1985, 99 Stat. 944 ; Pub. L. 99–272, title XIX, §19011(a), (d)(3), Apr. 7, 1986, 100 Stat. 372 , 379; Pub. L. 99–576, title II, §237(a), (b)(1), Oct. 28, 1986, 100 Stat. 3267 ; Pub. L. 100–322, title I, §102(a), May 20, 1988, 102 Stat. 492 ; Pub. L. 100–687, div. B, title XII, §1202, Nov. 18, 1988, 102 Stat. 4125 ; Pub. L. 101–508, title VIII, §8013(a), Nov. 5, 1990, 104 Stat. 1388–346 ; Pub. L. 102–4, §5, Feb. 6, 1991, 105 Stat. 15 ; Pub. L. 102–54, §14(b)(10), June 13, 1991, 105 Stat. 283 ; renumbered §1710 and amended Pub. L. 102–83, §§4(a)(3), (4), (b)(1), (2)(E), 5(a), (c)(1), Aug. 6, 1991, 105 Stat. 404–406 ; Pub. L. 102–405, title III, §302(c)(1), Oct. 9, 1992, 106 Stat. 1984 ; Pub. L. 103–210, §§1(a), 2(a), Dec. 20, 1993, 107 Stat. 2496 , 2497; Pub. L. 103–446, title XII, §1201(d)(2), Nov. 2, 1994, 108 Stat. 4684 ; Pub. L. 103–452, title I, §103(a)(1), Nov. 2, 1994, 108 Stat. 4786 ; Pub. L. 104–110, title I, §101(a)(1), Feb. 13, 1996, 110 Stat. 768 ; Pub. L. 104–262, title I, §§101(a), (b), (d)(2)–(4), 102(a), Oct. 9, 1996, 110 Stat. 3178 , 3179, 3181; Pub. L. 104–275, title V, §505(c), Oct. 9, 1996, 110 Stat. 3342 ; Pub. L. 105–33, title VIII, §§8021(a)(1), 8023(b)(1), (2), Aug. 5, 1997, 111 Stat. 664 , 667; Pub. L. 105–114, title II, §209(a), title IV, §402(a), Nov. 21, 1997, 111 Stat. 2290 , 2294; Pub. L. 105–368, title I, §102(a), title X, §1005(b)(3), Nov. 11, 1998, 112 Stat. 3321 , 3365; Pub. L. 106–117, title I, §§101(f), 112(1), title II, §201(b), Nov. 30, 1999, 113 Stat. 1550 , 1556, 1561; Pub. L. 106–419, title II, §224(b), Nov. 1, 2000, 114 Stat. 1846 ; Pub. L. 107–135, title II, §§202(b), 209(a), 211, Jan. 23, 2002, 115 Stat. 2457 , 2464, 2465; Pub. L. 107–330, title III, §308(g)(6), Dec. 6, 2002, 116 Stat. 2829 ; Pub. L. 108–170, title I, §102, Dec. 6, 2003, 117 Stat. 2044 ; Pub. L. 109–444, §2(a), Dec. 21, 2006, 120 Stat. 3304 ; Pub. L. 109–461, title II, §211(a)(3)(B), title X, §§1003, 1006(b), Dec. 22, 2006, 120 Stat. 3419 , 3465,

3468; Pub. L. 110–161, div. I, title II, §231, Dec. 26, 2007, 121 Stat. 2273 ; Pub. L. 110–181, div. A, title XVII, §1707, Jan. 28, 2008, 122 Stat. 493 ; Pub. L. 110–329, div. E, title II, §224, Sept. 30, 2008, 122 Stat. 3713 ; Pub. L. 110–387, title IV, §409, title VIII, §§803, 804(a), Oct. 10, 2008, 122 Stat. 4130 , 4141; Pub. L. 111–163, title V, §§513, 517, May 5, 2010, 124 Stat. 1164 , 1167; Pub. L. 112–154, title I, §§102(a), 112, Aug. 6, 2012, 126 Stat. 1167 , 1176; Pub. L. 113–37, §2(c), Sept. 30, 2013, 127 Stat. 524 ; Pub. L. 113–175, title I, §107, Sept. 26, 2014, 128 Stat. 1903 ; Pub. L. 113–235, div. I, title II, §243, Dec. 16, 2014, 128 Stat. 2568 ; Pub. L. 114–2, §7, Feb. 12, 2015, 129 Stat. 36 ; Pub. L. 114–58, title I, §101, title VI, §601(4), Sept. 30, 2015, 129 Stat. 532 , 538; Pub. L. 114–198, title IX, §915(b), July 22, 2016, 130 Stat. 765 ; Pub. L. 114–223, div. A, title II, §243(b), Sept. 29, 2016, 130 Stat. 884 ; Pub. L. 114–228, title I, §101, Sept. 29, 2016, 130 Stat. 936 ; Pub. L. 114–315, title VI, §603(b), title VIII, §802(3), Dec. 16, 2016, 130 Stat. 1570 , 1591; Pub. L. 115–62, title I, §101, Sept. 29, 2017, 131 Stat. 1160 ; Pub. L. 115–232, div. A, title VIII, §809(n)(1)(B), Aug. 13, 2018, 132 Stat. 1843 ; Pub. L. 115–251, title I, §101, Sept. 29, 2018, 132 Stat. 3168 ; Pub. L. 116–23, §2(f), June 25, 2019, 133 Stat. 969 ; Pub. L. 116–159, div. E, title I, §5101, Oct. 1, 2020, 134 Stat. 748 ; Pub. L. 116–283, div. A, title IX, §926(a)(21), Jan. 1, 2021, 134 Stat. 3830 ; Pub. L. 117–168, title I, §§102(a), (c), 103(a), 111(a), (b), title IV, §403(c), Aug. 10, 2022, 136 Stat. 1761 , 1762, 1765, 1766, 1781; Pub. L. 117–180, div. E, title I, §101, Sept. 30, 2022, 136 Stat. 2136 ; Pub. L. 117–328, div. U, title I, §101(a), Dec. 29, 2022, 136 Stat. 5407 ; Pub. L. 118–83, div. B, title III, §301, Sept. 26, 2024, 138 Stat. 1539 .)

Editorial Notes

References in Text

Section 491 of title 14, referred to in subsec. (a)(2)(D), was redesignated section 2732 of title 14 by Pub. L. 115–282, title I, §116(b), Dec. 4, 2018, 132 Stat. 4226 , and references to section 491 of title 14 deemed to refer to such redesignated section, see section 123(b)(1) of Pub. L. 115–282, set out as a References to Redesignated Sections of Title 14 note preceding section 101 of Title 14, Coast Guard.

Section 3 of the Agent Orange Act of 1991, referred to in subsec. (e)(2)(A)(ii), is section 3 of Pub. L. 102–4, which is set out as a note under section 1116 of this title.

Codification

The text of subsec. (f) of section 1712 of this title, which was transferred to this section, redesignated subsec. (g), and amended by Pub. L. 104–262, §101(b)(2), was based on Pub. L. 86–639, §1, July 12, 1960, 74 Stat. 472 ; Pub. L. 91–102, Oct. 30, 1969, 83 Stat. 168 ; Pub. L. 93–82, title I, §103(a), Aug. 2, 1973, 87 Stat. 180 ; Pub. L. 94–581, title I, §103(a)(3)–(7), title II, §202(f)(2), Oct. 21, 1976, 90 Stat. 2844 , 2856; Pub. L. 96–22, title I, §102(b), June 13, 1979, 93 Stat. 47 ; Pub. L. 97–37, §5(b), Aug. 14, 1981, 95 Stat. 937 ; Pub. L. 97–72, title I, §103(b)(2), Nov. 3, 1981, 95 Stat. 1049 ; Pub. L. 97–295, §4(17)(C), Oct. 12, 1982, 96 Stat. 1306 ; Pub. L. 99–166, title I, §104, Dec. 3, 1985, 99 Stat. 944 ; Pub. L. 99–272, title XIX, §19011(b)(2), Apr. 7, 1986, 100 Stat. 375 ; Pub. L. 99–576, title II, §§202(1), 237(b)(2), Oct. 28, 1986, 100 Stat. 3254 , 3267; Pub. L. 100–322, title I, §101(e)(1), May 20, 1988, 102 Stat. 491 ; Pub. L. 101–508, title VIII, §8013(b), Nov. 5, 1990, 104 Stat. 1388–346 ; Pub. L. 102–83, §§4(a)(3), (4), (b)(1), (2)(E), 5(c)(1), Aug. 6, 1991, 105 Stat. 404–406 .

Prior Provisions

A prior section 1710 was renumbered section 3510 of this title.

Amendments

2024-Subsec. (f)(2)(B). Pub. L. 118–83 substituted "September 30, 2025" for "September 30, 2024".

2022-Subsec. (a)(2)(E). Pub. L. 117–328 designated existing provisions as introductory provisions, substituted "of-" for "of the Mexican border period or of World War I;", and added cls. (i) to (iii).

Subsec. (a)(2)(F). Pub. L. 117–168, §102(a), substituted "who is a toxic-exposed veteran, in accordance with subsection (e)" for "who was exposed to a toxic substance, radiation, or other conditions, as provided in subsection (e)".

Subsec. (e)(1)(D). Pub. L. 117–168, §111(b), inserted "(including any veteran who, in connection with service during such period, received the Armed Forces Expeditionary Medal, Service Specific Expeditionary Medal, Combat Era Specific Expeditionary Medal, Campaign Specific Medal, or any other combat theater award established by a Federal statute or an Executive order)" after "Persian Gulf War".

Subsec. (e)(1)(G) to (I). Pub. L. 117–168, §103(a)(1)(A), added subpars. (G) to (I).

Subsec. (e)(2)(B). Pub. L. 117–168, §103(a)(1)(B), substituted "(F), (G), (H), or (I)" for "or (F)" and "service, testing, or activity" for "service or testing".

Subsec. (e)(3)(A). Pub. L. 117–168, §111(a)(1), substituted "September 11, 2001" for "January 27, 2003" and "10-year period" for "five-year period".

Subsec. (e)(3)(B). Pub. L. 117–168, §111(a)(2), amended subpar. (B) generally. Prior to amendment, subpar. (B) read as follows: "With respect to a veteran described in paragraph (1)(D) who is discharged or released from the active military, naval, air, or space service after January 1, 2009, and before January 1,

2011, but did not enroll to receive such hospital care, medical services, or nursing home care pursuant to such paragraph during the five-year period described in subparagraph (A), the one-year period beginning on the date of the enactment of the Clay Hunt Suicide Prevention for American Veterans Act."

Subsec. (e)(3)(C). Pub. L. 117–168, §111(a)(3), struck out subpar. (C) which read as follows: "With respect to a veteran described in paragraph (1)(D) who is discharged or released from the active military, naval, air, or space service on or before January 27, 2003, and did not enroll in the patient enrollment system under section 1705 of this title on or before such date, the three-year period beginning on January 27, 2008."

Subsec. (e)(4)(A). Pub. L. 117–168, §403(c), added subpar. (A) and struck out former subpar. (A) which read as follows: "The term 'Vietnam-era herbicide-exposed veteran' means a veteran (i) who served on active duty in the Republic of Vietnam (including offshore of such Republic as described in section 1116A(d) of this title) during the period beginning on January 9, 1962, and ending on May 7, 1975, and (ii) who the Secretary finds may have been exposed during such service to dioxin or was exposed during such service to a toxic substance found in a herbicide or defoliant used for military purposes during such period."

Subsec. (e)(4)(C). Pub. L. 117–168, §102(c), added subpar. (C).

Subsec. (e)(6). Pub. L. 117–168, §103(a)(2), added par. (6).

Subsec. (f)(2)(B). Pub. L. 117–180 substituted "September 30, 2024" for "September 30, 2022".

2021-Subsec. (a)(2)(B). Pub. L. 116–283 substituted "air, or space service" for "or air service".

Subsec. (e)(3). Pub. L. 116–283 substituted "air, or space service" for "or air service" in subpars. (A) to (C).

2020-Subsec. (f)(2)(B). Pub. L. 116–159 substituted "September 30, 2022" for "September 30, 2020".

2019-Subsec. (e)(4). Pub. L. 116–23 inserted "(including offshore of such Republic as described in section 1116A(d) of this title)" after "served on active duty in the Republic of Vietnam".

2018-Subsec. (a)(2)(D). Pub. L. 115–232 substituted "section 7271, 8291, or 9271 of title 10" for "section 3741, 6241, or 8741 of title 10".

Subsec. (f)(2)(B). Pub. L. 115–251 substituted "September 30, 2020" for "September 30, 2019".

2017-Subsec. (f)(2)(B). Pub. L. 115–62 substituted "September 30, 2019" for "September 30, 2017".

2016-Subsec. (a)(2)(D). Pub. L. 114–315, §603(b), inserted ", who was awarded the medal of honor under section 3741, 6241, or 8741 of title 10 or section 491 of title 14," after "war".

Subsec. (e)(1)(F). Pub. L. 114–315, §802(3), inserted comma after "1953" in introductory provisions.

Subsec. (f)(2)(B). Pub. L. 114–228 substituted "September 30, 2017" for "September 30, 2016".

Subsec. (g)(3). Pub. L. 114–198 and Pub. L. 114–223 amended par. (3) identically, substituting "with respect to the following:" for "with respect to home health services", inserting subpar. (A) designation and "Home health services" before "under section 1717 of this title", and adding subpar. (B).

2015-Subsec. (e)(1)(D). Pub. L. 114–58, §601(4)(A), struck out "(as defined in section 1712A(a)(2)(B) of this title)" after "hostilities".

Subsec. (e)(1)(F)(viii). Pub. L. 114–58, §601(4)(B), substituted "Myelodysplastic" for "Myleodysplasic".

Subsec. (e)(3). Pub. L. 114–2 amended par. (3) generally. Prior to amendment, par. (3) read as follows: "Hospital care, medical services, and nursing home care may not be provided under or by virtue of subsection (a)(2)(F) in the case of care for a veteran described in paragraph (1)(D) who-

"(A) is discharged or released from the active military, naval, or air service after the date that is five years before the date of the enactment of the National Defense Authorization Act for Fiscal Year 2008, after a period of five years beginning on the date of such discharge or release; or

"(B) is so discharged or released more than five years before the date of the enactment of that Act and who did not enroll in the patient enrollment system under section 1705 of this title before such date, after a period of three years beginning on the date of the enactment of that Act."

Subsec. (f)(2)(B). Pub. L. 114–58, §101, substituted "September 30, 2016" for "September 30, 2015".

2014-Subsec. (e)(1)(F). Pub. L. 113–235, §243, substituted "August 1, 1953" for "January 1, 1957," in introductory provisions.

Subsec. (f)(2)(B). Pub. L. 113–175 substituted "September 30, 2015" for "September 30, 2014".

2013-Subsec. (f)(2)(B). Pub. L. 113–37 substituted "September 30, 2014" for "September 30, 2013".

2012-Subsec. (e)(1)(F). Pub. L. 112–154, §102(a)(1), added subpar. (F).

Subsec. (e)(2)(B). Pub. L. 112–154, §102(a)(2), substituted "(E), or (F)" for "or (E)".

Subsec. (f)(2)(B). Pub. L. 112–154, §112, substituted "September 30, 2013" for "September 30, 2012".

2010-Subsec. (e)(1)(C). Pub. L. 111–163, §513(2), substituted "paragraph (2)" for "paragraphs (2) and (3)" and inserted "between August 2, 1990, and November 11, 1998," after "on active duty".

Subsec. (e)(3). Pub. L. 111–163, §513(1), substituted "subsection (a)(2)(F)" for "subsection (a)(2)(F)-" in introductory provisions, struck out subpar. (C) designation before "in the case", redesignated cls. (i) and (ii) of former subpar. (C) as subpars. (A) and (B), respectively, realigned margins, and struck out former subpars. (A) and (B), which read as follows:

"(A) in the case of care for a veteran described in paragraph (1)(A), after December 31, 2002;

"(B) in the case of care for a veteran described in paragraph (1)(C), after December 31, 2002; and".

Subsec. (f)(2)(B). Pub. L. 111–163, §517, amended subpar. (B) generally. Prior to amendment, subpar. (B) read as follows: "before September 30, 2010, an amount equal to $10 for every day the veteran receives hospital care and $5 for every day the veteran receives nursing home care."

2008-Subsec. (e)(1)(E). Pub. L. 110–387, §803(b), substituted "paragraph (2)" for "paragraphs (2) and (3)".

Subsec. (e)(3)(B). Pub. L. 110–387, §803(a)(1), inserted "and" after the semicolon at end.

Subsec. (e)(3)(C). Pub. L. 110–387, §803(a)(2), substituted a period at end for "; and".

Pub. L. 110–181 amended subpar. (C) generally. Prior to amendment subpar. (C) read as follows: "in the case of care for a veteran described in paragraph (1)(D), after a period of 2 years beginning on the date of the veteran's discharge or release from active military, naval, or air service; and".

Subsec. (e)(3)(D). Pub. L. 110–387, §803(a)(3), struck out subpar. (D) which read as follows: "in the case of care for a veteran described in paragraph (1)(E), after December 31, 2007".

Subsec. (f)(1). Pub. L. 110–387, §409(1), inserted "(except if such care constitutes hospice care)" after "nursing home care".

Subsec. (f)(2)(B). Pub. L. 110–387, §804(a), which directed substitution of "September 30, 2010" for "September 30, 2008", was executed by making the substitution for "September 30, 2009" to reflect the probable intent of Congress and the amendment by Pub. L. 110–329. See below.

Pub. L. 110–329 substituted "September 30, 2009," for "September 30, 2008,".

Subsec. (g)(1). Pub. L. 110–387, §409(2), inserted "(except if such care constitutes hospice care)" after "medical services".

2007-Subsec. (f)(2)(B). Pub. L. 110–161 substituted "September 30, 2008," for "September 30, 2007,".

2006-Subsec. (a)(4). Pub. L. 109–461, §211(a)(3)(B), struck out "and" before "the requirement in section 1710B of this title" and inserted ", and the requirement in section 1745 of this title to provide nursing home care and prescription medicines to veterans with service-connected disabilities in State homes" after "a program of extended care services".

Subsec. (e)(3)(D). Pub. L. 109–461, §1006(b), provided that as of the enactment of Pub. L. 109–461, the amendments made by Pub. L. 109–444 were deemed for all purposes not to have taken effect and that Pub. L. 109–444 ceased to be in effect. See Amendment notes below and section 1006(b) of Pub. L. 109–461, set out as a Coordination of Provisions With Pub. L. 109–444 note under section 101 of this title.

Pub. L. 109–461, §1003, substituted "December 31, 2007" for "December 31, 2005".

Pub. L. 109–444, which substituted "December 31, 2007" for "December 31, 2005", was terminated by Pub. L. 109–461, §1006(b). See Amendment notes above.

2003-Subsec. (e)(1)(E). Pub. L. 108–170, §102(1), added subpar. (E).

Subsec. (e)(2)(B). Pub. L. 108–170, §102(2), substituted "subparagraph (C), (D), or (E) of paragraph (1)" for "paragraph (1)(C) or (1)(D)" and "service or testing described in such subparagraph" for "service described in that paragraph".

Subsec. (e)(3)(D). Pub. L. 108–170, §102(3), added subpar. (D).

2002-Subsec. (e)(1)(D). Pub. L. 107–330 substituted "November 11, 1998" for "the date of the enactment of this subparagraph".

Subsec. (e)(3)(B). Pub. L. 107–135, §211, substituted "December 31, 2002" for "December 31, 2001".

Subsec. (f)(1). Pub. L. 107–135, §202(b)(1), inserted "or (4)" after "paragraph (2)".

Subsec. (f)(2)(B). Pub. L. 107–135, §209(a), substituted "September 30, 2007" for "September 30, 2002".

Subsec. (f)(4), (5). Pub. L. 107–135, §202(b)(2), (3), added par. (4) and redesignated former par. (4) as (5).

2000-Subsec. (a)(4). Pub. L. 106–419 inserted "the requirement in section 1710A(a) of this title that the Secretary provide nursing home care," after "medical services," and struck out comma after "extended care services".

1999-Subsec. (a)(1). Pub. L. 106–117, §101(f)(1), struck out ", and may furnish nursing home care," after "medical services" in introductory provisions.

Subsec. (a)(2)(A). Pub. L. 106–117, §101(f)(2), inserted "or, with respect to nursing home care during any period during which the provisions of section 1710A(a) of this title are in effect, a compensable service-connected disability rated less than 70 percent" after "50 percent".

Subsec. (a)(2)(D). Pub. L. 106–117, §112(1), inserted "or who was awarded the Purple Heart" after "former prisoner of war".

Subsec. (a)(4). Pub. L. 106–117, §101(f)(3), inserted ", and the requirement in section 1710B of this title that the Secretary provide a program of extended care services," after "medical services".

Subsec. (a)(5). Pub. L. 106–117, §101(f)(4), added par. (5).

Subsec. (g)(1). Pub. L. 106–117, §201(b)(1), substituted "in the case of each outpatient visit the applicable amount or amounts established by the Secretary by regulation" for "the amount determined

under paragraph (2) of this subsection".

Subsec. (g)(2). Pub. L. 106–117, §201(b)(2), substituted "which the Secretary shall establish by regulation." for "equal to 20 percent of the estimated average cost (during the calendar year in which the services are furnished) of an outpatient visit in a Department facility. Such estimated average cost shall be determined by the Secretary."

1998-Subsec. (e)(1)(D). Pub. L. 105–368, §102(a)(1), added subpar. (D).

Subsec. (e)(2)(A)(ii). Pub. L. 105–368, §1005(b)(3), substituted "section 3" for "section 2".

Subsec. (e)(2)(B). Pub. L. 105–368, §102(a)(2), inserted "or (1)(D)" after "paragraph (1)(C)".

Subsec. (e)(3)(A). Pub. L. 105–368, §102(a)(3)(A), struck out "and" at end.

Subsec. (e)(3)(B). Pub. L. 105–368, §102(a)(3)(B), substituted "December 31, 2001; and" for "December 31, 1998."

Subsec. (e)(3)(C). Pub. L. 105–368, §102(a)(3)(C), added subpar. (C).

Subsec. (e)(5). Pub. L. 105–368, §102(a)(4), added par. (5).

1997-Subsec. (a)(2)(B). Pub. L. 105–114, §402(a), struck out "compensable" before "disability".

Subsec. (a)(2)(F). Pub. L. 105–114, §209(a)(1), substituted "other conditions" for "environmental hazard".

Subsec. (e)(1)(C). Pub. L. 105–114, §209(a)(2), substituted "served" for "the Secretary finds may have been exposed while serving" and "associated with such service" for "associated with such exposure" and struck out "to a toxic substance or environmental hazard" after "Persian Gulf War".

Subsec. (e)(2)(B). Pub. L. 105–114, §209(a)(3), substituted "the service" for "an exposure".

Subsec. (f)(2)(B). Pub. L. 105–33, §8021(a)(1), inserted "before September 30, 2002," after "(B)".

Subsec. (f)(4), (5). Pub. L. 105–33, §8023(b)(1), redesignated par. (5) as (4) and struck out former par. (4) which read as follows: "Amounts collected or received on behalf of the United States under this subsection shall be deposited in the Treasury as miscellaneous receipts."

Subsec. (g)(4). Pub. L. 105–33, §8023(b)(2), struck out par. (4) which read as follows: "Amounts collected or received by the Department under this subsection shall be deposited in the Treasury as miscellaneous receipts."

1996-Subsec. (a). Pub. L. 104–262, §101(a), amended subsec. (a) generally, revising and restating provisions in former pars. (1) to (3) relating to eligibility for care as pars. (1) to (4).

Subsec. (c)(1). Pub. L. 104–262, §101(d)(2), substituted "section 1712(a)" for "section 1712(b)".

Subsec. (e)(1)(A), (B). Pub. L. 104–262, §102(a)(1), added subpars. (A) and (B) and struck out former subpars. (A) and (B) which read as follows:

"(A) Subject to paragraphs (2) and (3) of this subsection, a veteran-

"(i) who served on active duty in the Republic of Vietnam during the Vietnam era, and

"(ii) who the Secretary finds may have been exposed during such service to dioxin or was exposed during such service to a toxic substance found in a herbicide or defoliant used in connection with military purposes during such era,

is eligible for hospital care and nursing home care under subsection (a)(1)(G) of this section for any disability, notwithstanding that there is insufficient medical evidence to conclude that such disability may be associated with such exposure.

"(B) Subject to paragraphs (2) and (3) of this subsection, a veteran who the Secretary finds was exposed while serving on active duty to ionizing radiation from the detonation of a nuclear device in connection with such veteran's participation in the test of such a device or with the American occupation of Hiroshima and Nagasaki, Japan, during the period beginning on September 11, 1945, and ending on July 1, 1946, is eligible for hospital care and nursing home care under subsection (a)(1)(G) of this section for any disability, notwithstanding that there is insufficient medical evidence to conclude that such disability may be associated with such exposure."

Subsec. (e)(1)(C). Pub. L. 104–262, §101(d)(3), substituted "hospital care, medical services, and nursing home care under subsection (a)(2)(F)" for "hospital care and nursing home care under subsection (a)(1)(G) of this section".

Subsec. (e)(2). Pub. L. 104–262, §102(a)(2), added par. (2) and struck out former par. (2) which read as follows: "Hospital and nursing home care may not be provided under subsection (a)(1)(G) of this section with respect to a disability that is found, in accordance with guidelines issued by the Under Secretary for Health, to have resulted from a cause other than an exposure described in subparagraph (A), (B), or (C) of paragraph (1) of this subsection."

Subsec. (e)(3). Pub. L. 104–262, §102(a)(2), added par. (3) and struck out former par. (3) which read as follows: "Hospital and nursing home care and medical services may not be provided under or by virtue of subsection (a)(1)(G) of this section after December 31, 1996."

Pub. L. 104–110 substituted "after December 31, 1996" for "after June 30, 1995, or, in the case of care for a veteran described in paragraph (1)(C), after December 31, 1995".

Subsec. (e)(4). Pub. L. 104–262, §102(a)(2), added par. (4).

Subsec. (e)(4)(A). Pub. L. 104–275 substituted "during the period beginning on January 9, 1962, and ending on May 7, 1975," for "during the Vietnam era," in cl. (i) and "such period" for "such era" in cl. (ii).

Subsec. (f)(1). Pub. L. 104–262, §101(d)(4)(A), substituted "subsection (a)(3)" for "subsection (a)(2)".

Subsec. (f)(3)(E). Pub. L. 104–262, §101(d)(4)(B), substituted "paragraph (3) of subsection (a)" for "section 1712(a) of this title" and "subsection (g)" for "section 1712(f) of this title".

Subsec. (f)(3)(F). Pub. L. 104–262, §101(d)(4)(C), substituted "subsection (g)" for "section 1712(f) of this title".

Subsec. (g). Pub. L. 104–262, §101(b)(2), redesignated subsec. (f) of section 1712 of this title as subsec. (g) of this section and substituted "subsection (a)(3) of this section" for "section 1710(a)(2) of this title" in par. (1). See Codification note above.

Pub. L. 104–262, §101(b)(1), redesignated subsec. (g) as (h).

Subsec. (h). Pub. L. 104–262, §101(b)(1), redesignated subsec. (g) as (h).

1994-Subsec. (e)(3). Pub. L. 103–452 substituted "June 30, 1995" for "June 30, 1994" and "December 31, 1995" for "December 31, 1994".

Subsec. (f)(3)(E). Pub. L. 103–446 substituted "section 1712(a)" for "section 1712(f)" and "section 1712(f)" for "section 1712(f)(4)".

1993-Subsec. (a)(1)(G). Pub. L. 103–210, §1(a)(1), substituted "substance, radiation, or environmental hazard" for "substance or radiation".

Subsec. (e)(1)(C). Pub. L. 103–210, §1(a)(2)(A), added subpar. (C).

Subsec. (e)(2). Pub. L. 103–210, §1(a)(2)(B), substituted "subparagraph (A), (B), or (C)" for "subparagraph (A) or (B)".

Subsec. (e)(3). Pub. L. 103–210, §2(a), substituted "June 30, 1994" for "December 31, 1993".

Pub. L. 103–210, §1(a)(2)(C), inserted before period at end ", or, in the case of care for a veteran described in paragraph (1)(C), after December 31, 1994".

1992-Subsec. (e)(2). Pub. L. 102–405 substituted "Under Secretary for Health" for "Chief Medical Director".

1991-Pub. L. 102–83, §5(a), renumbered section 610 of this title as this section.

Subsec. (a)(1). Pub. L. 102–83, §5(c)(1), substituted "1151" for "351" in subpar. (C) and "1722(a)" for "622(a)" in subpar. (I).

Pub. L. 102–83, §4(b)(1), (2)(E), substituted "Secretary" for "Administrator" in two places in introductory provisions.

Subsec. (a)(1)(H). Pub. L. 102–54 substituted "the Mexican border period" for "the Spanish-American War, the Mexican border period,".

Subsec. (a)(3). Pub. L. 102–83, §5(c)(1), substituted "1703" for "603" and "1720" for "620".

Pub. L. 102–83, §4(b)(1), (2)(E), substituted "Secretary" for "Administrator".

Pub. L. 102–83, §4(a)(3), (4), substituted "Department" for "Veterans' Administration".

Subsec. (b). Pub. L. 102–83, §4(b)(1), (2)(E), substituted "Secretary" for "Administrator" wherever appearing.

Subsec. (b)(2)(A). Pub. L. 102–83, §5(c)(1), substituted "1503" for "503" and "1521(d)" for "521(d)".

Subsec. (c). Pub. L. 102–83, §5(c)(1), substituted "1712(b)" for "612(b)".

Pub. L. 102–83, §4(b)(1), (2)(E), substituted "Secretary" for "Administrator" wherever appearing.

Pub. L. 102–83, §4(a)(3), (4), substituted "Department" for "Veterans' Administration" wherever appearing.

Subsec. (d). Pub. L. 102–83, §5(c)(1), substituted "1720" for "620".

Pub. L. 102–83, §4(b)(1), (2)(E), substituted "Secretary" for "Administrator".

Subsec. (e)(1). Pub. L. 102–83, §4(b)(1), (2)(E), substituted "Secretary" for "Administrator" in subpars. (A)(ii) and (B).

Subsec. (e)(3). Pub. L. 102–4 substituted "1993" for "1990".

Subsec. (f)(3)(E), (F). Pub. L. 102–83, §5(c)(1), substituted "1712(f)" for "612(f)" and "1712(f)(4)" for "612(f)(4)" in subpar. (E) and "1712(f)" for "612(f)" in subpar. (F).

Subsec. (g). Pub. L. 102–83, §4(b)(1), (2)(E), substituted "Secretary" for "Administrator".

1990-Subsec. (a)(1)(I). Pub. L. 101–508, §8013(a)(1)(A), substituted "section 622(a)" for "section 622(a)(1)".

Subsec. (a)(2). Pub. L. 101–508, §8013(a)(1)(B), added par. (2) and struck out former par. (2) which read as follows:

"(A) To the extent that resources and facilities are available, the Administrator may furnish hospital care and nursing home care which the Administrator determines is needed to a veteran for a non-service-connected disability if the veteran has an income level described in section 622(a)(2) of this title.

"(B) In the case of a veteran who is not described in paragraph (1) of this subsection or in subparagraph (A) of this paragraph, the Administrator may furnish hospital care and nursing home care which the Administrator determines is needed to the veteran for a non-service-connected disability-

"(i) to the extent that resources and facilities are otherwise available; and

"(ii) subject to the provisions of subsection (f) of this section."

Subsec. (f)(1), (2). Pub. L. 101–508, §8013(a)(2)(A), added pars. (1) and (2) and struck out former pars. (1) and (2) which read as follows:

"(1) The Administrator may not furnish hospital care or nursing home care under this section to a veteran who is eligible for such care by reason of subsection (a)(2)(B) of this section unless the veteran agrees to pay to the United States the applicable amount determined under paragraph (2) of this subsection.

"(2) A veteran who is furnished hospital care or nursing home care under this section and who is required under paragraph (1) of this subsection to agree to pay an amount to the United States in order to be furnished such care shall be liable to the United States for an amount equal to the lesser of-

"(A) the cost of furnishing such care, as determined by the Administrator; and

"(B) the amount determined under paragraph (3) of this subsection."

Subsec. (f)(3)(A), (B). Pub. L. 101–508, §8013(a)(2)(B), substituted "paragraph (2)(A)(ii)" for "paragraph (2)(B)".

1988-Subsec. (b). Pub. L. 100–233 amended subsec. (b) generally. Prior to amendment, subsec. (b) read as follows: "The Administrator, within the limits of Veterans' Administration facilities, may furnish domiciliary care to-

"(1) a veteran who was discharged or released from the active military, naval, or air service for a disability incurred or aggravated in line of duty, or a person who is in receipt of disability compensation, when such person is suffering from a permanent disability or tuberculosis or neuropsychiatric ailment and is incapacitated from earning a living and has no adequate means of support; and

"(2) a veteran who is in need of domiciliary care if such veteran is unable to defray the expenses of necessary domiciliary care."

Subsec. (e)(3). Pub. L. 100–687 substituted "December 31, 1990" for "September 30, 1989".

1986-Subsec. (a). Pub. L. 99–576, §237(a), inserted "who is in receipt of, or" after "veteran" in par. (1)(C).

Pub. L. 99–272, §19011(a)(1), amended subsec. (a) generally. Prior to amendment, subsec. (a) read as follows: "The Administrator, within the limits of Veterans' Administration facilities, may furnish hospital care or nursing home care which the Administrator determines is needed to-

"(1)(A) any veteran for a service-connected disability; or

"(B) any veteran for a non-service-connected disability if such veteran is unable to defray the expenses of necessary hospital or nursing home care;

"(2) a veteran whose discharge or release from the active military, naval, or air service was for a disability incurred or aggravated in line of duty;

"(3) a person (A) who is in receipt of, or but for the receipt of retirement pay would be entitled to, disability compensation, or (B) who, but for a suspension pursuant to section 351 of this title (or both such a suspension and the receipt of retired pay), would be entitled to disability compensation, but only to the extent that such person's continuing eligibility for such care is provided for in the judgment or settlement described in such section;

"(4) a veteran who is a former prisoner of war;

"(5) a veteran who meets the conditions of subsection (e) of this section; and

"(6) any veteran for a non-service-connected disability if such veteran is sixty-five years of age or older."

Subsec. (e)(1)(A), (B). Pub. L. 99–272, §19011(d)(3)(A), substituted "is eligible for hospital care and nursing home care under subsection (a)(1)(G)" for "may be furnished hospital care or nursing home care under subsection (a)(5)".

Subsec. (e)(2), (3). Pub. L. 99–272, §19011(d)(3)(B), substituted "subsection (a)(1)(G)" for "subsection (a)(5)".

Subsec. (f). Pub. L. 99–272, §19011(a)(2), added subsec. (f).

Subsec. (f)(3)(F). Pub. L. 99–576, §237(b)(1), added subpar. (F).

Subsec. (g). Pub. L. 99–272, §19011(a)(2), added subsec. (g).

1985-Subsec. (e)(3). Pub. L. 99–166 substituted "after September 30, 1989" for "after the end of the one-year period beginning on the date the Administrator submits to the appropriate committees of Congress the first report required by section 307(b)(2) of the Veterans Health Programs Extension and Improvement Act of 1979 (Public Law 96–151; 93 Stat. 1098)".

1983-Subsec. (a)(3). Pub. L. 98–160 inserted "(A)" after "a person" and, after "disability compensation", inserted "or (B) who, but for a suspension pursuant to section 351 of this title (or both such a suspension and the receipt of retired pay), would be entitled to disability compensation, but only to the extent that such person's continuing eligibility for such care is provided for in the judgment or settlement described in such section".

1981-Subsec. (a). Pub. L. 97–72, §102(a)(1), added cl. (5) and redesignated former cl. (5) as (6).

Pub. L. 97–37 added cl. (4) and redesignated former cl. (4) as (5).

Subsec. (e). Pub. L. 97–72, §102(a)(2), added subsec. (e).

1979-Subsec. (c). Pub. L. 96–22 inserted provisions relating to the furnishing of dental services and treatment and related dental appliances for non-service-connected dental conditions or disabilities of veterans.

1976-Pub. L. 94–581, §202(d)(1), inserted ", nursing home," in section catchline.

Subsec. (a). Pub. L. 94–581, §§202(d)(2), 210(a)(1)(A), (B), substituted "the Administrator determines" for "he determines" in provisions preceding par. (1) and substituted "such veteran" for "he" and "necessary hospital or nursing home care" for "necessary hospital care" in subpar. (B) of par. (1).

Subsec. (b)(1). Pub. L. 94–581, §210(a)(1)(C), substituted "such person" for "he".

Subsec. (b)(2). Pub. L. 94–581, §§202(d)(3), 210(a)(1)(B), substituted "a veteran who is in need of domiciliary care if such veteran" for "a veteran of any war or of service after January 31, 1955, who is in need of domiciliary care, if he".

Subsec. (c). Pub. L. 94–581, §210(a)(1)(B), substituted "for which such veteran is hospitalized" for "for which he is hospitalized".

Subsec. (d). Pub. L. 94–581, §202(d)(4), substituted "direct jurisdiction" for "direct and exclusive jurisdiction".

1973-Subsec. (a). Pub. L. 93–82, §102(1), (2), extended authority of the Administrator to furnish nursing home care, and in par. (1)(B), substituted "any veteran for a" for "a veteran of any war or of service after January 31, 1955, for".

Subsec. (c). Pub. L. 93–82, §102(3), expanded provision regarding medical services to include nursing home care and struck out requirement that the Administrator make a determination in each instance that the non-service-connected disability would be in the veteran's interest, would not prolong his hospitalization, and, would not interfere with the furnishing of hospital facilities to other veterans.

Subsec. (d). Pub. L. 93–82, §102(4), added subsec. (d).

1970-Subsec. (a). Pub. L. 91–500 added cl. (4).

1966-Pub. L. 89–358 inserted "or of service after January 31, 1955," after "veteran of any war" in subsecs. (a)(1)(B) and (b)(2).

Subsec. (c). Pub. L. 89–785 added subsec. (c).

1962-Subsec. (a)(1). Pub. L. 87–583 provided for hospital care to any veteran for a service-connected disability instead of to a veteran of any war for a service-connected disability incurred or aggravated during a period of war in subpar. (A) and incorporated existing provisions in subpar. (B).

Statutory Notes and Related Subsidiaries

Effective Date of 2022 Amendment

Pub. L. 117–328, div. U, title I, §101(b), Dec. 29, 2022, 136 Stat. 5408 , provided that: "The amendment made by subsection (a) [amending this section] shall take effect on March 31, 2023."

Pub. L. 117–168, title I, §111(e), Aug. 10, 2022, 136 Stat. 1766 , provided that: "This section [amending this section] and the amendments made by this section shall take effect on October 1, 2022."

Amendment by section 403(c) of Pub. L. 117–168 effective Aug. 10, 2022, with additional provisions for different applicability dates applying to various categories of veterans and claimants for compensation, see section 403(e) of Pub. L. 117–168, set out as a note under section 1116 of this title.

Effective Date of 2019 Amendment

Amendment by Pub. L. 116–23 effective Jan. 1, 2020, see section 2(g) of Pub. L. 116–23, set out as an Effective Date note under section 1116A of this title.

Effective Date of 2018 Amendment

Amendment by Pub. L. 115–232 effective Feb. 1, 2019, with provision for the coordination of amendments and special rule for certain redesignations, see section 800 of Pub. L. 115–232, set out as a note preceding section 3001 of Title 10, Armed Forces.

Effective Date of 2013 Amendment

Amendment by Pub. L. 113–37 effective Oct. 1, 2013, see section 4(a) of Pub. L. 113–37, set out as a note under section 322 of this title.

Effective Date of 2012 Amendment

Pub. L. 112–154, title I, §102(d), Aug. 6, 2012, 126 Stat. 1169 , provided that:

"(1) IN GENERAL.-The provisions of this section [enacting section 1787 of this title and amending this section] and the amendments made by this section shall take effect on the date of the enactment of this Act [Aug. 6, 2012].

"(2) APPLICABILITY.-Subparagraph (F) of section 1710(e)(1) of such title [probably means title 38, United States Code], as added by subsection (a), and section 1787 of title 38, United States Code, as added by subsection (b)(1), shall apply with respect to hospital care and medical services provided on or after the date of the enactment of this Act."

EFFECTIVE DATE OF 2006 AMENDMENT

Pub. L. 109–461, title II, §211(a)(5), Dec. 22, 2006, 120 Stat. 3419 , provided that: "The amendments made by this subsection [enacting section 1745 of this title and amending this section and sections 1741 and 1745 of this title] shall take effect 90 days after the date of the enactment of this Act [Dec. 22, 2006]."

EFFECTIVE DATE OF 2002 AMENDMENT

Amendment by section 202(b) of Pub. L. 107–135 effective Oct. 1, 2002, see section 202(c) of Pub. L. 107–135, set out as a note under section 1705 of this title.

EFFECTIVE DATE OF 1999 AMENDMENT

Amendment by section 101(f) of Pub. L. 106–117 effective Nov. 30, 1999, with provisions of subsec. (f) of this section not applicable to any day of nursing home care on or after the effective date of regulations under section 101(h)(2) of Pub. L. 106–117, see section 101(h) of Pub. L. 106–117, set out as an Effective Date note under section 1710B of this title.

Pub. L. 106–117, title II, §201(c), as added by Pub. L. 106–419, title II, §224(c), Nov. 1, 2000, 114 Stat. 1846 , provided that: "The amendments made by subsection (b) [amending this section] shall apply with respect to medical services furnished under section 1710(a) of title 38, United States Code, on or after the effective date of the regulations prescribed by the Secretary of Veterans Affairs to establish the amounts required to be established under paragraphs (1) and (2) of section 1710(g) of that title, as amended by subsection (b)."

EFFECTIVE DATE OF 1997 AMENDMENT

Pub. L. 105–33, title VIII, §8023(g), Aug. 5, 1997, 111 Stat. 668 , provided that:

"(1) Except as provided in paragraph (2), this section [enacting section 1729A of this title, amending this section and sections 712, 1722A, and 1729 of this title, and enacting provisions set out as notes under sections 1729 and 1729A of this title] and the amendments made by this section shall take effect on October 1, 1997.

"(2) The amendments made by subsection (d) [amending section 1729 of this title] shall take effect on the date of the enactment of this Act [Aug. 5, 1997]."

EFFECTIVE DATE OF 1996 AMENDMENT

Amendment by Pub. L. 104–275 effective Jan. 1, 1997, with no benefit to be paid or provided by reason of such amendment for any period before such date, see section 505(d) of Pub. L. 104–275, set out as a note under section 101 of this title.

EFFECTIVE DATE OF 1993 AMENDMENT

Pub. L. 103–210, §1(c)(1), Dec. 20, 1993, 107 Stat. 2497 , provided that: "The amendments made by subsections (a) and (b) [amending this section and section 1712 of this title] shall take effect as of August 2, 1990."

EFFECTIVE DATE OF 1990 AMENDMENTS

Pub. L. 102–145, §111, Oct. 28, 1991, 105 Stat. 970 , provided that: "Notwithstanding any other provision of this joint resolution or any other law, the amendments made by sections 8012 and 8013 of the Omnibus Budget Reconciliation Act of 1990 (Public Law 101–508) [enacting section 622A [now 1722A] of this title and amending this section and sections 612 [now 1712] and 622 [now 1722] of this title] shall remain in effect through the period covered by this joint resolution [see section 106 of Pub. L. 102–145, 105 Stat. 970 , as amended by Pub. L. 102–163, 105 Stat. 1048]."

Pub. L. 102–109, §111, Sept. 30, 1991, 105 Stat. 553 , provided that: "Notwithstanding any other provision of this joint resolution or any other law, the amendments made by sections 8012 and 8013 of the Omnibus Budget Reconciliation Act of 1990 (Public Law 101–508) [enacting section 622A [now 1722A] of this title and amending this section and sections 612 [now 1712] and 622 [now 1722] of this title] shall remain in effect through the period covered by this joint resolution [see section 106 of Pub. L. 102–109, 105 Stat. 553]."

Pub. L. 101–508, title VIII, §8013(d), (e), Nov. 5, 1990, 104 Stat. 1388–347 , as amended by Pub. L. 102–139, title V, §518(b), Oct. 28, 1991, 105 Stat. 779 ; Pub. L. 102–568, title VI, §606(b), Oct. 29, 1992, 106 Stat. 4343 ; Pub. L. 103–66, title XII, §12002(a), Aug. 10, 1993, 107 Stat. 414 ; Pub. L. 105–33, title VIII, §8021(a)(2), Aug. 5, 1997, 111 Stat. 665 , provided that:

"(d) EFFECTIVE DATE.-The amendments made by this section [amending this section and sections 612 and 622 [now 1712 and 1722] of this title] shall apply with respect to hospital care and medical services received after October 31, 1990, or the date of the enactment of this Act [Nov. 5, 1990], whichever is later.

"[(e) Repealed. Pub. L. 105–33, title VIII, §8021(a)(2), Aug. 5, 1997, 111 Stat. 665 .]"

EFFECTIVE DATE OF 1986 AMENDMENTS

Pub. L. 99–576, title II, §237(c), Oct. 28, 1986, 100 Stat. 3267 , provided that: "The amendments made by this section [amending this section and section 612 [now 1712] of this title] shall take effect as of April 7, 1986."

Pub. L. 99–272, title XIX, §19011(f), Apr. 7, 1986, 100 Stat. 380 , provided that:

"(1) Except as provided in paragraph (2), the amendments made by this section [amending this section and sections 525, 601, 612, 612A, 620, 622, and 663 [now 1525, 1701, 1712, 1712A, 1720, 1722, and 1763] of this title and enacting provisions set out as notes under this section and section 1722 of this title] shall apply to hospital care, nursing home care, and medical services furnished on or after July 1, 1986.

"(2)(A) The provisions of sections 610 and 622 [now 1710 and 1722] of title 38, United States Code, as in effect on the day before the date of the enactment of this Act [Apr. 7, 1986], shall apply with respect to hospital and nursing home care furnished on or after July 1, 1986, to veterans furnished such care or services on June 30, 1986, but only to the extent that such care is furnished with respect to the same episode of care for which it was furnished on June 30, 1986, as determined by the Administrator pursuant to regulations which the Administrator shall prescribe.

"(B) During the months of July and August 1986, the Administrator may, in order to continue a course of treatment begun before July 1, 1986, furnish medical services to a veteran on an ambulatory or outpatient basis without regard to the amendments made by this section.

"(C) For the purposes of this paragraph, the term 'episode of care' means a period of consecutive days-

"(i) beginning with the first day on which a veteran is furnished hospital or nursing home care; and

"(ii) ending on the day of the veteran's discharge from the hospital or nursing home facility, as the case may be."

EFFECTIVE DATE OF 1981 AMENDMENT

Pub. L. 97–37, §5(d), Aug. 14, 1981, 95 Stat. 937 , provided that: "The amendments made by this section [amending this section and section 612 [now 1712] of this title] shall take effect on October 1, 1981".

EFFECTIVE DATE OF 1979 AMENDMENT

Amendment by Pub. L. 96–22 effective Oct. 1, 1979, see section 107 of Pub. L. 96–22, set out as a note under section 1701 of this title.

EFFECTIVE DATE OF 1976 AMENDMENT

Amendment by Pub. L. 94–581 effective Oct. 21, 1976, see section 211 of Pub. L. 94–581, set out as a note under section 111 of this title.

EFFECTIVE DATE OF 1973 AMENDMENT

Amendment by Pub. L. 93–82 effective Sept. 1, 1973, see section 501 of Pub. L. 93–82, set out as a note under section 1701 of this title.

SAVINGS PROVISION

Pub. L. 104–262, title I, §102(b), Oct. 9, 1996, 110 Stat. 3182 , provided that: "The provisions of sections 1710(e) and 1712(a) of title 38, United States Code, as in effect on the day before the date of the enactment of this Act [Oct. 9, 1996], shall continue to apply on and after such date with respect to the furnishing of hospital care, nursing home care, and medical services for any veteran who was furnished such care or services before such date of enactment on the basis of presumed exposure to a substance or radiation under the authority of those provisions, but only for treatment for a disability for which such care or services were furnished before such date."

SAVINGS PROVISION FOR PUB. L. 100–322

Pub. L. 100–322, title I, §102(c), May 20, 1988, 102 Stat. 493 , provided that: "The amendment made by subsection (a) [amending this section] shall not limit or restrict the eligibility for domiciliary care of a

veteran who was a patient or a resident in a State home facility or a Veterans' Administration domiciliary facility during the period beginning on January 1, 1987, and ending on April 1, 1988."

Assessments of Implementation and Operation

Pub. L. 117–168, title I, §104, Aug. 10, 2022, 136 Stat. 1763 , provided that:

"(a) Initial Resource Assessment and Report.-Not later than 180 days after the date of the enactment of this Act [Aug. 10, 2022], the Secretary of Veterans Affairs shall-

"(1) complete an assessment to determine-

"(A) the personnel and material resources necessary to implement section 103 [amending this section] (including the amendments made by such section); and

"(B) the total number of covered veterans, as such term is defined in section 1119(c) of title 38, United States Code (as added by section 302), who receive hospital care or medical services furnished by the Secretary under chapter 17 of such title, disaggregated by priority group specified in section 1705(a) of such title; and

"(2) submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives a report containing the findings of the assessment completed under paragraph (1), including a specific determination as to whether the Department has the personnel and material resources necessary to implement section 103.

"(b) Information Systems.-Not later than October 1, 2024, the Secretary shall establish information systems to assess the implementation of section 103, including the amendments made by such section, and use the results of assessments under such systems to inform the reports under subsection (c).

"(c) Annual Reports.-

"(1) Reports.-Not later than October 1, 2025, and on an annual basis thereafter until October 1, 2033, the Secretary shall submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives a report on the following:

"(A) The effect of the implementation of, and the provision and management of care under, section 103 (including the amendments made by such section) on the demand by veterans described in subparagraphs (G), (H), and (I) of section 1710(e)(1) of title 38, United States Code (as added by such section 103) for health care services furnished by the Secretary.

"(B) Any differing patterns of demand for health care services by such veterans, disaggregated by factors such as the relative distance of the veteran from medical facilities of the Department and whether the veteran had previously received hospital care or medical services furnished by the Secretary under chapter 17 of such title.

"(C) The extent to which the Secretary has met such demand.

"(D) Any changes, during the year covered by the report, in the delivery patterns of health care furnished by the Secretary under chapter 17 of such title, and the fiscal impact of such changes.

"(2) Matters.-Each report under paragraph (1) shall include, with respect to the year covered by the report, detailed information on the following:

"(A) The total number of veterans enrolled in the patient enrollment system who, during such year, received hospital care or medical services furnished by the Secretary under chapter 17 of title 38, United States Code.

"(B) Of the veterans specified in subparagraph (A), the number of such veterans who, during the preceding three fiscal years, had not received such care or services.

"(C) With respect to the veterans specified in subparagraph (B), the cost of providing health care to such veterans during the year covered by the report, shown in total and disaggregated by-

"(i) the level of care; and

"(ii) whether the care was provided through the Veterans Community Care Program.

"(D) With respect to the number of veterans described in subparagraphs (G), (H), and (I) of section 1710(e)(1) of title 38, United States Code (as added by section 103), the following (shown in total and disaggregated by medical facility of the Department, as applicable):

"(i) The number of such veterans who, during the year covered by the report, enrolled in the patient enrollment system.

"(ii) The number of such veterans who applied for, but were denied, such enrollment.

"(iii) The number of such veterans who were denied hospital care or a medical service furnished by the Secretary that was considered to be medically necessary but not of an emergency nature.

"(E) The numbers and characteristics of, and the type and extent of health care furnished by the Secretary to, veterans enrolled in the patient enrollment system (shown in total and disaggregated by medical facility of the Department).

"(F) The numbers and characteristics of, and the type and extent of health care furnished by the Secretary to, veterans not enrolled in the patient enrollment system (disaggregated by each class

of eligibility for care under section 1710 of title 38, United States Code, and further shown as a total per class and disaggregated by medical facility of the Department).

"(G) The specific fiscal impact (shown in total and disaggregated by geographic health care delivery areas) of changes in the delivery patterns of health care furnished by the Secretary under chapter 17 of such title as a result of the implementation of section 103 (including the amendments made by such section).

"(d) DEFINITIONS.-In this section:

"(1) PATIENT ENROLLMENT SYSTEM.-The term 'patient enrollment system' means the patient enrollment system of the Department of Veterans Affairs established and operated under section 1705(a) of title 38, United States Code.

"(2) VETERANS COMMUNITY CARE PROGRAM.-The term 'Veterans Community Care Program' means the program established under section 1703 of title 38, United States Code."

CONTACT OF CERTAIN VETERANS TO ENCOURAGE RECEIPT OF COMPREHENSIVE MEDICAL EXAMINATIONS

Pub. L. 116–214, title II, §204, Dec. 5, 2020, 134 Stat. 1037 , provided that:

"(a) NOTICE.-Not later than 90 days after the date of the enactment of this Act [Dec. 5, 2020], the Under Secretary of Health of the Department of Veterans Affairs shall seek to contact each covered veteran by mail, telephone, or email to encourage each covered veteran to receive medical examinations including the following:

"(1) A comprehensive physical examination.

"(2) A comprehensive mental health examination.

"(3) A comprehensive eye examination if the covered veteran has not received such an examination in the year immediately preceding the date of such examination.

"(4) A comprehensive audiological examination if the covered veteran has not received such an examination in the year immediately preceding the date of such examination.

"(b) EXAMINATIONS.-

"(1) VA HEALTH CARE FACILITIES.-If a covered veteran elects to receive more than one examination described in subsection (a) at a health care facility of the Department of Veterans Affairs, the Under Secretary of Health shall seek to furnish all such scheduled examinations on the same day.

"(2) COMMUNITY CARE.-Pursuant to subsection (d) or (e) of section 1703 of title 38, United States Code, a covered veteran may receive an examination described in subsection (a) from a health care provider described in subsection (c) of that section.

"(c) TRANSPORTATION.-

"(1) BENEFICIARY TRAVEL PROGRAM.-Pursuant to section 111 of title 38, United States Code, the Secretary of Veterans Affairs may pay for a rural covered veteran to travel to a health care facility to receive an examination described in subsection (a).

"(2) SHUTTLE SERVICE.-The Under Secretary of Health shall seek to enter into agreements with non-profit organizations to provide shuttle service to rural covered veterans for examinations described in subsection (a).

"(d) REPORT REQUIRED.-Not later than 18 months after the date of the enactment of this Act, the Secretary of Veterans Affairs shall submit to Congress a report regarding how many covered veterans scheduled examinations described in subsection (a) after receiving a letter, telephone call, or email under that subsection.

"(e) DEFINITIONS.-In this section:

"(1) The term 'covered veteran' means a veteran who-

"(A) is enrolled in the patient enrollment system of the Department of Veterans Affairs under section 1705 of title 38, United States Code; and

"(B) has not received health care furnished or paid for by the Secretary of Veterans Affairs during the two years immediately preceding the date in subsection (a)(1).

"(2) The term 'rural covered veteran' means a covered veteran-

"(A) who lives in an area served by the Office of Rural Health of the Department of Veterans Affairs; and

"(B) whom [sic] the Under Secretary of Health determines requires assistance to travel to a health care facility to receive an examination described in subsection (a).

"(3) The term 'veteran' has the meaning given that term in section 101 of title 38, United States Code."

REPORT ON LOCATIONS WHERE WOMEN VETERANS ARE USING HEALTH CARE FROM DEPARTMENT OF VETERANS AFFAIRS

Pub. L. 116–214, title III, §302, Dec. 5, 2020, 134 Stat. 1039 , provided that:

"(a) REPORT.-Not later than 90 days after the date of the enactment of this Act [Dec. 5, 2020], and annually thereafter, the Secretary of Veterans Affairs shall submit to the Committees on Veterans' Affairs of the House of Representatives and the Senate a report on the use by women veterans of health care from the Department of Veterans Affairs.

"(b) ELEMENTS.-Each report required by subsection (a) shall include the following information:

"(1) The number of women veterans who reside in each State.

"(2) The number of women veterans in each State who are enrolled in the patient enrollment system of the Department under section 1705(a) of title 38, United States Code.

"(3) Of the women veterans who are so enrolled, the number who have received health care under the laws administered by the Secretary at least one time during the one-year period preceding the submission of the report.

"(4) The number of women veterans who have been seen at each medical facility of the Department during such year, disaggregated by facility.

"(5) The number of appointments that women veterans have had at a medical facility of the Department during such year, disaggregated by-

"(A) facility; and

"(B) appointments for-

"(i) primary care;

"(ii) specialty care; and

"(iii) mental health care.

"(6) For each appointment type specified in paragraph (5)(B), the number of appointments completed in-person and the number of appointments completed through the use of telehealth.

"(7) If known, an identification of the medical facility of the Department in each Veterans Integrated Service Network with the largest rate of increase in patient population of women veterans as measured by the increase in unique women veteran patient use.

"(8) If known, an identification of the medical facility of the Department in each Veterans Integrated Service Network with the largest rate of decrease in patient population of women veterans as measured by the decrease in unique women veterans patient use."

PILOT PROGRAM ON ASSISTANCE FOR CHILD CARE FOR CERTAIN VETERANS RECEIVING HEALTH CARE

Pub. L. 111–163, title II, §205, May 5, 2010, 124 Stat. 1144 , as amended by Pub. L. 113–37, §2(i), Sept. 30, 2013, 127 Stat. 525 ; Pub. L. 113–175, title I, §103, Sept. 26, 2014, 128 Stat. 1903 ; Pub. L. 114–58, title I, §105, Sept. 30, 2015, 129 Stat. 532 ; Pub. L. 114–228, title I, §105, Sept. 29, 2016, 130 Stat. 937 ; Pub. L. 115–62, title I, §105, Sept. 29, 2017, 131 Stat. 1161 ; Pub. L. 115–251, title I, §106, Sept. 29, 2018, 132 Stat. 3168 ; Pub. L. 116–159, div. E, title I, §5104, Oct. 1, 2020, 134 Stat. 748 ; Pub. L. 116–315, title V, §5107(a)(2), Jan. 5, 2021, 134 Stat. 5031 , provided that:

"(a) PILOT PROGRAM REQUIRED.-The Secretary of Veterans Affairs shall carry out a pilot program to assess the feasibility and advisability of providing, subject to subsection (b), assistance to qualified veterans described in subsection (c) to obtain child care so that such veterans can receive health care services described in subsection (c).

"(b) LIMITATION ON PERIOD OF PAYMENTS.-Assistance may only be provided to a qualified veteran under the pilot program for receipt of child care during the period that the qualified veteran-

"(1) receives the types of health care services described in subsection (c) at a facility of the Department; and

"(2) requires travel to and return from such facility for the receipt of such health care services.

"(c) QUALIFIED VETERANS.-For purposes of this section, a qualified veteran is a veteran who is-

"(1) the primary caretaker of a child or children; and

"(2)(A) receiving from the Department-

"(i) regular mental health care services;

"(ii) intensive mental health care services; or

"(iii) such other intensive health care services that the Secretary determines that provision of assistance to the veteran to obtain child care would improve access to such health care services by the veteran; or

"(B) in need of regular or intensive mental health care services from the Department, and but for lack of child care services, would receive such health care services from the Department.

"(d) LOCATIONS.-The Secretary shall carry out the pilot program in no fewer than three Veterans Integrated Service Networks selected by the Secretary for purposes of the pilot program.

"(e) TERMINATION.-The authority to carry out a pilot program under this section shall terminate on the date of the enactment of the Deborah Sampson Act of 2020 [Jan. 5, 2021].

"(f) FORMS OF CHILD CARE ASSISTANCE.-

"(1) IN GENERAL.-Child care assistance under this section may include the following:

"(A) Stipends for the payment of child care offered by licensed child care centers (either directly or through a voucher program) which shall be, to the extent practicable, modeled after the Department of Veterans Affairs Child Care Subsidy Program established pursuant to section 630 of the Treasury and General Government Appropriations Act, 2002 (Public Law 107–67; 115 Stat. 552) [now 40 U.S.C. 590(g)].

"(B) Direct provision of child care at an on-site facility of the Department of Veterans Affairs.

"(C) Payments to private child care agencies.

"(D) Collaboration with facilities or programs of other Federal departments or agencies.

"(E) Such other forms of assistance as the Secretary considers appropriate.

"(2) AMOUNTS OF STIPENDS.-In the case that child care assistance under this section is provided as a stipend under paragraph (1)(A), such stipend shall cover the full cost of such child care.

"(g) REPORT.-Not later than 6 months after the completion of the pilot program, the Secretary shall submit to Congress a report on the pilot program. The report shall include the findings and conclusions of the Secretary as a result of the pilot program, and shall include such recommendations for the continuation or expansion of the pilot program as the Secretary considers appropriate.

"(h) AUTHORIZATION OF APPROPRIATIONS.-There is authorized to be appropriated to the Secretary of Veterans Affairs to carry out the pilot program $1,500,000 for each of fiscal years 2010, 2015, 2016, 2017, 2018, 2019, 2020, 2021, and 2022."

[Pub. L. 116–315, §5107(a)(2), which directed amendment of section 205(e) of Pub. L. 111–163, set out above, by substituting "the date of the enactment of the Deborah Sampson Act of 2020" for "September 30, 2020", was executed by making the substitution for "September 30, 2022" to reflect the probable intent of Congress and the amendment by Pub. L. 116–159, which had substituted "September 30, 2022" for "September 30, 2020". For establishment of child care assistance program by Pub. L. 116–315, see section 1709C of this title.]

GRANTS FOR VETERANS SERVICE ORGANIZATIONS FOR TRANSPORTATION OF HIGHLY RURAL VETERANS

Pub. L. 111–163, title III, §307, May 5, 2010, 124 Stat. 1154 , as amended by Pub. L. 113–175, title I, §104, Sept. 26, 2014, 128 Stat. 1903 ; Pub. L. 114–58, title I, §106, Sept. 30, 2015, 129 Stat. 532 ; Pub. L. 114–228, title I, §106, Sept. 29, 2016, 130 Stat. 937 ; Pub. L. 115–62, title I, §106, Sept. 29, 2017, 131 Stat. 1161 ; Pub. L. 115–251, title I, §107, Sept. 29, 2018, 132 Stat. 3168 ; Pub. L. 116–159, div. E, title I, §5105, Oct. 1, 2020, 134 Stat. 748 , provided that:

"(a) GRANTS AUTHORIZED.-

"(1) IN GENERAL.-The Secretary of Veterans Affairs shall establish a grant program to provide innovative transportation options to veterans in highly rural areas.

"(2) ELIGIBLE RECIPIENTS.-The following may be awarded a grant under this section:

"(A) State veterans service agencies.

"(B) Veterans service organizations.

"(3) USE OF FUNDS.-A State veterans service agency or veterans service organization awarded a grant under this section may use the grant amount to-

"(A) assist veterans in highly rural areas to travel to Department of Veterans Affairs medical centers; and

"(B) otherwise assist in providing transportation in connection with the provision of medical care to veterans in highly rural areas.

"(4) MAXIMUM AMOUNT.-The amount of a grant under this section may not exceed $50,000.

"(5) NO MATCHING REQUIREMENT.-The recipient of a grant under this section shall not be required to provide matching funds as a condition for receiving such grant.

"(b) REGULATIONS.-The Secretary shall prescribe regulations for-

"(1) evaluating grant applications under this section; and

"(2) otherwise administering the program established by this section.

"(c) DEFINITIONS.-In this section:

"(1) HIGHLY RURAL.-The term 'highly rural', in the case of an area, means that the area consists of a county or counties having a population of less than seven persons per square mile.

"(2) VETERANS SERVICE ORGANIZATION.-The term 'veterans service organization' means any organization recognized by the Secretary of Veterans Affairs for the representation of veterans under section 5902 of title 38, United States Code.

"(d) AUTHORIZATION OF APPROPRIATIONS.-There is authorized to be appropriated $3,000,000 for each of fiscal years 2010 through 2022 to carry out this section."

CONTINUATION OF AUTHORITY

Pub. L. 110–92, §161, as added by Pub. L. 110–149, §2, Dec. 21, 2007, 121 Stat. 1819 , provided that: "Notwithstanding section 106 [121 Stat. 990], the authority to provide care and services under section 1710(e)(1)(E) of title 38, United States Code, shall continue in effect through September 30, 2008."

PERSONAL EMERGENCY RESPONSE SYSTEM FOR VETERANS WITH SERVICE-CONNECTED DISABILITIES

Pub. L. 107–135, title II, §210, Jan. 23, 2002, 115 Stat. 2464 , provided that:

"(a) EVALUATION AND STUDY.-The Secretary of Veterans Affairs shall carry out an evaluation and study of the feasibility and desirability of providing a personal emergency response system to veterans who have service-connected disabilities. The evaluation and study shall be commenced not later than 60 days after the date of the enactment of this Act [Jan. 23, 2002].

"(b) REPORT.-Not later than 180 days after the date of the enactment of this Act, the Secretary shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report on the evaluation and study under subsection (a). The Secretary shall include in the report the Secretary's findings resulting from the evaluation and study and the Secretary's conclusion as to whether the Department of Veterans Affairs should provide a personal emergency response system to veterans with service-connected disabilities.

"(c) AUTHORITY TO PROVIDE SYSTEM.-If the Secretary concludes in the report under subsection (b) that a personal emergency response system should be provided by the Department of Veterans Affairs to veterans with service-connected disabilities-

"(1) the Secretary may provide such a system, without charge, to any veteran with a service-connected disability who is enrolled under section 1705 of title 38, United States Code, and who submits an application for such a system under subsection (d); and

"(2) the Secretary may contract with one or more vendors to furnish such a system.

"(d) APPLICATION.-A personal emergency response system may be provided to a veteran under subsection (c)(1) only upon the submission by the veteran of an application for the system. Any such application shall be in such form and manner as the Secretary may require.

"(e) DEFINITION.-For purposes of this section, the term 'personal emergency response system' means a device-

"(1) that can be activated by an individual who is experiencing a medical emergency to notify appropriate emergency medical personnel that the individual is experiencing a medical emergency; and

"(2) that provides the individual's location through a Global Positioning System indicator."

CHIROPRACTIC TREATMENT

Pub. L. 107–135, title II, §204, Jan. 23, 2002, 115 Stat. 2459 , as amended by Pub. L. 115–141, div. J, title II, §245(a), Mar. 23, 2018, 132 Stat. 822 , provided that:

"(a) REQUIREMENT FOR PROGRAM.-Subject to the provisions of this section, the Secretary of Veterans Affairs shall carry out a program to provide chiropractic care and services to veterans through Department of Veterans Affairs medical centers and clinics.

"(b) ELIGIBLE VETERANS.-Veterans eligible to receive chiropractic care and services under the program are veterans who are enrolled in the system of patient enrollment under section 1705 of title 38, United States Code.

"(c) LOCATION OF PROGRAM.-(1) The program shall be carried out at sites designated by the Secretary for purposes of the program. The Secretary shall designate at least one site for such program in each geographic service area of the Veterans Health Administration. The sites so designated shall be medical centers and clinics located in urban areas and in rural areas.

"(2) The program shall be carried out at not fewer than two medical centers or clinics in each Veterans Integrated Service Network by not later than December 31, 2019, and at not fewer than 50 percent of all medical centers in each Veterans Integrated Service Network by not later than December 31, 2021.

"(d) CARE AND SERVICES AVAILABLE.-The chiropractic care and services available under the program shall include a variety of chiropractic care and services for neuro-musculoskeletal conditions, including subluxation complex.

"(e) OTHER ADMINISTRATIVE MATTERS.-(1) The Secretary shall carry out the program through personal service contracts and by appointment of licensed chiropractors in Department medical centers and clinics.

"(2) As part of the program, the Secretary shall provide training and materials relating to chiropractic care and services to Department health care providers assigned to primary care teams for the purpose of familiarizing such providers with the benefits of chiropractic care and services.

"(f) REGULATIONS.-The Secretary shall prescribe regulations to carry out this section.

"(g) CHIROPRACTIC ADVISORY COMMITTEE.-(1) The Secretary shall establish an advisory committee to provide direct assistance and advice to the Secretary in the development and implementation of the chiropractic health program.

"(2) The membership of the advisory committee shall include members of the chiropractic care profession and such other members as the Secretary considers appropriate.

"(3) Matters on which the advisory committee shall assist and advise the Secretary shall include the following:

"(A) Protocols governing referral to chiropractors.

"(B) Protocols governing direct access to chiropractic care.

"(C) Protocols governing scope of practice of chiropractic practitioners.

"(D) Definition of services to be provided.

"(E) Such other matters the Secretary determines to be appropriate.

"(4) The advisory committee shall cease to exist on December 31, 2004."

Pub. L. 106–117, title III, §303, Nov. 30, 1999, 113 Stat. 1572 , provided that:

"(a) ESTABLISHMENT OF PROGRAM.-Not later than 120 days after the date of the enactment of this Act [Nov. 30, 1999], the Under Secretary for Health of the Department of Veterans Affairs, after consultation with chiropractors, shall establish a policy for the Veterans Health Administration regarding the role of chiropractic treatment in the care of veterans under chapter 17 of title 38, United States Code.

"(b) DEFINITIONS.-For purposes of this section:

"(1) The term 'chiropractic treatment' means the manual manipulation of the spine performed by a chiropractor for the treatment of such musculo-skeletal conditions as the Secretary considers appropriate.

"(2) The term 'chiropractor' means an individual who-

"(A) is licensed to practice chiropractic in the State in which the individual performs chiropractic services; and

"(B) holds the degree of doctor of chiropractic from a chiropractic college accredited by the Council on Chiropractic Education."

IMPLEMENTATION REPORT

Pub. L. 105–368, title I, §102(b), Nov. 11, 1998, 112 Stat. 3322 , required the Secretary of Veterans Affairs, not later than Oct. 1, 1999, to submit to Congress a report on the Secretary's plan for establishing and operating the system for collection and analysis of information required by subsec. (e)(5) of this section.

DEMONSTRATION PROJECTS FOR TREATMENT OF PERSIAN GULF ILLNESS

Pub. L. 105–114, title II, §209(b), Nov. 21, 1997, 111 Stat. 2290 , provided that:

"(1) The Secretary of Veterans Affairs shall carry out a program of demonstration projects to test new approaches to treating, and improving the satisfaction with such treatment of, Persian Gulf veterans who suffer from undiagnosed and ill-defined disabilities. The program shall be established not later than July 1, 1998, and shall be carried out at up to 10 geographically dispersed medical centers of the Department of Veterans Affairs.

"(2) At least one of each of the following models shall be used at no less than two of the demonstration projects:

"(A) A specialized clinic which serves Persian Gulf veterans.

"(B) Multidisciplinary treatment aimed at managing symptoms.

"(C) Use of case managers.

"(3) A demonstration project under this subsection may be undertaken in conjunction with another funding entity, including agreements under section 8111 of title 38, United States Code.

"(4) The Secretary shall make available from appropriated funds (which have been retained for contingent funding) $5,000,000 to carry out the demonstration projects.

"(5) The Secretary may not approve a medical center as a location for a demonstration project under this subsection unless a peer review panel has determined that the proposal submitted by that medical center is among those proposals that have met the highest competitive standards of clinical merit and the Secretary has determined that the facility has the ability to-

"(A) attract the participation of clinicians of outstanding caliber and innovation to the project; and

"(B) effectively evaluate the activities of the project.

"(6) In determining which medical centers to select as locations for demonstration projects under this subsection, the Secretary shall give special priority to medical centers that have demonstrated a capability to compete successfully for extramural funding support for research into the effectiveness and cost-effectiveness of the care provided under the demonstration project."

PATIENT PRIVACY FOR WOMEN PATIENTS

Pub. L. 104–262, title III, §322, Oct. 9, 1996, 110 Stat. 3196 , provided that:

"(a) IDENTIFICATION OF DEFICIENCIES.-The Secretary of Veterans Affairs shall conduct a survey of each medical center under the jurisdiction of the Secretary to identify deficiencies relating to patient privacy afforded to women patients in the clinical areas at each such center which may interfere with appropriate treatment of such patients.

"(b) CORRECTION OF DEFICIENCIES.-The Secretary shall ensure that plans and, where appropriate, interim steps to correct the deficiencies identified in the survey conducted under subsection (a) are developed and are incorporated into the Department's construction planning processes and, in cases in which it is cost-effective to do so, are given a high priority.

"(c) REPORTS TO CONGRESS.-The Secretary shall compile an annual inventory, by medical center, of deficiencies identified under subsection (a) and of plans and, where appropriate, interim steps, to correct such deficiencies. The Secretary shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives, not later than October 1, 1997, and not later than October 1 each year thereafter through 1999 a report on such deficiencies. The Secretary shall include in such report the inventory compiled by the Secretary, the proposed corrective plans, and the status of such plans."

HOSPICE CARE STUDY

Pub. L. 104–262, title III, §341, Oct. 9, 1996, 110 Stat. 3205 , provided that:

"(a) STUDY REQUIRED.-The Secretary of Veterans Affairs shall conduct a research study to determine the desirability of the Secretary furnishing hospice care to terminally ill veterans and to evaluate the most cost-effective and efficient way to do so. The Secretary shall carry out the study using resources and personnel of the Department.

"(b) CONDUCT OF STUDY.-In carrying out the study required by subsection (a), the Secretary shall-

"(1) evaluate the programs, and the program models, through which the Secretary furnishes hospice care services within or through facilities of the Department of Veterans Affairs and the programs and program models through which non-Department facilities provide such services;

"(2) assess the satisfaction of patients, and family members of patients, in each of the program models covered by paragraph (1);

"(3) compare the costs (or range of costs) of providing care through each of the program models covered by paragraph (1); and

"(4) identify any barriers to providing, procuring, or coordinating hospice services through any of the program models covered by paragraph (1).

"(c) PROGRAM MODELS.-For purposes of subsection (b)(1), the Secretary shall evaluate a variety of types of models for delivery of hospice care, including the following:

"(1) Direct furnishing of full hospice care by the Secretary.

"(2) Direct furnishing of some hospice services by the Secretary.

"(3) Contracting by the Secretary for the furnishing of hospice care, with a commitment that the Secretary will provide any further required hospital care for the patient.

"(4) Contracting for all required care to be furnished outside the Department.

"(5) Referral of the patient for hospice care without a contract.

"(d) REPORT.-Not later than April 1, 1998, the Secretary shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report on the research study. The report shall set forth the Secretary's findings and recommendations. The Secretary shall include in the report information on the extent to which the Secretary advises veterans concerning their eligibility for hospice care and information on the number of veterans (as of the time of the report) who are in each model of hospice care described in subsection (c) and the average cost per patient of hospice care for each such model."

RATIFICATION OF ACTIONS DURING PERIOD OF EXPIRED AUTHORITY

Pub. L. 106–419, title II, §224(d), Nov. 1, 2000, 114 Stat. 1846 , provided that: "Any action taken by the Secretary of Veterans Affairs under section 1710(g) of title 38, United States Code, during the period beginning on November 30, 1999, and ending on the date of the enactment of this Act [Nov. 1, 2000] is hereby ratified."

Pub. L. 104–110, title I, §103, Feb. 13, 1996, 110 Stat. 769 , provided that: "Any action taken by the Secretary of Veterans Affairs before the date of the enactment of this Act [Feb. 13, 1996] under a provision of law amended by this title [amending this section, sections 1712, 1720A, 1720C, 3703, 3710, 3720, 3731, 3735, 7451, 7618, and 8169 of this title, sections 11448 and 11450 of Title 42, The Public Health and Welfare, and provisions set out as notes under sections 1712, 1718, and 7721 of this title] that was taken during the period beginning on the date on which the authority of the Secretary under that provision of law expired and ending on the date of the enactment of this Act shall be considered to have the same force and effect as if the amendment to that provision of law made by this title had been in effect at the time of that action."

Pub. L. 103–452, title I, §105, Nov. 2, 1994, 108 Stat. 4787 , provided that: "Any action of the Secretary of Veterans Affairs under section 1710(e) of title 38, United States Code, during the period beginning on July 1, 1994, and ending on the date of the enactment of this Act [Nov. 2, 1994] is hereby ratified."

Reimbursement for Hospital, Nursing Home or Outpatient Services Expenses

Pub. L. 103–210, §1(c)(2), Dec. 20, 1993, 107 Stat. 2497 , directed Secretary of Veterans Affairs, on request, to reimburse any veteran who paid the United States an amount under 38 U.S.C. 1710(f) or 1712(f) for hospital care, nursing home care, or outpatient services furnished by the Secretary to the veteran before Dec. 20, 1993, on the basis of a finding that the veteran may have been exposed to a toxic substance or environmental hazard during the Persian Gulf War, with amount of reimbursement to be amount that was paid by the veteran for such care or services.

Health Care Services for Women

Pub. L. 102–585, title I, §106, Nov. 4, 1992, 106 Stat. 4947 , provided that:

"(a) General Authority.-In furnishing hospital care and medical services under chapter 17 of title 38, United States Code, the Secretary of Veterans Affairs may provide to women the following health care services:

"(1) Papanicolaou tests (pap smears).

"(2) Breast examinations and mammography.

"(3) General reproductive health care, including the management of menopause, but not including under this section infertility services, abortions, or pregnancy care (including prenatal and delivery care), except for such care relating to a pregnancy that is complicated or in which the risks of complication are increased by a service-connected condition.

"(b) Responsibilities of Directors of Facilities.-The Secretary shall ensure that directors of medical facilities of the Department identify and assess opportunities under the authority provided in title II of this Act [38 U.S.C. 8111 note] to (1) expand the availability of, and access to, health care services for women veterans under sections 1710 and 1712 of title 38, United States Code, and (2) provide counseling, care, and services authorized by this title [see Short Title of 1992 Amendment note set out under section 101 of this title]."

Report on Health Care and Research

Pub. L. 102–585, title I, §107, Nov. 4, 1992, 106 Stat. 4947 , as amended by Pub. L. 104–262, title III, §324, Oct. 9, 1996, 110 Stat. 3197 , provided that:

"(a) In General.-Not later than January 1 of 1993 and each year thereafter through 1998, the Secretary of Veterans Affairs shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report on the provision of health care services and the conduct of research carried out by, or under the jurisdiction of, the Secretary relating to women veterans.

"(b) Contents.-The report under subsection (a) shall include the following information with respect to the most recent fiscal year before the date of the report:

"(1) The number of women veterans who have received services described in section 106 of this Act [set out as a note above] in facilities under the jurisdiction of the Secretary (or the Secretary of Defense), shown by reference to the Department facility which provided (or, in the case of Department of Defense facilities, arranged) those services;

"(2) A description of (A) the services provided at each such facility (including information on the number of inpatient stays and the number of outpatient visits through which such services were provided), and (B) the extent to which each such facility relies on contractual arrangements under section 1703 or 8153 of title 38, United States Code, to furnish care to women veterans in facilities which are not under the jurisdiction of the Secretary where the provision of such care is not furnished in a medical emergency.

"(3) The steps taken by each such facility to expand the provision of services at such facility (or under arrangements with a Department of Defense facility) to women veterans.

"(4) A description (as of October 1 of the year preceding the year in which the report is submitted) of the status of any research relating to women veterans being carried out by or under the jurisdiction of the Secretary, including research under section 109 of this Act [former 38 U.S.C. 7303 note].

"(5) A description of the actions taken by the Secretary to foster and encourage the expansion of such research."

Coordination of Women's Services

Pub. L. 102–585, title I, §108, Nov. 4, 1992, 106 Stat. 4948 , provided that: "The Secretary of Veterans Affairs shall ensure that an official in each regional office of the Veterans Health Administration shall serve

as a coordinator of women's services. The responsibilities of such official shall include the following:

"(1) Conducting periodic assessments of the needs for services of women veterans within such region.

"(2) Planning to meet such needs.

"(3) Assisting in carrying out the purposes of section 106(b) of this title [set out above].

"(4) Coordinating the training of women veterans coordinators who are assigned to Department facilities in the region under the jurisdiction of such regional coordinator.

"(5) Providing appropriate technical support and guidance to Department facilities in that region with respect to outreach activities to women veterans."

Population Study of Women Veterans

Pub. L. 102–585, title I, §110, Nov. 4, 1992, 106 Stat. 4948 , as amended by Pub. L. 103–452, title I, §102(c), Nov. 2, 1994, 108 Stat. 4786 , directed Secretary of Veterans Affairs, in consultation with Advisory Committee on Women Veterans, to conduct a study to determine needs of veterans who are women for health-care services, based on an appropriate sample of veterans who are women, and to submit to Congress, not later than 9 months after Nov. 4, 1992, an interim report describing information and advice obtained from Advisory Committee and status of study, and to submit, not later than Dec. 31, 1995, a final report describing results of study.

Demonstration Project To Evaluate Installation of Telephones for Patient Use at Department of Veterans Affairs Health-Care Facilities

Pub. L. 102–585, title V, §525, Nov. 4, 1992, 106 Stat. 4960 , directed Secretary of Veterans Affairs to carry out a demonstration project to evaluate feasibility and desirability of providing telephone service in patient rooms in Department of Veterans Affairs health-care facilities which do not currently provide such service, use of telephones by patients of such health-care facilities, and relative feasibility and cost-effectiveness of a variety of options for providing such service, and submit to Congress a report on the demonstration project not later than Sept. 30, 1994.

Reports on Furnishing of Health Care and Implementation of Changes in Eligibility

Pub. L. 99–272, title XIX, §19011(e), Apr. 7, 1986, 100 Stat. 379 , as amended by Pub. L. 100–527, §10(1), (2), Oct. 25, 1988, 102 Stat. 2640 , 2641; Pub. L. 101–237, title II, §201(d), Dec. 18, 1989, 103 Stat. 2066 ; Pub. L. 102–40, title III, §302, May 7, 1991, 105 Stat. 208 ; Pub. L. 102–83, §5(c)(2), Aug. 6, 1991, 105 Stat. 406 ; Pub. L. 102–291, §4, May 20, 1992, 106 Stat. 179 , directed Administrator of Veterans Affairs to submit to Congress a report for each fiscal year through fiscal year 1992 concerning implementation of the amendments made by section 19011 of Pub. L. 99–272, which amended this section and sections 1525, 1701, 1712, 1712A, 1720, 1722, and 1763 of this title and enacted provisions set out as notes under this section and section 1722 of this title, specified detailed information required to be submitted in each report, and provided that each report be submitted not later than the Feb. 1 following the end of the fiscal year for which it is submitted.

Chiropractic Services Pilot Program

Pub. L. 99–166, title I, §109, Dec. 3, 1985, 99 Stat. 948 , directed Administrator of Veterans' Affairs to conduct a pilot program to evaluate therapeutic benefits and cost-effectiveness of furnishing certain chiropractic services to veterans eligible for medical services under this chapter, provided that the pilot program be carried out during period beginning Jan. 1, 1986, and ending Dec. 31, 1988, and directed Administrator to submit to Committees on Veterans' Affairs of Senate and House of Representatives not later than Apr. 1, 1989, a report on implementation, operation, and results of the pilot program.

[1] *See References in Text note below.*

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or on the distribution of power and responsibilities between the Federal Government and Indian tribes.

E. Unfunded Mandates Reform Act

The Unfunded Mandates Reform Act of 1995 (2 U.S.C. 1531–1538) requires Federal agencies to assess the effects of their discretionary regulatory actions. In particular, the Act addresses actions that may result in the expenditure by a State, local, or tribal government, in the aggregate, or by the private sector of $100,000,000 (adjusted for inflation) or more in any one year. Though this rule will not result in such an expenditure, we do discuss the effects of this rule elsewhere in this preamble.

F. Environment

We have analyzed this rule under Department of Homeland Security Directive 023–01, Rev. 1, associated implementing instructions, and Environmental Planning COMDTINST 5090.1 (series), which guide the Coast Guard in complying with the National Environmental Policy Act of 1969 (42 U.S.C. 4321–4370f), and have determined that this action is one of a category of actions that do not individually or cumulatively have a significant effect on the human environment. This rule involves a safety zone lasting only 1 hour that will prohibit entry within a 500-foot radius of a fireworks display center in position 45°21′58.80″ N 85°01′54.38″ W in Bay Harbor, MI. It is categorically excluded from further review under paragraph L[60(a)] of Appendix A, Table 1 of DHS Instruction Manual 023–01–001–01, Rev. 1. A Record of Environmental Consideration supporting this determination is available in the docket. For instructions on locating the docket, see the **ADDRESSES** section of this preamble.

G. Protest Activities

The Coast Guard respects the First Amendment rights of protesters. Protesters are asked to call or email the person listed in the **FOR FURTHER INFORMATION CONTACT** section to coordinate protest activities so that your message can be received without jeopardizing the safety or security of people, places or vessels.

List of Subjects in 33 CFR Part 165

Harbors, Marine safety, Navigation (water), Reporting and record keeping requirements, Security measures, Waterways.

For the reasons discussed in the preamble, the Coast Guard amends 33 CFR part 165 as follows:

PART 165— REGULATED NAVIGATION AREAS AND LIMITED ACCESS AREAS

■ 1. The authority citation for part 165 continues to read as follows:

Authority: 46 U.S.C. 70034, 70051; 33 CFR 1.05–1, 6.04–1, 6.04–6, and 160.5; Department of Homeland Security Delegation No. 00170.1, Revision No. 01.3.

■ 2. Add § 165.T09–0671 to read as follows:

§ 165.T09–0671 Safety Zone; Steve Hemberger Wedding Fireworks, Bay Harbor, MI.

(a) *Location.* The following area is a safety zone: All navigable water within 500-feet of the fireworks launching location in position 45°21′58.80″ N 85°01′54.38″ W (NAD 83).

(b) *Definitions.* As used in this section, *designated representative* means a Coast Guard Patrol Commander, including a Coast Guard coxswain, petty officer, or other officer operating a Coast Guard vessel and a Federal, State, and local officer designated by or assisting the Captain of the Port Sault Sainte Marie (COTP) in the enforcement of the safety zone.

(c) *Regulations.* (1) In accordance with the general regulations in § 165.23, entry into, transiting, or anchoring within the safety zone described in paragraph (a) is prohibited unless authorized by the Captain of the Port, Sault Sainte Marie or his designated representative.

(2) Before a vessel operator may enter or operate within the safety zone, they must obtain permission from the Captain of the Port, Sault Sainte Marie, or his designated representative via VHF Channel 16 or telephone at (906) 635–3233. Vessel operators given permission to enter or operate in the safety zone must comply with all orders given to them by the Captain of the Port, Sault Sainte Marie or his designated representative.

(d) *Enforcement period.* This section will be enforced from 11 p.m. on October 1, 2022 until 12 a.m. on October 2, 2022.

Dated: September 1, 2022.

A.R. Jones,

Captain of the Port Sault Sainte Marie.

[FR Doc. 2022–19387 Filed 9–8–22; 8:45 am]

BILLING CODE 9110–04–P

DEPARTMENT OF VETERANS AFFAIRS

38 CFR Part 17

RIN 2900–AR57

Reproductive Health Services

AGENCY: Department of Veterans Affairs.

ACTION: Interim final rule with request for comments.

SUMMARY: The Department of Veterans Affairs (VA) amends its medical regulations to remove the exclusion on abortion counseling and establish exceptions to the exclusion on abortions in the medical benefits package for veterans who receive care set forth in that package, and to remove the exclusion on abortion counseling and expand the exceptions to the exclusion on abortions for Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) beneficiaries.

DATES:

Effective date: This interim final rule is September 9, 2022.

Comment date: Comments must be received on or before October 11, 2022.

ADDRESSES: Comments may be submitted through *www.regulations.gov*. Except as provided below, comments received before the close of the comment period will be available at *www.regulations.gov* for public viewing, inspection, or copying, including any personally identifiable or confidential business information that is included in a comment. We post the comments received before the close of the comment period on the following website as soon as possible after they have been received: *http://www.regulations.gov*. VA will not post on *Regulations.gov* public comments that make threats to individuals or institutions or suggest that the individual will take actions to harm the individual. VA encourages individuals not to submit duplicative comments. We will post acceptable comments from multiple unique commenters even if the content is identical or nearly identical to other comments.

FOR FURTHER INFORMATION CONTACT: Dr. Shereef Elnahal, Under Secretary for Health, Department of Veterans Affairs, 810 Vermont Avenue NW, Washington, DC 20420, (202) 461–7671.

SUPPLEMENTARY INFORMATION:

I. Background

A. Brief Summary of this Interim Final Rule

On June 24, 2022, the Supreme Court in *Dobbs* v. *Jackson Women's Health*

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Organization, 142 S. Ct. 2228 (2022), overruled *Roe* v. *Wade*, 410 U.S. 113 (1973), and *Planned Parenthood of Southeastern Pennsylvania* v. *Casey*, 505 U.S. 833 (1992). *Dobbs*, 142 S. Ct. at 2279. After *Dobbs*, certain States have begun to enforce existing abortion bans and restrictions on care, and are proposing and enacting new ones, creating urgent risks to the lives and health of pregnant veterans and CHAMPVA beneficiaries in these States. In response, VA is acting to help to ensnre that, irrespective of wbat laws or policies States may impose, veterans who receive the care set forth in the medical benefits package will be able to obtain abortions, if determined needed by a health care professional, wben the life or the health of the pregnant veteran would be endangered if the pregnancy were carried to term or the pregnancy is the result of an act of rape or incest. Similarly, VA is acting to ensure CHAMPVA beneficiaries will be able to obtain abortions, if determined medically necessary and appropriate, when the health of the pregnant CHAMPVA beneficiary wonld be endangered if the pregnancy were carried to term or the pregnancy is the result of an act of rape or incest.

VA is taking this action because it has determined that providing access to abortion-related medical services is needed to protect the lives and health of veterans. *See* section 1710 of title 38, United States Code (U.S.C.); § 17.38(b) of title 38, Code of Federal Rogulations (CFR). As abortion bans come into force across the country, veterans in many Statos are no longer assured access to abortion services in their commuuities, even when those services are needed. VA has determined that an abortion is "needed" pursuaut to 38 U.S.C. 1710, when sought by a veteran, if determined needed by a health care professional, 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 an act of rape or incest. Unless VA removes its existing prohibitions on abortion-related care and makos clear that needed abortion-related care is authorized, these veterans will face serious threats to their life and health.

Similarly, VA has determined that providing access to abortion-related medical services is medically necessary and appropriate to protect the health of CHAMPVA beneficiaries. *See* 38 U.S.C. 1781; 38 CFR 17.270(b) (defining "CHAMPVA-covered services and supplies" as "those medical services and supplies tbat are medically necessary and appropriate for the treatment of a condition and that are not specifically excluded under [38 CFR 17.272(a)(1)] through (84)"). CHAMPVA beneficiaries in many States are also no longer assured access to abortion services in their communities. Unless VA removes existing prohibitions on abortion-related care and makes clear that medically necessary and appropriate abortion-related care is authorized, these CHAMPVA beneficiaries will face serious threats to their health.

VA is therefore taking this action to avert imminent and future harm to the veterans and CHAMPVA beneficiaries whose interests Congress entrusted VA to serve.

B. VA Authority To Provide Abortions ond Abortion Counseling Under 38 U.S.C. 1710 (Medical Benefits Package)

Pursuant to VA's general treatment authority for veterans, VA "sball furnish" specified veterans with "hospital care and medical services which the Secretary determines to be needed." 38 U.S.C. 1710(a)(1)–(2). For veterans not described in paragraphs (1) and (2), the Secretary "may," subject to certain limitations, "furnish hospital care" and "medical services . . . which the Secretary determines to be needed." 38 U.S.C. 1710(a)(3). As relevant here, such "medical services" include "medical examination, treatment," "[s]urgical services," and "[p]reventive health services." 38 U.S.C. 1701(6).

VA implements its general treatment authority, and the Secretary determines what care is "needed," 38 U.S.C. 1710(a)(1)–(3), by regulation through VA's medical benefits package. 38 CFR 17.38. The medical benefits package consists of a wide range of basic and preventive care, including inpatient and ontpatient medical and surgical care, prescription drugs, emergency care (as authorized by statute and regulation), pregnancy and delivery services (to the extent authorized hy law),[1] aud periodic medical exams. 38 CFR 17.38(a). Care included in the medical benefits package is "provided to individuals only if it is determined by appropriate health care professionals that the care is needed to promote, preserve, or restore the health of the individual and is in accord with generally accepted standards of medical practico." 38 CFR 17.38(b).

Some care is specifically excluded from the medical benefits package because the Secretary has determined it is not "needed" within the meaning of 38 U.S.C. 1710(a)(1)–(3). 38 CFR 17.38(c); 64 FR 54207, 54210 (Oct. 6, 1999). Among other services, "[a]bortions and abortion counseling" are currently exclnded from the medical benefits package, witb no exceptions. 38 CFR 17.38(c)(1).

VA first established the medical benefits package in 1999. 64 FR 54217. The Veterans' Health Care Eligibility Reform Act of 1996, Public Law 104–262, 10 Stat. 3177, mandated that VA implement a national enrollment system to manage the delivery of health care services to eligible veterans. When VA developed regulations to implement this national enrollment system, VA recognized the need to also regulate the health care services it provided. 64 FR 54210. VA did not explain the rationale behind the exclusion of abortions and abortion counseling from the medical benefits package wben it was established in 1999. At the time, *Roe* had been reaffirmed in relevant part by *Casey*, and VA was aware that veterans of reproductive age enrolled in its health care system could access abortion services in their communities.

After the *Dobbs* decision, however, veterans living in States that ban or restrict abortion services may no longer be able to receive such medical services in their communities, including in States that now restrict access to abortion even in cases of rape or incest or where the health of the pregnant individual is in danger. It is thus essential for the lives and health of our veterans that abortions be made available if determined needed by a health care professional when: (1) the life or health of the pregnant veteran would be endangered if the pregnancy were carried to term; or (2) the pregnancy is the result of an act of rape or incest. VA has also determined that abortion counseling is needed so that veterans can make informed decisions about their health care.

VA has determined that such medical care is "needed" within the meaning of VA's general treatment autbority, 38 U.S.C. 1710(a). This means that such care may be provided if an appropriate health care professional determines that such care is needed to promote, preserve, or restore the health of the individual and is in accord with generally accepted standards of medical practice. 38 CFR 17.38(b)(1)–(3). VA can therefore provide abortion counseling and covered abortions pursuant to 38 U.S.C. 1710 and 38 CFR 17.38.

The Veteraus Health Care Act of 1992, Public Law 102–585, 106 Stat. 4943 (VHCA), does not prohibit VA's amendment of its medical benefits package in this manner. When that law

[1] The language "to the extent authorized by law" in 38 CFR 17.38 means to the extent VA has legal authority to provido such services under 38 U.S.C.1710. 64 FR 54210 (Nov. 10, 1999).

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was enacted in 1992, prior to the 1996 enactment of the Veterans' Health Care Eligibility Reform Act, VA health care was subject to a patchwork of eligibility criteria, and care was largely linked only to service-connected conditions. *See* 38 U.S.C. 1710 (Supp. I 1994) (authority under which hospital and nursing home care were provided prior to 1996); 38 U.S.C. 1712 (Supp. I 1994) (authority under which medical services were provided prior to 1996). The VHCA, in relevant part, was designed to improve the health care services available to women veterans.[2] Section 106(a) of the VHCA stated that VA could provide "women" with "[p]apanicolaou tests (pap smears)," "[b]reast examinations and mammography," and "[g]eneral reproductive health care . . . , but not including under this section infertility services, abortions, or pregnancy care (including prenatal and delivery care), except for such care relating to a pregnancy that is complicated or in which the risks of complication are increased by a service-connected condition." Public Law 102–585, sec. 106(a).[3]

Section 106 did not limit VA's authority to provide care under any other provision of law. The "but not including" language in section 106 of the VHCA limited only the services provided "under this section," meaning that while section 106 barred the provision of any abortion or infertility service under section 106 of the VHCA, it did not limit VA's authority to provide such services under any other statutory provision such as 38 U.S.C. 1710 or 38 U.S.C. 1712. Public Law 102–585, sec. 106(a). Consequently, a veteran might have been eligible for infertility services for a service-connected disability under 38 U.S.C. 1712,[4] even though that veteran would have been ineligible for infertility services under section 106 because of that section's exclusions. VA has consistently interpreted section 106 in this fashion.[5]

In 1996, the Veterans' Health Care Eligibility Reform Act made major changes to eligibility for VA health care and, as noted above, directed VA to establish a system of patient enrollment to manage the provision of care. The purpose behind eligibility reform was to replace the old system with a system where an enrolled veteran could receive whatever medical care and services are deemed needed. *See* House of Representatives Report No. 104–690, at 4 (1996) ("[The Act] would substitute a single uniform eligibility standard for the complex array of standards governing access to VA hospital and outpatient care. While the new standard is a simple one, more importantly, it employed a clinically appropriate 'need for care' test, thereby ensuring that medical judgment rather than legal criteria will determine when care will be provided and the level at which that care will be furnished."); *id.* at 13 ("[The Act] would substitute a single, streamlined eligibility provision—based on clinical need for care—for the complex array of disparate rules currently governing veterans' eligibility for hospital and outpatient care."). The Veterans' Health Care Eligibility Reform Act effectively overtook section 106 of the VHCA.[6] For example, a veteran in 1992 was only eligible for pregnancy and delivery care under section 106 if the pregnancy was complicated or the risks of complication were increased by a service-connected condition. Public Law 102–585, sec. 106(a). In contrast, general pregnancy and delivery services were included in the medical benefits package when it was established in 1999 pursuant to VA's authority in 38 U.S.C. 1710. 64 FR 54210; 38 CFR 17.38(a)(1)(xiii). Moreover, while section 106 of the VHCA provided that infertility services could not be provided under that section, infertility services (with the exception of in vitro fertilization) were also included in the medical benefits package pursuant to VA's authority under 38 U.S.C. 1710. *Id.* Consequently, for decades, VA has offered general pregnancy care and certain infertility services under 38 U.S.C. 1710. *Id.* VA no longer relies on section 106 of the VHCA to provide such services or any other services.

Congress has ratified VA's interpretation that section 106 of the VHCA does not limit the medical care that the VA may provide pursuant to its authority under 38 U.S.C. 1710. Most recently, when Congress enacted the Deborah Sampson Act of 2020, Public Law 116–315, tit. V (2021), it created a central office to, inter alia, "monitor[ ] and encourag[e] the activities of the Veterans Health Administration with respect to the provision, evaluation, and improvement of health care services provided to women veterans by the Department." 38 U.S.C. 7310(b)(1). Congress defined "health care" for these purposes as "the health care and services included in the medical benefits package provided by the Department as in effect on the day before the date of the enactment of this Act [Jan. 5, 2021]." 38 U.S.C. 7310 note.[7] Given that VA's medical benefits package as of that date included services that were excluded from the coverage of Section 106 of the VHCA, Congress ratified VA's interpretation that it may provide for these services pursuant to its authority under 38 U.S.C. 1710, notwithstanding section 106. Indeed, the fact that the Deborah Sampson Act of 2020 did not reference section 106 of the VHCA and only referenced VA's medical benefits package shows that Congress did not interpret section 106 of the VHCA as a limitation on VA's authority to provide care to "women veterans."[8]

Furthermore, the fact that VA does not rely on section 106 of the VHCA and instead relies on 38 U.S.C. 1710(a)(1)–(3) to provide pap smears, breast exams and mammography, or general reproductive health services, pregnancy or infertility services confirms that

[2] 102 Cong. Rec. 32,367 (1992).

[3] Prior to the enactment of section 106(a), VA provided gynecology services, including mammograms and screening for cervical cancer, under the Department's authority to provide preventative health services pursuant to 38 U.S.C. 1762. General Accounting Office (GAO)/Human Resources Division (HRD)–92–23 *VA Health Care for Women: Despite Progress, Improvements needed* (January 1992) p. 3 (*https://www.gao.gov/assets/hrd-92-23.pdf*). However, the legislative history of the VHCA generally, and section 106 specifically, indicates that Congress sought to provide statutory support for the services VA already provided pursuant to its existing authority. Senate Report No. 102–409, p. 40 (1992) (discussing the intent behind S. 2973, section 201, *Well-women care services*, "The Committee expects that providing explicit authority to furnish cancer-screening procedures will lead VA to redouble its efforts in this critical area. The Committee believes that these services are not only vital to women veterans, but they are also in line with VA's goal to emphasize preventative health-care services within the system."); *see also* 102 Congressional Record 34,299 (1992) ("The measure also incorporates the exception to the bar on furnishing pregnancy care reflected in VA regulations (at 39 CFR 17.48(h) [sic]) associated with care relating to a complicated pregnancy, as well as the instance in which the risks of complication are increased by a service-connected condition.").

[4] 102 Congressional Record 34,299 (1992).

[5] Veterans Health Administration (VHA) Directive 10–93–151, December 6, 1993; Letter from Secretary Denis McDonough to Senator Jerry Moran, July 7, 2021.

[6] As detailed above, section 106 of the VHCA was intended to reinforce VA's existing authority to provide preventative health care services to women veterans. *See* 38 U.S.C. 1762; 38 CFR 17.30(m)(1); Public Law 102–585, sec. 513. The subsequent 1996 amendments to 38 U.S.C. 1710 and the 1999 rulemaking establishing the medical benefits package overtook VA's need to rely on section 106 to provide certain women's health care to women veterans.

[7] 38 U.S.C. 7310(b)(6) authorizes the Office of Women's Health to "promote the expansion and inclusion of clinical . . . activities of [VHA]." Additionally, subsection (b)(9) authorizes the Office to "carry out such other duties as the Under Secretary for Health may require." Thus, the Office of Women's Health can address health care and services that were not included in the medical benefits package on the day before the date of enactment of the Deborah Sampson Act of 2020.

[8] Letter to Denis McDonough from 24 U.S. Senators, July 28, 2022.

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section 106's prohibition on providing certain services "under this section" simply is no longer operative.

VA's authority under 38 U.S.C. 1710 is different from authorities governing the provision of health care by other Federal agencies. Pursuant to the 1996 amendment, by statute, VA "shall" (and, for some categories of veterans, "may") furnish care that "the Secretary determines to be needed" to veterans, with no exclusion for abortion. 38 U.S.C. 1710(a)(1)–(3). Other Federal agencies, by contrast, are subject to underlying statutory restrictions or restrictions in their appropriations acts concerning certain abortions. For instance, Federal funds available to the Departments of Labor, Health and Human Services, and Education are subject to an appropriations restriction known as the "Hyde Amendment." Congress has included the Hyde Amendment in those agencies' annual appropriations legislation for more than forty years. In its current form, the Hyde Amendment provides that no covered funds "shall be expended for any abortion" or "for health benefits coverage that includes coverage of abortion," except "if the pregnancy is the result of an act of rape or incest; or . . . in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed." Consolidated Appropriations Act, 2022, Public Law 117–103, Div. H, secs. 506–07, 136 Stat. 49. The breadth of the Hyde Amendment's exception has varied over the years, but since fiscal year 1994, the Hyde Amendment has included an exception for the life of the woman and for pregnancies resulting from acts of rape or incest. *See, e.g.*, Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 1994, Public Law 103–112, Sec. 509, 107 Stat. 1082, 1113 (1993). No similar statutory restriction applies to VA.

C. VA Authority To Provide Abortions and Abortion Counseling for CHAMPVA Beneficiaries

By statute, VA's "Secretary is authorized to provide" specified "medical care" to certain spouses, children, survivors, and caregivers of veterans who meet specific eligibility criteria. 38 U.S.C. 1781(a). This health benefits program is known as CHAMPVA. VA must provide "for medical care" under CHAMPVA "in the same or similar manner and subject to the same or similar limitations as medical care is" provided by the Department of Defense to active-duty family members, retired service members and their families, and others under the TRICARE (Select) program. 38 U.S.C. 1781(b); *see* 32 CFR 199.1(r), 199.17(a)(6)(ii)(D). VA has regulated services covered by CHAMPVA to mean those medical services that are medically necessary and appropriate for the treatment of a condition and that are not specifically excluded. 38 CFR 17.270(b).

The current CHAMPVA regulations exclude coverage for abortions, except when a physician certifies that the abortion was performed because the life of the woman would be endangered if the fetus were carried to term, 38 CFR 17.272(a)(64), and also exclude coverage for abortion counseling, 38 CFR 17.272(a)(65). The current CHAMPVA regulations do not include coverage for abortions when the pregnancy is the result of an act of rape or incest.

In contrast, TRICARE (Select) provides coverage for abortions when the pregnancy is the result of an act of rape or incest, or when a physician certifies that the life of the woman would be endangered if the fetus were carried to term, and it provides coverage for counseling for covered abortions.[9]

In this rule, VA amends its CHAMPVA regulations by removing the exclusion for abortion counseling and permitting abortions when the health of the pregnant beneficiary would be endangered if the pregnancy were carried to term, or when the pregnancy is the result of an act of rape or incest. This amendment will better align coverage under CHAMPVA with coverage under TRICARE (Select).

Coverage under CHAMPVA will deviate from coverage under TRICARE (Select) because CHAMPVA will cover abortions when the health of the CHAMPVA beneficiary is at risk and will cover abortion counseling for non-covered abortions. VA, however, has determined that, overall, the relevant care provided under CHAMPVA will still be sufficiently "similar" to that provided under TRICARE (Select). 38 U.S.C. 1781(b). Section 1781(b) does not require CHAMPVA and TRICARE (Select) to be administered identically. Rather, by referring to care that is "similar," the statute permits VA flexibility to administer the program for CHAMPVA beneficiaries. For this reason, not every aspect of CHAMPVA will find a corollary in TRICARE (Select).

VA has previously deviated from TRICARE (Select) in amending its CHAMPVA regulations to provide care that goes beyond the benefits offered by TRICARE (Select). Generally, VA determined that these deviations were necessary to best provide services to the CHAMPVA population while remaining "similar" to TRICARE (Select). For example, TRICARE (Select) does not include an annual physical exam benefit for all TRICARE (Select) beneficiaries; instead, that benefit is limited to certain circumstances.[10] VA has exercised its discretion to deviate from TRICARE (Select) and provide annual physical exams to all CHAMPVA beneficiaries. 38 CFR 17.272(30)(xiii). VA did not believe that limiting the provision of annual exams was appropriate from a clinical perspective. 83 FR 2396, 2401 (Jan. 17, 2018). Annual physical exams are beneficial for both CHAMPVA beneficiaries and VA because they may identify serious medical issues before they progress. *Id.* Additionally, TRICARE (Select) does not waive beneficiary costs associated with preventive services for TRICARE (Select) beneficiaries who are Medicare-eligible in cases in which those services are not covered by Medicare. VA's CHAMPVA regulations, however, do waive cost-sharing requirements for preventive services for Medicare-eligible beneficiaries. VA determined that enforcing cost-sharing requirements for Medicare-eligible beneficiaries for preventive services would unfairly disadvantage them as compared to CHAMPVA beneficiaries with other health insurance. 83 FR 2404.

Thus, VA has previously regulated to provide CHAMPVA benefits beyond those benefits offered by TRICARE (Select) if providing such health care would better promote the long-term health of CHAMPVA beneficiaries. In so doing, VA is still providing for health care in a manner similar to TRICARE (Select), but the care is being provided in a manner that best serves the CHAMPVA population. Similarly, here, VA is aligning CHAMPVA benefits with TRICARE (Select) benefits in certain ways, VA is also providing benefits beyond those offered by TRICARE (Select) in order to better promote the long-term health of CHAMPVA beneficiaries. For the reasons discussed further below, VA finds that allowing abortions for CHAMPVA beneficiaries when there is a risk to the CHAMPVA

[9] *Covered Services, Abortions*, TRICARE, *http://tricare.mil/CoveredServices/IsItCovered/Abortions* (last visited Aug. 22, 2022).

[10] *Covered Services, Physicals*, TRICARE, *http://tricare.mil/CoveredServices/IsItCovered/Physicals* (last visited Aug. 22, 2022).

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beneficiary's health and providing abortion counseling for both covered and noncovered abortions is both medically necessary and appropriate to promote the long-term health of CHAMPVA beneficiaries.

II. Abortions in Limited Circumstances Under 38 U.S.C. 1710 and 1781

A. Abortions When the Life or Health of the Pregnant Veteran Would Be Endangered if the Pregnancy Is Carried to Term Are Needed

VA has determined that access to abortions is "needed," 38 U.S.C. 1710(a)(1)–(3), and such care may be provided to veterans when an appropriate health care professional determines that such care "is needed to promote, preserve, or restore the health of the individual and is in accord with generally accepted standards of medical practice," 38 CFR 17.38(b), when the life or health of the pregnant veteran would be endangered if the pregnancy were carried to term. Abundant evidence supports VA's determination.

Research has shown that while most pregnancies progress without incident, pregnancy and childbirth in the United States can result in physical harm and even death for certain pregnant individuals. From 1998 to 2005, the U.S. mortality rate associated with live births was 8.8 deaths per 100,000 live births, and maternal mortality rates have increased staggeringly since then.[11] A 2019 study reviewed mortality data from 2007 to 2015 from the National Association for Public Health Statistics and Information Systems, which includes information on all deaths in the 50 States and the District of Columbia (DC). The data showed that, during this time, within 38 States and DC, the maternal mortality rate rose to 17.9 deaths of individuals per 100,000 live births. This study identified the factors that likely contributed to this rising maternal mortality rate, including reduced access to family planning and reproductive health services through abortion clinic closures and legislation restricting abortions based on gestational age.[12]

Individuals at risk of pregnancy complications who do not have access to contraception or abortion may experience conditions resulting from pregnancies that can leave them at risk for loss of future fertility, significant morbidity, or death. According to the American College of Obstetricians and Gynecologists (ACOG) and Physicians for Reproductive Health, there are situations when pregnancy termination, in the form of treatment that may be considered to be an abortion, is the only medical intervention that can preserve a patient's health or save their life.[13] Pregnancy poses significant physiological changes on an individual's body, which can exacerbate underlying or preexisting conditions, like renal or cardiac disease, and can severely compromise health or even cause death.[14] During pregnancies, individuals may suffer from life-threatening conditions such as severe preeclampsia, newly diagnosed cancer requiring prompt treatment, and intrauterine infections.[15] Preeclampsia is a disorder associated with new-onset hypertension that can result in blood pressure swings, liver issues, and seizures, among other conditions.[16]

Some pregnant veterans may be at heightened risk for other pregnancy complications including hemorrhage, placenta accreta spectrum, and peripartum hysterectomy, among others.[17] Notably, the need for peripartum hysterectomy in such instances would cause not only morbidity, but loss of future fertility. Pregnancy-related complications may endanger the pregnant veteran's life or health. Abortion may be needed to protect the life or health of the pregnant veteran in these and other circumstances.

Veterans of reproductive age, in particular, have high rates of chronic medical and mental health conditions that may increase the risks associated with pregnancy.[18] Such conditions include chronic post-traumatic stress disorder, severe hypertension, and chronic renal disease.[19] When a health care professional determines that these conditions (potentially in combination with other factors) render an abortion needed to preserve the health of a veteran, access to an abortion is essential health care.

For all of the reasons discussed above, research supports the conclusion that an abortion may be needed to save the life or preserve the health of a veteran. 38 CFR 17.38(b). Therefore, VA is revising the medical benefits package to allow the provision of abortions in such circumstances.

B. Abortions When the Health of the Pregnant CHAMPVA Beneficiary Would Be Endangered if the Pregnancy Is Carried to Term Are Medically Necessary and Appropriate

Currently, abortions for CHAMPVA beneficiaries are excluded "except when a physician certifies that the life of the mother would be endangered if the fetus were carried to term." 38 CFR 17.272(a)(64). VA has determined that when the health of the pregnant CHAMPVA beneficiary would be endangered if the pregnancy were carried to term, access to abortions is also medically necessary and appropriate and such abortions should be covered CHAMPVA services. As explained above, VA is required to provide medically necessary and appropriate care under CHAMPVA to certain spouses, children, survivors, and caregivers of veterans who meet specific eligibility criteria. 38 U.S.C. 1781(a); 38 CFR 17.270 *et seq.* While this care must be "in the same or similar manner and subject to the same or similar limitations as medical care is" provided by the Department of Defense under TRICARE (Select), 38 U.S.C. 1781(b), VA has consistently maintained that "similar" does not mean "identical." VA requires that such care be medically

[11] Elizabeth G. Raymond & David A. Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 Obstetrics & Gynecology 215, 216 (2012); see also Marian F. MacDorman et al., *Recent Increases in the U.S. Maternal Mortality Rate: Disentangling Trends from Measurement Issues*, 128 Obstetrics & Gynecology 447 (2016) (finding a 26.6 percent increase in maternal mortality rates between 2000 and 2014).

[12] Summer Sholburne Hawkins et al., *Impact of State-Level Changes on Maternal Mortality: A Population-Based, Quasi-Experimental Study*, Am. Journal of Preventive Medicine, 85(2): 165–74 (2019).

[13] *Abortion Can Be Medically Necessary*, Am. College of Obstetricians and Gynecologists, Sep. 25, 2019. *http://www.acog.org/news/news-releases/2019/09/abortion-can-be-medically-necessary* (last visited Aug. 22, 2022).

[14] Victoria L. Meah, et al., *Cardiac output and related haemodynamics during pregnancy: a series of meta-analyses*, Heart J., 102:518–526 (2016).

[15] *Abortions later in Pregnancy*, Kaiser Family Foundation, Dec. 5, 2019. *http://www.kff.org/womens-health-policy/fact-sheet/abortions-later-in-pregnancy/* (last visited Aug. 22, 2022).

[16] ACOG Practice Bulletin No. 222, *Gestational Hypertension and Preeclampsia*, Am. College of Obstetricians and Gynecologists (Dec. 2018).

[17] ACOG Practice Bulletin No. 183, *Postpartum Hemorrhage*, Am. College of Obstetricians and Gynecologists (Oct. 2017); ACOG Obstetric Care Consensus, Placenta Accreta Spectrum (July 2012, reaff'd 2021); ACOG Practice Bulletin No. 198, *Prevention and Management of Obstetric Lacerations at Vaginal Delivery*, Am. College of Obstetricians and Gynecologists (Sept. 2018); ACOG Clinical Consensus No. 1, *Pharmacologic Stepwise Multimodal Approach for Postpartum Pain Management*, Am. College of Obstetricians and Gynecologists (Sept. 2021).

[18] Joan L. Combellick, et al., *Severe Maternal Morbidity Among a Cohort of Post-9/11 Women Veterans*, J Women's Health, 29(4):577–84 (Apr. 2020).

[19] Jonathan Shaw, et al., *Post-traumatic Stress Disorder and Antepartum Complications: a Novel Risk Factor for Gestational Diabetes and Preeclampsia*, Paediatr Perinat Epidemiol. 31(3):165–194 (May 2017); David Jones & John P. Hayslett, *Outcome of pregnancy in women with moderate or severe renal insufficiency*, N Engl J Med. 25;335(4):226–32 (Jul. 1996).

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necessary and appropriate for the treatment of a condition and not be specifically excluded under the CHAMPVA regulations. *See* 38 CFR 17.270(b) (defining CHAMPVA-covered services and supplies).

As discussed in the prior section, an abortion may be medically necessary and appropriate to protect a pregnant individual's health. Pregnancy can exacerbate underlying or preexisting conditions, like renal or cardiac disease, in such a way as to severely compromise the health of an individual.[20] Additionally, pregnant individuals may have their health endangered due to severe preeclampsia, newly diagnosed cancer requiring prompt treatment, and intrauterine infections.[21] In those circumstances, an abortion may be the only treatment available to protect the health of the pregnant CHAMPVA beneficiary. Thus, there may be instances when an abortion may be medically necessary and appropriate to prevent a pregnant CHAMPVA beneficiary's health from being endangered if the pregnancy was carried to term, and VA finds it necessary to deviate from TRICARE (Select) to provide abortions in these circumstances.

Accordingly, consistent with VA's regulatory requirements in 38 CFR 17.270(b), VA is revising the CHAMPVA regulations to allow the provision of abortions in such circumstances.

C. Abortions for Veterans When the Pregnancy Is the Result of an Act of Rape or Incest Are Needed

VA has also determined that access to abortions is "needed," 38 U.S.C. 1710(a)(1)–(3), and such care may be provided in accordance with 38 CFR 17.38(b), when the pregnancy is the result of an act of rape or incest.

There are severe health consequences associated with being forced to carry a pregnancy that is the result of rape or incest to term, including constant exposure to the violation committed against the individual which can cause serious traumatic stress and a risk of long-lasting psychological conditions such as anxiety and depression.[22] Those mental health consequences have a unique impact on veterans, who report higher rates of sexual trauma compared to their civilian peers.[23] Moreover, veterans are also more likely to have preexisting mental health conditions that would be compounded by the mental health consequences of being forced to carry a pregnancy to term if that pregnancy is the result of rape or incest. Thus, abortion access is critical to protect the lives and health of pregnant veterans whose pregnancy is the result of an act of rape or incest.

As discussed above, even where Congress has restricted the circumstances in which other Federal agencies may provide abortions, Congress has allowed funding when the pregnancy is the result of an act of rape or incest. VA agrees that abortions for pregnancies resulting from rape or incest are, where sought by the pregnant veteran, needed to protect the life and the health of the veteran consistent with the terms of 38 U.S.C. 1710. VA further expects that, in all but the most unusual circumstances, an individual's access to abortion in cases of pregnancy resulting from rape or incest would be "needed to promote, preserve, or restore the health of the individual" and would be "in accord with generally accepted standards of medical practice." 38 CFR 17.38(b).

D. Abortions for CHAMPVA Beneficiaries When Pregnancy Is the Result of an Act of Rape or Incest Are Medically Necessary and Appropriate

For similar reasons as discussed above, VA has determined that access to abortion when the pregnancy is the result of an act of rape or incest is medically necessary and appropriate and must be available to CHAMPVA beneficiaries. Allowing abortions in these circumstances better aligns with TRICARE (Select), which also allows abortions when the pregnancy is the result of an act of rape or incest.[24]

VA has determined that this change will provide CHAMPVA beneficiaries with care that is medically necessary and appropriate.

III. Abortion Counseling Under 38 U.S.C. 1710 and 1781

A. Abortion Counseling Is Needed Care for Veterons

Through this rulemaking, VA will remove the exclusion on abortion counseling in the medical benefits package from 38 CFR 17.38(c)(1). 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. Abortion counseling has three purposes: (1) to aid a pregnant individual in making a decision about an unwanted pregnancy, (2) to help the pregnant individual implement the decision, and (3) to assist the pregnant individual in controlling their future fertility.[25]

Removing the exclusion on abortion counseling from 38 CFR 17.38(c)(1) will allow VA to provide abortion counseling services to veterans who receive the care set forth in the medical benefits package. Such counseling is essential to ensure that veterans may make informed decisions about their care. Studies have shown that individuals have limited knowledge about the safety and risks of abortion.[26] Providing veterans with accurate information about abortions is needed to ensure that they can make informed decisions about their health care. *See also* 38 U.S.C. 7331; 38 CFR 17.32.

Abortion counseling should no longer be excluded from the medical benefits package. The provision of abortion counseling will enable a pregnant veteran to make a fully informed health care decision, just as counseling is offered or covered by VA regarding any other health care decision. As such, abortion counseling will be provided as part of conversations a veteran has with their provider related to pregnancy options care, when appropriate.

B. Abortion Counseling Is Medicolly Necessary and Appropriate for CHAMPVA Beneficiaries

Through this rulemaking, VA will remove the exclusion of abortion counseling from 38 CFR 17.272(a)(65). This will authorize the provision of abortion counseling for both covered

[20] Victoria L. Meah, et al., *Cardiac output and related haemodynamics during pregnancy: a series of meta-analyses*, HEART J., 102:518–526 (2016).

[21] *Abortions later in Pregnancy*, Kaiser Family Foundation, Dec. 5, 2019. *http://www.kff.org/womens-health-policy/fact-sheet/abortions-later-in-pregnancy/* (last visited Aug. 22, 2022).

[22] *Concluding observations of the Committee against Torture*, United Nations Committee Against Torture, 47th Sess., Oct. 31, 2011–Nov. 25, 2011 CAT/C/PRY/CO/4–6; Paraguay, p. 9, paragraph 22. *https://www2.ohchr.org/english/bodies/cat/docs/CAT.C.PRY.CO.4-6_en.pdf.*

[23] Carey Pulverman & Suzannah Creech, *The Impact of Sexual Trauma on the Sexual Health of Women Veterans: A Comprehensive Review*, Trauma Violence Abuse. 22(4): 656–671 (Oct. 2021). doi: 10.1177/1524838019870912.

[24] *See Covered Services, Abortions*, TRICARE, *https://tricare.mil/CoveredServices/IsItCovered/Abortions* (last visited Aug. 22, 2022).; 38 U.S.C. 1781(b); and 32 CFR 199.1(r), 199.17(a)(6)(ii)(D).

[25] Asher, J.D., *Abortion counseling*. American Journal of Public Health,63(5):686–8 (May 1972). *https://pubmed.ncbi.nlm.nih.gov/5024296/.*

[26] Ellen Weibe., et al., *Knowledge and Attitudes about Contraception and Abortion in Canada, US, UK, France and Australia*, Gynecology & Obstetrics, 5(9) (2015), *http://www.longdom.org/open-access/knowledge-and-attitudes-about-contraception-and-abortion-in-canada-us-uk-france-and-australia-40135.html.*

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and noncovered abortions to CHAMPVA beneficiaries. We acknowledge that this is broader than the abortion counseling provided under TRICARE (Select). However, the relevant care provided under CHAMPVA will still be sufficiently "similar" to that provided under TRICARE (Select). 38 U.S.C. 1781(b). As explained previously, 38 U.S.C. 1781(b) does not require CHAMPVA and TRICARE (Select) to be administered identically. Rather, by referring to care that is "similar," the statute permits VA flexibility to administer the program for CHAMPVA beneficiaries. For this reason, not every aspect of CHAMPVA will find a corollary in TRICARE (Select).

Indeed, as addressed throughout this rule, VA has previously provided CHAMPVA beneficiaries with health care services that exceed those services offered by TRICARE (Select). As discussed in the section above, abortion counseling will enable a pregnant CHAMPVA beneficiary to make a fully informed health care decision, just as counseling is offered or covered by VA when medically necessary and appropriate to make any other health care decision. Because providing CHAMPVA beneficiaries with accurate information about abortions is medically necessary to ensure that they can make informed decisions about their health and the care will be similar to that provided under TRICARE (Select), we believe it is appropriate to revise the CHAMPVA regulations to authorize the provision of abortion counseling for both covered and noncovered abortions to CHAMPVA beneficiaries.

Thus, VA finds that abortion counseling is beneficial for all CHAMPVA beneficiaries to receive accurate information about abortions. Therefore, we are including abortion counseling as a covered medical service under CHAMPVA.

IV. These Changes Will Promote Clarity and Parity Across Federal Agencies

VA believes it is important to provide at least the same reproductive health care services that other Federal agencies provide their beneficiaries. Many veterans and VA beneficiaries previously received health care from other Federal agencies, such as the Department of Defense, and those beneficiaries should have the same or greater access to services that they had previously and came to expect under other agency policies. This is particularly true for our veteran patients who earned their VA health care benefits through their military service and sacrifice to this country. It is unconscionable that they would not have access to at least these same critical services following their transition to civilian life.

As a result of this rulemaking, VA will also provide abortions when the health of the pregnant veteran or CHAMPVA beneficiary is endangered in addition to when the pregnancy threatens their life. This difference is due to VA's particular statutory authority in 38 U.S.C. 1710 to provide needed health care for veterans and VA's flexibility in administering the CHAMPVA program under 38 U.S.C. 1781, as discussed throughout. In contrast, other Federal agencies have different statutory authorities and additional limitations concerning the services they provide, such as the Hyde Amendment discussed above.

In addition, some post-*Dobbs* State and local laws purport to impose criminal liability or threaten suspension of the medical licenses of providers who perform abortions without authorization.[27] In the absence of clarity as to exactly what care is covered, this may result in a chilling effect on the provision of care, including abortions, to veterans and CHAMPVA beneficiaries. Denial of care because of uncertainty about the scope of changing State laws has already been evidenced outside of the Federal health system in certain States.[28] ACOG warns that the full scope of abortion restrictions' effects includes how physicians' ethical obligations to their patients and to the practice of medicine may be reshaped, redirected, or even contradicted by the threat posed by laws not founded in science or based on evidence.[29]

Consequently, VA is revising its medical benefits package and CHAMPVA regulations to promote clarity.

V. Preemption and Related Principles

As previously described, as a result of *Dobbs*, States and localities have begun to enforce existing abortion bans and restrictions on care, and are proposing and enacting new bans or restrictions, creating urgent risks to the lives and health of pregnant veterans and the health of pregnant CHAMPVA beneficiaries in those States. Such State and local bans and restrictions on care chill the provision of needed care for veterans and medically necessary and appropriate care for CHAMPVA beneficiaries. For instance, the Texas Medical Association sent a letter to the Texas Medical Board, seeking clarity on the Texas abortion restrictions as it received complaints that in some health care settings, physicians have been prohibited from providing medically appropriate care to women with ectopic pregnancies and other complications.[30] As reported even before the *Dobbs* decision, there is a climate of fear created by these abortion restrictions that has resulted not only in patients not having access to needed care but also in patients receiving medically inappropriate care.[31]

Accordingly, 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. VA previously issued a regulation, 38 CFR 17.419, in which VA confirmed the ability of VA health care professionals to practice their health care profession consistent with the scope and requirements of their VA employment, notwithstanding any State license, registration, certification, or other requirements that unduly interfere with their practice. The regulation provides that, in order to "provide the same complete health care and hospital services to beneficiaries in all States . . . conflicting State laws, rules, regulations, or requirements pursuant to such laws are without any force or effect, and State governments have no legal authority to enforce them in relation to actions by health care professionals within the scope of their VA employment." 38 CFR 17.419(c). Consistent with § 17.419, VA has

[27] *See e.g.*, Ark. Code Ann. sec. 5–61–404 (making abortion an unclassified felony); Idaho Code Ann. sec. 18–622 (making abortion a felony and requiring suspension of medical license); La. Rev. Stat. Ann. sec. 40:1061 (making abortion a criminal act and basis for professional disciplinary action); Tenn. Code Ann. sec. 39–15–216 (2019) (making abortion a felony); Tex. Health & Safety Code Ann. sec. 170A.004–05 (making abortion a felony and subject to a civil penalty).

[28] See, *e.g.*, Pam Belluck, *They Had Miscarriages, and New Abortion Laws Obstructed Treatment*, N.Y. Times, July 21, 2022, *https://www.nytimes.com/2022/07/17/health/abortion-miscarriage-treatment.html* (last visited Aug. 23, 2022).

[29] *Breaking the Law or Breaking the Oath? How Abortion Bans Betray America's Patients and Physicians*, Am. College of Obstetricians and Gynecologists, *http://www.acog.org/education-and-events/webinars/acog-nyu-how-abortion-bans-betray-americas-patients-physicians* (last visited Aug. 22, 2022).

[30] Allie Morris, *Texas Hospitals Fearing Abortion Law Delay Pregnant Women's Care, Medical Association Says*, Dallas News, July 14, 2022, *http://www.dallasnews.com/news/politics/2022/07/14/texas-hospitals-fearing-abortion-law-delay-pregnant-womens-care-medical-association-says* (last visited Aug. 22, 2022).

[31] Whitney Arey, et al., *A Preview of the Dangerous Future of Abortion Bans—Texas Senate Bill 8*, N Engl J Med; 387:388–390 (2022), *http://www.nejm.org/doi/full/10.1056/NEJMp2207423* (last visited Aug 22, 2022).

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determined that State and local laws, rules, regulations, or requirements that restrict, limit, otherwise impede access to, or regulate the provision of health care provided by VA pursuant to Federal law, would "unduly interfere[] with VA health care professionals' practice within the scope of VA employment." 38 CFR 17.419(b)(1). Accordingly, consistent with § 17.419, this rulemaking confirms that a State or local civil or criminal law that restricts, limits, or otherwise impedes a VA professional's provision of care permitted by this regulation would be preempted.

In addition, "[t]he Constitution's Supremacy Clause generally immunizes the Federal Government from State laws that directly regulate or discriminate against it," unless federal law authorizes such State regulation. *United States* v. *Washington*, 142 S. Ct. 1976, 1982 (2022). Therefore, States generally may not impose criminal or civil liability on VA employees who perform their duties in a manner authorized by federal law. *See, e.g., In re Neagle*, 135 U.S. 1, 62 (1890). 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.

VI. Changes to 38 CFR 17.38(c)(1)

Based on the rationale described above, we remove the exclusion on abortion counseling from § 17.38(c)(1). We revise § 17.38(c)(1) by adding paragraphs (c)(1)(i) and (ii) to state that the medical benefits package includes abortions in certain circumstances.

Section 17.38(c)(1)(i) permits abortions when the life or health of the pregnant veteran would be endangered if the pregnancy is carried to term. Assessment of the conditions, injuries, illness, or diseases that will qualify for this care will be made by appropriate health care professionals on a case-by-case basis. As appropriate, VA may issue supplemental guidance to inform these decisions.

Section 17.38(c)(1)(ii) permits abortions when the pregnancy is the result of an act of rape or incest. We are not requiring a veteran to present particular evidence such as a police report to qualify for this care. This is consistent with longstanding VA policy to treat eligible individuals who experienced military sexual trauma without evidence of the trauma. This approach, similar to in the context of military sexual trauma, removes barriers to providing care. Therefore, the regulation will provide that self-reporting from the pregnant veteran constitutes sufficient evidence.

VII. Changes to 38 CFR 17.272

Based on the rationale described above, we amend the CHAMPVA regulations at 38 CFR 17.272. We remove § 17.272(a)(65) that excludes abortion counseling from the CHAMPVA program. We revise current § 17.272(a)(64), which excludes abortions except when a physician certifies that the life of the pregnant beneficiary would be endangered if the fetus were carried to term, and we add § 17.272(a)(64)(i) and (ii).

Section 17.272(a)(64)(i) permits abortions when the life or health of the CHAMPVA beneficiary would be endangered if the pregnancy is carried to term. Assessment of the conditions, injuries, illnesses, or diseases that will qualify for this care will be made by appropriate health care professionals on a case-by-case basis. As appropriate, VA may issue supplemental guidance to inform these decisions.

Section 17.272(a)(64)(ii) permits abortions when the pregnancy is the result of an act of rape or incest. We are not requiring the CHAMPVA beneficiary to present particular evidence such as a police report to qualify for this care. This approach, as discussed above, removes barriers to providing care. Therefore, the regulation will provide that self-reporting from the pregnant CHAMPVA beneficiary constitutes sufficient evidence.

VIII. Regulatory Requirements

A. Executive Order 13132, Federalism

Executive Order 13132 establishes principles for preemption of State laws when those laws are implicated in rulemaking or proposed legislation. The order provides that, where a Federal statute does not expressly preempt State law, agencies shall construe any authorization in the statute for the issuance of regulations as authorizing preemption of State law by rulemaking only when the exercise of State authority directly conflicts with the exercise of Federal authority or there is clear evidence to conclude that the Congress intended the agency to have the authority to preempt State law.

As discussed above, consistent with 38 CFR 17.419, State and local laws, rules, regulations, or requirements are preempted to the extent those laws unduly interfere with Federal operations and the performance of Federal duties. That includes laws that States and localities might attempt to enforce in civil, criminal, or administrative matters against VA health care professionals acting in the scope of their VA authority and employment and that would prevent those individuals from providing care authorized by 38 U.S.C. 1701, 1710, 1781, 1784A, 7301, and 7310, and VA's implementing regulations. State and local laws, rules, regulations, or requirements are therefore without any force or effect to the extent of the conflict with Federal law, and State and local governments have no legal authority to enforce them in relation to actions by VA employees acting within the scope of their VA authority and employment.

Because all State and local laws, rules, regulations, or requirements that unduly interfere with VA's provision of reproductive health care have no force or effect, there are no actual or possible violations of such laws related to VA programs, operations, facilities, contracts, or information technology systems that would necessitate mandatory reporting by VA employees. 38 CFR 1.201–1.205. This rulemaking confirms VA's authority and discretion to manage its employees concerning the services that will be provided pursuant to this rulemaking.

Next, Executive Order 13132 requires that any regulatory preemption of State law must be restricted to the minimum level necessary to achieve the objectives of the statute pursuant to which the regulations that are promulgated. Under VA's regulations, State and local laws, rules, regulations, or other requirements are preempted only to the extent they unduly interfere with the ability of VA employees to furnish reproductive health care while acting within the scope of their VA authority and employment. Therefore, VA believes that the rulemaking is restricted to the minimum level necessary to achieve the objectives of the Federal statutes.

B. Administrative Procedure Act

The Administrative Procedure Act (APA), codified in part at 5 U.S.C. 553, generally requires that agencies publish substantive rules in the **Federal Register** for notice and comment and provide a 30-day delay before the rules becomes effective. An agency may forgo notice if the agency for good cause finds that compliance would be impracticable, unnecessary, or contrary to the public interest. 5 U.S.C. 553(b)(B). An agency may also bypass the APA's 30-day delay requirement if good cause exists, 5

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U.S.C. 553(d)(3), or if the rule "recognizes an exemption or relieves a restriction," 5 U.S.C. 553(d)(1). The Secretary of Veterans Affairs finds that there is good cause under the provisions of 5 U.S.C. 553(b)(B) to publish this rule without prior opportunity for public comment because it would be impracticable and contrary to the public interest and finds that there is good cause under 5 U.S.C. 553(d)(3) to bypass the 30-day delay requirement. The Secretary also finds that the 30-day delay is inapplicable as this rule is removing restrictions on abortion, in certain, limited circumstances, and on abortion counseling, 5 U.S.C. 553(d)(1).

As discussed at length above, leaving veterans and CHAMPVA beneficiaries without access to abortions and abortion counseling puts their health and lives at risk. Pregnancy and childbirth in the United States can result in physical harm or death to certain pregnant individuals,[32] as pregnant individuals may suffer from life-threatening conditions such as severe preeclampsia, newly diagnosed cancer requiring prompt treatment, and intrauterine infections,[33] and may have pre-existing conditions exacerbated by continuing the pregnancy.[34] In such cases, an abortion may be the only treatment available to save the health or life of the pregnant individual.[35] This is especially relevant because VA serves a population that is particularly vulnerable to adverse pregnancy outcomes. Pregnant veterans and CHAMPVA beneficiaries may be at heightened risk for pregnancy complications including hemorrhage, placenta accreta spectrum, and peripartum hysterectomy, among others.[36] Veterans of reproductive age, in particular, have high rates of chronic medical and mental health conditions that may increase the risks associated with pregnancy.[37] As lack of access to abortions can result in loss of future fertility, significant morbidity, or death, it is critical that veterans and CHAMPVA beneficiaries have access to abortions that are needed to save their lives and preserve their health. 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 that their health care providers can and will take swift and decisive action to provide needed health care.

The ability of veterans and CHAMPVA beneficiaries to receive abortions through VA is especially critical following State attempts to further ban abortion, which put the health and lives of veterans and CHAMPVA beneficiaries at risk.

When VA implemented the exclusion on abortions in the medical benefits package in 1999, veterans and other CHAMPVA beneficiaries had access to abortions in their communities. However, in *Dobbs*, the Supreme Court overruled the constitutional protections recognized in *Roe* and *Casey*. *Dobbs* has had an immediate or near-immediate effect because several States had laws banning abortion that were triggered upon the overruling of *Roe*. *Dobbs* has also led States and localities to consider new restrictions on abortion. As of August 2022, many States appear to be enforcing bans on abortion that do not include, or have limited, exceptions for when the pregnancy is due to rape or incest. Other States have bans on abortions with limited exceptions that are poised to take effect imminently. Additional State legislatures are introducing bans on abortion with limited exceptions. While some State courts have temporarily blocked the implementation of abortion bans, litigation in those States remains ongoing and other State courts have declined to enjoin their State's abortion ban.[38] These developments have made it, and will likely continue to make it, very difficult for many veterans and CHAMPVA beneficiaries to receive needed abortions in their communities. Additionally, ongoing litigation challenging individual State abortion bans causes confusion about where abortion remains legally accessible.[39]

Thousands of veterans and CHAMPVA beneficiaries are or may be impacted by abortion bans and the state of confusion related to where abortion remains legal. 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.[40] VA estimates that over 155,000 veterans ages 18 through 49 are potentially capable of pregnancy, enrolled in VA health care, and live in States that have enacted abortion bans or restrictions. Additionally, VA estimates there are more veterans who may be capable of pregnancy who are eligible for, but are not currently enrolled in or using, VA health care who could also be impacted by current and future abortion bans and restrictions imposed by the State in which they live. Additionally, based on VA data, almost 50,000 CHAMPVA beneficiaries may similarly be impacted.

Thus, State bans and restrictions on abortion present a serious threat to the health and lives of over one hundred thousand veterans and CHAMPVA beneficiaries who currently rely, or may rely in the future, on VA health care. These State laws will have an immediate detrimental impact on the lives and health of veterans and CHAMPVA beneficiaries who are unable to receive the care that was available before State restrictions following the *Dobbs* decision. This detrimental impact is underscored by the potential harmful effects associated with being denied an abortion, when an abortion is needed to protect the life or

[32] Elizabeth G. Raymond & David A. Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 Obstetrics & Gynecology 215, 216 (2012); see also Marian F. MacDorman et al., *Recent Increases in the U.S. Maternal Mortality Rate: Disentangling Trends from Measurement Issues* 128 Obstetrics & Gynecology 447 (2016) (finding a 26.6 percent increase in maternal mortality rates between 2000 and 2014). Victoria L. Meah, et al., *Cardiac output and related haemodynamics during pregnancy: a series of meta-analyses*, Heart J., 102:518–526 (2016).

[33] *Abortions later in Pregnancy*, Kaiser Family Foundation, Dec. 5, 2019. *http://www.kff.org/womens-health-policy/fact-sheet/abortions-later-in-pregnancy/* (last visited Aug. 22, 2022).

[34] Victoria L. Meah, et al., *Cardiac output and related haemodynamics during pregnancy: a series of meta-analyses*, Heart J., 102:518–526 (2016).

[35] *Abortion Can Be Medically Necessary*, Am. College of Obstetricians and Gynecologists, Sep. 25, 2019. *http://www.acog.org/news/news-releases/2019/09/abortion-can-be-medically-necessary* (last visited Aug. 22, 2022).

[36] ACOG Practice Bulletin No. 183, *Postpartum Hemorrhage*, Am. College of Obstetricians and Gynecologists (Oct. 2017); ACOG Obstetric Care Consensus, Placenta Accreta Spectrum (July 2012, reaff'd 2021); ACOG Practice Bulletin No. 198, *Prevention and Management of Obstetric Lacerations at Vaginal Delivery*, Am. College of Obstetricians and Gynecologists (Sept. 2018); ACOG Clinical Consensus No. 1, *Pharmacologic Stepwise Multimodal Approach for Postpartum Pain Management*, Am. College of Obstetricians and Gynecologists (Sept. 2021).

[37] Joan L. Combellick, et al., *Severe Maternal Morbidity Among a Cohort of Post-9/11 Women Veterans*, J Women's Health, 29(4):577–84 (Apr. 2020).

[38] *See, e.g.*, Katie Shepherd, Rachel Roubein, and Caroline Kitchener, *1 in 3 American women have already lost abortion access. More restrictive laws are coming.*, Wash. Post (Aug. 22, 2022, 3:36 p.m.), *http://www.washingtonpost.com/nation/2022/08/22/more-trigger-bans-loom-1-3-women-lose-most-abortion-access-post-roe/*; *see also, e.g.*, Idaho Code Ann. sec. 18–622, 18–622(3)(a)(ii) (prohibiting abortion in all instances, only providing affirmative defenses in case of life or health of pregnant individual); La. Rev. Stat. Ann. sec. 40:1061 (providing limited exception for life or health to abortion prohibition).

[39] *See, e.g.*, Ava Sasani and Emily Cochrane, *'I'm Carrying This Baby Just to Bury It': The Struggle to Decode Abortion Laws*, N.Y. Times (Aug. 19, 2022), *http://www.nytimes.com/2022/08/19/us/politics/louisiana-abortion-law.html*.

[40] *Issue Brief: State Abortion Bans Could Harm Nearly 15 Million Women of Color* Nat'l Partnership for Women & Families (Jul. 2022), *http://www.nationalpartnership.org/our-work/economic-justice/reports/state-abortion-bans-harm-woc.html*.

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health of the pregnant individual, or in cases of rape or incest—as described in prior portions of this preamble.

It is critical that this rule be published and be made effective immediately to ensure pregnant veterans and CHAMPVA beneficiaries have access to this important care. Indeed, delaying the issuance of this rule would increase the risk to their health and lives and put care out of reach for some pregnant veterans and CHAMPVA beneficiaries entirely. Time is also of the essence because, after the *Dobbs* decision, many State laws have prompted providers to cease offering abortion services altogether; thus, many veterans and CHAMPVA beneficiaries would face delays (including travel and wait times) if they were required to obtain, outside the VA, the treatment permitted under this rule. Each day, pregnant patients in the United States, some of whom are veterans or CHAMPVA beneficiaries, find themselves in need of abortion services in accord with generally accepted standards of medical practice. Delaying that care for the time required for notice and comment rulemaking would result in substantial health deterioration and risk the lives of some pregnant veterans and CHAMPVA beneficiaries. Allowing even one preventable death of a veteran or CHAMPVA beneficiary by limiting access to abortions is unacceptable.

For these reasons, the Secretary has concluded that ordinary notice and comment procedures would be impracticable and contrary to the public interest and there is good cause to issue this interim final rule with an immediate effective date. Accordingly, VA is issuing this rule as an interim final rule with an immediate effective date. As noted above, this interim final rule will have a 30-day comment period, after which the Secretary will consider and address the comments received in a subsequent **Federal Register** document announcing a final rule incorporating any changes made in response to the public comments.

C. Executive Orders 12866 and 13563

Executive Orders 12866 (Regulatory Planning and Review) and 13563 (Improving Regulation and Regulatory Review) direct agencies to assess the costs and benefits of available regulatory alternatives and, when regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, and other advantages; distributive impacts; and equity). Executive Order 13563 emphasizes the importance of quantifying both costs and benefits, reducing costs, harmonizing rules, and promoting flexibility. The Office of Information and Regulatory Affairs has determined that this rule is a significant regulatory action under Executive Order 12866. The Regulatory Impact Analysis associated with this rulemaking can be found as a supporting document at *http://www.regulations.gov*.

D. Regulatory Flexibility Act

The Secretary hereby certifies that this rule will not have a significant economic impact on a substantial number of small entities as they are defined in the Regulatory Flexibility Act, 5 U.S.C. 601–12. This is because the rule does not directly regulate or impose costs on small entities and because any effects on small entities will be indirect. On this basis, the Secretary certifies that the adoption of this rule will not have a significant economic impact on a substantial number of small entities as they are defined in the Regulatory Flexibility Act. Therefore, pursuant to 5 U.S.C. 605(b), the initial and final regulatory flexibility analysis requirements of 5 U.S.C. 603 and 604 do not apply to this rule.

E. Unfunded Mandates

The Unfunded Mandates Reform Act of 1995, see 2 U.S.C. 1532, requires that agencies prepare an assessment of anticipated costs and benefits before issuing any rule that may result in the expenditure by State, local, and tribal governments, in the aggregate, or by the private sector, of $100 million or more (adjusted annually for inflation) in any one year. This rule will have no such effect on State, local, and tribal governmeuts, or on the private sector.

F. Paperwork Reductioa Act

This rule contains no provisions constituting a collection of information under the Paperwork Reduction Act of 1995, 44 U.S.C. 3501–21.

List of Subjects in 38 CFR Part 17

Administrative practice and procedure, Alcohol abuse, Alcoholism, Claims, Day care, Dental health, Drug abuse, Foreign relations, Government contracts, Grant programs—health, Grant programs—veterans, Health care, Health facilities, Health professions, Health records, Homeless, Medical and dental schools, Medical devices, Medical research, Mental health programs, Nursing homes, Philippines, Reporting and recordkeeping requirements, Scholarships and fellowships, Travel and transportation expenses, Veterans.

Signing Authority

Denis McDonough, Secretary of Veterans Affairs, approved this document on August 29, 2022, and authorized the undersigned to sign and submit the document to the Office of the Federal Register for publication electronically as an official document of the Department of Veterans Affairs.

Michael P. Shores,

Director, Office of Regulation Policy & Management, Office of General Counsel, Department of Veterans Affairs.

For the reasons stated in the preamble, the Department of Veterans Affairs amends 38 CFR part 17 as follows:

PART 17—MEDICAL

■ 1. The authority citatiou for part 17 continues to read as follows:

Authority: 38 U.S.C. 501, and as noted in specific sections.

■ 2. Amend § 17.38 by revising paragraph (c)(1) to read as follows:

§ 17.38 Medical benefits package.

* * * * *

(c) * * *

(1) Abortions, except when:

(i) The life or the health of the pregnant veteran would be endangered if the pregnancy were carried to term; or

(ii) The pregnancy is the result of an act of rape or incest. Self-reporting from the pregnant veteran constitutes sufficient evidence that an act of rape or incest occurred.

* * * * *

■ 3. Amend § 17.272 by:

■ a. Revising paragraph (a)(64).

■ b. Removing paragraph (a)(65).

■ c. Redesignating current paragraphs (a)(66) through (84) as paragraphs (a)(65) through (83).

The revision reads as follows:

§ 17.272 Benefits limitations/exclusions.

(a) * * *

(64) Abortious, except when:

(i) The life or the health of the pregnant beneficiary would be endangered if the pregnancy were carried to term; or

(ii) The pregnancy is the result of an act of rape or incest. Self-reporting from the pregnant beneficiary constitutes sufficient evidence that an act of rape or incest occurred.

* * * * *

[FR Doc. 2022–19239 Filed 9–8–22; 8:45 am]

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This subsection is also amended to broaden the group of individuals who may act as Deputy Ethics Officials pursuant to delegations from the DAEO. Finally, 38 CFR 0.735–1(b)(2) is amended to include a citation to 5 CFR 2638.104(e) as the existing citation to 5 CFR 2638.204 is outdated.

Administrative Procedure Act

This final rule is a procedural rule that does not impose new rights, duties, or obligations on affected individuals but, rather, explains that the Secretary appoints Agency ethics officials and identifies the employees that may serve as Agency ethics officials. Therefore, it is exempt from the prior notice-and-comment and delayed-effective-date requirements of 5 U.S.C. 553. *See* 5 U.S.C. 553(b)(A) and (d)(3). This rule merely updates information regarding the delegation of Agency ethics officials, the employees who may serve in those roles, and the names of certain offices and employees in the Office of General Counsel.

Paperwork Reduction Act

This final rule contains no provisions constituting a collection of information under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501–3521).

Regulatory Flexibility Act

The initial and final regulatory flexibility analyses requirements of sections 603 and 604 of the Regulatory Flexibility Act, 5 U.S.C. 601–612, are not applicable to this rule because a notice of proposed rulemaking is not required for this rule. Even so, the Secretary hereby certifies that this final rule will not have a significant economic impact on a substantial number of small entities as they are defined in the Regulatory Flexibility Act. This rule will affect only: (1) Office of General Counsel (OGC) and VA employees who serve as Agency ethics officials, and (2) VA employees seeking ethics advice from these Agency ethics officials. Therefore, pursuant to 5 U.S.C. 605(b), the initial and final regulatory flexibility analysis requirements of 5 U.S.C. 603 and 604 do not apply.

Executive Orders 12866, 13563 and 14094

Executive Order 12866 (Regulatory Planning and Review) directs agencies to assess the costs and benefits of available regulatory alternatives and, when regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, and other advantages; distributive impacts; and equity). Executive Order 13563 (Improving Regulation and Regulatory Review) emphasizes the importance of quantifying both costs and benefits, reducing costs, harmonizing rules, and promoting flexibility. Executive Order 14094 (Executive Order on Modernizing Regulatory Review) supplements and reaffirms the principles, structures, and definitions governing contemporary regulatory review established in Executive Order 12866 of September 30, 1993 (Regulatory Planning and Review), and Executive Order 13563 of January 18, 2011 (Improving Regulation and Regulatory Review). The Office of Information and Regulatory Affairs has determined that this rulemaking is not a significant regulatory action under Executive Order 12866, as amended by Executive Order 14094. The Regulatory Impact Analysis associated with this rulemaking can be found as a supporting document at *www.regulations.gov*.

Assistance Listing

There are no Assistance Listing numbers and titles for the programs affected by this document.

Congressional Review Act

Pursuant to Subtitle E of the Small Business Regulatory Enforcement Fairness Act of 1996 (known as the Congressional Review Act) (5 U.S.C. 801 *et seq.*), the Office of Information and Regulatory Affairs designated this rule as not satisfying the criteria under 5 U.S.C. 804(2).

Unfunded Mandates

The Unfunded Mandates Reform Act of 1995 requires, at 2 U.S.C. 1532, that agencies prepare an assessment of anticipated costs and benefits before issuing any rule that may result in the expenditure by State, local, and tribal governments, in the aggregate, or by the private sector, of $100 million or more (adjusted annually for inflation) in any one year. This final rule will have no such effect on State, local, and tribal governments, or on the private sector.

List of Subjects in 38 CFR Part 0

Core Values, Characteristics and Customer Experience Principles of the Department, General Provisions, Standards of Ethical Conduct, and Related Responsibilities of Employees.

Signing Authority

Denis McDonough, Secretary of Veterans Affairs, approved this document on February 26, 2024, and authorized the undersigned to sign and submit the document to the Office of the Federal Register for publication electronically as an official document of the Department of Veterans Affairs.

Consuela Benjamin,

Regulations Development Coordinator, Office of Regulation Policy & Management, Office of General Counsel, Department of Veterans Affairs.

For the reasons set out in the preamble, the Department of Veterans Affairs amends 38 CFR part 0 as follows:

PART 0—VALUES, STANDARDS OF ETHICAL CONDUCT, AND RELATED RESPONSIBILITIES

■ 1. The authority citation for part 0 continues to read as follows:

Authority: 5 U.S.C. 301; 38 U.S.C. 501; see sections 201, 301, and 502(a) of E.O. 12674, 54 FR 15159, 3 CFR, 1989 Comp., p. 215 as modified by E.O. 12731, 55 FR 42547, 3 CFR, 1990 Comp., p. 306.

■ 2. Amend § 0.735–1 by revising paragraphs (a), (b)(1), and (b)(2) to read as follows:

§ 0.735–1 Agency ethics officials.

(a) *Designated Agency Ethics Official (DAEO).* The Secretary will designate attorneys from the Office of General Counsel to serve as the Designated Agency Ethics Official (DAEO) and Alternate Designated Agency Ethics Official (ADAEO).

(b) * * *

(1) The District Chief Counsels and attorneys on the Ethics Specialty Team are Deputy Ethics Officials. They have been delegated the authority to act for the DAEO pursuant to 5 CFR 2638.104(e).

(2) Other officials may also act as Deputy Ethics officials pursuant to delegations of one or more of the DAEO's duties from the DAEO.

[FR Doc. 2024–04442 Filed 3–1–24; 8:45 am]

BILLING CODE 8320–01–P

DEPARTMENT OF VETERANS AFFAIRS

38 CFR Part 17

RIN 2900–AR57

Reproductive Health Services

AGENCY: Department of Veterans Affairs.

ACTION: Final rule.

SUMMARY: The Department of Veterans Affairs (VA) is finalizing, without changes, an interim final rule that amended VA's medical regulations to remove the exclusion on abortion counseling in the medical benefits package; establish exceptions to the exclusion on abortions for veterans who

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receive care set forth in that package; and remove the exclusion on abortion counseling and expand the exceptions to the exclusion on abortions for Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) beneficiaries.

DATES: This rule is effective April 3, 2024.

FOR FURTHER INFORMATION CONTACT: Dr. Shereef Elnahal, Under Secretary for Health, Department of Veterans Affairs, 810 Vermont Avenue NW, Washington, DC 20420, (202) 461–0373.

SUPPLEMENTARY INFORMATION: In an interim final rule (IFR) published in the **Federal Register** (FR), VA amended its medical regulations to remove the exclusion on abortion counseling in the medical benefits package; establish exceptions to the exclusion on abortions for veterans who receive care set forth in that package; and remove the exclusion on abortion counseling and expand the exceptions to the exclusion on abortions for Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) beneficiaries. 87 FR 55287 (September 9, 2022).

VA provided a 30-day comment period on the IFR, which ended on October 11, 2022. VA received 57,901 comments, many of which were supportive of the IFR. The vast majority of the comments were a type of duplicated form response, where some requested clarifications or suggested changes to the IFR, and others merely expressed support or requested the IFR be rescinded without suggested clarifications or changes. VA summarizes and addresses all topics raised in relevant and significant comments below, but VA does not address any supportive comments below that did not also request clarifications or suggest substantive revisions.

I. Comments That Asserted VA Does Not Have Authority To Promulgate or Implement the IFR

Many commenters asserted that VA does not have the legal authority to promulgate or implement the IFR, most of which provided few details to explain their assertions. Other commenters cited to specific laws that they asserted conflicted with VA's provision of the health care services permitted by the IFR. VA addresses these comments below.

A. General Assertions of Lack of Authority

Many comments asserted that VA should rescind the IFR because VA has a longstanding policy regarding abortion and does not have the authority to impose the IFR in a manner that violates this policy. These comments generally assert that VA does not have authority to either promulgate or implement the IFR to remove the restriction on abortion counseling and create exceptions for abortions in certain circumstances in §§ 17.38 and 17.272 of title 38, Code of Federal Regulations (CFR).

VA does not make any changes to the rule and does not rescind the IFR based on these comments. As indicated in the IFR (see 87 FR 55288–55290), pursuant to VA's general treatment authority for veterans, VA "shall furnish" specified veterans with "hospital care and medical services which the Secretary determines to be needed." Section 1710(a)(1)–(2) of title 38, United States Code (U.S.C.). For veterans not described in paragraphs (1) and (2), the Secretary "may," subject to certain limitations, "furnish hospital care" and "medical services . . . which the Secretary determines to be needed," 38 U.S.C. 1710(a)(3). Such "medical services" include "medical examination, treatment," "[s]urgical services," and "[p]reventive health services." 38 U.S.C. 1701(6). VA implements its general treatment authority, and the Secretary determines what care is "needed," 38 U.S.C. 1710(a)(1)–(3), by regulation through VA's medical benefits package. 38 CFR 17.38. Care included in the medical benefits package is "provided to individuals only if it is determined by appropriate health care professionals that the care is needed to promote, preserve, or restore the health of the individual and is in accord with generally accepted standards of medical practice." 38 CFR 17.38(b). VA has determined that the health care services permitted under the IFR are "needed" within the meaning of VA's general treatment authority, 38 U.S.C. 1710, if an appropriate health care professional determines that such care is needed to promote, preserve, or restore the health of the individual and is in accord with generally accepted standards of medical practice. 38 CFR 17.38(b). Although VA previously did not have any exceptions to the exclusion on abortion in the medical benefits package, VA's authority as described above permits it to amend the medical benefits package through regulation. VA can therefore provide the health care services permitted under the IFR to veterans pursuant to 38 U.S.C. 1710 and 38 CFR 17.38. Similarly, VA has determined that providing access to such care is medically necessary and appropriate to protect the health of CHAMPVA beneficiaries. *See* 38 U.S.C. 1781; 38 CFR 17.270(b) (defining "CHAMPVA-covered services and supplies" as "those medical services and supplies that are medically necessary and appropriate for the treatment of a condition and that are not specifically excluded under [38 CFR 17.272(a)(1)] through (84)").

Several commenters suggested that the IFR usurps Congressional authority. Other commenters stated that VA is unable to provide the health care services permitted under the IFR because Congress has not funded them specifically, or that VA should not use taxpayer money to provide the health care services permitted under the IFR because VA does not have the legal right to do so, and it is contrary to the wishes of taxpayers. VA does not make changes to the rule based on these comments. The IFR did not usurp Congressional authority. VA, similar to other agencies in the Executive Branch, has the authority to promulgate regulations to interpret and implement laws passed by Congress, and such regulations may have the force and effect of law. In this instance, the IFR was promulgated and implemented pursuant to statute. 38 U.S.C. 1710, 1781; *see also id.* 501. VA does not receive separate appropriations for individual medical services, but instead receives appropriations generally for authorized services. While some taxpayers may disagree with this use of Federal funds, VA is authorized to provide and pay for care that is needed for veterans and medically necessary and appropriate for CHAMPVA beneficiaries.

B. Specific Assertions of Lack of Authority or Conflicting Authority

1. Lack of Authority Under 38 U.S.C. 1710

Commenters asserted that VA's interpretation of 38 U.S.C. 1710 to provide access to health care services permitted under the IFR was unsupported because the text of 38 U.S.C. 1710 does not expressly include these services and because VA has not previously invoked or construed 38 U.S.C. 1710 as authority for provision of these services. VA does not make changes to the rule based on these comments. The commenters' assertions regarding the text of 38 U.S.C. 1710 overlook that the terms "hospital care" and "medical services" as used in 38 U.S.C. 1710 are further defined in 38 U.S.C. 1701(5) and (6). As relevant here, "hospital care" is defined to include "medical services rendered in the

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course of hospitalization of any veteran'' and ''medical services'' is defined to include ''medical examination, treatment, and rehabilitative services,'' ''[s]urgical services,'' and ''[p]reventive health services'' (38 U.S.C. 1701(5) and (6)). The definitions of ''hospital care'' and ''medical services'' in 38 U.S.C. 1701(5) and (6) do not list more specific types of care or services. And, in describing categories of hospital care and medical services, 38 U.S.C. 1701 and 1710 do not enumerate every conceivable or commonly prescribed care or service, whether such care or service involves specific care or services such as abortion, prescription drugs, or completion of specific medical forms such as life insurance applications. Rather, such care and services are generally described in the VA medical benefits package codified in 38 CFR 17.38(a).

The medical benefits package consists of a wide range of basic and preventive care, including inpatient and outpatient medical and surgical care, prescription drugs, emergency care, pregnancy and delivery services, and periodic medical exams. 38 CFR 17.38(a). Whether hospital care or medical services under the medical benefits package are considered needed are determinations that 38 U.S.C. 1701 and 1710 leave to the Secretary's discretion. See 38 U.S.C. 1710(a)(1) (''The Secretary . . . shall furnish hospital care and medical services which the Secretary determines to be needed[.]''). The Secretary can include or exclude care in the medical benefits package based on whether the Secretary determines that care is ''needed'' within the meaning of 38 U.S.C. 1710(a)(1)–(3). 38 CFR 17.38(c).

After the Supreme Court issued its decision in *Dobbs* v. *Jackson Women's Health Organization*, 142 S. Ct. 2228 (2022), veterans living in States that ban or restrict abortions may no longer be able to receive needed medical services in their communities as a result of State restrictions. It is thus essential for the lives and health of our veterans that abortions be made available if determined needed by a health care professional when: (1) the life or health of the pregnant veteran would be endangered if the pregnancy were carried to term; or (2) the pregnancy is the result of an act of rape or incest.

Additionally, the commenters' assertions that VA has never previously invoked its authority under 38 U.S.C. 1710 to authorize the provision of abortions are incorrect. Before the regulatory promulgation of the medical benefits package in 1999, which excluded the health care services permitted under the IFR, VA policy authorized the provision of certain abortions. VHA Policy, Manual M–2, Professional Services Part XIV, Surgical Service, Change 27, paragraph 9.02a (July 26, 1977, partial rescission, expired on Jan. 7, 1999) (authorizing ''therapeutic . . . abortion as a proper treatment'' in some circumstances pursuant to the procedures described therein). This was permitted under VA's authority to provide hospital care and medical services under 38 U.S.C. 1710 and 38 U.S.C. 1712 (former medical services authority), respectively. As explained in the IFR, VA did not explain the rationale behind the exclusion of abortions and abortion counseling from the medical benefits package when it was established in 1999, but at the time, *Roe* v. *Wade*, 410 U.S. 113 (1973) had been reaffirmed in relevant part by *Casey*, and VA was aware that veterans could access abortions in their communities. 87 FR 55288. Following the *Dobbs* decision, States began to ban or restrict abortion services and veterans living in those States were losing access to such medical care. *Id.* Thus, VA explained in the IFR that this policy change was essential for the lives and health of the veterans that VA serves. *Id.*

VA makes no changes to the rule based on the assertions raised in these comments, as discussed above.

In support of the claim that 38 U.S.C. 1710 does not authorize VA's provision of the health care services permitted under the IFR, some commenters cited to testimony presented during a June 2022 legislative hearing before the House of Representatives Veterans Affairs Committee Subcommittee on Health and minutes from an August 2019 meeting of the Advisory Committee on Women Veterans. VA makes no changes to the rule based on this comment.

Neither the testimony presented during the June 2022 legislative hearing before the House of Representatives Veterans Affairs Committee Subcommittee on Health nor the minutes from the August 2019 meeting of the Advisory Committee on Women Veterans suggests that VA lacks authority under 38 U.S.C. 1710 to provide the health care services permitted under the IFR. The passage that the commenter cites from the Advisory Committee on Women Veterans meeting minutes refers to language from page 20 of the August 2019 Advisory Committee on Women Veterans meeting minutes, which refers to an update on the Committee's recommendation that VA pursue a regulatory change to remove the exclusion of abortions in cases of threat to the life of the mother, sexual assault, and incest from the medical benefits package. The minutes state:

> VA has declined the ACWV's recommendation and will not change the medical benefits package regulations to remove the exclusion of abortions and abortion counseling services. VA believes that Congress, as the representatives of the will of the American people, must take the lead on this sensitive and divisive issue. VA will take no further action on the matter without a legal mandate, and will work with the House Veterans Affairs Committee to provide technical assistance on related legislation.

VA has never indicated that it lacks statutory authority to include abortion counseling and abortions in its medical benefits package in a circumstance in which the VA Secretary determined that such care was needed. And notably, VA made this statement in response to ACWV's recommendations before the Supreme Court issued its decision in *Dobbs*.

In addition, during the June 2022 legislative hearing, VA was discussing a single, standalone bill, H.R. 345, that would have overridden VA's regulatory exclusion of abortion counseling by requiring the Department to provide this service to a veteran as appropriate. VA stated, ''[T]he bill would not authorize VA to provide abortions; it would only allow VA to provide patient education.'' This statement does not mean that VA otherwise lacks authority to provide abortions, merely that VA was providing testimony on a legislative measure that, if enacted, would have only overridden VA's then-exclusion of abortion counseling codified in VA regulations. VA also notes that such legislative discussions in 2022 do not provide a basis to narrowly construe the scope of VA's pre-existing statutory authority. *See, e.g., Bostock* v. *Clayton Cnty., Georgia*, 140 S. Ct. 1731, 1747 (2020) (''[S]peculation about why a later Congress declined to adopt new legislation offers a 'particularly dangerous' basis on which to rest an interpretation of an existing law a different and earlier Congress did adopt.'' (citing *Pension Benefit Guaranty Corporation* v. *LTV Corp.*, 496 U.S. 633, 650 (1990))).

One commenter, in further support of the assertion that VA did not have legal authority to issue the IFR, cited recent Supreme Court case law to argue that Federal agencies exceed their statutory authorities when they purport to find novel powers in long extant Federal statutes. *West Virginia* v. *Environmental Protection Agency*, 142 S. Ct. 2587 (2022); *National Federation of Independent Business* v. *Dept. of Labor*,

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142 S. Ct. 661 (2022). But those cases are inapposite because, as discussed, clear statutory authority supports this rulemaking. Pursuant to VA's general treatment authority provided by Congress, VA "shall furnish" specified veterans with "hospital care and medical services which the Secretary determines to be needed." 38 U.S.C. 1710(a)(1)–(2). For other veterans, the Secretary "may," subject to certain limitations, "furnish hospital care" and "medical services . . . which the Secretary determines to be needed." 38 U.S.C. 1710(a)(3). VA issued the IFR because the Secretary determined that it is "essential for the lives and health of our veterans that abortions be made available if determined needed by a health care professional when: (1) the life or health of the pregnant veteran would be endangered if the pregnancy were carried to term; or (2) the pregnancy is the result of an act of rape or incest." 87 FR 55288. The Secretary also determined that "abortion counseling is needed so that veterans can make informed decisions about their health care." *Id.* at 55292. The Secretary thus "determined that such medical care is 'needed' within the meaning of VA's general treatment authority," which "means that such care may be provided if an appropriate health care professional determines that such care is needed to promote, preserve, or restore the health of the individual and is in accord with generally accepted standards of medical practice." *Id.* at 55288. *See also* 38 U.S.C. 1781(a); 38 CFR 17.270(b); 87 FR 55290–92 (discussing the VA Secretary's authority and determinations regarding CHAMPVA beneficiaries).

The Secretary has previously exercised authority under 38 U.S.C. 1710 to amend 38 CFR 17.38 to add new services to the medical benefits package services. For example, VA added to the medical benefits package pregnancy and delivery services to the extent authorized by Federal law. See 64 FR 54217. VA also added newborn care as a service provided under the medical benefits package. See 76 FR 78569. Such care was authorized pursuant to 38 U.S.C. 1710 and 1786.

The decisions the commenter cites also are distinguishable because, as discussed above, this is not the first time that VA has relied on relevant statutory authority in this manner. As stated before, VA policy authorized the provision of certain abortions. VHA Policy, Manual M–2, Professional Services Part XIV, Surgical Service, Change 27, paragraph 9.02a. (July 26, 1977, partial rescission, expired on Jan. 7, 1999)) (authorizing "therapeutic . . . abortion as a proper treatment" in some circumstances pursuant to the procedures described therein).

The determination not to continue this medical service when the medical benefits package regulation was established in 1999 was based on a VA policy decision, not because VA's general treatment authority did not cover this medical service. Indeed, the fact that abortion was specifically excluded from the medical benefits package under 38 CFR 17.38(c) makes clear that VA has long held the position that abortion and abortion counseling is medical care that the Secretary is statutorily authorized, pursuant to his discretion, to include in the medical benefits package under § 17.38(a). Although VA maintained the exclusion on abortion care starting from the effective date of the medical benefits package in 1999 until 2022, as stated in the preamble to the IFR, Congress has authorized VA to amend its medical benefits package when the Secretary determines such change is warranted. Contrary to the commenter's assertion, VA's reading of 38 U.S.C. 1710 is not novel but supported by past readings of VA's medical care treatment authority; the commenter's cited case law is thus not applicable to this rulemaking. VA makes no changes to the rule based on this comment.

2. Conflict With Section 106 of the Veterans Health Care Act of 1992

Many commenters generally stated that the IFR violates section 106 of the Veterans Health Care Act of 1992 (VHCA), Public Law (Pub. L.) 102–585, 106 Stat. 4943, and that therefore VA should rescind the IFR. VA does not make any changes to the rule or rescind the IFR based on these comments. As explained in the preamble to the IFR, the VHCA barred the provision of abortion, infertility, and much of prenatal and delivery care but only under section 106 of the VHCA. It did not limit VA's authority to provide such services under any other statutory provision such as 38 U.S.C. 1710 or 38 U.S.C. 1712. Public Law 102–585, sec. 106(a). *See* 87 FR 55288–289. Moreover, in 1996, the Veterans' Health Care Eligibility Reform Act effectively overtook section 106 of the VHCA by enacting major changes to eligibility for VA health care, including by amending 38 U.S.C. 1710, and directing VA to establish a system of patient enrollment to manage the provision of care. *See* 87 FR 55289. The purpose behind eligibility reform was to replace the old system with a system where an enrolled veteran could receive whatever medical care and services are deemed needed. *See* House of Representatives Report No. 104–690, at 4 (1996). Consequently, for decades, VA has offered general pregnancy care and certain infertility services under 38 U.S.C. 1710, despite the VHCA's prohibition on providing such services under section 106. *Id.* VA has not relied on section 106 of the VHCA to provide such services or any other services.

Other commenters more specifically asserted that section 106 of the VHCA was still operable to prohibit abortion in VA health care programs, and provided more specific supporting rationale, as addressed below.

a. General Versus Specific Canon of Statutory Construction

Some commenters asserted that, under traditional rules of statutory construction, the more specific and targeted treatment of abortion in section 106 of the VHCA governs over the more general treatment of health care in the Veterans Health Care Eligibility Reform Act of 1996 and 38 U.S.C. 1710. As further explained below, this canon of construction is applicable when two statutory provisions are in conflict, but section 106 does not conflict with VA's authority to provide abortions under other statutory provisions such as 38 U.S.C. 1710 and 1712 (former medical services authority). Consequently, the focus of commenters on the general versus specific canon is mistaken, and VA does not make changes to the rule based on these comments.

By its plain terms, section 106 of the VHCA does not circumscribe the Secretary's authority to determine what hospital care and medical services are needed under 38 U.S.C. 1710. Section 106 affirmatively authorized VA to provide certain healthcare services to women, including "[g]eneral reproductive health care," but provided that this authorization for general reproductive health care did "not includ[e] *under this section* infertility services, abortions, or pregnancy care (including prenatal and delivery care), except for such care relating to a pregnancy that is complicated or in which the risks of complication are increased by a service-connected condition." (emphasis added). The phrase "under this section" means that while section 106 bars the provision of any abortion or infertility or general pregnancy services under section 106 of the VHCA, it does not limit VA's authority to provide such services under any other statutory provision, such as VA's general treatment authority, 38 U.S.C. 1710. *See, e.g., Intergovernmental Immunity for the Department of Veterans Affairs and Its Employees*

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When Providing Certain Abortion Services, 46 Op. O.L.C., __, at *1, 7–8 (Sept. 21, 2022), *https://www.justice.gov/d9/2022-11/2022-09-21-va_immunity_for_abortion_services.pdf* (noting that the IFR represented a reasonable exercise of the VA Secretary's discretion to provide medical services).

Accordingly, the commenters' reliance on the "general/specific canon" is misplaced. Moreover, as the Supreme Court has acknowledged, the general/specific canon is not an absolute rule and can be overcome by textual indications that point to the general and specific provisions coexisting, rather than the specific governing the general. *See RadLAX Gateway Hotel* v. *Amalgamated Bank*, 566 U.S. 639, 646 (2012). In this case, section 106 specifies that abortions cannot be provided "under this section" of the VHCA, but it does not prohibit VA from providing abortions under other statutory provisions such as 38 U.S.C. 1710 and 1712 (former medical services authority).

VA's interpretation of section 106 in this respect has been long-standing. VA has never interpreted section 106 to prohibit the Department from providing health care under other statutory authorities. For example, as discussed above, VA continued to provide certain abortions as well as therapeutic surgical sterilizations, a type of infertility treatment, after the passage of section 106 and until promulgation of the final rule establishing VA's medical benefits package in October of 1999. *See* VHA Policy, Manual M–2, Professional Services Part XIV, Surgical Service, Change 27, paragraph 9.02a. (July 26, 1977, partial rescission, expired on Jan. 7, 1999) (authorizing "therapeutic . . . abortion as a proper treatment" in some circumstances pursuant to the procedures described therein).

A VA policy published in 1993 also demonstrates this long-standing interpretation of section 106. With VA's increased focus on health services available for women veterans, VA published VHA Directive 10–93–151, Health Care Services for Women Including General Reproductive Health Care for Women Veterans under tbe Women Veterans Health Program Act of 1992 (Pub. L. 102–585) (dated Dec. 6, 1993, rescinded Dec. 29, 1994). In para. 2.b. of this 1993 policy, VA squarely addressed section 106's relation to other treatment laws. Specifically, VA explained that the exclusions from "general reproductive healthcare" (set forth in section 106(a)(3)) "do not constitute a ban on the Secretary's authority to provide infertility or abortion services as otherwise authorized under 38 United States Code (U.S.C.) Chapter 17." It also explained how the authorities granted in section 106 "are not new," as VA medical centers "have provided cancer screening to women for some time," and it further described how "general reproductive health care" is "within the purview of gynecology." To this point, when later issuing the medical benefits package, VA included, within covered basic care, infertility services (such as reverse voluntary sterilization and infertility services other than in vitro fertilization) because they meet the criteria for inclusion, *i.e.*, "care that is determined by appropriate healthcare professionals to be needed to promote, preserve, or restore the health of the individual and to be in accord with generally accepted standards of medical practice." 64 FR 54207, 54210.

Similarly, VA has provided some infertility services (excluding in vitro fertilization (IVF) pursuant to 38 CFR 17.38(c)(2)) and pregnancy-related services under 38 U.S.C. 1710 for decades. See 87 FR 55289; see also 64 FR 54210; VHA Directive 10–93–151, December 6, 1993. Section 106 excludes "infertility services" and "pregnancy care" in addition to "abortion" from care provided under section 106. (We note that section 106 does not further define these terms.) Commenters' reliance on section 106 to object to VA's addition of abortion to care provided under 38 U.S.C. 1710 overlooks VA's longstanding provision of infertility services (excluding IVF) and pregnancy-related services under 38 U.S.C. 1710, which shows that section 106 does not limit VA's other healthcare authorities. And VA has long recognized that a veteran could be eligible for certain infertility services (excluding IVF) for a service-connected disability under (former) 38 U.S.C. 1712 (former authority under which outpatient medical services were provided prior to 1996), even though that veteran would have been ineligible for infertility services under section 106 of the VHCA. 87 FR 55289.

The IFR explained that Congress enacted the VHCA at a time when "VA health care was subject to a patchwork of eligibility criteria, and care was largely linked only to service-connected conditions," and how "[t]he VHCA, in relevant part, was designed to improve the health care services available to women veterans." 87 FR 55288–89. Section 106 of the VHCA, however, was effectively overtaken by a subsequent statutory and regulatory overhaul of VA's medical benefits system, which extended eligibility for hospital care and medical services. The Veterans' Health Care Eligibility Reform Act of 1996 established a system in which an eligible veteran could receive whatever medical care and services the Secretary determines are "needed." 38 U.S.C. 1710; *see, e.g.*, H.R. Rep. No. 104–690, at 4 (1996); *see also id.* ("While the new standard is a simple one, more importantly, it employed a clinically appropriate 'need for care' test, thereby ensuring that medical judgment rather than legal criteria will determine when care will be provided and the level at which that care will be furnished."); *id.* at 13 ("[The Act] would substitute a single, streamlined eligibility provision—based on clinical need for care—for the complex array of disparate rules currently governing veterans' eligibility for hospital and outpatient care."). As explained in the IFR, "[t]he Veterans' Health Care Eligibility Reform Act effectively overtook section 106 of the VHCA," and "section 106's prohibition on providing certain services 'under this section' simply is no longer operative." 87 FR 55289–90.

b. VA's Interpretation of the Phrase "But Not Including Under This Section" in Section 106 of VHCA

Some commenters further asserted that VA's interpretation of the phrase "but not including under this section" in section 106 of the VHCA, as reiterated in the IFR (87 FR 55289), was invalid, arguing that such language does not limit abortion restrictions to only that healthcare for women veterans that was provided under section 106. In support of this assertion, the commenters proffered that certain prefatory language in section 106(a) qualifies the "under this section" language in section 106(a)(3) such that the exclusion on abortions there must be read to apply to all hospital care and medical services under chapter 17 of title 38.

VA does not make changes to the rule based on these comments, which misunderstand VA's statutory authority. The VHCA, in relevant part, was designed to improve the health care services available to women veterans. 102 Cong. Rec. 32,367 (1992). Section 106(a) of the VHCA stated that "[i]n furnishing hospital care and medical services under chapter 17 of title 38, United States Code,"—prefatory language applicable to all of section 106—VA could provide "women" with "[p]apanicolaou tests (pap smears)," "[b]reast examinations and mammography," and "[g]eneral reproductive health care . . . , but not including under this section infertility services, abortions, or pregnancy care

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(including prenatal and delivery care), except for such care relating to a pregnancy that is complicated or in which the risks of complication are increased by a service-connected condition.'' Public Law 102–585, sec. 106(a).

As explained above, the VHCA has heen effectively overtaken hy laws that Congress has subsequently enacted. But even taking section 106 on its own terms, the commenters' interpretation of section 106(a)'s prefatory language would render the important ''under this section'' qualifier in section 106(a)(3) a nullity, contrary to longstanding precedent. *Nat'l Ass'n af Mfrs.* v. *Dep't of Def.,* 583 U.S. 109, 128–29 (2018) (''As this Court has noted time and time again, the Court is 'obliged to give effect, if possible, to every word Congress used.' '' (quoting *Reiter* v. *Sonotone Corp.,* 442 U.S. 330, 339 (1979)). If section 106(a)'s prefatory language precluded VA from providing abortion care under its other statutory authorities, then section 106(a)(3)'s ''under this section'' qualifier would be ''a dead letter.'' *United States* v. *Atl. Rsch. Corp.,* 551 U.S. 128, 137 (2007). By contrast, VA's longstanding interpretation of section 106 faithfully reads the statute ''as a whole.'' *Id.* at 135 (quoting *King* v. *St. Vincent's Hospital,* 502 U.S. 215, 221 (1991)). In addition, VA finds support for this in the legislative history accompanying the enactment of section 106. See Joint Explanatory Statement on H.R. 5193, 1992 U.S.C.C.A.N. 4186, 4189–90 (noting ''[t]he inclusion of the phrase 'nnder this section' underscores the intent of the Committees not to limit such anthority as the Secretary may have to provide any infertility services under Chapter 17.''). As explained, moreover, the commenters' interpretation is inconsistent with the plain meaning (and VA's decades-long interpretation) of the phrase ''under this section.''

c. VA's Furnishing of In-Vitro Fertilization Services

Commenters asserted that section 106 of the VHCA remains in effect to prohibit VA from furnishing the health care services permitted under the IFR, citing as evidence the proposition that VA required a special amendment, the ''Mnrray Amendment,'' to carve out an exception from section 106 of the VHCA so that VA could provide IVF services. The Murray Amendment is a reference to section 260 of Public Law 114–223, Division A, title II, enacted on September 29, 2016, and renewed in subsequent fiscal years. Section 260(a)(1) of Public Law 114–223 provides, notwithstanding any other provision of law, that the amounts appropriated or otherwise made available to VA for the Medical Services account may be used to provide fertility counseling and treatment using assisted reproductive technology to a covered veteran or the spouse of a covered veteran, subject to certain statutory and regulatory limitations.

VA does not make changes to the rule based on these comments. VA disagrees with the commenters' assertion that independent authority to provide IVF care was needed to supersede section 106. The Murray Amendment established new authority to provide fertility connseling and treatment nsing assisted reproductive technology not only to a covered veteran but also to the spouse of a covered veteran. It was needed because 38 U.S.C. 1710 does not extend, and never has extended, to a veteran's spouse. See 38 U.S.C. 1710 (referring only to veterans) and 38 U.S.C. 1781 through 1789 (VA's statutory authorities to provide health care to persons other than veterans, which do not extend IVF care to non-veterans). Independent authority was needed to authorize VA to also include the spouses of covered veterans in the VA-furnished IVF episode of care. But the Murray Amendment was not necessary to enable VA to provide infertility services to the veterans themselves under 38 U.S.C. 1710. And as explained above, section 106 has no impact on VA's authority to provide medical services pursuant to section 1710 or any statutory authority other than section 106 itself. In short, the Murray Amendment did not and does not inplicate section 106 of the VHCA.

d. Effect of Deborah Sampson Act of 2020

Some commenters asserted that section 106 of the VHCA must prohibit VA from furnishing the health care services permitted under the IFR becanse the Deborah Sampson Act of 2020 (Pnb. L. 116–315, title V, subtitle A) defined ''health care'' as ''the health care and services included in the medical benefits package provided by the Department before January 5, 2021,'' sec. 5101 of Pnblic Law 116–315, and on January 4, 2021, the health care and services included in tho medical benefits package provided by the Department did not include abortion or abortion counseling. The commenters argued that Congress thus approved of the exclusion of abortion and abortion counseling.

VA does not make changes to the rule based on these comments. The IFR explained that the Deborah Sampson Act of 2020, Public Law 116–315, title V, section 5001 (2021) ''created a central office to, inter alia, 'monitor[ ] and encourag[e] the activities of the Veterans Health Administration with respect to the provision, evaluation, and improvement of health care services provided to women veterans by the Department.' '' 87 FR 55289 (quoting 38 U.S.C. 7310(b)(1)) (alterations in original). Congress defined ''health care'' for these purposes as ''the health care and services included in the medical benefits package provided by the Department as in effect on the day before the date of the enactment of this Act [Jan. 5, 2021].'' *Id.* (quoting 38 U.S.C. 7310 note). At the time, the medical benefits package included (and still includes) care that would have been excluded under the commenters' interpretation of section 106 of the VHCA, such as prenatal and delivery services.

The IFR stated that ''[gliven that VA's medical benefits package as of that date included services that were excluded from the coverage of Section 106 of the VHCA, Congress ratified VA's interpretation that it may provide for these services pursuant to its authority under 38 U.S.C. 1710, notwithstanding section 106. Indeed, the fact that the Deborah Sampson Act of 2020 did not reference section 106 of the VHCA and only referenced VA's medical benefits package shows that Congress did not interpret section 106 of the VHCA as a limitation on VA's authority to provide care to 'women veterans.' '' 87 FR 55289.

Contrary to the commenter's assertioo, the fact that VA had not, in its discretion, exercised its authority at the time of the Act to provide abortions or make exceptions to the regulatory exclusion on abortion does not mean that VA lacks statutory authority under 38 U.S.C. 1710 to determine that abortions in some cases constitute needed care and to accordingly amend its exclusion by regulation. As VA explained in the IFR, the Deborah Sampson Act of 2020 recognized 38 U.S.C. 1710 as a separate treatment authority unaffected and not limited by section 106. In fact, the terms of 38 U.S.C. 7310A(g)(2) as added by the Deborah Sampson Act of 2020 define, for purposes of VA's annual reporting requirement, gender-specific services to include: ''mammography, obstetric care, gynecological care, and such other services as the Secretary determines appropriate,'' some of which VA would not have authority to provide ''under the commenters' interpretation of section 106. *See also supra* I.B.2. Thns, section 106 and its limits on certain care under section 106 of Public Law 102–

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585 were clearly not seen by Congress in promulgating the Deborah Sampson Act of 2020 as having any effect on VA's exercise of authority under 38 U.S.C. 1710.

Nothing in the Deborah Sampson Act of 2020 prohibits VA from removing exclusions from the medical benefits package under 38 U.S.C. 1710. VA recognizes that 38 U.S.C. 7310, Note, (Pub. L. 116–315, title V, section 5101(b)(2)) provides that: "The references to health care and the references to services in sections 7310 and 7310A of title 38, United States Code, as added by paragraph (1), are references to the health care and services included in the medical benefits package provided by the Department as in effect on the day before the date of the enactment of this Act [Jan. 5, 2021]." Congress did not, through that language, freeze in place the types of medical services that VA is authorized to provide under its general treatment authorities. Section 7310 of title 38, U.S.C. relates to the establishment of the Office of Women's Health within VHA and its mission, and 38 U.S.C. 7310A relates to annual reports on Women's Health to be submitted to Congress. Nothing in either statute prohibits VA from expanding the medical benefits package or services or from providing additional information beyond what is required under 38 U.S.C. 7310 and 7310A. And these sections impose no limits on VA's general treatment authority in 38 U.S.C. 1710.

To the contrary, some of the functions of the Office of Women's Health set forth in 38 U.S.C. 7310(b) are to promote the expansion and improvement of clinical activities of VHA with respect to the health care of women veterans and to carry out such other duties as the Under Secretary for Health may require. On its face, the function of the Office to "expand and improve" clinical activities of VHA contemplates VA's authority to modify the medical benefits package to include additional services with respect to the health care of women veterans.

e. Repeal of Section 106 of the VHCA

Some commenters asserted that section 106 has not been expressly repealed and further that repeals by implication are not favored, citing *Branch* v. *Smith*, 538 U.S. 254, 273 (2003), and *Posadas* v. *National City Bank*, 296 U.S. 497 (1936). VA does not make any changes to the rule based on these comments.

At the outset, VA notes that this issue is immaterial because, even if section 106 remained in force, it would not constrain VA's authority to provide services (whether abortions, prenatal care, or other services) limited under section 106 but authorized under other statutory provisions such as 38 U.S.C. 1710 and former 38 U.S.C. 1712. Rather, the limitation in section 106 regarding care "under this section" applies only to section 106.

Regardless, VA disagrees with commenters that section 106 remains in force. As discussed above and in the preamble to the IFR, the Veterans' Health Care Eligibility Reform Act effectively overtook section 106 of the VHCA by establishing a new standard to focus on medical necessity as "the sole criterion of eligibility for VA hospital care and medical services." [1] The "need for care" test was meant to 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." [2] To the extent the commenters would construe section 106 of the VHCA to restrict VA's authority to provide a specific type of health care or service under separate statutory authorities, regardless of a finding of medical need, that restriction would irreconcilably conflict with VA's furnishing of any needed health care or services under 38 U.S.C. 1710. Indeed, for decades, VA has offered general pregnancy care and certain infertility services under 38 U.S.C. 1710 and has not relied on section 106 of the VHCA to provide such services or any other services.

3. Conflict With State Laws

Many commenters generally opined that the IFR violates State laws. VA does not make changes to the rule based on these comments.

The Supremacy Clause of the U.S. Constitution, U.S. Const. art. VI, cl. 2., generally prohibits States from interfering with or controlling the operations of the Federal government, and therefore immunizes the Federal government from State laws that directly regulate it. "[W]hen a federal agency 'perform[s] a federal function pursuant to a law validly enacted by Congress[,] . . . under the Supremacy Clause, the states may not prohibit or, by regulation, significantly burden the manner of its execution without the consent of the United States.'" *Intergovernmental Immunity for the Department of Veterans Affairs and Its Employees When Providing Certain Abortion Services*, 46 Op. O.L.C., __, at *4 (Sept. 21, 2022), *https://www.justice.gov/d9/2022-11/2022-09-21-va_immunity_for_abortion_services.pdf*. Applying this principle to VA's IFR, the Department of Justice's Office of Legal Counsel concluded that "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." *Id.* at *10.

Moreover, VA promulgated a regulation at 38 CFR 17.419 that explicitly preempts any State laws, rules, regulations, or requirements that conflict with a VA health care professional's practice within the scope of their VA employment. As explained in the IFR, consistent with § 17.419, VA has determined that State and local laws, rules, regulations, or requirements, to the extent those laws unduly interfere with Federal operations and the performance of Federal duties, are preempted. That includes laws that States and localities might attempt to enforce in civil, criminal, or administrative matters against VA employees. State and local governments lack legal authority to enforce such laws, rules, regulations, or requirements in relation to health care and medical services provided by VA employees acting within the scope of their VA authority and employment.

One commenter asserted that VA has no basis in Federal law to claim "blanket preemption" in States that prohibit or restrict abortion, and other commenters relatedly stated that VA must be specific with regards to its claim of Federal supremacy. Such comments noted specific kinds of State laws that they asserted VA must either adhere to or demonstrate are explicitly preempted. Other commenters stated that Federal agencies cannot preempt State law unless an explicit conflict exists.

VA does not make changes to the rule based on these comments. It is not clear what the commenter meant by "blanket preemption." VA has been specific as to the scope of preemption; as VA previously confirmed in 38 CFR 17.419, and reiterated in the IFR, VA health care professionals may practice their health care profession consistent with the scope and requirements of their VA employment, notwithstanding any State law or license, registration, certification, or other requirements that unduly interfere with their practice. VA's regulation provides that, in order to "provide the same complete health care and hospital service to beneficiaries in all States as required by 38 U.S.C. 7301, conflicting State laws, rules, regulations, or requirements pursuant to such laws are without any force or effect, and State governments have no legal authority to

[1] H.R. REP. NO. 104–690, at 11.

[2] Id. at 4.

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enforce them in relation to actions by health care professionals within the scope of their VA employment." 38 CFR 17.419. Consistent with the Supremacy Clause and § 17.419, the IFR further explainod that a Stato or local civil or criminal law that restricts, limits, or otherwise impedes a VA professional's provision of needed medical care within the scope of their VA employment, including the health care services permitted under the IFR, would be preempted. VA employees, including health care professionals who provide care and VA employees who facilitate that health care, such as VA employees in administrative positions who schedulo abortion procodures and VA employees who provide transportation to the veteran or CHAMPVA beneficiary to the VA facility for reproductive health care, may not he held liable undcr State or local law or regulation for reasonably performing their Federal duties.

In response to comments that raised specific State requirements related to abortion, and further suggested that VA must show whether such requirements are specifically preempted, we do not make changes. As a general matter, VA determines whether a State law "unduly interferes on a case-by-case basis." See Authority of VA Professionals to Practice Health Care, 85 FR 71838, 71842 (Nov. 12, 2020); Intergovernmental Immunity for the Department of Veterans Affairs and Its Employees When Providing Certain Abortion Services, 46 Op. O.L.C., __, at *10 (Sept. 21, 2022), *https://www.justice.gov/d9/2022-11/2022-09-21-va_immunity_for_abortion_services.pdf.* Accordingly, consistent with VA's existing regulations and the authorities discussed above, any State and local laws and regulations that VA determines would prevent or undnly interfere with VA health care professionals providing needed care as permitted by this rule, would be preempted.

Several commenters referenced a court case related to HHS's interpretation of the Emergency Medical Treatment and Labor Act (EMTALA), which VA believes meant to reference an injunction issued by the U.S. District Court for the Northern District of Texas, *Texas* v. *Becerra,* 623 F. Snpp. 3d 696 (N.D. Tex. 2022), *aff'd,* 89 F.4th 529 (5th Cir. 2024), where the district court was interpreting the specific language of this different statute that applies to certain hospitals that receive Medicare funding. The court was not interpreting VA's statutory authority, or related statutory language applicable here, and its decision and reasoning are not applicable to VA's IFR.

One commenter asserted, without any supporting authority, that VA is required to show a compelling interest to preempt State laws. As VA explained in tho IFR, pursuant to its authoritios in 38 U.S.C. 1710 and 1781, VA implemented the IFR to avert imminent and future harm to veterans and CHAMPVA beneficiaries whose interests Congress entrnsted VA to serve. As explained above, 38 CFR 17.419(c) preempts "conflicting State laws, rules, regulations, or requirements pursuant to such laws" to the extent the State law unduly interferes with VA's ability "provide the same complete health care and hospital services to beneficiarios in all Statos" including, but not limited to, abortion. VA takes no action based on this comment.

4. Conflict With the Holding in Dobbs and the Tenth Amendment

Some commenters stated that the *Dobbs* decision delegated abortion matters to States rather than the Federal government, and further that the Tenth Amendment of the United States Constitution limits VA's authority to proempt State law. VA takes no action based on these comments. The *Dobbs* decision overturned *Roe* v. *Wade,* 410 U.S. 113 (1973), and *Planned Parenthood of Southeastern Pennsylvania* v. *Casey,* 505 U.S. 833 (1992), and in no way affects VA's Federal statutory authority to develop regulations and policy related to the agency's own provision of needed medical care, including the health care services permitted nnder the IFR. VA furnishes hospital care and medical services determined to be needed pursuant to VA's general treatment authority for veterans (38 U.S.C. 1710), and pursuant to rogulation through VA's medical benefits package (38 CFR 17.38). VA has determined that the hcalth care services permitted by the IFR are needed. Similarly, VA has determined that providing access to such care is medically necessary and appropriate to protect the health of CHAMPVA beneficiaries. *See* 38 U.S.C. 1781; 38 CFR 17.270(b) (defining "CHAMPVA-covered services and supplies" as "those medical services and supplies that are medically necessary and appropriate for the treatment of a condition and that are not specifically excluded under [38 CFR 17.272(a)(1)] through (84)"). As explained above, the Supremacy Clause of the United States Constitution prohibits statcs from restricting Federal agencies and their employees acting within the scope of their Federal authority from providing abortion services. *See generally Intergovernmental Immunity for the Department of Veterons Affoirs and Its Employees When Providing Certain Abortion Services,* 46 Op. O.L.C., __, (Sept. 21, 2022), *https://www.justice.gov/d9/2022-11/2022-09-21-vo_immunity_for_abortion_services.pdf.*

The Tenth Amendment of the United States Constitution provides that the powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people. VA is a Federal health care system, the operations of which are governed by Federal law, consistent with title 38, United States Code. VA's authority to furnish health care to veterans and CHAMPVA beneficiaries has been granted by Federal statnte as described above. VA's issuing of the IFR does not encroach on any rights reserved to the States or to the people and is not a violation of the Tenth Amendment to the United States Constitution. The statement of preemption of conflicting State law under the IFR is consistent with 38 CFR 17.419(c) and lawful pursuant to the Supremacy Clause, U.S. Const. art. VI, cl. 2.

5. Conflict With Department of Defense Authorities

Commenters alleged that this rule violates 10 U.S.C. 1093 and that VA cannot or should not provide broader access to abortion counseling and abortions than DoD. Multiple of these commenters further asserted that it is hard to imagine that Congress intended for former members of the armed services and their dependents to have access to abortion under VA programs when current service members do not have such access under DoD programs, and one commenter incorrectly stated that VA Medical Centers are facilities within the control of DoD. VA does not make changes to the rule hased on these comments.

Section 1093 of title 10 of the U.S. Code establishes that DoD may not nse funds or facilities "to perform abortions except where the life of the mother would he endangered if the fetus were carried to term or in a case in which the prognancy is the rosnlt of an act of rape or incest." Section 1093 applies only to the use of DoD funds and facilities, not to VA funds and facilities. VA notes, however, that the terms of 10 U.S.C. 1093 conflict with the assertions made by some commenters that active-duty members of the armed services can never receive abortions under DoD programs.

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To the extent that some of these commenters raised the issue of dependents of service members having access to services in VA programs that they would not have under DoD programs for dependents, the statute governing VA's coverage for CHAMPVA beneficiaries specifically recognizes the possibility of differences in what care is covered under this VA program as opposed to the care covered under the similar DoD program, *i.e.*, TRICARE (Select). Congress did not require that VA furnish identical medical benefits to those not eligible for TRICARE (Select). Rather, the law directs VA to provide CHAMPVA beneficiaries with medical care ''in the same *or similar* manner and snbject to tbe same *or similar* limitations as medical care'' furnished to DoD TRICARE Select beneficiaries. 38 U.S.C. 1781(b) (emphases added). Indeed, prior to the IFR, CHAMPVA was not identical to TRICARE (Select). *See, e.g.*, 87 FR 55290. For example, the former did not include access to abortions in cases of rape or incest, while the latter did. The IFR brought CHAMPVA more in line with TRICARE (Select) in this regard. The commenter does not address the statute's repeated use of the phrase ''or similar.'' That text recognizes differences may exist between the two programs' respective beneficiary popnlations and their needs. As VA explained in the IFR, VA has previously regulated to provide CHAMPVA benefits beyond those benefits offered by TRICARE (Select) if providing such health care would better promote the long-term health of CHAMPVA beneficiaries. 87 FR 55290. Further, CHAMPVA beneficiaries (unlike TRICARE (Select) beneficiaries) inclnde family caregivers of veterans, not just oligible dependents. 38 U.S.C. 1720G(a)(3)(A)(ii)(IV). Consistent with the statute's plain meaning, VA provides CHAMPVA beneficiaries certain care that is ''similar,'' but not necessarily identical, to care provided to beneficiaries of TRICARE (Select). *See, e.g.*, 73 FR 65552 (November 4, 2008) (adding coverage for medically necessary prostheses because of significant conditions and removing exclusion of enuretic devices despite each not being covered hy TRICARE (Select)); 87 FR 41594 (July 13, 2022) (providing coverage for annual physical exams, even though exclnded in TRICARE (Select)).

6. Conflict With the Antideficiency Act

Commenters stated that VA is barred from providing or paying for ahortion or abortion counseling pursuant to the Antideficiency Act. VA does not make changes to the rule based on these comments. The Antideficiency Act, 31 U.S.C. 1341(a), generally prohibits Federal agencies from making expenditures in excess of available appropriations or in advance of appropriations. Per 31 U.S.C. 1349(a) and 1350, there are penalties associated with violations of the Antideficiency Act.

In this case, the Antideficiency Act is not implicated because Congress appropriated funds to VA to perform authorized services. Per title II of division J of the Consolidated Appropriations Act, 2021 (Pnb. L. 116–260), title II of division J of the Consolidated Appropriations Act, 2022 (Pub. L. 117–103) and title II of division J of the Consolidated Appropriations Act, 2023 (Pub. L. 117–328), funds appropriated for fiscal years 2022, 2023, and 2024 to the Medical Services appropriations account bave been made available ''[f]or necessary expenses for furnishing, as authorized by law, inpatient and outpatient care and treatment to beneficiaries of the Department of Veterans Affairs and veterans described in section 1705(a) of title 38, United States Code, including care and treatment in facilities not under the jurisdiction of the Department.'' The Medical Community Care appropriations acconnt for fiscal years 2022, 2023, and 2024, has been made available ''[f]or necessary expenses for furnishing health care to individuals pursuant to chapter 17 of title 38, United States Code, at non-Department facilities.'' Title II, Division J, Consolidated Appropriations Act, 2021 (Pnb. L. 116–260); Title II, Division J, Consolidated Appropriations Act, 2022 (Pnb. L. 117–103); Title II, Division J, Consolidated Appropriations Act, 2023 (Pub. L. 117–328). More specifically, the Medical Services appropriation is for necessary expenses of inpatient and outpatient VA beneficiary care provided by VA at VA facilities and Government facilities for which VA contracts. The Medical Community Care appropriation is for necessary expenses of providing healthcare to VA beneficiaries in the community—facilities other than VA facilities and Government facilities for which VA contracts.

As explained, an abortion is authorized care under 38 U.S.C. 1710, the IFR, and the medical benefits package when a health care professional determines it to be needed and in accord with generally accepted standards of medical practice and: (1) the life or the health of the pregnant veteran would be endangered if the pregnancy were carried to term; or (2) the pregnancy is the result of an act of rape or incest. Expenditures associated with such authorized care may he made from VA's Medical Services and—when appropriate—Medical Community Care accounts.

The IFR also authorizes the provision of medically necessary abortions and abortion counseling under VA's CHAMPVA program, 38 U.S.C. 1781, under the circumstances described in the rule. Medical Services and Medical Community Care account funds are used for the CHAMPVA program and may therefore be used for authorized connseling and care. Such expenditures are proper and do not violate VA's appropriations act or the Antideficiency Act.

7. Conflict With the Hyde Amendment

Some commenters stated that VA is barred from providing or paying for the healtb care services permitted under the IFR pnrsuant to what is referred to as the Hyde Amendment. VA does not make changes to the rule based on these comments.

VA is not subject to the Hyde Amendment, which addresses Federal funds available to the Departments of Labor, Health and Human Services, and Education in legislation on annual appropriations. Division H of Public Law 117–328; *see also* 87 FR 55290. Accordingly, VA is not barred by the Hyde Amendment from spending its funds to provide authorized health care services permitted by the IFR.

8. Conflict With the Assimilative Crimes Act and VA-Related Regulation

Some commenters asserted that the IFR violates the Assimilative Crimes Act, 18 U.S.C. 13, which allows the Federal government to prosecute a State crime as a Federal offense in limited circumstances when such offense has been committed on an area within the jurisdiction of the United States known as a Federal enclave and is not otherwise a Federal offense. These commenters appeared to assert that if a State makes it a crime to perform an abortion, any abortion performed in that State, in the absence of a Federal law prohibiting such performing of an abortion, would be unlawful under 18 U.S.C. 13 if performed on Federal property. Relatedly, one commenter alleged that the rule conflicts with 38 CFR 1.218(c)(3), which states that nothing contained in the rules and regulations set forth under 38 CFR 1.218(a) shall be construed to abrogate any other Federal laws or regulations, including assimilated offenses under 18 U.S.C. 13, or any State or local laws and regulations applicable to the area in which the property is situated.

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VA does not make changes to the rule based on these comments. As some of these commenters acknowledged, the Department of Justice's Office of Legal Counsel (OLC) has examined whether the Assimilative Crimes Act would apply to Federal employees performing their duties in a manner authorized by Federal law, while on a Federal enclave, which may include VA hospitals. OLC concluded that Federal employees engaging in such conduct would not violate that statute and could not be prosecuted by the Federal government under that law. *Application of the Assimilative Crimes Act to Conduct of Federal Employees Authorized by Federal Law*, 46 Op. O.L.C. __ (Aug. 12, 2022), *https://www.justice.gov/olc/file/1527726/download*. The reasoning in that opinion applies to VA employees on Federal enclaves who are providing care in accordance with their Federal duties authorized under the IFR. The commenter did not provide any response to this analysis, other than to reiterate the commenter's view that Federal law "places significant limitations on abortions in VA programs." As explained, however, VA has statutory authority to provide the health care services permitted under the IFR.

Furthermore, the IFR is not in conflict with 38 CFR 1.218(c)(3), which provides, "Nothing contained in the rules and regulations set forth in paragraph (a) of this section shall be construed to abrogate any other Federal laws or regulations, including assimilated offenses under 18 U.S.C. 13 or any State or local laws and regulations applicable to the area in which the property is situated." Paragraph (a) of such section describes rules and regulations that apply at a property under the charge and control of VA, and to persons entering such property, including, for example, conduct related to gambling, use of service animals, creation of disturbances, and vehicular and pedestrian traffic. 38 CFR 1.218(a). This provision is unrelated to matters of medical practice or the provision of medical benefits. It does not subject VA and its employees to State or other local restrictions on any form of medical care that VA staff are authorized to furnish, including VA's provision of health care services permitted under the IFR. Additionally, because the Assimilative Crimes Act has no application to VA employees practicing within the scope of their VA practice, as explained above, the portion of 38 CFR 1.218(c)(3) referring to the Act has no application to care provided under the IFR.

9. Conflict With Interstate Prohibitions Under 18 U.S.C. 1461 and 1462

Commenters alleged that the IFR violates 18 U.S.C. 1461 and 1462. Section 1461, in pertinent part, prohibits the mailing of "[e]very article or thing designed, adapted, or intended for producing abortion, or for any indecent or immoral use" and "[e]very article, instrument, substance, drug, medicine, or thing which is advertised or described in a manner calculated to lead another to use or apply it for producing abortion, or for any indecent or immoral purpose." Section 1462, in pertinent part, prohibits the knowing use of "any express company or other common carrier or interactive computer service" for transportation across State lines of "any drug, medicine, article, or thing designed, adapted, or intended for producing abortion, or for any indecent or immoral use[.]" These commenters also alleged that violation of these laws then support offenses under 18 U.S.C. 1961(1)(B) and 18 U.S.C. 552 (prohibiting Federal employees from aiding and abetting persons engaged in violation of laws prohibiting dealing in, among other things, the means for procuring abortion).

VA does not make changes to the rule based on these comments because the IFR is consistent with 18 U.S.C. 1461. In December 2022, OLC concluded that 18 U.S.C. 1461 does not prohibit the mailing of certain drugs that can be used to perform abortions where the sender lacks the intent that the recipient of the drugs will use them unlawfully. Because there are manifold ways in which recipients in every State may lawfully use such drugs, the mere mailing of such drugs to a particular jurisdiction is an insufficient basis for concluding that the sender intends them to be used unlawfully. *See Application of the Comstock Act to the Mailing of Prescription Drugs That Can Be Used for Abortions*, 46 Op. O.L.C., , at 1 (Dec. 23, 2022), *https://www.justice.gov/d9/opinions/attachments/2023/01/03/2022-12-23_-_comstock_act_1.pdf*. In support of this conclusion, the OLC opinion explains that there are uses of these medications that State law does not prohibit, including mailing of abortion medications intended, for example, to be used pursuant to Federal authorities. Federal agencies, including VA, provide lawful abortions pursuant to their Federal authorities; therefore the mailing of abortion medications intended to be used lawfully pursuant to those authorities would not violate 18 U.S.C. 1461. This opinion further explains that the same analysis is applicable to the cognate provision 18 U.S.C. 1462. *Id.* at 2 n.3. Because any mailing or other transporting across State lines of certain medications or items under the IFR would not violate 18 U.S.C. 1461 or 1462, there is no subsequent potential offense under 18 U.S.C. 1961(1)(B) and 18 U.S.C. 552.

10. Conflict With the Major Questions Doctrine

Commenters alleged that this rule violates the major questions doctrine, referencing *West Virginia* v. *Environmental Protection Agency*, 142 S. Ct. 2587 (2022). Under such doctrine, an agency must identify clear congressional authorization for its exercise of authority in " 'extraordinary cases' in which the 'history and the breadth of the authority that [the agency] has asserted,' and the 'economic and political significance' of that assertion, provide a 'reason to hesitate before concluding that Congress' meant to confer such authority." *Id.* at 2608 [alterations in original]. VA does not make changes to the rule based on these comments. As explained above, VA has not found "a newfound power" in an "ancillary provision" of the Veterans' Health Care Eligibility Reform Act of 1996, as the Supreme Court found the Environmental Protection Agency had done with the Clean Power Plan. *West Virginia*, 142 S. Ct. at 2602, 2610. Congress expressly delegated to the Secretary of Veterans Affairs the authority to "furnish hospital care [and] medical services . . . which the Secretary determines to be needed." 38 U.S.C. 1710(a)(1)–(3). Identifying the medical services "determine[d] to be needed" for veterans is clearly within VA's authority. As discussed above, prior to promulgation of the final rule establishing VA's medical benefits package in October of 1999, VHA Policy, Manual M–2, Professional Services Part XIV, Surgical Service, Change 27, paragraph 9.02a. (July 26, 1977, partial rescission, expired on Jan. 7, 1999), recognized the need for and authorized the provision of a "therapeutic . . . abortion as a proper treatment" in some circumstances pursuant to the procedures described therein. The IFR is thus a traditional exercise of VA's established authority to determine what medical services are "needed" and, therefore, to decide what specific medical services VA will cover or provide under the medical benefits package.

Additionally, Congress has directed VA to provide "for medical care" under CHAMPVA "in the same or similar manner and subject to the same or similar limitations as medical care is" provided under TRICARE (Select). As

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explained in the IFR, VA has previously deviated from TRICARE (Select) in amending its CHAMPVA regulations to provide services that best promote the long-term health of CHAMPVA beneficiaries while remaining sufficiently "similar" to TRICARE (Select). 87 FR 55290–55291. Thus, this IFR is also a traditional exercise of VA's authority to administer CHAMPVA and decide what medical services are medically necessary and appropriate for CHAMPVA coverage while remaining sufficiently "similar" to TRICARE (Select).

11. The Born Alive Infants Protection Act

One commenter inquired what VA will do to comply with its obligations under the Born Alive Infants Protection Act of 2002, and further stated that VA fails to explain what policies and procedures are in place to ensure that any children born alive after attempted abortions are given appropriate medical care in the same manner as other children born alive. The Born-Alive Infants Protection Act of 2002, Public Law 107–207, was enacted August 5, 2002, and is codified at 1 U.S.C. 8. The Act clarifies that, for purposes of any Act of Congress or any ruling, regulation, or interpretation of the various Federal agencies, the meaning of the words "person," "human being," "child," or "individual" "shall include any infant member of the species homo sapiens who is born alive at any stage of development." VA is subject to, and will continue to comply with, the provisions found in 1 U.S.C. 8. Additionally, VA is authorized to provide certain health care services to a newborn child of a woman veteran receiving care from VA. 38 U.S.C. 1784A and 1786. VA does not make changes to the rule based on this comment.

II. Comments That Raised Concerns With VA's Good Cause Analysis To Issue an IFR

VA issued an IFR, in which the changes to 38 CFR 17.38 and 17.272, were effective immediately upon publication, and the public comment period began on the date of publication. 87 FR 55287. VA found that good cause justified forgoing advance notice for public comment and a delayed effective date. 5 U.S.C. 553(b)(B), (d)(3). VA cited its urgent need to provide access to abortion counseling and to abortions in cases of rape or incest or where the life or health of the pregnant individual is in danger following *Dobbs*. After *Dobbs*, some States had begun to enforce existing abortion bans and restrictions on care and were proposing and enacting new bans and restrictions containing limited exceptions for medical necessity; some also included exceptions for pregnancy that is the result of rape or incest. These measures were creating urgent risks to the lives and health of pregnant veterans and CHAMPVA beneficiaries in those States. 87 FR 55294. VA received comments that opposed VA's issuance of an IFR based on general assertions that VA's good cause justification was insufficient, although only some of these comments directly addressed VA's good cause. VA notes at the outset that our request for comment in the IFR and issuance of this final rule have overtaken any assertions concerning a lack of good cause. In any event, VA addresses below the comments it received concerning VA's good cause for making the IFR effective immediately.

A. General Assertions That Good Cause Was Not Established

Some commenters asserted that VA's good cause justification was insufficient for general reasons unrelated to VA's rationales supporting good cause. Many of the duplicated form responses that VA received as comments asserted that the IFR violated the Administrative Procedure Act (APA) and stated that the APA requires that the public have an opportunity to provide comment on matters of public interest before a rule is effective. VA does not change course based on these comments. The APA, codified in part at 5 U.S.C. 553, generally requires that agencies publish substantive rules in the **Federal Register** for notice and comment and provide at least a 30-day delay before the rules become effective. 5 U.S.C. 553(b), (d). However, an agency may forgo prior notice if the agency for good cause finds that compliance would be impracticable, unnecessary, or contrary to the public interest (5 U.S.C. 553(b)(B)) and may also bypass the APA's 30-day delayed effective date requirement if good cause exists (5 U.S.C. 553(d)(3)), or if the rule "grants or recognizes an exemption or relieves a restriction" (5 U.S.C. 553(d)(1)). VA found good cause under 5 U.S.C. 553(b)(B), ((d)(3), and also explained that the IFR removed certain restrictions (*see* 87 FR 55294–96), and therefore did not violate the APA in issuing the IFR.

Other commenters asserted that although a Federal agency is allowed to publish an IFR, VA did not demonstrate that it had good cause to do so. Because these commenters did not specifically assert or explain why they believed VA did not demonstrate good cause, VA does not change course based on these comments. As VA explained in the IFR, VA had good cause to make the IFR effective immediately because delaying its effectiveness would leave many veterans and CHAMPVA beneficiaries without access to needed and medically necessary and appropriate health care—abortions and abortion counseling that VA is able to provide under the IFR—thus putting their health and lives at risk. 87 FR 55295–96. Immediate effectiveness was critical following State actions to further ban or restrict abortion post-*Dobbs*. *Id*. These State bans and restrictions on abortion presented a serious threat to the health and lives of over one hundred thousand veterans and CHAMPVA beneficiaries who relied, or may rely in the future, on VA health care. *Id*. VA determined that such bans and restrictions would have an immediate detrimental impact on the lives and health of veterans and CHAMPVA beneficiaries who are unable to receive the care that was available in the community before the *Dobbs* decision, especially as State laws prompted providers to cease offering abortion services altogether. 87 FR 55295–55296. This detrimental impact is underscored by the potential harmful effects associated with being denied an abortion when an abortion is needed to protect the life or health of the pregnant individual or when the pregnancy is the result of an act of rape or incest. *Id*. As noted in the IFR, it was estimated that up to 53 percent of veterans of reproductive age may be living in States that either had already banned abortions or were soon expected to ban abortions, following *Dobbs*. 87 FR 55295. VA also estimated that nearly 50,000 CHAMPVA beneficiaries could have been impacted by such those then-current or expected bans. *Id*.

Some commenters asserted that the substantive provisions of the IFR were generally not in the public interest or in States' interests (for those States that have instituted more stringent restrictions on abortions or more burdensome requirements on abortion counseling), and therefore VA could not have provided adequate good cause. These commenters did not offer specific reasons why VA did not have good cause to issue the IFR; rather, they seemed to assert that because they deemed a substantive provision of an IFR to generally be against the public or States' interests, then a good cause justification must necessarily fail. In invoking the public interest prong of the good cause exemption, the question is not whether a substantive provision of a rule, itself, would be contrary to public interest in the minds of some, but

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whether following "ordinary procedures—generally presumed to serve the public interest—would in fact harm that interest." *Mack Trucks, Inc.* v. *EPA*, 682 F.3d 87, 95 (D.C. Cir. 2012). For the reasons explained in the IFR, VA provided good cause for why providing advance notice and comment would be contrary to public interest. *See, e.g.*, 87 FR 55294–96.

B. Specific Assertions That Good Cause Was Not Established

Some commenters asserted that VA's good cause justification was insufficient for reasons more directly related to the reasons VA stated in finding good cause. These commenters did not agree with VA's statement of urgent need to provide access to the health care services permitted under the IFR following the ruling in *Dobbs*, which resulted in some States severely restricting and banning abortion. VA groups and summarizes such comments below.

Some commenters asserted that the IFR was not urgently needed because every, or nearly every, State that restricts abortion permits exceptions when the life of the pregnant individual would be endangered were the pregnancy carried to term, and further that some of those States also permit exceptions where the pregnancy was the result of rape or incest. These commenters generally seemed to assert that if many or enough of the States had similar exceptions for abortions as the IFR, then there could not be sufficient need among veterans to access the health care services permitted under the IFR from VA to support good cause.

VA does not change course based on these comments. The fact that some, but not all, States might permit similar access to care as VA is not sufficient to prevent endangerment to the life or health of pregnant individuals that VA serves. *See* 87 FR 55288 (concluding that care available under the IFR is needed and medically necessary and appropriate). In fact, even though some States may allow an abortion to prevent the endangerment to the life of a pregnant individual, they may not allow an abortion to prevent the endangerment to the health of a pregnant individual. When pregnant veterans and CHAMPVA beneficiaries face pregnancy-related complications that their VA health care providers have determined are putting their health or lives at risk or are pregnant due to an act of rape or incest, they must be confident that their providers can take the clinically necessary action to provide needed and medically necessary and appropriate health care. And even in States that restrict abortions subject to exceptions similar to VA's, abortion access is often subject to additional restrictions that VA, on the basis of its authorities and obligations, has not adopted, such as timeframe limitations, evidentiary requirements, or prerequisite procedures (such as mandatory waiting periods or required ultrasounds), which could delay delivery of care that is often time sensitive. VA must always ensure it can consistently meet the medical needs of veterans and CHAMPVA beneficiaries across its healthcare system. Even one State presents enough risk to the lives and health of veterans and CHAMPVA beneficiaries to support VA's good cause justification in the IFR. As the IFR states, "[a]llowing even one preventable death of a veteran or CHAMPVA beneficiary by limiting access to abortions is unacceptable." 87 FR at 55296.

Commenters further asserted that VA's statements of good cause were not substantiated because VA did not cite specific cases where needed and medically necessary and appropriate care would not be permitted. In so doing, commenters argued that VA must conduct a more thorough analysis to more specifically identify those individuals who cannot get the care VA has found to be needed and medically necessary and appropriate. Those commenters are incorrect. VA explained that "certain States have begun to enforce abortion bans and restrictions on care, and are proposing and enacting new ones." *Id.* at 55288; *see also id.* at 55293, 55295 (citing examples and describing the evolving legal landscape). VA also documented the pressing need to ensure that *all* of the veterans and CHAMPVA beneficiaries for which VA provides healthcare have access to needed and medically necessary and appropriate care. *Id.* at 55291–92.

Other commenters asserted that VA has not issued statements regarding, or otherwise does not have, a clear plan to implement the provisions of the IFR despite asserting an emergency to support good cause. These commenters seemed to argue that there can be no need to forgo notice and comment procedures and dispense with a delayed effective date if VA is not yet ready to implement the IFR on a large-scale level. That is incorrect: VA was prepared to offer health care services permitted under the IFR on the day the IFR was published.

To the extent commenters posit that abortion is harmful to patients or is never necessary—that abortions are, essentially, illegitimate medical services, thereby negating VA's good cause argument and grounds for publishing the IFR—the commenters failed to provide a rationale for, and to demonstrate the basis for, this position. The VA Secretary has determined that the health care services permitted under the IFR are needed pursuant to 38 U.S.C. 1710 and are medically necessary and appropriate pursuant to 38 U.S.C. 1781, as implemented by 38 CFR 17.270 *et seq.*, and VA has authority to provide these services under the terms of the IFR, as explained there. As non-exhaustive examples, the IFR identified conditions such as "severe preeclampsia, newly diagnosed cancer requiring prompt treatment, and intrauterine infections, and . . . pre-existing conditions exacerbated by continuing the pregnancy," for which pregnancy termination "may be the only treatment available to save the health or life of the pregnant individual." 87 FR 55295. In States that restrict access to abortion services, treatment delayed so VA could seek prior public comment would have been treatment denied.

Other commenters asserted that the timing of VA's publication of the IFR, being two months after publication of the *Dobbs* decision (and four montbs after such decision "leaked" as stated in the comments) was too late to justify VA's statement of need in support of its good cause. In support of this assertion, these commenters proffered that because VA was aware that the Supreme Court could overturn *Roe*, prior to the *Dobbs* decision, and because some States had taken anticipatory action prior to the *Dobbs* decision, VA would have issued the IFR sooner if there were an actual emergent need. VA does not change course based on these comments. The administrative process for VA to weigh policy, make decisions, draft a rulemaking, and have that rulemaking clear all required reviews prior to publication in the **Federal Register** can routinely take substantial effort and time. Indeed, the Supreme Court has found that an agency taking two months to prepare a 73-page rule did not constitute "delay" inconsistent with the Secretary's finding of good cause. *Missouri*, 142 S. Ct. at 654. Here, the publication of the IFR was completed at the earliest possible time and ensures that, irrespective of contrary State laws post-*Dobbs*, veterans and CHAMPVA beneficiaries can receive access to the needed and medically necessary and appropriate health care services permitted under the IFR.

One commenter opined that the IFR lacked good cause because VA has always provided care to pregnant individuals in life-threatening

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circumstances, including treatment for ectopic pregnancies or miscarriages, which were covered under VA's medical benefits package prior to the IFR. In support, the commenter cited to Veterans Health Administration (VHA) Directive 1330.03, titled Maternity Health Care and Coordination, dated November 3, 2020. The commenter further stated that providing such lifesaving care to a pregnant individual is not an abortion and is already allowed. This commenter seemed to assert that because VA provided some lifesaving treatment to manage certain complications associated with pregnancy prior to the IFR, that there could not have been an emergency to warrant VA's issuance of the IFR. While VA agrees that the care identified by the commenter has been lawfully provided, as discussed herein and in the IFR (for example, see 87 FR 55291), there are many life- and health-endangering complications of pregnancy other than ectopic pregnancies and miscarriages where abortion would be the needed or necessary treatment, and prior to the IFR, VA's medical benefits package did not provide access to care in such circumstances.

One commenter opined that the IFR did not have good cause since it undermines what the commenter described as the "pro-life policy stance" of Congress and further disregards governmental interests, including "interest in safeguarding preborn human life". VA disagrees with the commenter's assertion and implemented the IFR pursuant to the authority Congress granted VA to furnish eligible veterans and CHAMPVA beneficiaries with medical services that VA determines to be needed and medically necessary and appropriate. 38 U.S.C. 1710, 1781; 87 FR 55291–55293. The changes made by the IFR were within the scope of the authority Congress has provided to VA.

III. Comments Asserting That the IFR Is Too Broad

Commenters raised concerns with various aspects of the IFR being overly broad so as to allow for abortions for reasons beyond the circumstances stated in the IFR. VA summarizes and addresses those comments below.

A. Lack of Definition of Abortion

One commenter opined that the IFR avoided clarity by not defining abortion. VA does not make changes to the rule based on this comment. VA does not specifically define in its regulations the other various types of care provided under the medical benefits package or covered by CHAMPVA. As the medical field is constantly evolving, attempting to define medical terms in regulation could be arbitrary or outdated based on evolving standards of practice and thus could result in unintended limitations on the provision of life and health-saving care. Therefore, and consistent with other treatments listed in such regulations, VA does not find it appropriate to define the term abortion in regulation.

B. The Term "Health" Is Too Broad or Not Defined

Several commenters asserted that the term "health," in the context of the exception permitting abortion if a health care provider determines that the "health" of the pregnant individual would be endangered were the fetus carried to term, was too broad in scope. Some asserted that the lack of definition for the term "health" means VA will provide abortions in all circumstances, or, essentially, allow for "elective abortions." Other commenters more specifically asserted that the Supreme Court broadly defined "health" for purposes of abortion as "physical, emotional, psychological, familial, and the woman's age—relevant to the wellbeing of the patient. All these factors may relate to health." *Doe* v. *Bolton*, 410 U.S. 179, 192 (1973). These commenters argue that a rule permitting abortion for reasons of health without further qualification or limitation could be interpreted in a way that increases access to abortions beyond the scope stated in the IFR.

VA does not make changes to the term "health" or further define or characterize it in regulation based on these comments. VA has existing statutory and regulatory authorities that establish when needed care provided under the medical benefits package may be provided to an individual veteran and when medically necessary services are covered by CHAMPVA.

As explained in the IFR, VA's general treatment authority requires the Secretary to determine what "hospital care and medical services" are "needed." 38 U.S.C. 1710. Consistent with this authority and under the IFR, VA provides an abortion to a veteran only if an appropriate health care professional determines that such care is in accord with generally accepted standards of medical practice and is needed to promote, preserve, or restore the health of the individual, consistent with the definitions set forth by existing VA regulations. 38 CFR 17.38(b).

With respect to CHAMPVA, VA provides beneficiaries with medical services and supplies if the services and supplies are "medically necessary and appropriate for the treatment of a condition" and "not specifically excluded from program coverage." *See* 38 CFR 17.272(a). With respect to abortions, VA would provide or reimburse for the care only if the life or the health of the pregnant beneficiary would be endangered if the pregnancy were carried to term or if the pregnancy is the result of an act of rape or incest. See *id.* at § 17.272(a)(64).

Because determining whether a pregnant individual's health is endangered necessarily requires an individualized assessment by a health professional, VA does not believe it is appropriate to define the term "health" in regulation. Attempting to define every single condition, illness, and other circumstance (and combination of such circumstances) that could be included under such a definition would likely be arbitrary and incomplete and thus could result in veterans and CHAMPVA beneficiaries not receiving needed and medically necessary and appropriate care.

C. Breadth of Determinations by, or Quolifications of, Health Care Professionals

One commenter asserted "the phrase 'if determined to be needed by' a medical professional . . . allows abortion on demand" because it generally allows a provider to say such care is "needed for mental anguish or anxiety". VA does not make changes to the rule based on this comment. As stated above, the IFR does not allow for abortions in all circumstances; rather, it allows only those permitted under the circumstances described in the IFR when the life or health of the individual would be endangered if the pregnancy were carried to term or when the pregnancy is the result of rape or incest. The decision of whether a veteran's health is endangered is a clinical decision made on an individual, case-by-case basis using the standard provided in 38 CFR 17.38(b) for the provision of health care to veterans. VA health care professionals consider a veteran's health in terms of the veteran's whole health when determining if care is needed to promote, preserve, or restore the health of the individual and is also in accord with generally accepted standards of medical practice, pursuant to 38 CFR 17.38(b). As to CHAMPVA beneficiaries, a determination is likewise performed on a case-by-case basis, with the health care provider determining if the care is medically necessary and appropriate for the treatment of a condition and not specifically excluded from program coverage. *See* 38 CFR 17.272(a).

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Multiple commenters raised concerns that VA did not indicate in the IFR the qualifications or professional competence required for VA health care professionals to furnish the health care services permitted nnder the IFR. One commenter more specifically alleged that, to merely permit a "health care professional" (as that term was used in the preamble of the IFR) to determine the clinical need for an abortion would allow for personnel without any gynecological or obstetrical skill or experience to make such determination. One commenter more generally raised concerns about who determines whether the life of the pregnant individual is at risk and at what degree, and other commenters specifically requested that VA ensure only physician-led teams are making these clinical eligibility decisions.

VA does not make changes to the rule based on these comments. As a preliminary matter, VA regulations specify that care in the medical benefits package will only be provided if an "*appropriate* health care professional[ ]" determines that it is needed. 38 CFR 17.38(b) (emphasis added). VA health care professionals are not permitted to provide any medical care, including making determinations abont needed care, beyond the scope of their VA practice, training, expertise, and demonstrated skills and abilities. 38 U.S.C. 7402 and 38 CFR 17.419. Regarding the expressed concerns about the term "health care professional," or the lack of defined qualifications or occupations in the IFR to designate that a "health carc profcssional" is permitted to determine whether an abortion is medically necessary, VA notes that the regulations revised by the IFR (38 CFR 17.38 and 38 CFR 17.272) only address the coverage of health care and not the provision of health care by a "health care professional" or the training or credentials they must possess. Therefore, this final rule will not specify particular occupations or qualifications for a VA health care professional to provide either abortion counseling or abortions under the circumstances identified through this rule. VA reiterates that only an appropriate health care professional can make determinations about what care is needed. A VA health care professional is not and will not be permitted to provide any medical care beyond the scope of their VA practice, training, expertise, and demonstrated skills and abilities in any context, including if providing either abortion counseling or abortions.

Regarding the comment that inquired about the degree of risk to life to be ascertained when determining whether an abortion is medically necessary, that determination is made by the appropriate health care professional on a case-by-case basis; VA will not establish a threshold degree of risk to life that is required before an individual is determined eligible for an abortion through VA because every case is clinically distinct. Regarding the requests that VA only permit decisions about the provision of abortions to be made by physician-led teams, VA restates from above that this final rule will not specify particular occupations or qualifications for a VA health care professional to provide either abortion counseling or abortions. VA does not intend for any occupation to perform clinical duties beyond their occupational training and expertise, and their practice will be consistent with generally accepted standards of care.

One commenter stated that the regulations were vague and can leave room for interpretation, and further suggested that VA have a service that would allow doctors or staff the ability to get a second opinion, feedback, and ability for quick determinations or assistance. VA does not make changes to the rule based on this comment. The IFR does not restrict VA health care professionals' ability to seek consultations for assistance with determinations of clinical necessity for any health care or service provided, to include the health care services permitted by the IFR.

D. Lack of Gestational Limits

Commenters raised concerns that the IFR did not establish gestational age limits beyond which an abortion would not be permitted, which they asserted will authorize VA to provide abortions for reasons beyond the circumstances permitted in the IFR. Most of these commenters did not offer specific support for this concern. Other commenters asserted that an abortion is only necessary up to a certain gestational age. One commenter specifically inquired about a gestational age limit for pregnancies that were the result of rape or incest, and relatedly other comments stated that some States that permit abortion in cases where the pregnancy is the result of rape or incest also have gestational age limits for such abortions. VA does not make changes to the rule based on these comments. As explained, the IFR does not permit the provision and coverage of abortions in all circumstances. The preamble to the IFR explains that VA has authority under 38 U.S.C. 1710 to furnish veterans with hospital care and medical services that the Secretary determines to be needed. 87 FR 55288. Consistent with this authority, VA would provide an abortion to a veteran only if determined needed by a health care professional when (1) the life or health of the pregnant veteran would be endangered if the pregnancy were carried to term; or (2) the pregnancy is the result of an act of rape or incest. This means that in either case such care may be provided only if an appropriate health care professional determines that such care is needed to promote, preserve, or restore the health of the individual and is in accord with generally accepted standards of medical practice. 38 CFR 17.38(b)(1)–(3).

Additionally, VA has authority under 38 U.S.C. 1781 to provide CHAMPVA beneficiaries with medical care. 87 FR 55290. Pursuant to 38 CFR 17.270(b), VA provides those medical services that are medically necessary and appropriate for the treatment of a condition and that are not specifically excluded. Consistent with these authorities, VA would provide an abortion to a CHAMPVA beneficiary only if such care is medically necessary and appropriate when (1) the life or health of the pregnant beneficiary would be endangered if the pregnancy were carried to term; or (2) the pregnancy is the result of an act of rape or incest. 38 CFR 17.272(a)(64).

The decision about whether a pregnancy endangers the veteran's or CHAMPVA beneficiary's life or health, and the needed care or medically necessary and appropriate treatment, must be made on a case-by-case basis by appropriate healthcare professionals consistent with 38 CFR 17.38 and 17.270(b). As life and health endangering pregnancy complications can arise throughout a pregnancy, imposing a time limit after which VA could not provide needed or medically necessary and appropriate care could be potentially dangerous to veterans and CHAMPVA beneficiaries and would bc inconsistent with VA's authority to provide needed health care to veterans and medically necessary and appropriate health care to CHAMPVA beneficiaries and contrary to VHA's primary function to provide a complete medical and hospital service for the medical care and treatment of veterans. 38 U.S.C. 1710, 38 CFR 17.38; 38 U.S.C. 7301(b); 38 U.S.C. 1781; 38 CFR 17.270(b). Each patient's situation is different, and the decision about whether to continue a pregnancy that endangers the veteran or CHAMPVA beneficiary's life or health must be made on a case-by-case basis by the pregnant patient in consultation with appropriate health care professionals based on the

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best medical evidence and accepted standards of medical practice. As to comments that specifically inquired about gestational age limits in cases where pregnancies are the result of rape or incest, we reiterate the statements above that establishing limits would be inconsistent with VA's authority to provide needed health care to veterans and medically necessary and appropriate health care to CHAMPVA beneficiaries and contrary to VHA's primary function to provide a complete medical and hospital service for the medical care and treatment of veterans. 38 U.S.C. 1710, 38 CFR 17.38, 38 U.S.C. 7301(b), 38 U.S.C. 1781, 38 CFR 17.270(b).

IV. Comments Related to the Exception for Abortion if the Life of the Pregnant Individual Would Be Endangered

The IFR revised 38 CFR 17.38(c)(1) to establish an exception for an abortion if the life of the pregnant veteran would be endangered if the pregnancy were carried to term. Below VA summarizes comments that specifically raised concerns with this exception, other than those already addressed in this rulemaking.

Commenters who opposed the IFR generally stated that it is rare that the life of a pregnant individual is truly threatened by pregnancy or delivery. VA does not make changes to the rule based on these comments as VA disagrees. Endangerment to even one veteran's life would be sufficient, and regardless, VA refers commenters to the discussion in the IFR that details how pregnant individuals may face life-threatening conditions, and abortion may be the only medical intervention available that can preserve their life. *See* 87 FR 55291. As noted in the IFR, while research has shown most pregnancies progress without incident, from 1998 to 2005, the U.S. maternal mortality rate associated with live births was 8.8 deaths per 100,000 live births, and maternal mortality rates have increased staggeringly since then. *Id.* A 2019 study reviewed mortality data from 2007 to 2015 from the National Association for Public Health Statistics and Information Systems, which includes information on all deaths in the 50 States and the District of Columbia (DC). *Id.* The data showed that, during this time, within 38 States and DC, the maternal mortality rate rose to 17.9 deaths of individuals per 100,000 live births. *Id.* Additionally, in 2020 and 2021, maternal mortality rates increased to 23.8 and 32.9 deaths per 100,000 live births, respectively. *Id.* The study identified abortion clinic closures and legislation restricting access to abortion as factors that likely contributed to this rise in maternal mortality rates. *Id.*

One commenter more specifically stated that the presence of underlying health conditions prior to pregnancy does not mean a patient's life is in danger when they are pregnant, and further asserted that such cases merely require more skill and attentiveness by a provider that specializes in obstetrics and gynecology. VA does not make changes to the rule based on this comment, which seems to be stating that a pregnancy can always be carried to term without the pregnant veteran's life ever being endangered by either preexisting health conditions or health conditions arising during pregnancy, if and when a correct approach is used by providers. This assertion is incorrect. As VA described in the IFR, there are circumstances in which abortion may be the only medical intervention available that can preserve a pregnant veteran's life. *See* 87 FR 55291. VA has amended the medical benefits package to allow VA to provide abortions in certain circumstances, including when an appropriate healthcare professional determines that such care is needed to save a pregnant veteran's life, which is critical now that some States are enforcing and enacting abortion restrictions that could result in the delay or denial of such life-saving treatment.

Relatedly, other commenters stated that the presence of health conditions (such as preeclampsia, as noted in one comment) in pregnant individuals are not life threatening as they can be resolved by the induction of labor or the performance of a c-section, and therefore an abortion is not necessary to preserve the pregnant individual's health or life. One commenter further asserted that a fetus is viable at approximately 24 weeks gestational age, and if the health of the pregnant patient was a concern, birth could be induced, or a cesarean section (c-section) performed, to save the life of both the pregnant patient and the child. VA does not make changes to the rule based on these comments. Similar to our response to related comments above, VA recognizes that there are circumstances in which abortion may be the only medical intervention available that can preserve a pregnant veteran's life, and the decision about the needed care or medically necessary treatment must be made on a case-by-case basis by appropriate healthcare professionals consistent with 38 CFR 17.38 and applying the applicable clinical standards discussed throughout this preamble.

V. Comments Related to the Exception for Abortion if the Health of the Pregnant Individual Would Be Endangered

Several commenters raised concerns about the exception for an abortion if the health of the pregnant individual would be endangered if the pregnancy were carried to term. Below VA summarizes comments that specifically raised concerns with this exception, other than as already addressed in this rulemaking.

One commenter suggested that VA revise the regulatory text in § 17.38(c)(1) to additionally include "wellbeing" because the addition of "wellbeing" would encompass mental and emotional health. This commenter raised concerns that the rule was not clear that mental health was included in the consideration of the "health" of the pregnant veteran as opposed to applying solely to physical health. Another commenter asked that VA acknowledge in the text of the rule that the exception for abortions for the health of the pregnant beneficiary includes mental health in addition to physical health. VA does not make any changes to the rule based on these comments. Both physical and mental health are included in the meaning of the term "health" under 38 CFR 17.38 and 38 CFR 17.272. *See also* 87 FR 55291 (explaining that both chronic medical and mental health conditions increase risks associated with pregnancy, and health care professionals may determine "that these conditions (potentially in combination with other factors) render an abortion needed to preserve the health of a veteran[.]"). VA therefore does not believe it is necessary to revise the regulatory text as the commenters suggest. *See also supra* Part III.B above.

One commenter asserted the IFR implied that all pregnancies threaten the health of the pregnant individual, and that abortions would be permitted in all circumstances based on the threat to the pregnant individual's health. The commenter states that authorizing abortions when there is a threat to health is an "ideological" statement and not a medical determination. The commenter further requests that VA enumerate these "threats to their health" in writing. VA makes no changes to the rule based on this comment. See Section III.B. above. VA has determined that abortions may be authorized when carrying the pregnancy to term endangers the health of the pregnant individual and VA has authority to provide these services under the terms of the IFR, as explained in the IFR and herein. Further, medical

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determinations regarding threats to health must be made by healthcare professionals on a case-by-case basis and be consistent with established standards of care.

VI. Comments Related to the Exception for Abortions in Cases of Rape or Incest

The IFR revised 38 CFR 17.38(c)(1) and 38 CFR 17.272(a) to establish an exception for an abortion if the pregnancy were the result of rape or incest. Below VA summarizes comments that specifically raised concerns with this exception other than as already addressed in this rulemaking.

A. Evidence of the Incident of Rape or Incest

Several commenters alleged that a person's statement that a pregnancy resulted from rape or incest is not sufficient evidence to support the provision of abortion, particularly as a provider has no obligation to confirm such statement.

VA does not make changes to the rule based on these comments. As VA explained in the IFR, the self-reporting from the pregnant veteran constitutes sufficient evidence, and the rule does not require a veteran or CHAMPVA beneficiary to present particular evidence such as a police report to qualify for this care. 87 FR 55294. This is consistent with longstanding VA policy to treat eligible individuals who experienced military sexual trauma without additional evidence of the trauma. *Id.* This approach is appropriate as it removes barriers to providing needed or medically necessary and appropriate care. *Id.* VA does not believe it is appropriate to require a provider to separately investigate or confirm the veteran or CHAMPVA beneficiary's self-reporting that an act of rape or incest occurred. Requiring such proof or confirmation could harm the provider-patient relationship, and it is unnecessary.

It is a part of routine practice for VA providers to take and rely on many types of patient-reported information (family, trauma, work, medical, legal, and other histories, for instance), as part of their clinical evaluations and assessments. For instance, VA providers make a clinical eligibility determination as to whether an individual is eligible for military sexual trauma-related treatment under 38 U.S.C. 1720D without requiring additional proof that this experience occurred, as already stated herein. See VHA Directive 1115(1), Military Sexual Trauma (MST) Program.

The comments misunderstand the function of the rape or incest exception. By operation of the IFR, patient self-reports of rape or incest constitute sufficient evidence for the VA provider to establish and document that this exception is met. 38 CFR 17.38(c)(1)(ii), 17.272(a)(64)(ii). There is no reason to treat these patient self-reports differently from self-reports supporting other sought-after medical care; nor do these comments provide any rationale for doing so. In any case where the rape or incest exception applies, the VA provider must still determine that an abortion meets the clinical standard set forth in 38 CFR 17.38(b) or 17.272(a), as applicable.

B. Assertions That Rape or Incest Exception Is Not Medically Necessary

One commenter opined that in the case of a pregnancy that is the result of rape or incest, an abortion can never be "needed" or "medically necessary and appropriate" and that patients who experience mental health issues following acts of rape or incest should be provided counseling and support, not abortions. VA does not make changes to the rule based on this comment. As VA explained in the IFR, VA has determined that abortions for pregnancies resulting from rape or incest, when sought by a pregnant veteran and clinically determined to be needed to promote, preserve, or restore the health of the veteran and in accord with generally accepted standards of medical practice, are needed consistent with the terms of 38 U.S.C. 1710. As noted in the IFR, there are severe health consequences associated with being forced to carry a pregnancy that is the result of rape or incest to term, including constant exposure to the violation committed against the individual which can cause serious traumatic stress and a risk of long-lasting psychological conditions. 87 FR 55292. Such consequences can have a particular impact on veterans, who report higher rates of sexual trauma compared with civilian peers. *Id.* In addition, veterans are more likely to have preexisting mental health conditions that would be compounded by the mental health consequences of being forced to carry a pregnancy to term if that pregnancy is the result of rape or incest. *Id.* In addition, for similar reasons to those discussed above and in the IFR, and because it is "similar" to the care offered under TRICARE (Select), *see* 38 U.S.C. 1781(b), VA has also determined, for purposes of 38 CFR 17.272(a), that access to abortion when the pregnancy is the result of an act of rape or incest is medically necessary and appropriate and so must be available to CHAMPVA beneficiaries. 87 FR 55292.

C. Investigation or Reporting

Commenters raised concerns about whether evidence of sexual abuse will be investigated or reported. To the extent these commenters might want VA to regulate such investigation or reporting for purposes of providing the health care services permitted under the IFR, VA does not make changes to the rule. For the reasons already explained herein, self-reports are sufficient to establish that an act of rape or incest occurred. Further, this approach is similar to how VA providers, who are not investigators, consider other types of patient self-reported information such as military sexual trauma; other trauma; and medical, personal, health information and history. VA will investigate claims of rape or incest to the extent they occurred on VA property or involved a VA employee, consistent with VHA Directive 5019.02, which relates to reporting of harassment, sexual assault, and other public safety incidents in VHA. Additionally, consistent with VHA Directive 1199(2), VA providers will report claims of abuse, as necessary and required by Federal law.

VII. Availability of the Health Care Services Permitted Under the IFR to Non-Veterans and Non-CHAMPVA Beneficiaries

A. Spina Bifida Health Care Benefits Program

One commenter inquired into whether the health care services permitted under the IFR will be available to beneficiaries in VA's Spina Bifida Health Care Benefits Program. VA considers this comment outside the scope of the rulemaking as VA did not amend the regulations for such program; only the regulations for the medical benefits package and CHAMPVA were amended by the IFR. VA makes no changes to the rule based on this comment.

B. Nonveterans

This same commenter inquired into whether the health care services permitted under the IFR will be available to nonveterans for emergency services on a humanitarian basis. VA is authorized to provide humanitarian care under 38 U.S.C. 1784 and medical screening and stabilization for an emergency medical condition under 38 U.S.C. 1784A, but VA considers this comment to be outside the scope of the rulemaking as VA only amended the regulations for the medical benefits

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package and CHAMPVA, which determine care for veterans and CHAMPVA beneficiaries, respectively. VA makes no changes to the rule based on this comment.

C. "Wives of Military Members"

Another commenter inquired whether "wives of military members" will be eligible for the health care services permitted under the IFR. To the extent such individuals have veteran status and are receiving their medical care through VA (specifically care included in tbe medical benefits package), or else are CHAMPVA beneficiaries, then they would be eligible for health care services in the circumstances permitted by the IFR. However, to the extent the commenter is referring to individuals who do not have veteran status or are not CHAMPVA beneficiaries, these individuals are not covered by the amendments made by the IFR. VA makes no changes to the rule based on this comment.

VIII. Comments That Stated Abortion Was Not Health Care or Is Otherwise Harmful

Many commenters stated that abortion is not health care. Some of these commenters did not provide any supporting rationale for this statement, while others asserted that abortion could not be health care because the practice of medicine is supposed to preserve life, not end life. VA does not make changes to the rule based on these comments. As VA explained in the IFR and herein, abortions are health care and may be needed to preserve the life or health of a pregnant individual. Pregnant individuals may face life and health-threatening conditions, where abortion may be the only medical intervention available that can preserve their health or life.[3] *See* 87 FR 55291.

Many commenters opposed VA providing access to abortions because they asserted that abortions can be harmful to pregnant individuals. Some commenters stated that abortions can result in emotional harm or complications for pregnant individuals but did not offer support, evidence, or a rationale for such assertions. Some commenters asserted similar opinions but posited distinct harms and cited certain literature. VA does not make changes to the rule based on these comments.

All medical care may pose a risk of complications to some patients. In every instance of care, medical practice requires practitioners to balance the risks of providing needed or medically necessary and appropriate care with the risks of not doing so, a calculation guided by clinical standards and informed by reliable data. The patient must then also balance the risks of receiving needed or medically necessary and appropriate care with the risks of not doing so, and VA obtains informed consent for any medical care pursuant to its existing informed consent requirements set forth in 38 CFR 17.32 (implementing 38 U.S.C. 7331). As explained in the IFR (87 FR 55291) and herein, research has shown that while most pregnancies progress without incident, pregnancy and childbirth in the United States can result in physical harm and even death for pregnant individuals.[4] Without access to comprehensive reproductive health care, including abortion, such individuals may experience conditions resulting from their pregnancy that can leave tbem at risk for loss of future fertility, significant morbidity, or death. In such instances, an abortion may be the only medical intervention that can preserve that individual's health or save their life.[5]

The health care profession understands that abortions are safe medical interventions.[6] A study available to the public and cited in the IFR addressed the rate of abortion complications and concluded that, contrary to the unsupported assertion by commenters, the most common type of complications from abortions are minor and treatable.[7] The scientific evidence also shows that the risk of complication or mortality from abortion is less than the risk of complication or mortality from other common clinical procedures.[8]

A 2018 consensus study report from the National Academy of Medicine (National Academies of Sciences, Engineering, and Medicine (NASEM)) reviewed the then available evidence on the safety and quality of legal abortions in the United States and concluded that having an abortion does not increase an individual's risk of secondary infertility, pregnancy-related hypertensive disorders, abnormal placentation, preterm birth, or breast cancer.[9] This review by NASEM also found that having an abortion does not increase a person's risk of depression, anxiety, or posttraumatic stress disorder.[10]

One commenter opined that allowing access to abortion counseling or abortions via telehealth is harmful. The commenter provides no evidence or rationale for this assertion. VA makes no changes to the rule based on this comment. Telehealth is widely implemented at VA to provide high-quality care to veterans and eligible beneficiaries, enhancing access to care in appropriate cases. *See* 38 U.S.C. 1730C. Abortion counseling as well as some abortions can be provided through telehealth in accord with generally accepted standards of medical practice. VA will only provide medical care, whether in-person or through telehealth, that is consistent with generally accepted standards of care.

Commenters also raised concerns that the rule did not include informed consent or standards for medical evaluations to ensure that an abortion would not lead to further medical complications or harm for women. VA does not make changes to the rule based on these comments. In determining whether to recommend *any* treatment or procedure, VA providers take into consideration all relevant clinical factors, that is, they conduct a medical evaluation based on a number of clinical factors. Decisions as to which treatment or procedures to recommend are clinical judgments made in accord with generally accepted standards of care. Informed consent is not required as part of the provider's individual undertaking of a differential diagnosis or decision process as to available and recommended treatment options. These clinical evaluation steps occur before the provider's professional recommendation is decided. Informed consent only applies to the receipt of

[3] Martha B. Kole, Jennifer Villavicencio, and Erika G. Werner, *Reproductive services for the patient at increased risk for morbidity and mortality during the second trimester.* Semin Perinatol, 44 (5), 151270 (2020).

[4] Elizabeth G Raymond & David A Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States,* 119 Obstetrics & Gynecology 215, 216 (2012); see also Marian F. MacDorman et al., *Recent Increases in the U.S. Maternal Mortality Rate: Disentangling Trends from Measurement Issues,* 128 Obstetrics & Gynecology 447 (2016) (finding a 26.6 percent increase in maternal mortality rates between 2000 and 2014).

[5] *Abortion Can Be Medically Necessary,* Am. College of Obstetricians and Gynecologists, Sep. 25, 2019. *http://www.acog.org/news/news-releases/2019/09/abortion-can-be-medically-necessary* (last visited Aug. 22, 2022).

[6] *Abortion Access Fact Sheet.* The American College of Obstetrics and Gynecology. 2023. *https://www.acog.org/advocacy/abortion-is-essential/come-prepared/abortion-access-fact-sheet* (last visited May 15, 2023).

[7] Desai Upadhyay, et al. *Incidence of emergency department visits and complications after abortion,* Obstet Gynecol; 125(1):175–183 (2105).

[8] *Abortion Access Fact Sheet.* The American College of Obstetrics and Gynecology. 2023. *https://www.acog.org/advocacy/abortion-is-essential/come-prepared/abortion-access-fact-sheet* (last visited May 15, 2023).

[9] *The Safety and Quality of Abortion Care in the United States.* National Academies of Sciences, Engineering, and Medicine (Mar. 2018), *https://nap.nationalacademies.org/catalog/24950/the-safety-and-quality-of-abortion-care-in-the-united-states.*

[10] Id.

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VA recommended treatment or procedures, which the patient can then decide to reject or accept. No medical treatment or procedure may be performed without the prior, voluntary, and fully informed consent of the patient. 38 CFR 17.32(b). 38 U.S.C. 7331; 38 CFR 17.32. As part of informed consent discussion, the practitioner must explain in plain language understandable to the patient the nature of the proposed procedure or treatment; expected benefits; reasonably foreseeable associated risks, complications, side effects; reasonable and available alternatives; and anticipated result if nothing is done, among other information. *See* 38 CFR 17.32(c)(2).

IX. Comments Related to Employee Rights and Protections and Rights of the Public

Commenters raised concerns related to employees' religious and conscience-based protections, including under the First Amendment, the Religious Freedom Restoration Act, the Public Health Service Act (including the Coats-Snowe Amendment), and Title VII of the Civil Rights Act of 1964. Commenters further asserted that VA is forcing VA employees to provide abortions that may be criminal offenses under State or local law, and one commenter specifically inquired whether any or all VA employees will be responsible for assisting with "emergency abortions." VA does not make any changes to the rule based on these comments. In implementing the IFR and this rule, VA adheres to all applicable Federal laws relating to employee rights and protections, including protections based on an employee's religious or conscience-based objection to abortion. VA has a policy in place for reasonable accommodation requests, where employees may request to be excused from providing, participating in, or facilitating an aspect of clinical care, including reproductive health clinical care authorized by this rule. See, AUSHO Memorandum, *Processing Employee Requests to be Excused from Aspects of the Provision of Reproductive Health Care within the Veterans Health Administration* (Jan. 6, 2023). Pursuant to that policy, VA health care professionals that object to furnishing the care covered by this rulemaking to veterans or CHAMPVA beneficiaries may request to be excused from that care and such requests will be individually assessed under the applicable Federal law. If excusal is requested, supervisors should grant interim excusal for employees from duties or training regarding reproductive health care while requests are being processed.

Commenters also raised concerns regarding whether those providing the health care services permitted under the IFR, including VA employees and non-VA providers, would be protected by VA against State action, such as potential enforcement of State criminal, civil, or administrative penalties related to the provision of the health care services permitted under the IFR. To the extent a VA employee provides the health care services permitted under the IFR within the scope of their VA employment as authorized by Federal law, they could not legally be subject to adverse State actions. As described above, State and local laws, rules, regulations, and requirements that unduly interfere with health care professionals' practice will have no force or effect when such professionals are practicing health care while working within the scope of their VA employment. 38 CFR 17.419.

Moreover, as further described above, in circumstances where there is a conflict between Federal and State law, Federal law would prevail in accordance with the Supremacy Clause under Article VI, clause 2, of the U.S. Constitution. The Department of Justice's Office of Legal Counsel has issued an opinion confirming that States may not impose criminal or civil liability on VA employees who provide or facilitate abortions or related services in a manner authorized by Federal law, including this rule. *See* 46 Op. O.L.C. __ (Sept. 21, 2022); *www.justice.gov/olc/opinion/intergovernmental-immunity-department-veterans-affairs-and-its-employees-when-providing*. If States attempt to subject VA employees to legal action for appropriately carrying out their Federal duties the Department of Justice will support and provide representation to those employees.

Several commenters additionally asserted that performing an abortion would violate a VA health care professional's Hippocratic oath, where some of these comments further noted that this oath requires individuals who take it to "do no harm" in the practice of medicine. VA does not make changes to the rule based on these comments. An abortion would be provided pursuant to the rule to veterans only when determined by appropriate healthcare professionals to be needed to promote, preserve, or restore the health of the individual and to be in accord with generally accepted standards of medical practice; and to CHAMPVA beneficiaries when medically necessary and appropriate.

Some commenters appeared to allege that the IFR violates their First Amendment rights and religious freedoms as members of the public, without providing rationale or support for such statements. Unlike the comments above that raised specific First Amendment and religious freedom concerns for VA health care professionals, these comments did not assert or explain why they believed the IFR violated their First Amendment rights or religious freedoms as members of the public. VA's IFR authorizes the provision of abortions and abortion counseling to veterans and CHAMPVA beneficiaries in certain circumstances. It does not limit the First Amendment rights or religious freedoms of the public.

X. Comments Specifically Concerning Abortion Counseling

The IFR revised 38 CFR 17.38(c)(1) and 17.272(a) to remove a prohibition on VA providing access to abortion counseling. Below VA summarizes comments that specifically raised concerns with this revision, other than as already addressed in this rulemaking.

A. Provision of Abortion Counseling

Multiple commenters raised various concerns about VA's provision of abortion counseling. The commenters stated that abortion counseling should be unbiased, and that VA should not "direct" pregnant individuals to have an abortion. The commenters further suggested that abortion counseling should include discussion of options other than abortion and should also include information about the negative effects of abortion. One commenter further implied that VA is not providing counseling about options other than abortion specifically for victims of rape or incest.

VA does not make changes to the rule based on these comments. Prior to the IFR, VA could not discuss abortion as an option with pregnant patients, but VA has always provided counseling to pregnant patients about pregnancy options such as carrying the pregnancy to term and adoption. Under the IFR, VA now provides the full range of pregnancy options counseling to individuals who are pregnant, which includes all options related to that individual's pregnancy and is not limited to discussing only the option of abortion. This is consistent with Centers for Disease Control and Prevention guidance.[11] As explained in the IFR,

[11] *Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs*. Centers for Disease Control and

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abortion counseling is part of pregnancy options counseling and is a component of comprehensive, patient-centered, high-quality reproductive health care, and is needed care for veterans, and medically necessary and appropriate for CHAMPVA beneficiaries, because such counseling will enable a pregnant individual to make a fully informed health care decision, just as counseling offered or covered by VA regarding other health care treatments enables the patient to make an informed decision. *See* 87 FR 55292–93. Such pregnancy options counseling is provided in a neutral, non-directive, and unbiased manner to ensure patients receive the most complete and accurate information regarding available treatment options. VA does not direct a patient towards a specific option when it conducts pregnancy options counseling. The rule also makes clear that VA's determinations that such counseling is needed care (as to veterans) and medically necessary and appropriate (as to CHAMPVA beneficiaries)—and the accompanying regulatory amendments—were not limited to instances in which the pregnancy is the result of rape or incest. *See, e.g., id* at 55293–94.

B. Post-Abortion Counseling

Another commenter suggested VA provide post-abortion counseling and support for the pregnant individual and their spouse. VA does not make changes to the rule based on this comment. To the extent a veteran requests counseling or mental health support from VA after an abortion or any other type of medical service, such care is available to veterans as part of the medical benefits package. VA would also cover such counseling and mental health support for CHAMPVA beneficiaries. However, and as explained herein, VA does not have authority to provide such counseling under the medical benefits package or CHAMPVA to non-veterans and non-VA beneficiaries, respectively.

XI. Comments Specific to CHAMPVA

Prior to the IFR, the CHAMPVA program at 38 CFR 17.272(a)(64) covered abortions for beneficiaries when the life of the beneficiary would be endangered if the pregnancy were carried to term. The IFR revised § 17.272(a)(64) to: (i) expand the exception on the exclusion of abortion to cover cases where the health of the pregnant CHAMPVA beneficiary would be endangered if the pregnancy were carried to term; and (ii) to establish an exception to the exclusion of abortion to cover cases where the pregnancy of the CHAMPVA beneficiary is the result of an act of rape or incest. Below VA addresses comments that specifically raised concerns with these changes to CHAMPVA, other than as already addressed in this rulemaking.

A. CHAMPVA and TRICARE

One commenter stated that VA does not have authority to provide medical care under the CHAMPVA program in the same manner as under the TRICARE program because TRICARE and CHAMPVA are separate programs and CHAMPVA covers medical care only to those specifically identified at 38 U.S.C. 1781(a). The commenter further stated that VA does not effectively argue that CHAMPVA and TRICARE coverage should be aligned. VA does not make any changes to the rule based on this comment. It appears that the commenter may misunderstand the CHAMPVA authority. VA has authority to furnish medical care to CHAMPVA beneficiaries pursuant to 38 U.S.C. 1781. Section 1781(b) establishes that VA must provide such care "in the same or similar manner and subject to the same or similar limitations as medical care" is provided by DoD under the TRICARE program.

Other commenters asserted that the IFR's changes to the CHAMPVA regulations were not the same or similar to what is permitted under TRICARE. Specifically, these comments noted that the exclusion to provide abortions if the health of an individual were endangered, as well as furnishing abortion counseling for any reason (and not just in those cases for which abortions would be covered by TRICARE), were too broad to be considered the same or similar to what is permitted under TRICARE. Notably, these comments also incorrectly argued that the CHAMPVA exception to protect the health of the pregnant individual without further qualification or limitation could be interpreted in a way that increases access to abortion services beyond the scope stated in the IFR.

VA does not make changes to the rule based on these comments. As explained in the IFR and herein, TRICARE (Select) provides coverage for abortions when the pregnancy is the result of an act of rape or incest, or when a physician certifies that the life of the woman would be endangered if the pregnancy were carried to term. 87 FR 55290. CHAMPVA regulations previously allowed for abortions only when a physician certifies that the abortion was performed because the life of the woman would be endangered if the pregnancy were carried to term. *See* 38 CFR 17.272(a)(64); 87 FR 55290. Pursuant to VA's authority in 38 U.S.C. 1781, VA amended the CHAMPVA regulations to better align coverage under CHAMPVA with coverage under TRICARE (Select). In this regard, VA amended its regulations to additionally provide coverage of abortions when the pregnancy is the result of an act of rape or incest. Although VA also revised the regulations to cover abortions when the health of the CHAMPVA beneficiary would be endangered if the pregnancy were carried to term, in contrast with coverage under TRICARE (Select), coverage under CHAMPVA must be provided in the "same or similar" manner and subject to the "same or similar" limitations as TRICARE (Select). 38 U.S.C. 1781(b); *see* 87 FR 55290. By referring to care that is "similar," the statute permits VA flexibility to administer the program for CHAMPVA beneficiaries. If Congress had intended for VA to administer the program for CHAMPVA beneficiaries in a manner equivalent to TRICARE (Select), 38 U.S.C. 1781(b) simply could have required VA provide "the same" care in "the same" manner as TRICARE (Select); however, the statute recognizes that there will be differences in how VA administers CHAMPVA. VA determined that the care provided under this rule is similar to that provided by DOD under TRICARE (Select), which covers abortions to beneficiaries when there is a medical risk to the pregnant individual if the pregnancy were carried to term or if the pregnancy is the result of an act of rape or incest. *Id.* The flexibility to administer CHAMPVA in a manner "similar" to TRICARE (Select) also recognizes that VA serves a different population than TRICARE under a different authority. Section 1781(b) of 38 U.S.C. authorizes VA to provide care directly to CHAMPVA beneficiaries through VA facilities, and beneficiaries who receive care at a VA facility are eligible for the same medical services as a veteran. In exercising our discretion to provide care in a "similar" manner to TRICARE (Select), we have concluded it lies within our discretion to determine that abortions in the circumstances authorized by the IFR should be made available to all CHAMPVA beneficiaries, not just those who receive their care through VA facilities. As explained, it is important to provide medically necessary and appropriate abortion care when the health of the pregnant individual is endangered, as determined by an appropriate medical professional under

Prevention. April 25, 2014. *https://www.cdc.gov/mmwr/preview/mmwrhtml/rr6304a1.htm?s_cid=rr6304a1_w* (last visited December 6, 2023).

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generally accepted standards of care, to better promote the long-term health of CHAMPVA beneficiaries, which is consistent with VA's past practices related to implementing CHAMPVA.

Regarding the portion of these comments related to VA furnishing abortion counseling under CHAMPVA for any beneficiary and not just in those cases for which an abortion would be covered hy TRICARE, we reiterate from above that VA finds this more comprehensive abortion counseling to be sufficiently similar to that under TRICARE (Select). VA's broader coverage may deviate for purposes of promoting the long-term health of CHAMPVA beneficiaries by covering the most complete and accurate information available regarding various pregnancy and health care options, regardless of whether CHAMPVA would cover any such abortion the beneficiary receives. *See also* 87 FR 55292–93.

B. CHAMPVA Care at VA Facilities

One commenter stated that 38 U.S.C. 1781 authorizes, but does not mandate, the provision of CHAMPVA care at VA facilities through the CHAMPVA In-House Treatment Initiative (CITI). The commenter suggested that VA ensure that VA facilities provide access to abortion to CHAMPVA beneficiaries through the CITI program, particularly in localities where abortions are banned or restricted. VA does not make changes to the rule based on this comment. The provision of CHAMPVA care at VA facilities through the CITI program is permissible under 38 U.S.C. 1781(b), which provides that those VA medical facilities that are equipped to provide CHAMPVA beneficiaries care may do so only to the extent they are not being utilized for the care of eligible veterans. Because the capacity, projected demands, and care needs of veterans at each VA Medical Center can fluctuate, VA cannot ensure that a certain number of VA facilities or facilities in any particular State or region will participate in the CITI program at any given time. However, where a VA facility operates a CITI program, it will provide the health care services permitted by the IFR to CHAMPVA beneficiaries who are eligible to receive care through CITI consistent with the IFR and to the extent that facility's resources are not being utilized for the care of eligible veterans. Further, it remains the case that the CITI program may expand to additional VA facilities if such facilities are equipped to provide the care and treatment and are not being utilized for the care of eligible veterans, without any revisions to VA regulations.

C. Provision of Abortions and Abortion Counseling to Those Under Age 18

One commenter asserted that VA should clarify that it is not requiring its health care professionals to perform any abortions on those under the age of 18, and that parental notification and consent is required for any abortion. Another commenter similarly stated that it was unclear what protocols will be put in place to ensure that children of veterans who may be eligible to receive abortions through the VA have received proper parental consent. VA makes no changes to the rule based on these comments.

In accordance with VHA Directive 1004.01, dated December 12, 2023, it is VA policy that if a patient is considered a minor under State law in the jurisdiction where the VA facility is located, then that patient is not presumed to have decision-making capacity for giving informed consent. As a result, for patients considered minors, consent would be obtained from the patient's parent or legal guardian, except as otherwise provided by law. And as also consistent with this VA policy, if the patient is not considered a minor under State law, for example, by virtue of a State court order awarding emancipation to the minor or automatic emancipation under State law based on certain events, parental notification and consent would not be required.

XII. Comments Related to Fatal Fetal Anomalies

One commenter recommends VA revise the rule to include an exception to allow abortions for fatal fetal anomalies. VA makes no changes based on this comment. The commenter provides no rationale for the proposal that abortions be provided absent the circumstances identified in the rule, or for a finding that the proposed expansion would constitute needed care (for veterans) or medically necessary and appropriate care (for CHAMPVA beneficiaries) under 38 U.S.C. 1710 and 1781. As explained herein and in the IFR, VA has determined that abortions are needed or medically necessary and appropriate care, as required under VA's statutory authorities, when the life or health of the pregnant veteran or CHAMPVA beneficiary would be endangered if the pregnancy were carried to term or when the pregnancy is the result of an act of rape or incest. It is up to the provider to determine if the specific clinical facts of the individual case establish that the carrying to term of a fetus with a fatal fetal anomaly would endanger the life or health of a pregnant veteran or CHAMPVA beneficiary. That is, it would be up to the provider to make the necessary clinical determination.

XIII. Comments Related to VA Mission and Funding

Several commenters opined that VA should not use its limited resources for abortion as VA facilities are for veteran care. These commenters expressed concerns regarding the impact of the health care services permitted under the IFR on VA's provision of other needed care. VA makes no changes to the rule based on these comments. As explained in the IFR and throughout this final rule, abortions can also be needed health care for veterans and medically necessary and appropriate for CHAMPVA beneficiaries. Pursuant to authorized appropriations, detailed above, VA receives and uses funding to furnish medical care authorized under the medical benefits package, which now includes abortions in certain circumstances and abortion counseling. VA's provision of the health care services permitted under the IFR does not impact or preclude VA's provision of all other needed health care.

XIV. Comments That VA Should Expand Access to Abortion

Several commenters opined that VA should permit access to abortions for any reason, not just in the circumstances identified in the IFR. One of these commenters asserted that VA's statutory authority permits abortion care in all circumstances, not just in cases where the life or health of the pregnant patient would be endangered if the pregnancy were carried to term, or when the pregnancy is the result of rape or incest. Consistent with its authorities, and as discussed throughout this rule and the IFR, VA has removed exclusions for certain care that VA has, at this time, determined to be "needed" (for veterans) and "medically necessary and appropriate" (for CHAMPVA beneficiaries). We decline to change course based on these comments.

Some commenters supported a legislative change to permit VA to provide access to abortions for any reason. Those comments regarding Congress's ability to amend VA's statutory authority are outside the scope of this rulemaking.

Some commenters otherwise asserted that the IFR's framing of VA's regulatory changes as prohibitions on abortion with exceptions could be confusing, perhaps to the detriment of veterans or CHAMPVA beneficiaries. As discussed, given VA's statutory authorities and regulations concerning determinations that care is "needed" or "medically

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necessary and appropriate''—as well as a preexisting prohibition with ''exceptions'' for abortion care nnder VA's implementing regulations for CHAMPVA (38 CFR 17.272)—it was appropriate to regulate in this consistent manner. VA has and will continue to issue appropriate gnidance to ensure that VA health care professionals understand that abortion is permitted under the exceptions as outlined in the IFR, and again directs veterans, CHAMPVA beneficiaries, and external stakeholders to VA's public-facing websites for clarifying information: *www.womenshealth.va.gov/WOMENSHEALTH/topics/abortion-services.asp.*

XV. Comments Outside the Scope of the IFR

Many commenters raised concerns that were outside the scope of the rulemaking, in addition to those noted above. VA has briefly summarized those concerns below; VA does not make any changes to the rule based on them.

A. Mandated Provision of Abortion or Any Related Reproductive Health Services

One commenter suggested VA clarify that ''the rule cannot mandate coverage for abortion or situationally for any related reproductive health services.'' To the extent the comment was simply asking VA to clarify this point, we reiterate that the covered health care and services permitted under the IFR are available to veterans and CHAMPVA beneficiaries when their health care provider determines they are needed or medically necessary and appropriate. The decision to pursue a particular course of treatment is the pregnant individual's decision, made in consultation with a provider, VA does not make that decision for the individual.

B. VA's Implementation of the IFR

Multiple commenters made statements or asked questions about VA's implementation plan(s) related to the IFR. VA finds comments related to VA's implementation beyond the scope of the IFR as these are administrative matters not controlled by the regulations that were revised by the IFR. Nonetheless, VA provides summaries and responses below for the purposes of transparency and as appropriate.

One commenter opined that VA must make explicit its plan to implement the rule. VA has made relevant information available on its website. *See www.womenshealth.va.gov/WOMENSHEALTH/topics/abortion-services.asp.* As stated there, VA is taking steps to guarantee veterans and CHAMPVA beneficiaries have access to abortion-related care, as authorized by this rule, anywhere in the country.

One commenter stated that a VHA website related to community care provisions (*https://www.va.gov/communitycare/programs/veterans/general_care.asp*) provided that VA facilities do not provide maternity care which suggests that veterans can only receive medical care related to pregnancy (and therefore abortions) through VA's community care providers. The commenter raised a concern about how eligible veterans would be able to access the health care services permitted under the IFR if they were solely available in the community and those community providers would be required to adhere to State law requirements. Relatedly, another commenter inquired whether VA will be providing the health care services permitted nnder the IFR within its VA medical facilities or referring individuals out to the community in other States.

VA does provide some maternity care services to veterans in VA medical facilities, and to the extent that VA can furnish the health care services permitted by the IFR directly, it will do so. Since the IFR published and became effective, VA has made efforts to ensure it has adequate capacity to provide abortion care at VA facilities, including abortion counseling. Regarding needed health care services permitted by the IFR that cannot be furnished in VA facilities (due to lack of resources such as staff or equipment, for instance), VA may refer such care to VA community care providers where that health care is available, consistent with existing VA regulations (see, for instance, 38 CFR 17.4000 *et seq.*).

Several commenters raised concerns that the IFR does not explain the types of abortion methods that will be permitted or prohibited by VA. As noted above, VA does not generally find it appropriate to regulate the types of methods of care or procedures that are permitted or prohibited. Doing so could unnecessarily restrict the provision of care, including abortions, and result in negative impact or harm to our patients. The type of abortion provided will vary on a case-to-case basis, and appropriate VA medical professionals must be able to determine, in accord with generally accepted standards of medical practice, how best to treat all individuals.

One commenter opined that VA should clarify in guidance that no additional administrative barriers should delay or impede access to the health care services permitted under the IFR determined to be appropriate by a health care professional. Neither the IFR nor this final rule adds administrative barriers to delay or impede access to the health care services permitted under the IFR. VA will ensure its health care professionals furnish this care consistent with the manner in which they furnish all other authorized health care.

One commenter inquired as to whether VA will have funding for the provision of this care, if VA will provide medication abortion, and if VA will have necessary providers available to provide this care. VA is using and will continue to use its current funding for the provision of health care authorized under 38 U.S.C. 1710 and 1781 to provide health care services in the circumstances permitted under the IFR. VA will ensure that experienced and trained VA providers are available to provide abortions, including medication abortion. Another commenter relatedly recommended that VA equip its pharmacists with the authority and infrastructure to support mail dispensary of medication abortion drugs. VA pharmacists do have the authority to mail medications.

Another commenter urged VA to include virtual counseling and medication abortion as part of the care authorized under the IFR. As explained previously in this rule, abortion counseling may be provided virtually through telehealth in accord with generally accepted standards of care. VA will provide medication abortions when needed and medically appropriate and in a manner consistent with Federal law.

Another commenter suggested that VA clarify that sexual assault survivors can receive the full range of health care without barriers, especially as the majority of sexual assaults are not reported, and survivors may distrust the police or fear retaliation from a known perpetrator. Veterans who are eligible for VA health care and CHAMPVA beneficiaries are able to receive the full range of health care authorized under the medical benefits package and CHAMPVA, respectively, regardless of whether they are a sexual assault survivor. VA notes that it has military sexual trauma coordinators at every VA medical facility that can further assist eligible individuals in accessing needed military sexual trauma care. For additional information, please see *www.va.gov/health-care/health-needs-conditions/military-sexual-trauma/.*

One commenter appeared to support VA's training of medical students and residents to provide the health care services permitted under the IFR.

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Similar to the provision of all other health care provided by VA, medical students and residents may receive training from VA regarding the provision of the health care services permitted under the IFR. Such training would be conducted pursuant to an affiliation agreement between an educational institution and a VA facility, and under the clinical supervision of an appropriate health care professional.

One commenter stated that not all VA facilities are located on exclusive Federal property, and therefore it would seem necessary to alert individuals seeking an abortion at such a VA facility that VA cannot guarantee that such individuals would not be prosecuted under State law even though the VA medical provider would appear to be protected. The commenter further stated that a better option would be to have VA authorize transport at government expense of such an individual to a VA facility in a State that does not criminalize abortion. Relatedly, commenters inquired how VA will address State action concerns because not all veterans live in areas that permit abortion counseling or services and that there should be measures to ensure travel across State lines if necessary, and generally noted that VA needs to ensure that veterans feel safe in accessing abortion care.

For the portions of these comments that assert or question VA's jurisdiction or control of its facilities, any care or services furnished by VA in a manner authorized by Federal law, including by this rule, would preempt conflicting State law that would penalize VA employees for performing their Federal functions, regardless of any specific land ownership or leasing arrangements (for instance, such as if a VA facility is co-located to a State-sponsored academic institution).

To the extent these comments may raise concerns that needed abortion counseling or abortions cannot be furnished in VA facilities (due to lack of resources such as staff or equipment, for instance), VA reiterates from earlier in this discussion that VA may refer such care to VA community care providers where available.

Insofar as some comments concerned potential travel needed to obtain the health care services permitted under the IFR, veterans would have access to both Beneficiary Travel and Veterans Transportation Program benefits if so eligible under VA regulations at 38 CFR part 70.

Finally, insofar as commenters suggested that VA alert certain individuals seeking abortions that VA cannot guarantee that such individuals would not be prosecuted under State law, VA is a health care provider, and VA attorneys have no authority to provide any legal advice to veterans or CHAMPVA beneficiaries.

C. Suggested Alternatives to VA Providing Access to Abortion

Commenters asserted that instead of access to the health care services permitted under the IFR they believed pregnant individuals should be given the option of emotional and physical support throughout their pregnancies and post-partum experiences, specifically including prenatal medical attention. Other commenters similarly indicated that instead of providing access to abortions, VA should direct pregnant individuals to support groups that are available and, if such individuals do not wish to keep a child after giving birth, to help them through the adoption process. As with all comments discussed in this section, VA finds these comments to be beyond the scope of the IFR.

These commenters seem to assert that abortion would not be necessary if pregnant individuals were given more support during prenatal, pregnancy, or postpartum stages, or offered choices beyond abortion, which seems to assume that VA is providing access to abortion procedures for reasons other than medical necessity. However, the IFR permits abortions to be provided only when the life or health of the pregnant individual would be endangered if the pregnancy were carried to term or when the pregnancy is the result of an act of rape or incest. VA provides care to veterans when such care is determined by an appropriate health care professional to be needed to promote, preserve, or restore the health of the veteran and is in accord with generally accepted standards of medical practice, and provides care for CHAMPVA beneficiaries that is medically necessary and appropriate. The need for health care services permitted under the IFR would not be prevented by increased access to support groups or to a particular level of maternity care services. Moreover, VA's pregnancy options counseling, discussed above, includes abortion counseling and all other pregnancy options. The course of treatment is the pregnant individual's decision, made in consultation with a provider, and nothing in the IFR changes this.

To the extent the commenters might be expressing that lack of maternity care services could endanger a pregnant individual's life or health if the pregnancy were carried to term, maternity care services provided by VA include comprehensive pre- and post-partum care and services. VA will continue to provide comprehensive maternity care in addition to the health care services permitted by the IFR in the circumstances stated in the rule.

Regarding the request in the comments that VA assist pregnant individuals with the adoption process if they did not want to keep a child after giving birth, VA does provide pregnancy options counseling as part of its furnishing of maternity care services, and this pregnancy options counseling includes providing information on adoption.

Severability

The purpose of this section is to clarify VA's intent with respect to the severability of provisions of this rule. Each provision and portion of this rule is capable of operating independently. If any provision or portion of this rule is determined by judicial review or operation of law to be invalid, that partial invalidation will not render the remainder of this rule invalid. As explained in the IFR and above, VA amended its regulations because it determined that providing access to abortion-related medical care is needed to protect the lives and health of veterans and is medically necessary and appropriate care for CHAMPVA beneficiaries. For those same reasons, VA intends each aspect of the rule to operate and ensure that such care is available, even if one portion of the rule is invalidated. For example, if a provision of the rule concerning benefits for CHAMPVA beneficiaries were held invalid, other provisions concerning CHAMPVA beneficiaries, and provisions concerning the care available to Veterans under the medical benefits package, could and should continue to operate independently. The provisions authorizing abortions in cases where the life or health of the pregnant veteran or CHAMPVA beneficiary would be endangered if the pregnancy were carried to term could operate independently should the provision authorizing abortions in cases where the pregnancy is due to an act of rape or incest be held invalid, and vice versa. The provisions authorizing VA to provide abortions could continue to operate should the provisions authorizing VA to provide abortion counseling be held invalid. We emphasize that this is a non-exhaustive list of examples. Likewise, if the application of any portion of this rule to a particular circumstance is determined to be invalid, the agency intends that

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the rule remain applicable to all other circumstances.

Administrative Procedure Act

VA has considered all relevant input and information contained in the comments submitted in response to the IFR (87 FR 55287) and, for the reasons set forth in the foregoing responses to those comments, has concluded that changes to the IFR are not warranted. Accordingly, based upon the authorities and reasons set forth in issuing the IFR (87 FR 55287), as supplemented by the additional reasons provided in this document in response to comments received, VA is adopting the provisions of the IFR as a final rule without changes.

Executive Order 13132, Federalism

Executive Order 13132 establishes principles for preemption of State laws when those laws are implicated in rulemaking or proposed legislation. The order provides that, where a Federal statute does not expressly preempt State law, agencies shall construe any authorization in the statute for the issuance of regulations as authorizing preemption of State law by rulemaking only when the exercise of State authority directly conflicts with the exercise of Federal authority or there is clear evidence to conclude that the Congress intended the agency to have the authority to preempt State law.

As discussed in the IFR, consistent with 38 CFR 17.419, State and local laws, rules, regulations, or requirements are preempted to the extent those laws unduly interfere with Federal operations or the performance of Federal duties. 87 FR 55293–55294. That includes laws that States and localities might attempt to enforce in civil, criminal, or administrative matters against VA health care professionals acting in the scope of their VA authority and employment and that would prevent those individuals from providing care authorized by 38 U.S.C. 1701, 1710, 1781, 1784A, 7301, and 7310, and VA's implementing regulations. State and local laws, rules, regulations, or requirements are therefore without any force or effect to the extent of the conflict with Federal law, and State and local governments have no legal authority to enforce them in relation to actions by VA employees acting within the scope of their VA authority and employment.

Because all State and local laws, rules, regulations, or requirements have no force or effect to the extent that they unduly interfere with the ability of VA employees to furnish reproductive health care while acting within the scope of their VA authority and employment, there are no actual or possible violations of such laws related to VA programs, operations, facilities, contracts, or information technology systems that would necessitate mandatory reporting by VA employees. 38 CFR 1.201–1.205. This rulemaking confirms VA's authority and discretion to manage its employees concerning the services that will be provided pursuant to this rulemaking.

Next, Executive Order 13132 requires that any regulatory preemption of State law must be restricted to the minimum level necessary to achieve the objectives of the statute pursuant to which the regulations are promulgated. Under VA's regulations, State and local laws, rules, regulations, or other requirements are preempted only to the extent they unduly interfere with the ability of VA employees to furnish needed or medically necessary and appropriate health care to veterans and CHAMPVA beneficiaries while acting within the scope of their VA authority and employment. Therefore, VA believes that the rulemaking is restricted to the minimum level necessary to achieve the objectives of the Federal statutes.

Executive Orders 12866, 13563, and 14094

Executive Order 12866 (Regulatory Planning and Review) directs agencies to assess the costs and benefits of available regulatory alternatives and, when regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, and other advantages; distributive impacts; and equity). Executive Order 13563 (Improving Regulation and Regulatory Review) emphasizes the importance of quantifying both costs and benefits, reducing costs, harmonizing rules, and promoting flexibility. Executive Order 14094 (Executive order on Modernizing Regulatory Review) supplements and reaffirms the principles, structures, and definitions governing contemporary regulatory review established in Executive Order 12866 of September 30, 1993 (Regulatory Planning and Review), and Executive Order 13563 of January 18, 2011 (Improving Regulation and Regulatory Review). The Office of Information and Regulatory Affairs has determined that this rule is a significant regulatory action under Executive Order 12866, as amended by Executive Order 14094. The Regulatory Impact Analysis associated with this rulemaking can be found as a supporting document at *https://www.regulations.gov*.

Regulatory Flexibility Act

The Secretary hereby certifies that this final rule will not have a significant economic impact on a substantial number of small entities as they are defined in the Regulatory Flexibility Act (5 U.S.C. 601–612). This final rule will not have a significant impact on a substantial number of small entities because the final rule does not directly regulate or impose costs on small entities and any effects will be indirect. Therefore, pursuant to 5 U.S.C. 605(b), the initial and final regulatory flexibility analysis requirements of 5 U.S.C. 603 and 604 do not apply.

Unfunded Mandates

The Unfunded Mandates Reform Act of 1995, see 2 U.S.C. 1532, requires that agencies prepare an assessment of anticipated costs and benefits before issuing any rule that may result in the expenditure by State, local, and tribal governments, in the aggregate, or by the private sector, of $100 million or more (adjusted annually for inflation) in any one year. This rule will have no such effect on State, local, and tribal governments, or on the private sector.

Paperwork Reduction Act

This rule contains no provisions constituting a collection of information under the Paperwork Reduction Act of 1995, 44 U.S.C. 3501–21.

Congressional Review Act

Pursuant to the Subtitle E of the Small Business Regulatory Enforcement Fairness Act of 1996 (known as the Congressional Review Act) (5 U.S.C. 801 *et seq.*), the Office of Information and Regulatory Affairs designated this rule as not satisfying the criteria under 5 U.S.C. 804(2).

List of Subjects in 38 CFR Part 17

Administrative practice and procedure, Claims, Health care, Health facilities, Health professions, Health records, Medical devices, Medical research, Mental health programs, Veterans.

■ For the reasons stated in the preamble, the interim final rule amending 38 CFR part 17, which was published at 87 FR 55287 on September 9, 2022, is adopted as final.

Signing Authority

Denis McDonough, Secretary of Veterans Affairs, approved and signed this document on February 26, 2024, and authorized the undersigned to sign and submit the document to the Office of the Federal Register for publication

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electronically as an official document of the Department of Veterans Affairs.

Michael P. Shores,

Director, Office of Regulation Policy & Management, Office of General Counsel, Department of Veterans Affairs.

[FR Doc. 2024–04275 Filed 3–1–24; 8:45 am]

BILLING CODE 8320–01–P

POSTAL SERVICE

39 CFR Part 20

International Mail Manual; Incorporation by Reference

AGENCY: Postal Service™.

ACTION: Final rule.

SUMMARY: The Postal Service announces the issuance of the *Mailing Standards of the United States Postal Service, International Mail Manual* (IMM®) dated January 21, 2024, and its incorporation by reference in the *Code of Federal Regulations.*

DATES: This rule is effective March 4, 2024. The incorporation by reference of certain material listed in this rule is approved by the Director of the Federal Register as of March 4, 2024.

FOR FURTHER INFORMATION CONTACT: Dale Kennedy, (202) 268–6592.

SUPPLEMENTARY INFORMATION: The *International Mail Manual* (IMM) provides our standards for all international mailing services and references for the applicable prices. It was issued on January 21, 2024, and was updated with *Postal Bulletin* revisions through December 28, 2023. It replaces all previous editions.

The IMM continues to enable the Postal Service to fulfill its long-standing mission of providing affordable, universal mail service. It continues to: (1) increase the user's ability to find information; (2) increase the user's confidence that he or she has found the information they need; and (3) reduce the need to consult multiple sources to locate necessary information. The provisions throughout this issue support the standards and mail preparation changes implemented since the version of July 10, 2022. The *International Mail Manual* is available to the public on the Postal Explorer® internet site at *https://pe.usps.com.*

List of Subjects in 39 CFR Part 20

Administrative practice and procedure, Foreign relations, Incorporation by reference.

In view of the considerations discussed above, the Postal Service hereby amends 39 CFR part 20 as follows:

PART 20—INTERNATIONAL POSTAL SERVICE

■ 1. The authority citation for part 20 continues to read as follows:

Authority: 5 U.S.C. 552(a); 13 U.S.C. 301–307; 18 U.S.C. 1692–1737; 39 U.S.C. 101, 401, 403, 404, 407, 414, 416, 3001–3011, 3201–3219, 3403–3406, 3621, 3622, 3626, 3632, 3633, and 5001.

■ 2. Amend § 20.1 by revising paragraphs (a)(3) and (b) to read as follows:

§ 20.1 Incorporation by reference; Mailing Standards of the United States Postal Service, International Mail Manual.

(a) * * *

(3) *Inspection—NARA.* You may view this material at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, visit *www.archives.gov/federal-register/cfr/ibr-locations* or email *fr.inspection@nara.gov.*

(b) The Director of the Federal Register approved the IMM, updated January 21, 2024, for incorporation by reference as of March 4, 2024.

■ 3. Revise § 20.2 to read as follows:

§ 20.2 Effective date of the International Mail Manual.

The provisions of the *International Mail Manual* issued January 21, 2024 (incorporated by reference, see § 20.1), are applicable with respect to the international mail services of the Postal Service.

■ 4. Amend § 20.4 by adding an entry for "IMM" at the end of table 1 to read as follows:

§ 20.4 Amendments to the International Mail Manual.

* * * * *

TABLE 1 TO § 20.4—INTERNATIONAL MAIL MANUAL

International mail manual	Date of issuance
* * * * *	
IMM	January 21, 2024.

Sarah E. Sullivan,

Attorney, Ethics and Legal Compliance.

[FR Doc. 2024–04420 Filed 3–1–24; 8:45 am]

BILLING CODE 7710–12–P

POSTAL SERVICE

39 CFR Part 111

Domestic Mail Manual; Incorporation by Reference

AGENCY: Postal Service™.

ACTION: Final rule.

SUMMARY: The Postal Service announces the issuance of the *Mailing Standards of the United States Postal Service, Domestic Mail Manual* (DMM®) dated January 21, 2024, and its incorporation by reference in the *Code of Federal Regulations.*

DATES: This rule is effective March 4, 2024. The incorporation by reference of certain material listed in this rule is approved by the Director of the Federal Register as of March 4, 2024.

FOR FURTHER INFORMATION CONTACT: Dale Kennedy (202) 268–6592.

SUPPLEMENTARY INFORMATION: The *Mailing Standards of the United States Postal Service, Domestic Mail Manual* (DMM) provides the United States Postal Service's official prices and standards for all domestic mailing services. The most recent issue of the DMM is dated January 21, 2024. This issue of the DMM contains all Postal Service domestic mailing standards and continues to: (1) increase the user's ability to find information; (2) increase confidence that users have found all the information they need; and (3) reduce the need to consult multiple chapters of the Manual to locate necessary information. The issue dated January 21, 2024, sets forth specific changes, including new standards throughout the DMM to support the standards and mail preparation changes implemented since the version issued on July 10, 2022.

Changes to mailing standards will continue to be published through **Federal Register** documents and the *Postal Bulletin* and will appear in the next online version available via the Postal Explorer® website at: *https://pe.usps.com.*

List of Subjects in 39 CFR Part 111

Administrative practice and procedure, Incorporation by reference.

In view of the considerations discussed above, the Postal Service hereby amends 39 CFR part 111 as follows:

PART 111—GENERAL INFORMATION ON POSTAL SERVICE

■ 1. The authority citation for 39 CFR part 111 continues to read as follows:

Authority: 5 U.S.C. 552(a); 13 U.S.C. 301–307; 18 U.S.C. 1692–1737; 39 U.S.C. 101,

SEC. 106. HEALTH CARE SERVICES FOR WOMEN.

(a) GENERAL AUTHORITY.-In furnishing hospital care and medical services under chapter 17 of title 38, United States Code, the Secretary of Veterans Affairs may provide to women the following health care services:

(1) Papanicolaou tests (pap smears).

(2) Breast examinations and maromographf:

(3) General reproductive health care, including the management of menopause, but not including under this section infertility services, abortions, or pregnancy care (including prenatal and delivery care), except for such care relating to a pregnancy that is complicated or in which the risks of complication are increased by a service-connected condition.

(b) RESPONSIBILITIES OF DIRECTORS OF FACILITIES.-The Secretary shall ensure that directors of medical facilities of the Department identify and assess opportunities under the authority provided in title II *of* this Act to (1) expand the availability of, and access to, health care services for women veterans under sections 1710 and 1712 of title 38, United States Code, and (2) provide counseling, care, and services authorized by this title.

This content is from the eCFR and is authoritative but unofficial.

Title 38 —Pensions, Bonuses, and Veterans' Relief
Chapter I —Department of Veterans Affairs
Part 17 —Medical
Enrollment Provisions and Medical Benefits Package

Authority: 38 U.S.C. 501, and as noted in specific sections. Section 17.30 also issued under 38 U.S.C. 1701. Section 17.32 also issued under 38 U.S.C. 7331-7334. *See Part 17 for more*

§ 17.38 Medical benefits package.

(a) Subject to paragraphs (b) and (c) of this section, the following hospital, outpatient, and extended care services constitute the "medical benefits package" (basic care and preventive care):

(1) Basic care.

(i) Outpatient medical, surgical, and mental healthcare, including care for substance abuse.

(ii) Inpatient hospital, medical, surgical, and mental healthcare, including care for substance abuse.

(iii) Prescription drugs, including over-the-counter drugs and medical and surgical supplies available under the VA national formulary system.

(iv) Emergency care in VA facilities; and emergency care in non-VA facilities in accordance with sharing contracts or if authorized by§ 17.52(a)(3), § 17.53, § 17.54, §§ 17.120 through 17.132, or §§ 17.4000 through 17.4040.

(v) Bereavement counseling as authorized in § 17.98.

(vi) Comprehensive rehabilitative services other than vocational services provided under 38 U.S.C. chapter 31.

(vii) Consultation, professional counseling, marriage and family counseling, training, and mental health services for the members of the immediate family or legal guardian of the veteran or the individual in whose household the veteran certifies an intention to live, as necessary and appropriate, in connection with the veteran's treatment as authorized under 38 CFR 71.50.

(viii) Prosthetic and rehabilitative items and services as authorized under §§ 17.3200 through 17.3250, and eyeglasses and hearing aids as authorized under § 17.149.

(ix) Home health services authorized under 38 U.S.C. 1717 and 1720C.

(x) Reconstructive (plastic) surgery required as a result of disease or trauma, but not including cosmetic surgery that is not medically necessary.

(xi)

(A) Hospice care, palliative care, and institutional respite care; and

(B) Noninstitutional extended care services, including but not limited to noninstitutional geriatric evaluation, noninstitutional adult day health care, and noninstitutional respite care.

(xii) Payment of beneficiary travel as authorized under 38 CFR part 70.

(xiii) Pregnancy and delivery services, to the extent authorized by law.

(xiv) Newborn care, post delivery, for a newborn child for the date of birth plus seven calendar days after the birth of the child when the birth mother is a woman veteran enrolled in VA health care and receiving maternity care furnished by VA or under authorization from VA and the child is delivered either in a VA facility, or in another facility pursuant to a VA authorization for maternity care at VA expense.

(xv) Completion of forms (e.g., Family Medical Leave forms, life insurance applications, Department of Education forms for loan repayment exemptions based on disability, non-VA disability program forms) by healthcare professionals based on an examination or knowledge of the veteran's condition, but not including the completion of forms for examinations if a third party customarily will pay health care practitioners for the examination but will not pay VA.

(2) Preventive care, as defined in 38 U.S.C. 1701(9), which includes:

(i) Periodic medical exams.

(ii) Health education, including nutrition education.

(iii) Maintenance of drug-use profiles, drug monitoring, and drug use education.

(iv) Mental health and substance abuse preventive services.

(v) Immunizations against infectious disease.

(vi) Prevention of musculoskeletal deformity or other gradually developing disabilities of a metabolic or degenerative nature.

(vii) Genetic counseling concerning inheritance of genetically determined diseases.

(viii) Routine vision testing and eye-care services.

(ix) Periodic reexamination of members of high-risk groups for selected diseases and for functional decline of sensory organs, and the services to treat these diseases and functional declines.

(x) Chiropractic services.

(b) ***Provision of the "medical benefits package".*** Care referred to in the "medical benefits package" will be provided to individuals only if it is determined by appropriate health care professionals that the care is needed to promote, preserve, or restore the health of the individual and is in accord with generally accepted standards of medical practice.

(1) ***Promote health.*** Care is deemed to promote health if the care will enhance the quality of life or daily functional level of the veteran, identify a predisposition for development of a condition or early onset of disease which can be partly or totally ameliorated by monitoring or early diagnosis and treatment, and prevent future disease.

(2) ***Preserve health.*** Care is deemed to preserve health if the care will maintain the current quality of life or daily functional level of the veteran, prevent the progression of disease, cure disease, or extend life span.

(3) ***Restoring health.*** Care is deemed to restore health if the care will restore the quality of life or daily functional level that has been lost due to illness or injury.

(c) In addition to the care specifically excluded from the "medical benefits package" under paragraphs (a) and (b) of this section, the "medical benefits package" does not include the following:

(1) Abortions, except when:

(i) The life or the health of the pregnant veteran would be endangered if the pregnancy were carried to term; or

(ii) The pregnancy is the result of an act of rape or incest. Self-reporting from the pregnant veteran constitutes sufficient evidence that an act of rape or incest occurred.

(2) In vitro fertilization. Note: See § 17.380.

(3) Drugs, biologicals, and medical devices not approved by the Food and Drug Administration unless the treating medical facility is conducting formal clinical trials under an Investigational Device Exemption (IDE) or an Investigational New Drug (IND) application, or the drugs, biologicals, or medical devices are prescribed under a compassionate use exemption.

(4) Gender alterations.

(5) Hospital and outpatient care for a veteran who is either a patient or inmate in an institution of another government agency if that agency has a duty to give the care or services. This exclusion does not apply to veterans who are released from incarceration in a prison or jail into a temporary housing program (such as a community residential re-entry center or halfway house).

(6) Membership in spas and health clubs.

[64 FR 54217, Oct. 6, 1999, as amended at 67 FR 35039, May 17, 2002; 73 FR 36798, June 30, 2008; 75 FR 54030, Sept. 3, 2010; 76 FR 11339, Mar. 2, 1011; 76 FR 26172, May 5, 2011; 76 FR 78571, Dec. 19, 2011; 82 FR 6275, Jan. 19, 2017; 84 FR 26306, June 5, 2019; 86 FR 84259, Dec. 28, 2020; 87 FR 55296, Sept. 9, 2022; 88 FR 24483, Apr. 21, 2023]

This content is from the eCFR and is authoritative but unofficial.

Title 38 —Pensions, Bonuses, and Veterans' Relief
Chapter I —Department of Veterans Affairs
Part 0 —Values, Standards of Ethical Conduct, and Related Responsibilities
Subpart A —Core Values, Characteristics, and Customer Experience Principles of the Department

Source: 77 FR 41275, July 13, 2012, unless otherwise noted.
Authority: 5 U.S.C. 301; 38 U.S.C. 501; see sections 201, 301, and 502(a) of E.O. 12674, 54 FR 15159, 3 CFR, 1989 Comp., p. 215 as modified by E.O. 12731, 55 FR 42547, 3 CFR, 1990 Comp., p. 306.
Source: 31 FR 5828, Apr. 15, 1966, unless otherwise noted.

§ 0.605 Ethical framework principles for access to and use of veteran data.

(a) Veterans trust VA to promote and respect their privacy, confidentiality, and autonomy in the services we provide or support. We earn this trust when we adhere to VA's core values of integrity, commitment, advocacy, respect, and excellence (commonly referred to as ICARE).

(b) Consistent with the values listed in paragraph (a) of this section, VA must promote and ensure responsible practices whenever veteran data is accessed, shared, or used by VA or its partners. Veteran data is accessed, shared, and used for many purposes which are developing at an unparalleled pace. While the regulatory and policy framework that governs data access, sharing, and use sets important standards about what is required with respect to data access, sharing, and use, it does not always provide definitive guidance about how VA should manage access, sharing, or use of veteran data when regulation and policy permit organizational discretion, except in cases where there are already established federally protected classes.

(c) The following principles establish an overarching ethical framework for all individuals, groups, or entities to apply when managing access to, sharing of, or use of VA veteran data. All parties who have or obtain access to and use VA veteran data are encouraged to carefully consider and apply this principle-based ethical framework when not contradicted by other specific clinical, technical, fiscal, regulatory, professional, industry, and other standards. VA and its partners must apply this principle-based ethical framework when accessing, sharing or using veteran data unless prohibited by law. Consistent application of this framework will ensure the integrity and trustworthiness that veterans and other stakeholders expect and deserve when veteran data is accessed, shared, or used.

(1) *Principle 1. The primary goal for use of veteran data is for the good of veterans.* Veteran data is personal and sensitive. Use of veteran data by VA and its partners must have the primary goal of supporting and improving overall veteran health and wellness, and the delivery of benefits and services to veterans at large.

(2) *Principle 2. Veteran data should be used in a manner that ensures equity to veterans.* The proper use of veteran data by VA and its partners must help to ensure equity so that no veteran population is disproportionally excluded from the benefits of, or burdened by the risks of, data use because of race, color, religion, national origin, limited English proficiency, age, sex (including gender identity and transgender status), sexual orientation, pregnancy, marital and parental status, disability, or genetic information.

(3) *Principle 3. The sharing of veteran data should be based on the veteran's meaningful choice.* When regulation and policy permit organizational discretion, the sharing of veteran data by VA and its partners should be based on the veteran's meaningful choice to permit sharing their information for that specific purpose; exceptions for sharing based on a veteran's meaningful choice are treatment, payment, health care operations, public health and safety reporting, and when required by law. Timely, clear, relevant, concise, complete, and comprehensible information must be provided to the veteran to serve as a basis for their free and informed choice. A veteran's preference to change their mind about sharing or not sharing their information should be facilitated, with the understanding that information that has already been shared may be unable to be retrieved or retracted. A veteran's choice(s) about data sharing must not be the basis to deny care or benefits to which they are otherwise entitled. Meaningful choice may be expressed in many forms and a written requirement is not implied.

(4) *Principle 4. Access to and exchange of veteran data should be transparent and consistent.* Access to and the exchange of veteran data should be transparent and consistent, and in accordance with all applicable standards. For the Veterans Health Administration (VHA), this includes practices described in VHA's Notice of Privacy Practices. Data should only be shared or accessed for approved and specified purposes; there should be no unspecified use, or re-use of veteran data without VA agreement or approval. The release of veteran data for purposes other than those which were originally approved or specified, such as in an agreement, requires a separate approval and commitment of all parties to follow these principles. Failure to ensure such protections is a breach of veteran trust and confidentiality.

(5) *Principle 5. De-identified veteran data should not be reidentified without authorization.* Parties who receive de-identified veteran data must not attempt to re-identify the data in any manner without prior VA agreement or approval. VA considers unauthorized re-identification a breach of veteran trust and confidentiality.

(6) *Principle 6. There is an obligation of reciprocity for gains made using veteran data.* A financial or other gain from innovation by non-VA parties that uses veteran data obtained from VA creates a moral and tangible obligation of reciprocity to share this gain with veterans, veterans' service organizations, and/or veterans' causes. For example, parties could fulfill this obligation by giving back to the veteran community through support of veteran causes or organizations, by facilitating veteran access to innovations to which veteran data contributed, or, at a minimum, by publicly recognizing veteran contributions to the gain or innovation. Veteran data must not be sold by VA or its partners.

(7) *Principle 7. All parties are obligated to ensure data security, quality and integrity of veteran data.* All parties who send, receive, or use VA veteran data must ensure data security, quality, and integrity. In other words, that the data remain secure; accurate; complete; and representative of the data quality, meaning, and integrity when it was received or accessed from VA. Access to data by VA and its partners should be limited to the minimum amount needed to accomplish the stated purpose and should be terminated when no longer required. Data that are not necessary to accomplish the purpose for which it was obtained should not be retained longer than legally required. Transparency about breaches in data security, quality or integrity is also essential to promote trust and minimize impacts to veterans.

(8) *Principle 8. Veterans should be able to access to their own information. Veterans must have user-friendly access to their own information.* Access may be through electronic means such as mobile applications, web portals, or through convenient written or in-person processes.

(9) ***Principle 9. Veterans have the right to request amendments to their own information.*** Veterans must be able to request amendments to information in their VA records if they feel it is untimely, inaccurate, incomplete, or not relevant.

(d) As used in this section, *de-identified veteran data* means information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information is individually identifiable information or can be used by any means to identify an individual. For protected health information (PHI), veteran data is not de-identified unless in compliance with 45 CFR parts 160 and 164.

[87 FR 40452, July 7, 2022]

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Thursday, February 6, 2025

Presidential Documents

Title 3—

The President

Executive Order 14192 of January 31, 2025

Unleashing Prosperity Through Deregulation

By the authority vested in me as President by the Constitution and the laws of the United States of America, including the Budget and Accounting Act of 1921, as amended (31 U.S.C. 1101 *et seq.*), and in order to promote prudent financial management and alleviate unnecessary regulatory burdens, it is hereby ordered:

Section 1. *Purpose*. The ever-expanding morass of complicated Federal regulation imposes massive costs on the lives of millions of Americans, creates a substantial restraint on our economic growth and ability to build and innovate, and hampers our global competitiveness. Despite the magnitude of their impact, these measures are often difficult for the average person or business to understand, as they require synthesizing the collective meaning not just of formal regulations but also rules, memoranda, administrative orders, guidance documents, policy statements, and interagency agreements that are not subject to the Administrative Procedure Act, further increasing compliance costs and the risk of costs of non-compliance. It is the policy of my Administration to significantly reduce the private expenditures required to comply with Federal regulations to secure America's economic prosperity and national security and the highest possible quality of life for each citizen. To that end, it is important that for each new regulation issued, at least 10 prior regulations be identified for elimination. This practice is to ensure that the cost of planned regulations is responsibly managed and controlled through a rigorous regulatory budgeting process.

Sec. 2. *Policy*. It is the policy of the executive branch to be prudent and financially responsible in the expenditure of funds, from both public and private sources, and to alleviate unnecessary regulatory burdens placed on the American people.

Sec. 3. *Regulatory Cap for Fiscal Year 2025*. (a) Unless prohibited by law, whenever an executive department or agency (agency) publicly proposes for notice and comment or otherwise promulgates a new regulation, it shall identify at least 10 existing regulations to be repealed.

(b) For fiscal year 2025, which is in progress, the heads of all agencies are directed to ensure that the total incremental cost of all new regulations, including repealed regulations, being finalized this year, shall be significantly less than zero, as determined by the Director of the Office of Management and Budget (Director), unless otherwise required by law or instructions from the Director.

(c) In furtherance of the requirement of subsection (a) of this section, any new incremental costs associated with new regulations shall, to the extent permitted by law, be offset by the elimination of existing costs associated with at least 10 prior regulations.

(d) The Director shall provide the heads of agencies with guidance on the implementation of this section. Such guidance shall address, among other things, processes for standardizing the measurement and estimation of regulatory costs; standards for determining what qualifies as new and offsetting regulations; standards for determining the costs of existing regulations that are considered for elimination; processes for accounting for costs in different fiscal years; methods to oversee the issuance of rules with costs offset by savings at different times or different agencies; and emergencies

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and other circumstances that might justify individual waivers of the requirements of this section. The Director shall consider phasing in and updating these requirements.

Sec. 4. *Annual Regulatory Cost Submissions to the Office of Management and Budget*. Beginning with the Regulatory Plans, as required under Executive Order 12866 of September 30, 1993 (Regulatory Planning and Review), as amended, or any successor order for fiscal year 2026, and for each fiscal year thereafter:

(a) The head of each agency shall identify on an aggregated basis, for regulations that increase incremental cost, the offsetting regulations described in section 3(c) of this order, and provide the agency's best approximation of the total costs or savings associated with each new regulation or repealed regulation.

(b) Each regulation approved by the Director during the Presidential budget process shall be included in the Unified Regulatory Agenda required under Executive Order 12866, as amended, or any successor order. Unless otherwise required by law, no regulation shall be added to or removed from the Unified Regulatory Agenda without the approval of the Director. To accomplish the purposes of this order, the Director may also require additions to the Unified Regulatory Agenda and Regulatory Plan.

(c) Unless otherwise required by law, no regulation shall be issued by an agency if it was not included in the most recent version or update of the published Unified Regulatory Agenda as required under Executive Order 12866, as amended, or any successor order, unless the issuance of such regulation was approved in advance in writing by the Director.

(d) During the Presidential budget process, the Director shall identify to agencies a total amount of incremental costs that will be allowed for each agency in issuing new regulations and repealing regulations for each fiscal year after fiscal year 2025. No regulations exceeding the agency's total incremental cost allowance will be permitted in that fiscal year, unless required by law or approved in writing by the Director. The total incremental cost allowance may allow an increase or require a reduction in total regulatory cost.

(e) The Director shall provide the heads of agencies with guidance on the implementation of the requirements in this section.

Sec. 5. *Definition*. For purposes of this order, the term "regulation" or "rule" means an agency statement of general or particular applicability and future effect designed to implement, interpret, or prescribe law or policy or to describe the procedure or practice requirements of an agency, including, without limitation, regulations, rules, memoranda, administrative orders, guidance documents, policy statements, and interagency agreements, regardless of whether the same were enacted through the processes in the Administrative Procedure Act, but does not include:

(a) regulations issued with respect to a military, national security, homeland security, foreign affairs, or immigration-related function of the United States;

(b) regulations related to agency organization, management, or personnel; or

(c) any other specific regulation or category of regulations exempted by the Director, who shall exempt those regulations or categories of regulations that impose minimal costs or burdens on the private sector or that are requested to be exempted by the Assistant to the President and Chief of Staff or the Assistant to the President and Deputy Chief of Staff for Policy.

Sec. 6. *Implementation*. (a) The Director is charged with implementing this order, including by providing agencies with updated guidance on implementing the ten-for-one rule described in section 3(a) of this order, including processes for identifying regulations for elimination, determining what constitutes, generally and specifically, a "rule" or "regulation" for purposes of this order, estimating and standardizing regulatory costs, and ensuring

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compliance with the Administrative Procedure Act and other applicable laws.

(b) The Director shall revoke OMB Circular No. A–4 of November 9, 2023 (Regulatory Analysis), and all accompanying appendices, guidelines, and documents, and shall reinstate the prior version of Circular A–4, issued on September 17, 2003; and

(c) The Secretary of the Treasury and the Director shall reinstate the Memorandum of Agreement between the Department of the Treasury and the Office of Management and Budget of April 11, 2018, regarding review of tax regulations under Executive Order 12866.

Sec. 7. *Severability.* If any provision of this order, or the application of any provision to any person or circumstance, is held to be invalid, the remainder of this order and the application of its provisions to any other persons or circumstances shall not be affected thereby.

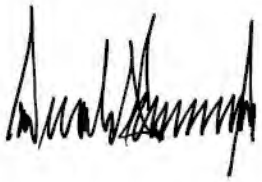
Sec. 8. *General Provisions.* (a) Nothing in this order shall be construed to impair or otherwise affect:

(i) the authority granted by law to an executive department, agency, or the head thereof; or

(ii) the functions of the Director of the Office of Management and Budget relating to budgetary, administrative, or legislative proposals.

(b) This order shall be implemented consistent with applicable law and subject to the availability of appropriations.

(c) This order is not intended to, and does not, create any right or benefit, substantive or procedural, enforceable at law or in equity by any party against the United States, its departments, agencies, or entities, its officers, employees, or agents, or any other person.



THE WHITE HOUSE,
January 31, 2025.

[FR Doc. 2025–02345
Filed 2–5–25; 8:45 am]
Billing code 3395–F4–P

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Federal Register
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Monday, October 4, 1993

Presidential Documents

Title 3—

The President

Executive Order 12866 of September 30, 1993

Regulatory Planning and Review

The American people deserve a regulatory system that works for them, not against them: a regulatory system that protects and improves their health, safety, environment, and well-being and improves the performance of the economy without imposing unacceptable or unreasonable costs on society; regulatory policies that recognize that the private sector and private markets are the best engine for economic growth; regulatory approaches that respect the role of State, local, and tribal governments; and regulations that are effective, consistent, sensible, and understandable. We do not have such a regulatory system today.

With this Executive order, the Federal Government begins a program to reform and make more efficient the regulatory process. The objectives of this Executive order are to enhance planning and coordination with respect to both new and existing regulations; to reaffirm the primacy of Federal agencies in the regulatory decision-making process; to restore the integrity and legitimacy of regulatory review and oversight; and to make the process more accessible and open to the public. In pursuing these objectives, the regulatory process shall be conducted so as to meet applicable statutory requirements and with due regard to the discretion that has been entrusted to the Federal agencies.

Accordingly, by the authority vested in me as President by the Constitution and the laws of the United States of America, it is hereby ordered as follows:

Section 1. *Statement of Regulatory Philosophy and Principles.*

(a) *The Regulatory Philosophy.* Federal agencies should promulgate only such regulations as are required by law, are necessary to interpret the law, or are made necessary by compelling public need, such as material failures of private markets to protect or improve the health and safety of the public, the environment, or the well-being of the American people. In deciding whether and how to regulate, agencies should assess all costs and benefits of available regulatory alternatives, including the alternative of not regulating. Costs and benefits shall be understood to include both quantifiable measures (to the fullest extent that these can be usefully estimated) and qualitative measures of costs and benefits that are difficult to quantify, but nevertheless essential to consider. Further, in choosing among alternative regulatory approaches, agencies should select those approaches that maximize net benefits (including potential economic, environmental, public health and safety, and other advantages; distributive impacts; and equity), unless a statute requires another regulatory approach.

(b) *The Principles of Regulation.* To ensure that the agencies' regulatory programs are consistent with the philosophy set forth above, agencies should adhere to the following principles, to the extent permitted by law and where applicable:

(1) Each agency shall identify the problem that it intends to address (including, where applicable, the failures of private markets or public institutions that warrant new agency action) as well as assess the significance of that problem.

(2) Each agency shall examine whether existing regulations (or other law) have created, or contributed to, the problem that a new regulation is

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intended to correct and whether those regulations (or other law) should be modified to achieve the intended goal of regulation more effectively.

(3) Each agency shall identify and assess available alternatives to direct regulation, including providing economic incentives to encourage the desired behavior, such as user fees or marketable permits, or providing information upon which choices can be made by the public.

(4) In setting regulatory priorities, each agency shall consider, to the extent reasonable, the degree and nature of the risks posed by various substances or activities within its jurisdiction.

(5) When an agency determines that a regulation is the best available method of achieving the regulatory objective, it shall design its regulations in the most cost-effective manner to achieve the regulatory objective. In doing so, each agency shall consider incentives for innovation, consistency, predictability, the costs of enforcement and compliance (to the government, regulated entities, and the public), flexibility, distributive impacts, and equity.

(6) Each agency shall assess both the costs and the benefits of the intended regulation and, recognizing that some costs and benefits are difficult to quantify, propose or adopt a regulation only upon a reasoned determination that the benefits of the intended regulation justify its costs.

(7) Each agency shall base its decisions on the best reasonably obtainable scientific, technical, economic, and other information concerning the need for, and consequences of, the intended regulation.

(8) Each agency shall identify and assess alternative forms of regulation and shall, to the extent feasible, specify performance objectives, rather than specifying the behavior or manner of compliance that regulated entities must adopt.

(9) Wherever feasible, agencies shall seek views of appropriate State, local, and tribal officials before imposing regulatory requirements that might significantly or uniquely affect those governmental entities. Each agency shall assess the effects of Federal regulations on State, local, and tribal governments, including specifically the availability of resources to carry out those mandates, and seek to minimize those burdens that uniquely or significantly affect such governmental entities, consistent with achieving regulatory objectives. In addition, as appropriate, agencies shall seek to harmonize Federal regulatory actions with related State, local, and tribal regulatory and other governmental functions.

(10) Each agency shall avoid regulations that are inconsistent, incompatible, or duplicative with its other regulations or those of other Federal agencies.

(11) Each agency shall tailor its regulations to impose the least burden on society, including individuals, businesses of differing sizes, and other entities (including small communities and governmental entities), consistent with obtaining the regulatory objectives, taking into account, among other things, and to the extent practicable, the costs of cumulative regulations.

(12) Each agency shall draft its regulations to be simple and easy to understand, with the goal of minimizing the potential for uncertainty and litigation arising from such uncertainty.

Sec. 2. *Organization.* An efficient regulatory planning and review process is vital to ensure that the Federal Government's regulatory system best serves the American people.

(a) *The Agencies.* Because Federal agencies are the repositories of significant substantive expertise and experience, they are responsible for developing regulations and assuring that the regulations are consistent with applicable law, the President's priorities, and the principles set forth in this Executive order.

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(b) *The Office of Management and Budget.* Coordinated review of agency rulemaking is necessary to ensure that regulations are consistent with applicable law, the President's priorities, and the principles set forth in this Executive order, and that decisions made by one agency do not conflict with the policies or actions taken or planned by another agency. The Office of Management and Budget (OMB) shall carry out that review function. Within OMB, the Office of Information and Regulatory Affairs (OIRA) is the repository of expertise concerning regulatory issues, including methodologies and procedures that affect more than one agency, this Executive order, and the President's regulatory policies. To the extent permitted by law, OMB shall provide guidance to agencies and assist the President, the Vice President, and other regulatory policy advisors to the President in regulatory planning and shall be the entity that reviews individual regulations, as provided by this Executive order.

(c) *The Vice President.* The Vice President is the principal advisor to the President on, and shall coordinate the development and presentation of recommendations concerning, regulatory policy, planning, and review, as set forth in this Executive order. In fulfilling their responsibilities under this Executive order, the President and the Vice President shall be assisted by the regulatory policy advisors within the Executive Office of the President and by such agency officials and personnel as the President and the Vice President may, from time to time, consult.

Sec. 3. *Definitions.* For purposes of this Executive order: (a) "Advisors" refers to such regulatory policy advisors to the President as the President and Vice President may from time to time consult, including, among others: (1) the Director of OMB; (2) the Chair (or another member) of the Council of Economic Advisers; (3) the Assistant to the President for Economic Policy; (4) the Assistant to the President for Domestic Policy; (5) the Assistant to the President for National Security Affairs; (6) the Assistant to the President for Science and Technology; (7) the Assistant to the President for Intergovernmental Affairs; (8) the Assistant to the President and Staff Secretary; (9) the Assistant to the President and Chief of Staff to the Vice President; (10) the Assistant to the President and Counsel to the President; (11) the Deputy Assistant to the President and Director of the White House Office on Environmental Policy; and (12) the Administrator of OIRA, who also shall coordinate communications relating to this Executive order among the agencies, OMB, the other Advisors, and the Office of the Vice President.

(b) "Agency," unless otherwise indicated, means any authority of the United States that is an "agency" under 44 U.S.C. 3502(1), other than those considered to be independent regulatory agencies, as defined in 44 U.S.C. 3502(10).

(c) "Director" means the Director of OMB.

(d) "Regulation" or "rule" means an agency statement of general applicability and future effect, which the agency intends to have the force and effect of law, that is designed to implement, interpret, or prescribe law or policy or to describe the procedure or practice requirements of an agency. It does not, however, include:

(1) Regulations or rules issued in accordance with the formal rulemaking provisions of 5 U.S.C. 556, 557;

(2) Regulations or rules that pertain to a military or foreign affairs function of the United States, other than procurement regulations and regulations involving the import or expnrt of non-defense articles and services;

(3) Regulations or rules that are limited to agency organization, management, or personnel matters; or

(4) Any other category of regulations exempted by the Administrator of OIRA.

(e) "Regulatory action" means any substantive action by an agency (normally published in the **Federal Register**) that promulgates or is expected to lead to the promulgation of a final rule or regulation, including notices

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of inquiry, advance notices of proposed rulemaking, and notices of proposed rulemaking.

(f) "Significant regulatory action" means any regulatory action that is likely to result in a rule that may:

(1) Have an annual effect on the economy of $100 million or more or adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, or tribal governments or communities;

(2) Create a serious inconsistency or otherwise interfere with an action taken or planned by another agency;

(3) Materially alter the budgetary impact of entitlements, grants, user fees, or loan programs or the rights and obligations of recipients thereof; or

(4) Raise novel legal or policy issues arising out of legal mandates, the President's priorities, or the principles set forth in this Executive order.

Sec. 4. *Planning Mechanism.* In order to have an effective regulatory program, to provide for coordination of regulations, to maximize consultation and the resolution of potential conflicts at an early stage, to involve the public and its State, local, and tribal officials in regulatory planning, and to ensure that new or revised regulations promote the President's priorities and the principles set forth in this Executive order, these procedures shall be followed, to the extent permitted by law:

(a) *Agencies' Policy Meeting.* Early in each year's planning cycle, the Vice President shall convene a meeting of the Advisors and the heads of agencies to seek a common understanding of priorities and to coordinate regulatory efforts to be accomplished in the upcoming year.

(b) *Unified Regulatory Agenda.* For purposes of this subsection, the term "agency" or "agencies" shall also include those considered to be independent regulatory agencies, as defined in 44 U.S.C. 3502(10). Each agency shall prepare an agenda of all regulations under development or review, at a time and in a manner specified by the Administrator of OIRA. The description of each regulatory action shall contain, at a minimum, a regulation identifier number, a brief summary of the action, the legal authority for the action, any legal deadline for the action, and the name and telephone number of a knowledgeable agency official. Agencies may incorporate the information required under 5 U.S.C. 602 and 41 U.S.C. 402 into these agendas.

(c) *The Regulatory Plan.* For purposes of this subsection, the term "agency" or "agencies" shall also include those considered to be independent regulatory agencies, as defined in 44 U.S.C. 3502(10). (1) As part of the Unified Regulatory Agenda, beginning in 1994, each agency shall prepare a Regulatory Plan (Plan) of the most important significant regulatory actions that the agency reasonably expects to issue in proposed or final form in that fiscal year or thereafter. The Plan shall be approved personally by the agency head and shall contain at a minimum:

(A) A statement of the agency's regulatory objectives and priorities and how they relate to the President's priorities;

(B) A summary of each planned significant regulatory action including, to the extent possible, alternatives to be considered and preliminary estimates of the anticipated costs and benefits;

(C) A summary of the legal basis for each such action, including whether any aspect of the action is required by statute or court order;

(D) A statement of the need for each such action and, if applicable, how the action will reduce risks to public health, safety, or the environment, as well as how the magnitude of the risk addressed by the action relates to other risks within the jurisdiction of the agency;

(E) The agency's schedule for action, including a statement of any applicable statutory or judicial deadlines; and

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(F) The name, address, and telephone number of a person the public may contact for additional information about the planned regulatory action.

(2) Each agency shall forward its Plan to OIRA by June 1st of each year.

(3) Within 10 calendar days after OIRA has received an agency's Plan, OIRA shall circulate it to other affected agencies, the Advisors, and the Vice President.

(4) An agency head who believes that a planned regulatory action of another agency may conflict with its own policy or action taken or planned shall promptly notify, in writing, the Administrator of OIRA, who shall forward that communication to the issuing agency, the Advisors, and the Vice President.

(5) If the Administrator of OIRA believes that a planned regulatory action of an agency may be inconsistent with the President's priorities or the principles set forth in this Executive order or may be in conflict with any policy or action taken or planned by another agency, the Administrator of OIRA shall promptly notify, in writing, the affected agencies, the Advisors, and the Vice President.

(6) The Vice President, with the Advisors' assistance, may consult with the heads of agencies with respect to their Plans and, in appropriate instances, request further consideration or inter-agency coordination.

(7) The Plans developed by the issuing agency shall be published annually in the October publication of the Unified Regulatory Agenda. This publication shall be made available to the Congress; State, local, and tribal governments; and the public. Any views on any aspect of any agency Plan, including whether any planned regulatory action might conflict with any other planned or existing regulation, impose any unintended consequences on the public, or confer any unclaimed benefits on the public, should be directed to the issuing agency, with a copy to OIRA.

(d) *Regulatory Working Group.* Within 30 days of the date of this Executive order, the Administrator of OIRA shall convene a Regulatory Working Group ("Working Group"), which shall consist of representatives of the heads of each agency that the Administrator determines to have significant domestic regulatory responsibility, the Advisors, and the Vice President. The Administrator of OIRA shall chair the Working Group and shall periodically advise the Vice President on the activities of the Working Group. The Working Group shall serve as a forum to assist agencies in identifying and analyzing important regulatory issues (including, among others (1) the development of innovative regulatory techniques, (2) the methods, efficacy, and utility of comparative risk assessment in regulatory decision-making, and (3) the development of short forms and other streamlined regulatory approaches for small businesses and other entities). The Working Group shall meet at least quarterly and may meet as a whole or in subgroups of agencies with an interest in particular issues or subject areas. To inform its discussions, the Working Group may commission analytical studies and reports by OIRA, the Administrative Conference of the United States, or any other agency.

(e) *Conferences.* The Administrator of OIRA shall meet quarterly with representatives of State, local, and tribal governments to identify both existing and proposed regulations that may uniquely or significantly affect those governmental entities. The Administrator of OIRA shall also convene, from time to time, conferences with representatives of businesses, nongovernmental organizations, and the public to discuss regulatory issues of common concern.

Sec. 5. *Existing Regulations.* In order to reduce the regulatory burden on the American people, their families, their communities, their State, local, and tribal governments, and their industries; to determine whether regulations promulgated by the executive branch of the Federal Government have become unjustified or unnecessary as a result of changed circumstances; to confirm that regulations are both compatible with each other and not

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duplicative or inappropriately burdensome in the aggregate; to ensure that all regulations are consistent with the President's priorities and the principles set forth in this Executive order, within applicable law; and to otherwise improve the effectiveness of existing regulations: (a) Within 90 days of the date of this Executive order, each agency shall submit to OIRA a program, consistent with its resources and regulatory priorities, under which the agency will periodically review its existing significant regulations to determine whether any such regulations should be modified or eliminated so as to make the agency's regulatory program more effective in achieving the regulatory objectives, less burdensome, or in greater alignment with the President's priorities and the principles set forth in this Executive order. Any significant regulations selected for review shall be included in the agency's annual Plan. The agency shall also identify any legislative mandates that require the agency to promulgate or continue to impose regulations that the agency believes are unnecessary or outdated by reason of changed circumstances.

(b) The Administrator of OIRA shall work with the Regulatory Working Group and other interested entities to pursue the objectives of this section. State, local, and tribal governments are specifically encouraged to assist in the identification of regulations that impose significant or unique burdens on those governmental entities and that appear to have outlived their justification or be otherwise inconsistent with the public interest.

(c) The Vice President, in consultation with the Advisors, may identify for review by the appropriate agency or agencies other existing regulations of an agency or groups of regulations of more than one agency that affect a particular group, industry, or sector of the economy, or may identify legislative mandates that may be appropriate for reconsideration by the Congress.

Sec. 6. *Centralized Review of Regulations.* The guidelines set forth below shall apply to all regulatory actions, for both new and existing regulations, by agencies other than those agencies specifically exempted by the Administrator of OIRA:

(a) *Agency Responsibilities.* (1) Each agency shall (consistent with its own rules, regulations, or procedures) provide the public with meaningful participation in the regulatory process. In particular, before issuing a notice of proposed rulemaking, each agency should, where appropriate, seek the involvement of those who are intended to benefit from and those expected to be burdened by any regulation (including, specifically, State, local, and tribal officials). In addition, each agency should afford the public a meaningful opportunity to comment on any proposed regulation, which in most cases should include a comment period of not less than 60 days. Each agency also is directed to explore and, where appropriate, use consensual mechanisms for developing regulations, including negotiated rulemaking.

(2) Within 60 days of the date of this Executive order, each agency head shall designate a Regulatory Policy Officer who shall report to the agency head. The Regulatory Policy Officer shall be involved at each stage of the regulatory process to foster the development of effective, innovative, and least burdensome regulations and to further the principles set forth in this Executive order.

(3) In addition to adhering to its own rules and procedures and to the requirements of the Administrative Procedure Act, the Regulatory Flexibility Act, the Paperwork Reduction Act, and other applicable law, each agency shall develop its regulatory actions in a timely fashion and adhere to the following procedures with respect to a regulatory action:

(A) Each agency shall provide OIRA, at such times and in the manner specified by the Administrator of OIRA, with a list of its planned regulatory actions, indicating those which the agency believes are significant regulatory actions within the meaning of this Executive order. Absent a material change in the development of the planned regulatory action, those not designated as significant will not be subject to review under this section unless, within 10 working days of receipt

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of the list, the Administrator of OIRA notifies the agency that OIRA has determined that a planned regulation is a significant regulatory action within the meaning of this Executive order. The Administrator of OIRA may waive review of any planned regulatory action designated by the agency as significant, in which case the agency need not further comply with subsection (a)(3)(B) or subsection (a)(3)(C) of this section.

(B) For each matter identified as, or determined by the Administrator of OIRA to be, a significant regulatory action, the issuing agency shall provide to OIRA:

(i) The text of the draft regulatory action, together with a reasonably detailed description of the need for the regulatory action and an explanation of how the regulatory action will meet that need; and

(ii) An assessment of the potential costs and benefits of the regulatory action, including an explanation of the manner in which the regulatory action is consistent with a statutory mandate and, to the extent permitted by law, promotes the President's priorities and avoids undue interference with State, local, and tribal governments in the exercise of their governmental functions.

(C) For those matters identified as, or determined by the Administrator of OIRA to be, a significant regulatory action within the scope of section 3(f)(1), the agency shall also provide to OIRA the following additional information developed as part of the agency's decision-making process (unless prohibited by law):

(i) An assessment, including the underlying analysis, of benefits anticipated from the regulatory action (such as, but not limited to, the promotion of the efficient functioning of the economy and private markets, the enhancement of health and safety, the protection of the natural environment, and the elimination or reduction of discrimination or bias) together with, to the extent feasible, a quantification of those benefits;

(ii) An assessment, including the underlying analysis, of costs anticipated from the regulatory action (such as, but not limited to, the direct cost both to the government in administering the regulation and to businesses and others in complying with the regulation, and any adverse effects on the efficient functioning of the economy, private markets (including productivity, employment, and competitiveness), health, safety, and the natural environment), together with, to the extent feasible, a quantification of those costs; and

(iii) An assessment, including the underlying analysis, of costs and benefits of potentially effective and reasonably feasible alternatives to the planned regulation, identified by the agencies or the public (including improving the current regulation and reasonably viable nonregulatory actions), and an explanation why the planned regulatory action is preferable to the identified potential alternatives.

(D) In emergency situations or when an agency is obligated by law to act more quickly than normal review procedures allow, the agency shall notify OIRA as soon as possible and, to the extent practicable, comply with subsections (a)(3)(B) and (C) of this section. For those regulatory actions that are governed by a statutory or court-imposed deadline, the agency shall, to the extent practicable, schedule rulemaking proceedings so as to permit sufficient time for OIRA to conduct its review, as set forth below in subsection (b)(2) through (4) of this section.

(E) After the regulatory action has been published in the **Federal Register** or otherwise issued to the public, the agency shall:

(i) Make available to the public the information set forth in subsections (a)(3)(B) and (C);

(ii) Identify for the public, in a complete, clear, and simple manner, the substantive changes between the draft submitted to OIRA for review and the action subsequently announced; and

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(iii) Identify for the public those changes in the regulatory action that were made at the suggestion or recommendation of OIRA.

(F) All information provided to the public by the agency shall be in plain, understandable language.

(b) *OIRA Responsibilities.* The Administrator of OIRA shall provide meaningful guidance and oversight so that each agency's regulatory actions are consistent with applicable law, the President's priorities, and the principles set forth in this Executive order and do not conflict with the policies or actions of another agency. OIRA shall, to the extent permitted by law, adhere to the following guidelines:

(1) OIRA may review only actions identified by the agency or by OIRA as significant regulatory actions under subsection (a)(3)(A) of this section.

(2) OIRA shall waive review or notify the agency in writing of the results of its review within the following time periods:

(A) For any notices of inquiry, advance notices of proposed rulemaking, or other preliminary regulatory actions prior to a Notice of Proposed Rulemaking, within 10 working days after the date of submission of the draft action to OIRA;

(B) For all other regulatory actions, within 90 calendar days after the date of submission of the information set forth in subsections (a)(3)(B) and (C) of this section, unless OIRA has previously reviewed this information and, since that review, there has been no material change in the facts and circumstances upon which the regulatory action is based, in which case, OIRA shall complete its review within 45 days; and

(C) The review process may be extended (1) once by no more than 30 calendar days upon the written approval of the Director and (2) at the request of the agency head.

(3) For each regulatory action that the Administrator of OIRA returns to an agency for further consideration of some or all of its provisions, the Administrator of OIRA shall provide the issuing agency a written explanation for such return, setting forth the pertinent provision of this Executive order on which OIRA is relying. If the agency head disagrees with some or all of the bases for the return, the agency head shall so inform the Administrator of OIRA in writing.

(4) Except as otherwise provided by law or required by a Court, in order to ensure greater openness, accessibility, and accountability in the regulatory review process, OIRA shall be governed by the following disclosure requirements:

(A) Only the Administrator of OIRA (or a particular designee) shall receive oral communications initiated by persons not employed by the executive branch of the Federal Government regarding the substance of a regulatory action under OIRA review;

(B) All substantive communications between OIRA personnel and persons not employed by the executive branch of the Federal Government regarding a regulatory action under review shall be governed by the following guidelines: (i) A representative from the issuing agency shall be invited to any meeting between OIRA personnel and such person(s);

(ii) OIRA shall forward to the issuing agency, within 10 working days of receipt of the communication(s), all written communications, regardless of format, between OIRA personnel and any person who is not employed by the executive branch of the Federal Government, and the dates and names of individuals involved in all substantive oral communications (including meetings to which an agency representative was invited, but did not attend, and telephone conversations between OIRA personnel and any such persons); and

(iii) OIRA shall publicly disclose relevant information about such communication(s), as set forth below in subsection (b)(4)(C) of this section.

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(C) OIRA shall maintain a publicly available log that shall contain, at a minimum, the following information pertinent to regulatory actions under review:

(i) The status of all regulatory actions, including if (and if so, when and by whom) Vice Presidential and Presidential consideration was requested;

(ii) A notation of all written communications forwarded to an issuing agency under subsection (b)(4)(B)(ii) of this section; and

(iii) The dates and names of individuals involved in all substantive oral communications, including meetings and telephone conversations, between OIRA personnel and any person not employed by the executive branch of the Federal Government, and the subject matter discussed during such communications.

(D) After the regulatory action has been published in the **Federal Register** or otherwise issued to the public, or after the agency has announced its decision not to publish or issue the regulatory action, OIRA shall make available to the public all documents exchanged between OIRA and the agency during the review by OIRA under this section.

(5) All information provided to the public by OIRA shall be in plain, understandable language.

Sec. 7. *Resolution of Conflicts.* To the extent permitted by law, disagreements or conflicts between or among agency heads or between OMB and any agency that cannot be resolved by the Administrator of OIRA shall be resolved by the President, or by the Vice President acting at the request of the President, with the relevant agency head (and, as appropriate, other interested government officials). Vice Presidential and Presidential consideration of such disagreements may be initiated only by the Director, by the head of the issuing agency, or by the head of an agency that has a significant interest in the regulatory action at issue. Such review will not be undertaken at the request of other persons, entities, or their agents.

Resolution of such conflicts shall be informed by recommendations developed by the Vice President, after consultation with the Advisors (and other executive branch officials or personnel whose responsibilities to the President include the subject matter at issue). The development of these recommendations shall be concluded within 60 days after review has been requested.

During the Vice Presidential and Presidential review period, communications with any person not employed by the Federal Government relating to the substance of the regulatnry action under review and directed to the Advisors or their staffs or to the staff of the Vice President shall be in writing and shall be forwarded by the recipient to the affected agency(ies) for inclusion in the public docket(s). When the communication is not in writing, such Advisors or staff memhers shall inform the outside party that the matter is under review and that any comments should be submitted in writing.

At the end of this review process, the President, or the Vice President acting at the request of the President, shall notify the affected agency and the Administrator of OIRA of the President's decision with respect to the matter.

Sec. 8. *Publication.* Except to the extent required by law, an agency shall not publish in the **Federal Register** or otherwise issue to the public any regulatory action that is subject to review under section 6 of this Executive order until (1) the Administrator of OIRA notifies the agency that OIRA has waived its review of the action or has completed its review without any requests for further consideration, or (2) the applicahle time period in section 6(b)(2) expires without OIRA having notified the agency that it is returning the regulatory action for further consideration under section 6(b)(3), whichever occurs first. If the terms of the preceding sentence have not been satisfied and an agency wants to publish or otherwise issue a

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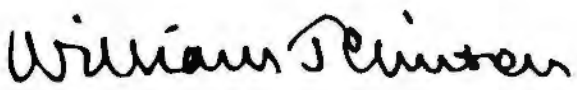
regulatory action, the head of that agency may request Presidential consideration through the Vice President, as provided under section 7 of this order. Upon receipt of this request, the Vice President shall notify OIRA and the Advisors. The guidelines and time period set forth in section 7 shall apply to the publication of regulatory actions for which Presidential consideration has been sought.

Sec. 9. *Agency Authority.* Nothing in this order shall be construed as displacing the agencies' authority or responsibilities, as authorized by law.

Sec. 10. *Judicial Review.* Nothing in this Executive order shall affect any otherwise available judicial review of agency action. This Executive order is intended only to improve the internal management of the Federal Government and does not create any right or benefit, substantive or procedural, enforceable at law or equity by a party against the United States, its agencies or instrumentalities, its officers or employees, or any other person.

Sec. 11. *Revocations.* Executive Orders Nos. 12291 and 12498; all amendments to those Executive orders; all guidelines issued under those orders; and any exemptions from those orders heretofore granted for any category of rule are revoked.



THE WHITE HOUSE,
September 30, 1993.

[FR citation 58 FR 51735]

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Presidential Documents

Executive Order 14219 of February 19, 2025

Ensuring Lawful Governance and Implementing the President's "Department of Government Efficiency" Deregulatory Initiative

By the authority vested in me as President by the Constitution and the laws of the United States of America, it is hereby ordered:

Section 1. *Purpose.* It is the policy of my Administration to focus the executive branch's limited enforcement resources on regulations squarely authorized by constitutional Federal statutes, and to commence the deconstruction of the overbearing and burdensome administrative state. Ending Federal overreach and restoring the constitutional separation of powers is a priority of my Administration.

Sec. 2. *Rescinding Unlawful Regulations and Regulations That Undermine the National Interest.* (a) Agency heads shall, in coordination with their DOGE Team Leads and the Director of the Office of Management and Budget, initiate a process to review all regulations subject to their sole or joint jurisdiction for consistency with law and Administration policy. Within 60 days of the date of this order, agency heads shall, in consultation with the Attorney General as appropriate, identify the following classes of regulations:

(i) unconstitutional regulations and regulations that raise serious constitutional difficulties, such as exceeding the scope of the power vested in the Federal Government by the Constitution;

(ii) regulations that are based on unlawful delegations of legislative power;

(iii) regulations that are based on anything other than the best reading of the underlying statutory authority or prohibition;

(iv) regulations that implicate matters of social, political, or economic significance that are not authorized by clear statutory authority;

(v) regulations that impose significant costs upon private parties that are not outweighed by public benefits;

(vi) regulations that harm the national interest by significantly and unjustifiably impeding technological innovation, infrastructure development, disaster response, inflation reduction, research and development, economic development, energy production, land use, and foreign policy objectives; and

(vii) regulations that impose undue burdens on small business and impede private enterprise and entrepreneurship.

(b) In conducting the review required by subsection (a) of this section, agencies shall prioritize review of those rules that satisfy the definition of "significant regulatory action" in Executive Order 12866 of September 30, 1993 (Regulatory Planning and Review), as amended.

(c) Within 60 days of the date of this order, agency heads shall provide to the Administrator of the Office of Information and Regulatory Affairs (OIRA) within the Office of Management and Budget a list of all regulations identified by class as listed in subsection (a) of this section.

(d) The Administrator of OIRA shall consult with agency heads to develop a Unified Regulatory Agenda that seeks to rescind or modify these regulations, as appropriate.

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Sec. 3. *Enforcement Discretion to Ensure Lawful Governance.*

(a) Subject to their paramount obligation to discharge their legal obligations, protect public safety, and advance the national interest, agencies shall preserve their limited enforcement resources by generally de-prioritizing actions to enforce regulations that are based on anything other than the best reading of a statute and de-prioritizing actions to enforce regulations that go beyond the powers vested in the Federal Government by the Constitution.

(b) Agency heads shall determine whether ongoing enforcement of any regulations identified in their regulatory review is compliant with law and Administration policy. To preserve resources and ensure lawful enforcement, agency heads, in consultation with the Director of the Office of Management and Budget, shall, on a case-by-case basis and as appropriate and consistent with applicable law, then direct the termination of all such enforcement proceedings that do not comply with the Constitution, laws, or Administration policy.

Sec. 4. *Promulgation of New Regulations.* Agencies shall continue to follow the processes set out in Executive Order 12866 for submitting regulations for review by OIRA. Additionally, agency heads shall consult with their DOGE Team Leads and the Administrator of OIRA on potential new regulations as soon as practicable. In evaluating potential new regulations, agency heads, DOGE Team Leads, and the Administrator of OIRA shall consider, in addition to the factors set out in Executive Order 12866, the factors set out in section 2(a) of this order.

Sec. 5. *Implementation.* The Director of the Office of Management and Budget shall issue implementation guidance, as appropriate.

Sec. 6. *Definitions.* (a) "Agency" has the meaning given to it in 44 U.S.C. 3502, except it does not include the Executive Office of the President or its components.

(b) "Agency head" shall mean the highest-ranking official of an agency, such as the Secretary, Administrator, Chairman, or Director.

(c) "DOGE Team Lead" shall mean the leader of the DOGE Team at each agency as described in Executive Order 14158 of January 20, 2025 (Establishing and Implementing the President's "Department of Government Efficiency").

(d) "Enforcement action" means all attempts, civil or criminal, by any agency to deprive a private party of life, liberty, or property, or in any way affect a private party's rights or obligations, regardless of the label the agency has historically placed on the action.

(e) "Regulation" shall have the meaning given to "regulatory action" in section 3(e) of Executive Order 12866, and also includes any "guidance document" as defined in Executive Order 13422 of January 18, 2007 (Further Amendment to Executive Order 12866 on Regulatory Planning and Review).

(f) "Senior appointee" means an individual appointed by the President, or performing the functions and duties of an office that requires appointment by the President, or a non-career member of the Senior Executive Service (or equivalent agency system).

Sec. 7. *Exemptions.* Notwithstanding any other provision in this order, nothing in this order shall apply to:

(a) any action related to a military, national security, homeland security, foreign affairs, or immigration-related function of the United States;

(b) any matter pertaining to the executive branch's management of its employees; or

(c) anything else exempted by the Director of the Office of Management and Budget.

Sec. 8. *Severability.* If any provision of this order, or the application of any provision to any person or circumstance, is held to be invalid, the remainder of this order and the application of its provisions to any other persons or circumstances shall not be affected thereby.

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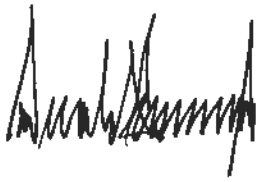
Sec. 9. *General Provisions*. (a) Nothing in this order shall be construed to impair or otherwise affect:

(i) the authority granted by law to an executive department, agency, or the head thereof; or

(ii) the functions of the Director of the Office of Management and Budget relating to budgetary, administrative, or legislative proposals.

(b) This order shall be implemented consistent with applicable law and subject to the availability of appropriations.

(c) This order is not intended to, and does not, create any right or benefit, substantive or procedural, enforceable at law or in equity by any party against the United States, its departments, agencies, or entities, its officers, employees, or agents, or any other person.



THE WHITE HOUSE,
February 19, 2025.

[FR Doc. 2025–03138
Filed 2–24–25; 8:45 am]
Billing code 3395–F4–P

Enclosure

Reproductive Health Services Interim Final Rule (IFR) (87 FR 55287)

A. The data in the following charts reflect abortions provided to Veterans from issuance of the IFR (September 9, 2022) through January 31, 2024.

Medication Abortion or Abortion Procedure

Medication	Procedure	Total
86	39	125

Abortion by Exception

Life	Health	Rape	Incest	Total
11	97	17	0	125

Medication Abortion by Exception

Life	Health	Rape	Incest	Total
7	65	14	0	86

Abortion Procedure by Exception

Life	Health	Rape	Incest	Total
4	32	3	0	39

B. The data in the following charts reflect abortions provided to Veterans from February 1, 2024, through January 31, 2025.

Medication Abortion or Abortion Procedure

Medication	Procedure	Total
83	24	107

Abortion by Exception

Life	Health	Rape	Incest	Total
12	80	15	0	107

Medication Abortion by Exception

Life	Health	Rape	Incest	Total
7	65	11	0	83

Abortion Procedure by Exception

Life	Health	Rape	Incest	Total
5	15	4	0	24

Department of Veterans Affairs
March 2025

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MATT REEL
DEMOCRATIC STAFF DIRECTOR

January 29, 2024

The Honorable Denis R. McDonough
Secretary
U.S. Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Dear Secretary McDonough:

Thank you for your prompt response to my January 17th letter regarding my request for a list of health conditions that the Department of Veterans Affairs (VA) would consider health exceptions to allow for a veteran to receive an abortion through the Veterans Health Administration (VHA). While I appreciate your timely response, tbe information you provided does not adequately fulfill Congress' request for information as part of our oversight authority and responsibility.

In my January 17th letter, I requested that you provide tbe full list of health conditions that have allowed a veteran to receive an abortion through VHA, not common health occurrences. Your response listed five "common categories of health conditions that may necessitate an abortion to protect the health of the Veteran." While I appreciate your disclosure of these broad categories, I already knew that the healtb conditions you listed can cause a risk for any woman to carry a pregnancy to term and with respect, your response does not answer my question. Therefore, I am once again requesting that you provide a specific list of all health conditions that have necessitated an abortion to be performed by VHA to protect the health of the veteran mother from September 9, 2022 to January 25, 2024.

Additionally, I request that you provide the Committee with:

1. The total number of abortions performed between September 9, 2022 to January 25, 2024 in each of the five categories listed in your January 23, 2024 letter;
2. The total number of abortions performed September 9, 2022 to January 25, 2024 for any health condition that is not listed in your January 23, 2024 letter;

3. The total number of medical and surgical abortions provided to veterans since September 9, 2022 disaggregated by the documented exception.

While I appreciate your concerns regarding protecting the privacy of patient information, I continue to be more concerned about patient safety. Deidentified and disaggregated data should not pose any greater risk to patients' privacy within the Veterans Health Administration than similarly deidentified and disaggregated data that is used to report on other veteran health conditions, trends, or procedures in similarly sensitive areas such as suicide or mental health.

Please provide a response to all the above requested information by February 2, 2024. Should you have any questions about this request, please contact the staff of my Committee.

Sincerely,



MIKE BOST
Chairman

Cc: The Honorable Mark Takano, Ranking Member

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

THE DIRECTOR

January 24, 2025

M-25-12

MEMORANDUM TO THE HEADS OF EXECUTIVE DEPARTMENTS AND AGENCIES

FROM: Matthew J. Vaeth, Acting Director

SUBJECT: Guidance Regarding Revocation of Executive Orders 14076 and 14079 and Complying with Statutory Restrictions on Taxpayer Funding for Abortion

Background

On January 24, 2025, President Trump signed the Executive Order (E.O.), *Enforcing the Hyde Amendment*. Among other things, the Executive Order rescinded E.O. 14076 of July 8, 2022 (*Protecting Access to Reproductive Healthcare Services*) and E.O. 14079 of August 3, 2022 (*Securing Access to Reproductive and Other Healthcare Services*), which had, among other things, directed Federal agencies to promote abortion.

Over more than five decades, Congress has enacted a series of laws to protect federal taxpayers from being forced to pay for abortion. Among these, the Hyde Amendment has been enacted annually in appropriations Acts for the Department of Health and Human Services since 1976. The revocation of these E.O.s is consistent with longstanding statutory restrictions on taxpayer funding for abortion.

Ending Federal support for abortion is also necessary to respect the Constitutional authority of the States, and the people therein, to enact laws protecting life, consistent with the Supreme Court's decision in *Dobbs v. Jackson Women's Health Organization*, 597 U.S. 215 (2022).

Guidance

It is the policy of this Administration not to use taxpayer funds to fund, facilitate, or promote abortion, including travel or transportation to obtain an abortion, consistent with the Hyde Amendment and other statutory restrictions on taxpayer funding for abortion.

Federal departments and agencies may, however, pay for or perform abortion in cases of rape, incest, or to save the life of the mother, provided that such payment or performance is authorized by Federal law and such abortion is permitted under State law.

Executive departments and agencies may no longer rely on E.O. 14076 or E.O. 14079, and shall strictly adhere to all statutory restrictions on taxpayer funding for abortion.

In accordance with this policy, the heads of all Executive departments and agencies shall—

(1) Within 60 days, reevaluate all policies, regulations, directives or other agency actions in conformity with the policy set out by the E.O., *Enforcing the Hyde Amendment*, including, but not limited to, those issued pursuant to E.O. 14076 or E.O. 14079, and consider rescinding such actions through rulemaking where appropriate or other lawful means;

(2) Within nine months, as appropriate, audit Federally funded projects, programs or activities in which Federal funds may be reasonably suspected to have been expended in violation of any statutory restriction on taxpayer funding for abortion, and take appropriate measures to address, and prevent the recurrence of, any violations; and

(3) submit a monthly report to the Office of Management and Budget (OMB) on their progress in carrying out this memorandum until all necessary actions are complete.

The heads of all departments and agencies are also reminded that the Antideficiency Act, 31 U.S.C. § 1341(a), generally prohibits Federal agencies from making expenditures in excess of available appropriations or in advance of appropriations. Under 31 U.S.C. §§ 1349(a) and 1350, there are penalties associated with violations of the Antideficiency Act. Providing funding for abortions in violation of any statutory restrictions on taxpayer funding for abortion, therefore, may give rise to such a violation.

If you have any questions regarding this Memorandum, please contact OMB's Office of General Counsel.

Definition:

For purposes of this memorandum, the term "statutory restriction on taxpayer funding for abortion" includes, but is not limited to, any of the following provisions of law:

(1) Sections 506 and 507 of the Labor, Health and Human Services Appropriations Act, 2024 (Division D of the Further Consolidated Appropriations Act, 2024, Public Law 118-47, March 23, 2024), or any similar provision in a predecessor or successor appropriations Act (commonly known as the Hyde Amendment)
(2) Section 1093 of title 10 of the United States Code
(3) Section 106(a)(3) of the *Veterans Health Care Act of 1992*, Pub. L. 102–585, title I, Nov. 4, 1992, 106 Stat. 4947 (38 U.S.C. 1710 note)
(4) Section 104(f)(1) of the Foreign Assistance Act of 1961 (22 U.S.C. 2151b(f)(1)), section 7018 and the fifth proviso under the heading "Global Health Programs" in the State, Foreign Operations, and Related Programs Appropriations Act, 2024 (Division F of the Further Consolidated Appropriations Act, 2024, Public Law 118-47, March 23, 2024), or any similar provision in a predecessor or successor appropriations Act (commonly known as tbe Helms Amendment)

(5) The seventh proviso under such heading, commonly known as the Siljander Amendment, or any similar provision in a predecessor or successor appropriations Act
(6) The fifth and sixth provisos under the heading "Peace Corps" in the State, Foreign Operations, and Related Programs Appropriations Act, 2024 (Division F of the Further Consolidated Appropriations Act, 2024, Public Law 118-47, March 23, 2024), or any similar provision in a predecessor or successor appropriations Act
(7) Sections 613, 614 of the Financial Services and General Government Appropriations Act, 2024 (Division B of the Further Consolidated Appropriations Act, 2024, Public Law 118-47, March 23, 2024), or any similar provision in a predecessor or successor appropriations Act (commonly known as the Smith Amendment)
(8) Section 1008 of the Public Health Service Act (42 U.S.C. 300a-6)
(9) Section 1303 of the Patient Protection and Affordable Care Act, Pub. L. 111–148, 124 Stat. 896 (42 U.S.C. 18023)
(10) Section 202 of the Commerce, Justice, Science, and Related Agencies Appropriations Act, 2024 (Division C of the Consolidated Appropriations Act, 2024, Public Law 118-42, March 9, 2024), or any similar provision in a predecessor or successor appropriations Act
(11) Section 806 of the Indian Health Care Improvement Act (25 U.S.C. 1676)
(12) Section 399Z–1(a)(3)(C), (f)(1)(B) of the Public Health Service Act [42 U.S.C. 280h-5(a)(3)(C), (f)(1)(B)]
(13) Sections 2105(c)(1),(7) and 2210(a)(16) of the Social Security Act (42 U.S.C. 1397ee(c)(1),(7), 1397jj(a)(16))
(14) Section 104(f)(3) of the Foreign Assistance Act of 1961 (22 U.S.C. 2151b(f)(3))

THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

December 17, 2018

The Honorable Mick Mulvaney
Director
Office of Management and Budget
Washington, DC 20503

Dear Director Mulvaney:

I am writing to request that you exempt the Department of Veterans Affairs (VA) from compliance with the requirements of Executive Order 13771, Reducing Regulation and Controlling Regulatory Costs (EO 13771 or "the Order"). The enclosed justification sheet provides the full reasoning for my request. In short, I am requesting this exemption because the type of regulatory actions within VA's authority are not within the primary focus of EO 13771; and requiring compliance with the Order undermines our ability to provide care and services to Veterans. Further, seeking individual waivers for regulatory actions on a case-by-case basis does not provide a sufficient solution to these issues.

EO 13771 requires Federal agencies to offset incremental costs and identify for elimination at least two prior regulations for every one new regulation issued. However, the purpose of the Order is inapposite to VA's mission. Rather than regulating an industry and requiring private expenditures to comply with Federal regulations, the overwhelming majority of VA's regulations address procedural and substantive questions necessary to administer the Veterans' benefits system. Further, requiring that VA comply with the requirements of the Order reduces VA's capacity to offer any new benefits or services to Veterans and their dependents. This is because implementing new benefit programs necessarily entails incurring non-benefit costs; and non-benefit costs from other programs must thus be reduced to offset these new non-benefit costs. These requirements are counterproductive to VA's efforts to serve Veterans and their dependents, while doing little to advance the Order's purpose to lessen costs on businesses and private entities.

Additionally, the Order's requirements hamper VA's ability to provide care and services to Veterans because they restrict the Department's ability to implement and maintain its regulatory agenda. Many of VA's authorizing statutes are permissive and must be implemented through regulation. However, VA's ability to promulgate such regulations is directly inhibited by the Order's requirements; thus, VA's ability to provide care and services is impeded. Alternatively, VA could simply choose to not implement new programs by regulations to avoid triggering the offset requirement. However, this is generally not a viable alternative because in many cases VA's programs require a clear regulatory framework to ensure proper administration.

Seeking individual waivers from you for regulatory actions on a case-by-case basis does not provide a meaningful solution to these issues. Based on OMB guidance provided in Memorandum M-17-21, Guidance Implementing EO 13771, "Reducing Regulation and Controlling Regulatory Costs," VA's regulatory actions generally do not fit within the categories that qualify for full exemptions, and the partial exemptions merely provide for a delay in complying with the requirements contained in the Order. As discussed more in detail in the enclosure, compliance with these requirements presents serious obstacles to fulfillment of the Department's mission of service to Veterans.

We believe that as the office responsible for implementing and maintaining compliance with the Order, OMB has the authority to exempt VA from its applicability. Based on the above considerations, and as more fully explained in the enclosure, we are requesting exemption from the requirements of E.O. 13771 to the extent they apply to VA's implementation of statutes governing provision of benefits to Veterans and their dependents and survivors.

Please respond to this request at the earliest possible time to ensure that VA is able to fulfill its mission of caring for Veterans and their dependents. I am available to discuss this issue further at your convenience, or your office may contact Mr. (b)(6) Director, Office of Regulation Policy and Management, at (b)(6) to address any questions you may have.

I look forward to your favorable decision on this issue; our Veterans are counting on us.

Sincerely,

Robert L. Wilkie

Robert L. Wilkie

Enclosure

Enclosure

Department of Veterans Affairs (VA)
Justification Sheet

Executive Order 13771 was signed by the President on January 30, 2017, and published at 82 Fed. Reg. 9339 (Feb. 3, 2017) (EO 13771 or "the Order"). The Order requires Federal agencies to identify for elimination at least two prior regulations for every one new regulation issued (see sections 1, 2(a) of E.O. 13771). The Order further requires that any new incremental costs associated with new regulations shall, to the extent permitted by law, be offset by the elimination of existing costs associated with at least two prior regulations (see sections 2(c), 3(a)). The Office of Management and Budget (OMB) has previously issued guidance by email to VA that all non-benefit costs must be offset, including personnel (i.e., full-time equivalent (FTE)), information technology (IT), and other administrative costs.

The purpose of the Order is to manage the "costs associated with the governmental imposition of private expenditures required to comply with Federal regulations." Section 1. This purpose is inapposite to VA's mission. While VA is an executive agency and operates within the legal structure governing rulemaking applicable to other agencies, VA is generally not a regulatory agency. Rather than regulating an industry, the overwhelming majority of VA's regulations address procedural and substantive questions necessary to administer the Veterans' benefits system. VA regulations generally do not impose economic costs on private actors, do not impose opportunity costs on society, and do not create compliance costs for businesses. Very few of VA's regulations are intended to or in effect regulate the conduct of the private sector. To the extent that VA's regulations do have such an effect, it is usually only upon those businesses that choose to enter into an agreement or contract with VA to provide goods or services.

Indeed, VA regulations facilitate the distribution of benefits and often have a positive effect on the economy. For example, VA's regulations implementing the Post-9/11 Veterans Educational Assistance Act of 2008 focus on supporting education and training opportunities for Veterans and in turn strengthen our Nation's workforce and economy. Likewise, VA is developing regulations to implement the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, which will expand access to community care for eligible Veterans and result in increased purchasing of care in the community, thereby benefiting private entities and providers.

Notwithstanding the minimal effect that VA regulations have on the private sector, VA is subject to the Order's limitations. Requiring that VA identify at least two existing regulations to be repealed and that the total incremental non-benefit cost of all new regulations be offset reduces VA's capacity to deliver existing benefits – to the extent it can do so consistent with governing statutory requirements if it is to offer any new benefits or services to Veterans and their dependents. This is because implementing new benefit programs necessarily entails incurring non-benefit costs. For

example, a new benefit program may require adapting existing or creating new IT capabilities, training employees on how to administer the program, and other related administrative costs. To offset these new non-benefit costs, non-benefit costs from other programs must be reduced. Whether this is accomplished by decreasing the number of FTEs assigned to a program, reducing allocations for IT functionality, or some other manner, the result is a decreased ability to administer and run other benefit programs. These requirements are counterproductive to VA's efforts to serve Veterans and their dependents, while doing little to advance the Order's purpose to lessen costs on businesses and private entities. Further, this produces a situation where Veterans are pitted against each other, as any new dollar spent has to be offset with a dollar saved, running in direct contravention of the principles of military service and shared sacrifice embodied within our Veterans' service to this Nation.

Additionally, the Order's requirements hamper VA's ability to provide care and services to Veterans because they restrict the Department's ability to implement and maintain its regulatory agenda. Without a robust and active regulatory agenda, Veterans will not receive the benefits that the Administration and Congress seek to provide them under law; and VA will be significantly impaired in its ability to manage and control how its benefits are administered. This is because many of VA's authorizing statutes are not mandates but instead permit—rather than require—VA to take certain actions. For example, 38 United States Code (U.S.C.) § 1708(a) authorizes VA to furnish eligible persons with temporary lodging in a Fisher House or other appropriate facility but does not require that the Department do so. VA's regulations implementing this authority (at 38 Code of Federal Regulations, Part 60) are governed by the Administrative Procedure Act (APA), 5 U.S.C. chapter 5, which requires the Department to promulgate regulations. In fact, many of VA's most important authorizing statutes explicitly require the Department to promulgate regulations, such as the authority to enroll Veterans for VA hospital care and medical services, 38 U.S.C. § 1705(a), and the authority to assist Veterans in traveling to and from medical appointments, 38 U.S.C. § 111(a). However, VA's ability to promulgate such regulations is directly inhibited by the Order's requirements; thus, VA's ability to provide care and services is impeded. As Congress continues to enact new legislation, these well-established programs and their regulations are potentially at risk if VA must find ways to deregulate them to accommodate new requirements.

Alternatively, VA could simply choose to not implement new programs by regulations to avoid triggering the offset requirement. However, regulations bind VA to behave in a consistent, predictable, and auditable manner across the country, so that Veterans in different states receive the same level of care and services. In many cases, the Department's programs require a clear regulatory framework to ensure proper administration. For example, VA's authorizations to provide care to Veterans in the community require complex rules regarding the quality and delivery of the care (e.g., regulations on residential care facilities); rates of payment (e.g., application of Medicare rate and how VA pays for services not covered by Medicare); appropriate and legal transfers of medical information; and eligibility determinations (e.g., to prevent fraud against the government and control costs). Again, however, VA's ability to promulgate

such regulations is directly inhibited by the Order's requirements. VA's Office of General Counsel strongly recommends against choosing to not implement new authorities by regulations for the reasons cited above and because such an approach would increase significantly the Department's risk in litigation.

I recognize that the OMB Director has authority under the Order to grant individual waivers of the requirements in EO 13771 (see section 2(d)). However, seeking individual waivers for regulatory actions on a case-by-case basis does not provide a meaningful solution to the issues I have noted. This is because VA's regulatory actions generally do not fit within the categories that qualify for full exemptions and because the partial exemptions merely provide for a delay in complying with the requirements contained in the Order.

OMB has provided guidance on obtaining waivers in Memorandum M-17-21, Guidance Implementing EO 13771, titled "Reducing Regulation and Controlling Regulatory Costs" issued on April 5, 2017. In Memorandum M-17-21, in response to question 33, OMB explained that four categories of regulatory actions may qualify for full or partial exemption from the Order's requirements: (1) expressly exempt actions; (2) emergency actions; (3) statutorily or judicially required actions; and (4) *de minimis* actions. VA's regulations generally do not fall within the first and fourth categories, which allow full exemptions. VA's regulations are not issued with respect to military, national security, or foreign affairs functions – as those terms have customarily been applied and generally are not *de minimis* actions. While we believe VA regulations logically could fall within the exemption for military functions, they have not historically been viewed as falling within the similar exemption provided in the APA. Nor would waivers under the second and third categories provide sufficient relief, because "[i]n most cases, exemptions for such rules will be granted with respect to the timing of required offsets," and "[a]gencies will generally still be required to offset such actions." While such partial exemptions would potentially provide VA some greater amount of flexibility in promulgating regulations, the Department would still ultimately be required to comply with the offset requirements. Compliance with these requirements presents serious obstacles to fulfillment of the Department's mission of service to Veterans.