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Dr. Shereef Elnahal
Under Secretary for Health
Department of Veterans Affairs
810 Vermont Avenue NW
Washington, D.C. 20420

Submitted Electronically

Attention: Comments in Response to Interim Final Rule, RIN2900-AR57

Dear Under Secretary for Health Dr. Elnahal:

The National Women's Law Center ("the Center") writes to comment on the Department of Veterans Affairs ("the Department") Interim Final Rule on Reproductive Health Services ("IFR").[1] The Center fights for gender justice – in the courts, in public policy, and in our society – working across the issues that are central to the lives of women and girls, including child care and early learning, education, reproductive rights and health, income security, and workplace justice. We believe that access to reproductive health care, including abortion, is vital to gender justice. Everyone, no matter where they live or their financial means, should have access to abortion when they need it, in their communities, without stigma, shame, or barriers. This includes veterans, and yet they have faced unique challenges in accessing abortion. The Department's rule eliminates harmful barriers to essential health care at VA. Access to abortion is necessary for the health and safety of veterans – and for all people – to determine their futures.

The Department's IFR is a critical action to ensure that veterans can obtain the abortion care they need, which is critical at all times but especially in this moment of unprecedented crisis in abortion access. After the Supreme Court declared that there is no constitutional right to abortion in *Dobbs v. Jackson Women's Health Organization*, states across the country are enforcing total or near-total abortion bans. Just two months after the decision, more than 20 million women lost access to abortion in their home state.[2] As of October 7, twelve states are enforcing total bans, one state is enforcing a six-week ban, and seven other states have tried to

[1] Interim Final Rule on Reproductive Health Services, 87 Fed. Reg. 55,287 (effective Sept. 9, 2022) (to be codified at 38 C.F.R. § 17) [hereinafter IFR].
[2] Katie Shepherd et al., *1 in 3 American Women Have Already Lost Abortion Access. More Restrictive Laws Are Coming*, WASH. POST (Aug. 22, 2022), https://www.washingtonpost.com/nation/2022/08/22/more-trigger-bans-loom-1-3-women-lose-most-abortion-access-post-roe/.

prohibit abortion, but are blocked by court orders.[3] Given the dire landscape for abortion access, many who need abortion care are being forced to travel to another state to reach clinic-based care. Others are unable to travel and will be forced to carry an unwanted pregnancy to term. Unfortunately, because of the prior existing restriction on VA care for abortion and because of numerous medically unnecessary anti-abortion laws enacted by states before the *Dobbs* decision, this has been the reality for many veterans even before the Supreme Court decision, but the situation is worsening every day.

Such a crisis demands immediate and comprehensive action from the Department, which is responsible for protecting the health needs of the more than nine million veterans enrolled in VA's program[4] as well as dependents and caregivers enrolled in CHAMPVA. Congress has given the Secretary the authority to define and develop a Medical Benefits Package to fit the needs of veterans. Over the past few decades, the Secretary has issued rulemaking pursuant to this authority in order to improve the provision of health care for its beneficiaries. And it is pursuant to this authority that the Secretary is properly promulgating the Department's most recent rule protecting abortion access for veterans.

Abortion care is health care – and the Center applauds the Department's action to preserve and promote veterans' health by issuing the IFR. The Center strongly supports the rule and urges the Department to ensure that all veterans can seamlessly access abortion care that will now be available through VA.

I. The Department has the statutory authority to provide abortions and abortion counseling, as outlined in its rule.

a. VA has authority to provide abortions and nondirective pregnancy options counseling under 38 U.S.C. 1710.

Under 38 U.S.C. 1710 ("Medical Benefits Package"), the Department is required to furnish "hospital care and medical services which the Secretary determines to be needed,"[5] for veterans specified in 38 U.S.C 1710 (a)(1)-(2), and may similarly decide to furnish such care to veterans specified in 38 U.S.C 1710 (a)(3). The Secretary identifies "needed" care that the Department will provide pursuant to 38 U.S.C. 1710 through rulemaking. For decades, the Department has undertaken rulemaking expanding the Medical Benefits Package.[6]

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[3] *After Roe Fell: Abortion Laws by State*, CTR. FOR REPROD. RIGHTS (last visited Oct. 11, 2022), https://reproductiverights.org/after-roe-fell-abortion-laws-by-state/.
[4] VETERANS HEALTH ADMIN., https://www.va.gov/health/aboutVHA.asp.
[5] 38 U.S.C. § 1710(a)(1)-(2).
[6] For example, *see* CONG. RSCH. SERV., IF10555, VETERANS HEALTH ADMINISTRATION: INTRODUCTION TO VETERANS HEALTH CARE (2019), https://crsreports.congress.gov/product/pdf/IF/IF10555; *see also* CONG. RSCH. SERV., IF11082, VETERANS HEALTH ADMINISTRATION: GENDER-SPECIFIC HEALTH CARE SERVICES FOR WOMEN VETERANS (2021) https://crsreports.congress.gov/product/pdf/IF/IF11082; *see also* Medical Benefits Package; Copayments for Extended Care Services, 67 Fed. Reg. 35,037 (effective May 17, 2022) (to be codified at 38 C.F.R § 17); *see also* Medical Benefits for Newborn Children of Certain Woman Veterans, 76 Fed, Reg. 78,569 (effective Dec. 19, 2011) (to be codified at 38 C.F.R § 17).

Given the current abortion crisis, the Department has properly recognized that the onslaught of state abortion bans has created "urgent risks to the lives and health"[7] of veterans and their loved ones, and that veterans across the country are now facing gaps in access to care. To protect access to that needed care, the Department amended the Medical Benefits Package to include abortion care. Additionally, the Department has eliminated the regulatory prohibition in the Medical Benefits Package that previously prohibited VA providers from offering nondirective pregnancy options counseling to their patients. The Department recognizes that if it did not take swift action in issuing this rulemaking, "veterans will face serious threats to their life and health."[8] Accordingly, pursuant to the authority under 38 U.S.C. 1710, the Department has expanded health care access relating to abortion care.

b. The Department has authority to provide abortion care which is not limited by previous legislation.

Access to health care for women veterans has long been a priority for Congress in giving the Department authority to meet veterans' needs. In 1992, Congress passed the Veterans Health Care Act of 1992 ("VHCA"). The law's purpose was, among other things, to improve the health care services available for women. There were eight titles within the Act. Title I, Sec. 106 specifically related to VA provision of health care services for women veterans, providing that:

> 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 complications are increased by a service-connected condition.[9]

At the time the VHCA passed, Congress recognized the lack of gender-specific care available to women veterans.[10] Despite the concern Congress had for ensuring health care for women veterans, the VHCA did not require the Department to provide or guarantee such care to women veterans; instead, the law stated that the Secretary "may provide" the care outlined in the law. This permissive authority allowed the Department to make its own decisions about how to meet the health care needs of women veterans. However, the VHCA's exclusion of infertility services, abortions, and pregnancy care except in certain circumstances was a harmful restriction of the Department's ability to meet those needs pursuant to Section 106; but it is worth noting that, with respect to abortion care, things were differently situated than they are now. At that time,

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[7] Interim Final Rule on Reproductive Health Services, 87 Fed. Reg. 55,287, 55,288 (effective Sept. 9, 2022) (to be codified at 38 C.F.R. § 17).
[8] Interim Final Rule on Reproductive Health Services, 87 Fed. Reg. 55,287, 55,288 (effective Sept. 9, 2022) (to be codified at 38 C.F.R. § 17).
[9] 38 U.S.C. § 1710 (emphasis added).
[10] "In 1981, Congress requested reports from the Government Accountability Office (GAO) on women veterans' access to VA benefits (https://go.usa.gov/xEBkM). At that time, GAO found that there was inadequate access to general health, gynecological, and obstetrical care." *See* CONG. RSCH. SERV., IF11082, VETERANS HEALTH ADMINISTRATION: GENDER-SPECIFIC HEALTH CARE SERVICES FOR WOMEN VETERANS (2021), https://crsreports.congress.gov/product/pdf/IF/IF11082.

abortion was legal; it was just after the U.S. Supreme Court reaffirmed *Roe v. Wade*, making clear how abortion is central to women's health, equality, and lives.[11]

Just a few years later, in 1996, Congress effectively overhauled medical care at the Department by passing the Veterans' Health Care Eligibility Reform Act ("1996 Reform Act"). The 1996 Reform Act expanded eligibility for VA's hospital and outpatient care and granted the Department broad authority to determine the scope of medical services it provides to veterans. Prior to its passage, the Department was only able to provide care to veterans "needed for the care of a 'disability.'"[12] The 1996 Reform Act eliminated this limitation, allowing the Department to determine its scope of health care provided by VA as either hospital or medical care that the Secretary determined as "needed."[13]

The 1996 Reform Act superseded the VHCA as it granted the Secretary broad authority to determine the care provided by the Department, including for women veterans.[14] Indeed, Congress was able to rely on this authority to provide needed reproductive health care that the VHCA Section 106 otherwise denied. In the first Medical Benefits Package promulgated after the 1996 Reform Act, the Secretary included a range of care that would be furnished to veterans, including maternity care and certain infertility treatments. Since then, the Department has provided maternity services, including comprehensive assessments of pregnant veterans, laboratory tests, prenatal screenings, ultrasounds, newborn care, pharmacy prescriptions during pregnancy and postpartum, education, and travel to obtain care.[15] Just as recently as 2020, the Department issued a directive that, "[i]t is VHA [Veterans Health Administration] policy that Veterans enrolled in VA's health care system have access to comprehensive maternity care."[16] The Medical Benefits Package also provides coverage of certain fertility services, including in vitro fertilization treatment for eligible beneficiaries.[17] The Department has provided this care for decades pursuant to its authority under the 1996 law, which supersedes the VHCA.

Even if the 1996 Reform Act did not override the exceptions included in the VHCA, the VHCA still does not preclude the Department from providing reproductive health care under authority separately granted by Congress. In outlining the care that the Department could provide to women veterans under Section 106 of the VHCA, Congress included limitations that only applied to Section 106; Section 106 of the VHCA makes clear that its restrictions on reproductive health care are only applicable to care provided pursuant to the authority "under this section." When Congress subsequently passed the 1996 Reform Act, overhauling VA's system of care, it provided separate and distinct authority for the Department to provide care to veterans once the Secretary determined such care was "needed." Subsequently, Congress endorsed the

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[11] *Planned Parenthood of Se. Pennsylvania v. Casey*, 112 S. Ct. 2791 (1992).
[12] *See* CONG. RSCH. SERV., R47191, DEPARTMENT OF VETERANS AFFAIRS: ABORTION POLICY 4 (2022), https://crsreports.congress.gov/product/pdf/R/R47191/2.
[13] *See* CONG. RSCH. SERV., R47191, DEPARTMENT OF VETERANS AFFAIRS: ABORTION POLICY 4 (2022), https://crsreports.congress.gov/product/pdf/R/R47191/2.
[14] Notably, in the 1996 law, Congress provided that the Department "shall furnish hospital care and medical services which the Secretary determines to be needed… and may furnish nursing home care, which the Secretary determines to be needed to any veteran," Veteran's Health Care Eligibility Public Reform Act of 1996, Pub. L. No. 104-262 (codified as amended at 38 U.S.C. §§ 1710(a)(1)(2)).
[15] VETERANS HEALTH ADMIN., DIRECTIVE 1330.03, MATERNITY HEALTH CARE AND COORDINATION, at 10-3 (2020).
[16] VETERANS HEALTH ADMIN., DIRECTIVE 1330.03, MATERNITY HEALTH CARE AND COORDINATION, at 3 (2020).
[17] 38 U.S.C. § 17.380.

Department's interpretation of its authority under the 1996 Reform Act. Just recently, Congress passed the Deborah Sampson Act of 2020 to improve health care access and services to women veterans.[18] The law defined "health care" as "health care and services included in the medical benefits package provided by the Department"[19] without reference to Section 106, further reaffirming that the Department has broad authority, notwithstanding the VHCA, to determine the scope of care it provides to veterans.

As the IFR recognizes, the VHCA does not restrict the Department's authority to update the Medical Benefits Package[20] to include abortion and nondirective options counseling.

c. The Department has authority to provide abortions and nondirective options counseling for CHAMPVA beneficiaries.

In the IFR, the Department also expands access to abortion care for veterans' loved ones and caregivers who are enrolled in the CHAMPVA health benefits program. Under CHAMPVA, the Department provides medical care to certain spouses, children, survivors, and caregivers of veterans who meet specific eligibility criteria.[21] As the IFR notes, the medical care provided under CHAMPVA must be in the "same or similar manner" as the care provided by the Department of Defense to active duty family members, retired service members and their families, and others under the TRICARE (Select) program.[22] Prior to the IFR, the CHAMPVA health benefits did not align with those under TRICARE (Select), which provides coverage for abortions in the case of rape, incest, or life endangerment of the pregnant person.[23] CHAMPVA had only permitted abortion in the case of life endangerment to the pregnant person,[24] meaning it fell short of the coverage provided by TRICARE (Select).

The Department is required by law to provide "same or similar"[25] care to CHAMPVA enrollees as TRICARE (Select). Congress gave the Department the authority to decide the scope of coverage for CHAMPVA as long as it is similar to that of TRICARE (Select). In determining that abortion coverage in the case of rape, incest, and endangerment to the health of the pregnant person, and providing nondirective options counseling, is similar to the care allowed for in TRICARE (Select), the Department has exercised the authority delegated to it by Congress. The Department's reasoning for making this change is that it is "necessary and appropriate to protect a pregnant individual's health,"[26] particularly given the current abortion crisis. Abortion bans harm the health of pregnant people – including those who care for and support our veterans. In providing coverage of health care through CHAMPVA, the Department has an obligation to

[18] Deborah Sampson Act of 2020, P. L. No. 116-315, tit. V (codified as amended at 38 U.S.C. § 7310).
[19] Deborah Sampson Act of 2020, P. L. No. 116-315, tit. V (codified as amended at 38 U.S.C. § 7310 note).
[20] Interim Final Rule on Reproductive Health Services, 87 Fed. Reg. 55,287, 55,289 (effective Sept. 9, 2022) (to be codified at 38 C.F.R. § 17).
[21] 38 U.S.C. § 1781(a) (authorizes the Department's secretary to provide specified "medical care" to CHAMPVA beneficiaries).
[22] 38 U.S.C. § 1781(b); *see* 32 C.F.R. §§ 199.1(r), 199.17(a)(6)(ii)(D).
[23] 38 U.S.C. § 17.272(a)(64), *amended by* 87 Fed. Reg. 55,287 on 9 Sep 2022.
[24] 10 U.S.C. § 1093.
[25] 38 U.S.C. § 1781(b); *see* 32 C.F.R. §§ 199.1(r), 199.17(a)(6)(ii)(D).
[26] Interim Final Rule on Reproductive Health Services, 87 Fed. Reg. 55,287, 55,292 (effective Sept. 9, 2022) (to be codified at 38 C.F.R. § 17).

provide coverage and counseling that fits their needs. Just as veterans need better access to abortion, their caretakers and loved ones do as well. As such, the Department is rightly compelled to make such changes to expand abortion care for CHAMPVA beneficiaries.

d. The Department's authority to provide abortion care through the IFR preempts state or local laws restricting access to abortion.

In order to protect the health of its beneficiaries, the Department has made clear that its regulation authorizing the provision of abortion care by VA providers preempts conflicting state laws. As already discussed, in just the few months since the *Dobbs* decision, states across the country are now enforcing total or near total abortion bans. These state laws have wreaked havoc on people's lives and in our laws. Providers, unsure of their legal liability, are turning away patients who need care, including in health and life emergencies.[27] Veterans in states with abortion bans can no longer go to community providers for abortion care when they need it. As the Department is under an obligation to care for the health and well-being of its beneficiaries and provide the same standard of care regardless of where the veteran lives, it has issued the IFR so that it can provide care to its veterans that the states otherwise disallow. States cannot interfere with this federal program that seeks to provide consistent care to its veterans.

The Supremacy Clause of the U.S. Constitution establishes that federal law prevails over any conflicting state laws.[28] As the Department notes, the Supremacy Clause "generally immunizes the Federal Government from State laws that directly regulate or discriminate against it."[29] State and local laws and regulations cannot prevent the federal VA program from providing needed abortion care to veterans. The Department has VA facilities in every state that has banned abortion, and in order to provide the same health care access to its beneficiaries in all states, the Department must be able to provide the care at its centers even in those states.[30] The IFR preempts conflicting state laws where those laws would prevent health care professionals "acting in the scope of VA authority and employment" [31] pursuant to statutory provisions authorizing such care. This is consistent with regulations previously issued by the Department, such as 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."[32]

This preemption authority is also reaffirmed by Executive Order 13132 (EO 13132).[33] EO 13132 provides that when there is no express preemption authority and the regulation conflicts with state law, agencies shall consider rulemaking as authorizing the preemption of

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[27] J. David Goodman & Azeen Ghorayshi, *Women Face Risks as Doctors Struggle with Medical Exceptions on Abortion*, N.Y. TIMES (Jul. 20, 2022), https://www.nytimes.com/2022/07/20/us/abortion-save-mothers-life.html.
[28] *See* U.S. Const. art. vi, cl. 2.
[29] *United States v. Washington*, 142 S. Ct. 1976, 1982 (2022).
[30] 38 C.F.R. § 17.419(c).
[31] Interim Final Rule on Reproductive Health Services, 87 Fed. Reg. 55,287, 55,294 (effective Sept. 9, 2022) (to be codified at 38 C.F.R. § 17).
[32] Interim Final Rule on Authority of VA Professionals to Practice Health Care, 85 Fed, Reg, 71,838 (effective Nov. 12, 2020) (to be codified at 38 C.F.R. § 17).
[33] Exec. Order No. 13132, 64 Fed. Reg. 43,255 (Aug. 10, 1999).

state law. Pursuant to 38 CFR 17.419 and this IFR, the Department has authorized the preemption of state law, meaning VA providers and related staff – as well as operations systems and services related to the provision of abortion care – are not subject to state laws that would interfere with the Department's ability to provide ethical, patient-centered care.

II. The Department should make clear that veterans can access abortion care when they need it.

Abortion care is essential to the health of our veterans. As the Department recognizes in the IFR, Congress has provided authority to VA to ensure all veterans under its care receive health care that is "needed."[34] The Department has correctly determined that providing access to abortion care is needed to protect the lives and health of veterans. The definition of "health" must include all the circumstances that surround a veteran's well-being, from mental health and physical health to social determinants of health such as stress stemming from financial instability that is compounded by facing an unintended pregnancy, high risks of pregnancy complications due to other health factors, and trauma or mood disorders that may be exacerbated by an unintended pregnancy.

While we believe it is the Department's intention to encompass health in its broadest sense given its responsibility to meet the needs of its veterans, using an "exceptions" framework may nevertheless cause confusion for both beneficiaries and providers. Moreover, we know that when exceptions exist in laws, there are often implementation challenges – from a lack of understanding of what exceptions qualify to processes that create insurmountable barriers – that keep people from getting the care they need and render the exceptions meaningless. For these reasons, we urge the Department to eliminate the exceptions framework and instead clarify that it will provide abortion care when needed by the veteran. However, if the Department maintains the exceptions, it must create clear guidance and seamless processes to ensure that those exceptions are not rendered meaningless.

With respect to implementation and ensuring there are no additional barriers to this care, the Center commends the Department's decision to provide abortion care to veterans who are survivors of sexual assault without requiring proof and that "self-reporting from the pregnant veteran constitutes sufficient evidence."[35] This is critical because the majority of sexual assaults are not reported, and survivors may distrust the police or fear retaliation from a known perpetrator.[36] In implementing the IFR, we urge the Department to make clear to survivors that they can receive the full range of health care they need at VA, including abortion care, without barriers.

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[34] Pursuant to 38 U.S.C. § 1710, the Secretary must provide "hospital care and medical services which the Secretary determines to be needed" to veterans under VA care. As such, the Secretary has authority to determine and amend the scope of care as "needed" including the provision of abortion and abortion counseling.

[35] Interim Final Rule on Reproductive Health Services, 87 Fed. Reg. 55,287, 55,294 (effective Sept. 9, 2022) (to be codified at 38 C.F.R. § 17).

[36] *Statistics*, NAT'L SEXUAL VIOLENCE RES. CTR., https://www.nsvrc.org/statistics (last visited Oct. 6, 2022).

III. The IFR is appropriately responsive to the needs of veterans under VA care, especially given the unique barriers and challenges veterans face with respect to abortion access and care.

Despite millions of people in the U.S. relying on the Department for their health care, the Department has historically not provided nor covered abortions or nondirective options counseling. While this has meant the Department was failing to meet the needs of veterans, it is appropriate that the Department has now re-evaluated and determined that access to abortion is "needed" pursuant to 38 U.S.C. 1710(a)(1)-(3). Without the changes outlined in the IFR, veterans will face increased risks to their life and health when seeking to terminate a pregnancy.

Currently, the Veterans Health Administration is the largest integrated healthcare system in the U.S., with over nine million veterans enrolled in the program.[37] There are nearly two million women[38] veterans living in the U.S., and they comprise approximately 10 percent of the total veteran community, in addition to the estimated thousands of trans men, non-binary veterans, and veterans who identify with a different gender who may need abortion care.[39] The pre-existing restriction on abortion for those who rely on VA has meant veterans already have been forced to navigate often insurmountable barriers to seek an abortion. However, after the *Dobbs* decision, the barriers veterans face will increase dramatically, as local abortion providers close their doors across the country in response to state abortion bans and increased criminalization of this essential health care. At the same time, veterans are subject to unique challenges that compound their difficulty in getting care – and would compound the harm were they to be denied that care from the VA system.

For example, veterans are at greater risk of mental health issues due to their service: veterans are 1.5 times more likely to die by suicide than non-veterans, and one-third of veterans who receive care through VA have been diagnosed with a mental health condition, most commonly depression, post-traumatic stress disorder (PTSD), and anxiety.[40] Women veterans are 2.5 times more at risk of suicide than their non-veteran women counterparts.[41] Nearly half of women veterans seeking reproductive health care through VA are diagnosed with mental health conditions; additionally, reproductive health care settings have recently been found to be crucial touchpoints for women veterans at risk of suicide.[42]

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[37] VETERANS HEALTH ADMIN., https://www.va.gov/health/aboutVHA.asp (last visited Sept. 30, 2022).
[38] *2019 Gender and Veteran Demographics*, U.S. DEP'T OF LAB., https://www.dol.gov/agencies/vets/womenveterans/womenveterans-demographics (last visited Sept. 30,2022).
[39] GARY J. GATES & JODY L. HERMAN, THE WILLIAMS INSTITUTE, TRANSGENDER MILITARY SERVICE IN THE UNITED STATES (2014), https://williamsinstitute.law.ucla.edu/wp-content/uploads/Trans-Military-Service-US-May-2014.pdf.
[40] GOV'T ACCOUNTABILITY OFF., VETERAN'S GROWING DEMAND FOR MENTAL HEALTH SERVICES (2021), https://www.gao.gov/assets/gao-21-545sp.pdf.
[41] *Statement for the Record of the Comm. on Veteran's Affairs U.S. H.R.* at 8 (2022) (statement of Marquis D. Barefield, Assistant Nat'l Legis. Dir., Disabled Am. Veterans), https://docs.house.gov/meetings/VR/VR00/20220929/115166/HHRG-117-VR00-20220929-SD008.pdf.
[42] Lindsey L. Monteith et al., *Preventing Suicide Among Women Veterans: Gender-Sensitive, Trauma-Informed Conceptualization*, 9 CURRENT TREATMENT OPTIONS IN PSYCHIATRY 186, 187 (2022), https://doi.org/10.1007/s40501-022-00266-2 (citing Claire A. Hoffmire et al., *Women Veterans' Perspectives on Suicide Prevention in Reproductive Health Care Settings: An Acceptable, Desired, Unmet Opportunity*, 32 WOMEN'S HEALTH ISSUES 418 (2022) "[f]irst qualitative examination of women veterans' perspectives regarding suicide prevention in VA reproductive healthcare settings.").

A study found that the high rates of mental health disorders among women veterans make them susceptible to negative health outcomes associated with unintended pregnancy.[43] For pregnant veterans, mental health conditions are often compounded by pregnancy,[44] leading to poor pregnancy outcomes.[45] Veterans of reproductive age have high rates of chronic medical and mental health conditions that may increase the risks associated with pregnancy. Such conditions include chronic PTSD,[46] severe hypertension,[47] and chronic renal disease.[48]

Women and gender minority veterans are also at greater risk of sexual assault and intimate partner violence. One in four women veterans reports experiencing military sexual trauma.[49] According to the Department, survivors of military sexual trauma may experience significant health impacts, including PTSD, depression and other mood disorders, and substance abuse disorders.[50] Women who are denied abortions, compared to women who are able to have an abortion, are also more likely to be tethered to an abuser and to be at risk for continued violence, even if they end the romantic relationship.[51] For the veteran and military community, this is especially troubling: the rate of spousal abuse in the military is twice as high as the rate

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[43] Colleen P. Judge-Golden et al., *The Association Between Mental Health Disorders and History of Unintended Pregnancy Among Women Veterans*, 33 J. OF GEN. INTERNAL MED. 2092 (2018), https://link.springer.com/article/10.1007/s11606-018-4647-8.

[44] Kristin M. Mattocks et al., *Pregnancy and Mental Health Among Women Veterans Returning from Iraq and Afghanistan*, 19 J. OF WOMEN'S HEALTH 2159 (2010), https://doi.org/10.1089/jwh.2009.1892 (study finding that "[v]eterans with a pregnancy were twice as likely to have a diagnosis of depression, anxiety, post-traumatic stress disorder (PTSD), bipolar disorder, or schizophrenia as those without a pregnancy.").

[45] *See eg.*, RL Copper et al., *The Preterm Prediction Study: Maternal Stress is Associated with Spontaneous Preterm Birth at Less Than Thirty-five Week's Gestation*, 175 AM. J. OF OBSTETRICS GYNECOLOGY 1286 (1996), https://doi.org/10.1016/S0002-9378(96)70042-X.

[46] Colleen Judge-Golden et al., *Prior Abortions and Barriers to Abortion Access Reported by Pregnant Women Veterans*, 37 J. OF GENERAL INTERNAL MED. 816 (2022), https://link.springer.com/article/10.1007/s11606-022-07576-4, (finding that "veterans reporting a prior abortion were significantly more likely to disclose history of military sexual trauma and diagnosis of post-traumatic stress disorder.").

[47] Jonathan G Shaw et al., *Post-traumatic Stress Disorder and Antepartum Complications: A Novel Risk Factor for Gestational Diabetes and Preeclampsia*, 31 PAEDIATR PERINAT EPIDEMIOL 185 (2017).

[48] David C. Jones & John P. Hayslett, *Outcome of Pregnancy in Women with Moderate or Severe Renal Insufficiency*, 335 NEW ENG. J. OF MED. 226 (1996).

[49] *Military Sexual Trauma*, DISABLED AM. VETERANS, https://www.dav.org/veterans/resources/military-sexual-trauma-mst/#:~:text=How%20common%3F,MST%20to%20VA%20are%20men (last visited Oct. 6, 2022).

[50] U.S. DEP'T OF VETERANS AFFAIRS, MILITARY SEXUAL TRAUMA (2021), https://www.mentalhealth.va.gov/docs/mst_general_factsheet.pdf.

[51] Women in abusive relationships who sought and obtained abortion care experienced a decrease in physical violence from the man involved in the pregnancy; women who sought but were denied care were not so fortunate. Pregnant women in abusive relationships are also at risk of being killed by their abusers. Sarah CM Roberts et al., *Risk of Violence from the Man Involved in the Pregnancy After Receiving or Being Denied an Abortion*, 12 BMC MED. 5 (2014), https://bmcmedicine.biomedcentral.com/articles/10.1186/s12916-014-0144-z; *see also* Sarah Miller et al., *The Economic Consequences of Being Denied an Abortion* (Nat'l Bureau of Econ. Rsch., Working Paper No. 26662, 2020) (women denied abortion were more likely to have sustained contact with the man involved in pregnancy); Deborah Tuerkheimer, *Conceptualizing Violence Against Pregnant Women*, 81 IND. L.J. 667, 672 (2006).

among the national population,[52] and the transition to civilian life may continue or exacerbate intimate partner violence.[53]

These examples of the unique conditions facing veterans serve to illustrate the broader point that abortion bans will have far-reaching impacts on veterans' health and lives, making abortion care "needed to promote, preserve, or restore the health of the individual."[54]

IV. Abortion is health care and is critical to a person's safety and well-being.

The IFR reflects core responsibilities of the agency: to "promote, preserve, or restore the health"[55] of the patient and to provide care that "is in accord with generally accepted standards of medical practice."[56] Abortion is health care and is standard medical practice. But before the *Dobbs* decision, the prohibition on abortion and abortion counseling at the Department interfered with that standard of practice and harmed the provider-patient relationship by forcing veterans to seek care outside of VA when they needed abortion care. Now, because of *Dobbs*, veterans are being denied the standard of practice at private providers as well.

Moreover, in addition to the specific challenges faced by veterans that make abortion care essential, there are well documented life-long consequences generally to pregnant people's life, health, and economic well-being when they are denied abortion care.

These factors make it clear that by issuing the IFR, the Department is meeting the health needs of its veterans while also ensuring its providers can provide the standard medical practice to their patients.

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[52] Sara Cammarta, *Ex-military Spouse Tells Congress Her Story of Domestic Abuse, Revealing Cracks in Military's Response to Incidents*, STARS AND STRIPES (May 26, 2021), https://www.stripes.com/theaters/us/2021-05-26/DOD-DOMESTICABUSE-1587141.html.

[53] For instance, some spouses of disabled veterans are caregivers who rely on income from VA. *See* Quil Lawrence, *After Combat Stress, Violence Can Show Up At Home*, NPR (Apr. 27, 2016), https://www.npr.org/sections/health-shots/2016/04/27/475908537/after-combat-stress-violence-can-show-up-at-home.

[54] 38 C.F.R. § 17.38(b).

[55] *See* 38 C.F.R. §17.38(b). "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."

[56] *Facts are Important: Abortion is Health Care*, AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, https://www.acog.org/advocacy/facts-are-important/abortion-is-healthcare (last visited Oct. 11, 2022) ("The fact is, abortion is an essential component of women's health care. The American College of Obstetricians and Gynecologists (ACOG), with over 57,000 members, maintains the highest standards of clinical practice and continuing education for the nation's women's health physicians. Abortion care is included in medical training, clinical practice, and continuing medical education."); *see also, ACOG, ACEP, and the AMA Lead Coalition of Amici in Support of the Federal Government Challenge to Idaho's Abortion Ban*, AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS (AUG. 16, 2022), https://www.acog.org/news/news-releases/2022/08/acog-acep-ama-lead-coalition-of-amici-support-challenge-idaho-abortion-ban, ("ACOG's brief states that '[t]he Idaho Law is inconsistent with bedrock principles of medical ethics, the safe and medically indicated provision of emergency care, and federal law ensuring that all patients in emergency settings receive medical treatment based on their individual health care needs.' In the case of complications of pregnancy, ACOG notes, this may and sometimes does include lifesaving abortion care.").

a. Denying someone an abortion risks their physical and mental health.

Carrying a pregnancy to term and childbirth can have severe health consequences. Women denied abortions report more life-threatening complications and chronic health conditions than those who receive abortion care. These complications include chronic migraines, joint pain, gestational hypertension, eclampsia,[57] and postpartum hemorrhage.[58] And in some cases, abortion is necessary to preserve the health of a pregnant person with an autoimmune disease such as lupus and other people who may have high-risk pregnancies.[59]

The U.S. has an alarmingly high maternal mortality rate; the rate of maternal deaths increased from 20.1 deaths per 100,000 live births (754 women) in 2019 to 23.8 deaths (861 women) in 2020.[60] This is especially disturbing when comparing data from ten similar nations; in the U.S., the risk of maternal mortality is fourteen times higher than in New Zealand, more than 3.5 times higher than in the United Kingdom, and nearly three times higher than in France – the country with the second highest mortality rate.[61] In the U.S., there is an increasing number of pregnant people with chronic health conditions, including hypertension and diabetes.[62]

Black and Native women are at a greater risk of pregnancy-related death due to institutional barriers and structural racism, including implicit bias. Black women generally are three times more at risk of pregnancy-related death than white women.[63] Between 2007-2016, the rate of pregnancy-related deaths for Black and American Indian or Alaska Native women aged 30 or above was four to five times greater than for white women of the same age group.[64] This is particularly concerning for the VA system and its requirement to ensure veterans' health needs are met because women veterans are more likely to be Black than non-veteran women (19

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[57] ADVANCING NEW STANDARDS IN REPROD. HEALTH, THE HARMS OF DENYING A WOMAN A WANTED ABORTION FINDINGS FROM THE TURNAWAY STUDY 2 (2020), https://www.ansirh.org/sites/default/files/publications/files/the_harms_of_denying_a_woman_a_wanted_abortion_4-16-2020.pdf.

[58] Committee on Practice Bulletins-Obstetrics, *Practice Bulletin No. 183: Postpartum Hemorrhage*, 130 OBSTET GYNECOL (2017), https://doi.org/10.1097/aog.0000000000002351; Am. Coll. of Obstetricians & Gynecologists & Soc'y for Maternal-Fetal Med., *Obstetric Care Consensus No. 7: Placenta Accreta Spectrum*, 132 OBSTET GYNECOL (2021) https://doi.org/10.1097/aog.0000000000002983; Committee on Practice Bulletins-Obstetrics, *Practice Bulletin No. 198: Prevention and Management of Obstetric Lacerations at Vaginal Delivery*, 132 OBSTET GYNECOL (2018), https://doi.org/10.1097/aog.0000000000002841; Am. Coll. of Obstetricians & Gynecologists Committee on Clinical Consensus-Obstetrics, *Pharmacologic Stepwise Multimodal Approach for Postpartum Pain Management: ACOG Clinical Consensus No. 1*, 138 OBSTET GYNECOL (2021), https://doi.org/10.1097/aog.0000000000004517.

[59] Jammie Law et al., *Termination is the Safest Course for Some High-risk Pregnancies. Dobbs Decision Threatens that Care*, STAT (Sept. 21, 2022), https://www.statnews.com/2022/09/21/termination-is-the-safest-course-for-some-high-risk-pregnancies-dobbs-decision-threatens-that-care/.

[60] DONNA L. HOYERT, NAT'L CTR. FOR HEALTH STAT, MATERNAL MORTALITY RATES IN THE UNITED STATES 1, 2020 (2022), https://dx.doi.org/10.15620/cdc:113967.

[61] Jamila Taylor et al., *The Worsening U.S. Maternal Health Crisis in Three Graphs*, CENTURY FOUND. (Mar. 2, 2022), https://tcf.org/content/commentary/worsening-u-s-maternal-health-crisis-three-graphs/.

[62] *Pregnancy Mortality Surveillance System*, CTR. FOR DISEASE CONTROL AND PREVENTION, https://www.cdc.gov/reproductivehealth/maternal-mortality/pregnancy-mortality-surveillance-system.htm (last visited Oct. 6, 2022).

[63] DONNA L. HOYERT, NAT'L CTR. FOR HEALTH STAT, MATERNAL MORTALITY RATES IN THE UNITED STATES, 2020 (2022), https://dx.doi.org/10.15620/cdc:113967.

[64] Emily E. Petersen et al., *Racial/Ethnic Disparities in Pregnancy-Related Deaths — United States, 2007–2016*, 68 MORBIDITY AND MORTALITY WKLY. REP. 762 (2019), http://dx.doi.org/10.15585/mmwr.mm6835a3.

percent of women veterans are Black compared to 12 percent of non-veteran women).[65] Alarmingly, a recent study of pregnancy-related deaths among American Indian or Alaska Native people found that nearly all deaths (93 percent) among this population were preventable.[66] Overall, more than 80 percent of pregnancy-related deaths are preventable, and a quarter of these deaths are due to mental health issues that include suicide or substance abuse,[67] an alarming statistic, especially when considering the high rates of suicide among veterans.

Being denied an abortion negatively impacts people's mental health and is associated with elevated anxiety and stress levels, low self-esteem, and lower life satisfaction,[68] as well as more chronic headaches or migraines.[69] Following the *Dobbs* decision, the American Psychological Association condemned the Supreme Court's ruling, stating that it "will exacerbate the mental health crisis America is already experiencing."[70] In one study of people seeking an abortion, those who encountered barriers such as traveling for care or having to delay the procedure were more likely to experience stress, anxiety, and depression. Of the key areas that influenced their psychological well-being, many cited a lack of autonomy – such as being forced to delay a pregnancy – as well as perceived stigma associated with abortion and reactions from friends and family.[71]

b. Abortion bans threaten people's economic security and well-being.

Economic security, health, and well-being are inextricably linked and are key to a person's ability to determine their own future. When people are denied the abortion care they seek, they can face devastating consequences – both in the immediate and long-term – on their

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[65] STEVEN GARASKY ET AL., IMPAQ INT'L, WOMEN VETERAN ECONOMIC AND EMPLOYMENT CHARACTERISTICS 1 (2016), https://www.dol.gov/sites/dolgov/files/OASP/legacy/files/WomenVeteranEconomicandEmploymentCharacteristics.pdf.

[66] SUSANNA TROST ET AL., CTR. FOR DISEASE CONTROL AND PREVENTION, PREGNANCY-RELATED DEATHS: DATA FROM MATERNAL MORTALITY REVIEW COMMITTEES IN 36 US STATES, 2017-2019 tbl. 3(2022), https://www.cdc.gov/reproductivehealth/maternal-mortality/erase-mm/data-mmrc-aian.html.

[67] Press Release, Ctr. for Disease Control and Prevention, Four in 5 Pregnancy-related Deaths in the U.S. are Preventable (Sept. 19, 2022), https://www.cdc.gov/media/releases/2022/p0919-pregnancy-related-deaths.html.

[68] M. Antonia Biggs et al., *Women's Mental Health and Well-being 5 Years After Receiving or Being Denied an Abortion: A Prospective, Longitudinal Cohort Study*, 74 JAMA PSYCHIATRY 169 (2017), https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2592320.

[69] ADVANCING NEW STANDARDS IN REPROD. HEALTH, THE HARMS OF DENYING A WOMAN A WANTED ABORTION FINDINGS FROM THE TURNAWAY STUDY 2 (2020),https://www.ansirh.org/sites/default/files/publications/files/the_harms_of_denying_a_woman_a_wanted_abortion_4-16-2020.pdf.

[70] *APA Decries SCOTUS Decision on Abortion*, AM. PSYCH. ASS'N (June 27, 2022) https://www.apa.org/news/press/releases/2022/06/scotus-abortion-decision; As the APA suggests, the U.S. is already experiencing a mental health crisis. For example, more than 50 million adults live with mental illness and more than 14 million live with serious mental illness which substantially impacts their life. *See* Mental Illness, NATIONAL INSTITUTE OF MENTAL HEALTH https://www.nimh.nih.gov/health/statistics/mental-illness (last visited Oct. 6, 2022). Instead of receiving care, many people in the U.S. face cost barriers and other institutional barriers that prevent them obtaining adequate support. *See* N.Y. Times Editorial Board, *The Solution to America's Mental Health Crisis Already Exists*, N.Y. TIMES (Oct. 42022), https://www.nytimes.com/2022/10/04/opinion/us-mental-health-community-centers.html.

[71] M. Antonia Biggs et al., *Developing and Validating the Psychosocial Burden Among People Seeking Abortion Scale* (PB-SAS), 15 PLOS ONE 2, 13 (2020) https://doi.org/10.1371/journal.pone.0242463.

financial well-being, job security, workforce participation, and earnings, which ultimately impact their ability to live a safe and healthy life. This is particularly detrimental to those struggling to make ends meet, including Black, Indigenous and People of Color, members of the LGBTQI+ community, immigrants, young people, those living in rural communities, and people with disabilities.

Many people seeking abortion care already struggle to make ends meet. In 2014, nearly half of abortion patients were women with family incomes below the Federal Poverty Level (FPL); women whose families earned less than 200 percent of the FPL made up an additional quarter of abortion patients.[72] Many veterans face financial stress that could be compounded by an unintended pregnancy: 1.5 million veterans live below the FPL and an additional 2.4 million live paycheck to paycheck.[73] Women veterans are at higher risk of experiencing homelessness and are more likely to be single parents compared to non-veteran women;[74] they are also more likely to experience food insecurity compared to their male counterparts.[75] Most women who seek an abortion are already parents, half of whom have more than one child.[76] A 2013 study found that 40 percent of women surveyed sought abortions because they were not prepared to support a child financially, while nearly 30 percent cited their need to focus on parenting existing children.[77]

In addition to the financial costs of having a child, women also face diminished earnings, interference with their career advancement, disruption of their education, and fewer resources for the children they already have.[78] This is especially true with respect to childbirth from

[72] Rachel K. Jones & Jenna Jerman, *Population Group Abortion Rates and Lifetime Incidence of Abortion: United States, 2008–2014*, 107 AM. J. PUB. HEALTH 1904, 1906 (2017).
[73] TAMARA DUBOWITZ, RAND CORP., FOOD INSECURITY AMONG VETERANS (2021), https://www.rand.org/pubs/perspectives/PEA1363-2.html.
[74] DISABLED AM. VETERANS, WOMEN VETERANS: THE LONG JOURNEY HOME (2014), https://www.dav.org/wp-content/uploads/women-veterans-study.pdf.
[75] TAMARA DUBOWITZ, RAND CORP., FOOD INSECURITY AMONG VETERANS (2021), https://www.rand.org/pubs/perspectives/PEA1363-2.html.
[76] Kortsmit K et al., *Abortion Surveillance – United States, 2019*, 70 MORBIDITY AND MORTALITY WKLY. REP. 1 (2021) http://dx.doi.org/10.15585/mmwr.ss7009a1.
[77] M Antonia Biggs et al., *Understanding Why Women Seek Abortions in the US*, 13 BMC WOMEN'S HEALTH AT 1, 6 (2013).
[78] While the data are specific to women here, transgender and non-binary individuals consistently face higher rates of discrimination in the workforce, compounding the economic hardships of parenthood. Studies show that 90 percent of transgender workers have experienced discrimination and harassment in the workplace, which often pushes them into unemployment or low-paid jobs that do not offer benefits such as health insurance. *See* KELLAN BAKER ET AL., CTR. FOR AM. PROGRESS, THE MEDICAID PROGRAM AND LGBT COMMUNITIES: OVERVIEW AND POLICY RECOMMENDATIONS 6 (2016), https://ampr.gs/37m9Eq7.

unintended pregnancies.[79] Studies show that having a child creates both an immediate decrease in women's earnings and a long-term drop in their lifetime earning trajectory.[80]

Even before *Dobbs*, pregnant people were struggling to access abortion. Ninety percent of U.S. counties did not have an abortion provider – forcing people to travel farther to get an abortion[81] and adding not only travel expenses, but also the costs of lodging and child care.[82] Prior to the IFR, any veteran seeking an abortion was forced to obtain care outside of VA, meaning paying out of pocket and potentially traveling long distances to find the nearest clinic. Oftentimes people need to take leave from work in order to travel long distances for multiple clinic visits,[83] but having to take time off of work can mean the loss of a paycheck or even a job, particularly for workers in low-paid and part-time jobs without sick leave and flexible schedules, who are disproportionately women and women of color.[84] These costs force many already struggling to make ends meet to forgo paying for basic necessities – such as bills, food, and even rent – in order to pay for an abortion.[85] Women who were denied abortions, compared to women who are able to have an abortion, are more likely to owe debt and be forced to incur negative

[79] Christine Dehlendorf et al., *Disparities in Abortion Rates: A Public Health Approach*, 103 AM. J. PUB. HEALTH 1772, 1775 (2013) ("Unintended childbirth is associated with decreased opportunities for education and paid employment[.]"); ADAM SONFIELD ET AL., GUTTMACHER INST., THE SOCIAL AND ECONOMIC BENEFITS OF WOMEN'S ABILITY TO DETERMINE WHETHER AND WHEN TO HAVE CHILDREN 14–15 (Mar. 2013), https://www.guttmacher.org/sites/default/files/report_pdf/social-economic-benefits.pdf.

[80] Christine Dehlendorf et al., *Disparities in Abortion Rates: A Public Health Approach*, 103 AM. J. PUB. HEALTH 1772, 1775 (2013) ("Unintended childbirth is associated with decreased opportunities for education and paid employment[.]"); ADAM SONFIELD ET AL., GUTTMACHER INST., THE SOCIAL AND ECONOMIC BENEFITS OF WOMEN'S ABILITY TO DETERMINE WHETHER AND WHEN TO HAVE CHILDREN 14–15 (Mar. 2013), (reviewing studies that document how controlling family timing and size contribute to educational and economic advancements).

[81] For example, after Texas passed H.B. 2 – which the Supreme Court held violated the Constitution for imposing an undue burden on people seeking abortion care in the state – more than half of Texas's abortion facilities closed, causing the number of women of reproductive age living more than 50 miles from a clinic to double. *See Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2296 (2016). As another example, Louisiana Act 620 – which the Supreme Court also held was unconstitutional for creating an undue burden – would have drastically reduced the number of abortion providers in the state, leaving just one provider in one clinic in a state with nearly one million women of reproductive age. *See June Med. Servs. v. Russo*, 140 S. Ct. 2103, 2129 (2020). A resident relying on public transportation would either be forced to travel out of state or pay to travel to the one remaining clinic in the state, which could involve nearly twenty hours of round-trip travel time for just one trip. *June Med. Servs. v. Russo*, 140 S. Ct. 2103, 2130 (2020).

[82] See ALYSSA LLAMAS ET AL., GEO. WASH. JACOBS INST. OF WOMEN'S HEALTH, PUBLIC HEALTH IMPACTS OF STATE-LEVEL ABORTION RESTRICTIONS: OVERVIEW OF RESEARCH & POLICY IN THE UNITED STATES 20-2 (2018), https://publichealth.gwu.edu/sites/default/files/downloads/projects/JIWH/Impacts_of_State_Abortion_Restrictions.pdf.

[83] Additionally, women are at risk of being fired by an employer for taking time off to seek abortion care. For instance, Nicole Ducharme was fired from her job as a bartender and server in Louisiana in 2017. She told her manager that she was pregnant and needed two days off to have an abortion, but was fired on the day of the procedure. *See* Angela Underwood, *U.S. District Court Rules that State Law Forbids Abortion Discrimination in Workplace*, LA. REC. (July 1, 2019), https://louisianarecord.com/stories/512676950-u-s-district-court-rules-that-state-law-forbidsabortion-discrimination-in-workplace.

[84] CLAIRE EWING-NELSON, NAT'L WOMEN'S LAW CTR., PART-TIME WORKERS ARE PAID LESS, HAVE LESS ACCESS TO BENEFITS—AND MOST ARE WOMEN 1, 5 (2020), https://nwlc.org/wp-content/uploads/2020/02/Part-Time-Workers-Factsheet-2.26.20.pdf.

[85] One study found that one-third of women getting an abortion had to delay or forgo paying bills, food, and even rent. One-half relied on financial assistance from others, but such assistance is never assured. *See* Rachel K. Jones et al., *At What Cost? Payment for Abortion Care by U.S. Women*, 23 WOMEN'S HEALTH ISSUES 173, 176 (2013).

"public records" (such as bankruptcy or eviction) on their credit reports after giving birth.[86] When people are struggling to make ends meet, abortion bans can drive them further into economic insecurity, creating ripple effects that harm their day-to-day and long-term health. For female veterans who are more likely to live in poverty than male veterans,[87] and, similarly, trans veterans who are more likely to live in poverty than their cisgender peers,[88] the cost of travel, lodging, child care, and medical procedures could ultimately mean carrying an unwanted pregnancy to term.

These burdens fall hardest on, and perpetuate historic and on-going oppressions against, those who already face hurdles to seeking care, including Black, Indigenous and other people of color who are especially likely to live in poverty and to face discrimination when seeking health care, by deepening existing economic disparities.[89] And it will only worsen following the Supreme Court decision, as states pass abortion bans that force clinics to close and hinder people from seeking the health care they need.

c. State abortion bans and restrictions have interfered with people's access to other types of essential health care, including other pregnancy care.

Since the overturning of *Roe v. Wade*, the myriad state laws restricting and banning abortion have interfered with access to other types of essential health care. The American Medical Association has expressed deep concerns over their providers' ability to provide care under the criminal laws being passed, including care for "ectopic pregnancies or… intrauterine infections, pre-eclampsia, malignancies, or hemorrhage during pregnancy."[14] As a result, patients have been turned away for care they need or forced to delay their care until their condition becomes critical;[90] other patients risk losing access to the medication they need even if they are not seeking an abortion.[91]

V. Conclusion

The Department must protect the health and well-being of the veterans it is entrusted to serve. At a time when extremist lawmakers are decimating abortion access, and the Supreme Court has declared that there is no constitutional right to abortion, the Department's IFR

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[86] Sarah Miller et al., *The Economic Consequences of Being Denied an Abortion* (Nat'l Bureau of Econ. Rsch., Working Paper No. 26662, 2020).
[87] DISABLED AM. VETERANS, WOMEN VETERANS: THE JOURNEY AHEAD 9 (2018) https://www.dav.org/wp-content/uploads/2018_Women-Veterans-Report-Sequel.pdf.
[88] Press Release, The Williams Inst. at UCLA Sch. of Law, Transgender Veterans as Healthy as Cisgender Veterans, Study Finds (Jul. 11, 2018), https://williamsinstitute.law.ucla.edu/ press/trans-vets-health-press-release/.
[89] *See generally* AMANDA FINS, NAT'L WOMEN'S LAW CTR., NATIONAL SNAPSHOT: POVERTY AMONG WOMEN & FAMILIES, 2020 (2020), https://nwlc.org/wp-content/uploads/2020/12/PovertySnapshot2020.pdf.
[90] Reese Oxner & Maria Mendez, *Texas Hospitals are Putting Pregnant Patients at Risk by Denying Care Out of Fear of Abortion Laws, Medical Group Says*, TEX. TRIBUNE (July 15, 2022), https://www.texastribune.org/2022/07/15/texas-hospitals-abortion-laws/.
[91] *Roe Reversal: The Impacts of Taking Away the Constitutional Right to an Abortion, Hearing Before the Subcomm. on Oversight and Investigations Comm. on Energy and Com. U.S. H.R.* 3-4 (2022) (statement of Jack Resneck, President of the Am. Med. Ass'n), https://energycommerce.house.gov/sites/democrats.energycommerce.house.gov/files/documents/Witness%20Testimony_Resneck_OI_2022.07.19_Redacted.pdf.

appropriately recognizes that veterans need abortion care. Its IFR ensures VA beneficiaries can reply upon the Department for the full spectrum of reproductive health care in order to obtain the care they need from their trusted VA system. The Department correctly notes that it would be "unconscionable"[92] to do otherwise in this current abortion crisis. The Department has the authority to issue this rule, and the Center strongly supports it. The Center further urges the Department to clarify that it will provide abortion care when needed by the veteran and eliminate the exceptions framework of the rule, or otherwise provide clear guidance to ensure that a veteran is able to get the abortion care they need. The Center commends the Department's actions to protect the health and well-being of veterans, and its commitment to do so without political interference.

We appreciate the opportunity to comment on this Interim Final Rule. We request that the supporting documentation that we have made available through direct links in our citations be considered part of the formal administrative record for purposes of the Administrative Procedure Act. For further information, please contact Leila Abolfazli, Director of Federal Reproductive Rights at the National Women's Law Center at labolfazli@nwlc.org.

[92] Interim Final Rule on Reproductive Health Services, 87 Fed. Reg. 55,287, 55,293 (effective Sept. 9, 2022) (to be codified at 38 C.F.R. § 17).