NATIONAL WOMEN'S LAW CENTER
Justice for Her. Justice for All.

September 3, 2025

Dr. Steven L. Lieberman
Under Secretary for Health
Department of Veterans Affairs
810 Vermont Avenue NW
Washington, D.C. 20420

Submitted Electronically

Attention: Comments in Response to Proposed Rule, RIN2900-AS31

Dear Under Secretary for Health Dr. Lieberman:

The National Women's Law Center ("the Center") writes to comment on the Department of Veterans Affairs ("the Department" or "VA") Proposed Rule on Reproductive Health Services ("proposed rule").[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. Access to reproductive health care, including abortion, is vital to gender justice. Everyone, regardless of their location or financial circumstances, should have access to abortion services that are free from stigma, barriers, or discrimination, including veterans and their loved ones.

The Department's proposal to reinstate the pre-2022 exclusions on abortions and abortion counseling callously seeks to abandon veterans and their loved ones at a time of unprecedented crisis in reproductive health care access. After the Supreme Court wrongfully declared that there is no constitutional right to abortion in *Dobbs v. Jackson Women's Health Organization*, states across the country began implementing total or near-total abortion bans. Now, three years after the decision, more than 60 million women live in states with banned or restricted access to

[1] Reproductive Health Services, 90 Fed. Reg. 36415 (proposed Aug. 4, 2025), https://www.govinfo.gov/content/pkg/FR-2025-08-04/pdf/2025-14687.pdf.

abortion care.[2] As of August 2025, twelve states are enforcing total bans, four states are enforcing six-week bans, three states are enforcing either twelve- or eighteen-week bans, and two other states have tried to prohibit abortion but have been blocked by the courts.[3]

Even before the *Dobbs* decision, however, the Department's absolute prohibition on abortion care and abortion counseling forced veterans and their dependents to navigate the difficult landscape of seeking abortion access outside of the health care system that was promised to them. This exclusion of coverage by the Department, coupled with the proliferation of state bans and restrictions, made accessing abortion services extremely difficult and expensive: even when abortion was a constitutional right, veterans were forced to travel longer distances and incur increased costs, including lodging, transportation, lost wages, child care, and the cost of the care itself. Those unable to travel out of state could be forced to carry an unwanted—and potentially dangerous[4]—pregnancy to term.

In 2022, in the wake of the *Dobbs* decision, the Department took a significant action toward addressing this inequity by amending its regulations to remove the exclusion on abortion counseling and recognize exceptions to the exclusion on abortions for veterans and their loved ones (the "2022 IFR").[5] The Department later finalized this rule in 2024 (the "2024 Final Rule").[6] This policy has been critical to ensuring that, regardless of the ever-shifting and restrictive landscape of state abortion laws, the more than nine million veterans enrolled in VA's program,[7] as well as dependents and caregivers enrolled in the Civilian Health and Medical Program of the Department of Veterans Affairs ("CHAMPVA"), would be able to access life- and health-preserving medical care.

The proposed rule now seeks to undo those critical changes and return to the pre-2022 policy that excluded this essential care. As set forth below, because the proposed rule fails to justify this policy reversal, errs in its analysis on the facts and the law, and poses a dangerous

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[2] Bianca Brosh, *Three years post-Dobbs: How to chart a new course for reproductive rights*, MSNBC (June 23, 2005, 4:56 PM), https://www.msnbc.com/know-your-value/out-of-office/three-years-post-dobbs-chart-new-course-reproductive-rights-rcna214569.

[3] *After Roe Fell: Abortion Laws by State*, CTR. FOR REPROD. RIGHTS, https://reproductiverights.org/after-roe-fell-abortion-laws-by-state/ (last visited Aug. 28, 2025).

[4] According to the Centers for Disease and Prevention, carrying high-risk pregnancies to term, such as those with known fatal fetal birth defects, can "endanger a woman's health even more than an uncomplicated pregnancy in the U.S., which has a far higher maternal mortality than other high-income nations." Nancy Montgomery, *Military Women Say DOD Reproductive Health Care Far From 'Seamless' in Post-ROE Era*, AM. LEGION (July 7, 2022), https://www.legion.org/information-center/news/newsletters/2022/july/military-women-say-dod-reproductive-health-care-far-from-seamless-in-post-roe-era#:~:text=For%20years%2C%20the%20only%20abortions,on%20intravenous%20antibiotics%2C%20she%20said.

[5] Interim Final Rule on Reproductive Health Services, 87 Fed. Reg. 55287 (effective Sept. 9, 2022) (to be codified at 38 C.F.R. pt. 17) [hereinafter IFR]; https://www.govinfo.gov/content/pkg/FR-2022-09-09/pdf/2022-19239.pdf.

[6] Final Rule on Reproductive Health Services, 89 Fed. Reg. 15452 (effective Apr. 3, 2024) (to be codified 38 C.F.R. pt. 17) [hereinafter Final Rule]; https://www.govinfo.gov/content/pkg/FR-2024-03-04/pdf/2024-04275.pdf.

[7] *About VHA*, VETERANS HEALTH ADMIN., https://www.va.gov/health/aboutVHA.asp (last visited Aug. 28, 2025).

threat to the lives and health of veterans and their beneficiaries, the Center strongly opposes the Department's proposed rule.

I. The Department properly exercised its authority to implement the 2022 IFR and 2024 Final Rule.

The proposed rule asserts that the Department's authority to implement the 2022 IFR was "legally questionable," relying on an erroneous interpretation of the Veterans Health Care Act of 1992 ("VHCA") and making vague accusations of "federal overreach."[8] These attempts to undermine the Department's prior rulemaking authority are meritless.

a. The Department acted consistent with its authority to determine what care is "needed" for veterans in the 2022 IFR and 2024 Final Rule.

Although the proposed rule stops short of taking a position on the continued force and effect of the VHCA, it nonetheless relies on the VHCA to argue that the Department's authority to implement the 2022 IFR was "at least, dubious and, at most, nonexistent."[9] The Department does not, however, engage in any meaningful analysis in this regard, nor does it address the extensive legal analysis it previously undertook when it concluded that the VHCA did not limit its authority to promulgate the 2022 IFR.

Section 106(a) of the VHCA states, in relevant part, that the Secretary may provide "[p]apanicolaou tests (pap smears)," "[b]reast examinations and mammography," and "[g]eneral 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."[10] At the time the VHCA passed, Congress recognized the lack of gender-specific care available to women veterans.[11] 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

[8]Reproductive Health Services, 90 Fed. Reg. 36415 (proposed Aug. 4, 2025), https://www.govinfo.gov/content/pkg/FR-2025-08-04/pdf/2025-14687.pdf.
[9] *Id*.
[10] 38 U.S.C. § 1710 (emphasis added).
[11] In 1981, Congress requested Government Accountability Office (GAO) reports on women veterans' access to VA benefits, which showed 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.

veterans. The VHCA's exclusion in Section 106 of infertility services, abortions, and pregnancy care except in certain circumstances was a harmful restriction on the Department's ability to meet those needs.

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").[12] Prior to its passage, the Department was only able to provide care to veterans "needed for the care of a 'disability.'"[13] The 1996 Reform Act eliminated this limitation, charging the Department with the obligation to provide hospital or medical care that the Secretary determined to be "needed."[14] Accordingly, under 38 U.S.C. § 1710, the Department is required to furnish "hospital care and medical services which the Secretary determines to be needed"[15] for veterans specified in 38 U.S.C § 1710 (a)(1)–(2), and may similarly furnish such care to veterans specified in 38 U.S.C § 1710 (a)(3). These determinations are called the "Medical Benefits Package."[16]

The legislative history of 38 U.S.C. § 1710 clarifies that the Secretary does not have unfettered discretion to determine what care is needed but rather must undertake that determination based on medical judgment and a clinical need for care.[17]

Consistent with that legislative intent, VA regulations provide that care is included in the Medical Benefits Package "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 C.F.R. § 17.38(b) (2025). For decades, the Department has undertaken rulemaking to identify and expand the care that is provided through the Medical Benefits Package.[18] Indeed, beginning with the rulemaking that implemented the very first Medical Benefits Package in 1999, the Department explained: [19]

> The Secretary has authority to provide healthcare as determined to be medically needed. In our view, medically needed constitutes

[12] Veterans' Health Care Eligibility Reform Act of 1996, Pub. L. No. 104-262; (codified as amended at 38 U.S.C. § 1710(a)).
[13] *See* CONG. RSCH. SERV., R47191, DEPARTMENT OF VETERANS AFFAIRS: ABORTION POLICY 4 (2022), https://crsreports.congress.gov/product/pdf/R/R47191/2.
[14] *Id*.
[15] 38 U.S.C. § 1710(a)(1)-(2).
[16] 38 C.F.R. § 17.38 (2025).
[17] *See* H.R. REP NO. 104-690, at 4 (1996) ("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 (1996) ("[The 1996 Reform 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.").
[18] 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 June 17, 2022) (codified at 38 C.F.R pt. 17); *see also* Medical Benefits for Newborn Children of Certain Woman Veterans, 76 Fed, Reg. 78,569 (effective Dec. 19, 2011) (codified at 38 C.F.R pt. 17).
[19] Enrollment-Provision of Hospital and Outpatient Care to Veterans. 64 Fed Reg. 54207-10 (Oct. 6, 1999). https://www.govinfo.gov/content/pkg/FR-1999-10-06/pdf/99-25871.pdf.

> 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. The care included in the proposed 'medical benefits package' is intended to meet these criteria.

As the Department recognized when it implemented the 2022 IFR, the 1996 Reform Act effectively superseded the VHCA, as it conferred upon the Secretary an obligation to provide "needed care," including for women veterans.[20] Indeed, the Department has relied on the 1996 Reform Act to provide needed reproductive health care services that the VHCA otherwise denied. For example, in the first Medical Benefits Package promulgated after the 1996 Reform Act, the Secretary included "pregnancy and delivery services" and certain "infertility services" among the range of "needed care" that would be furnished to veterans.[21] Since then, the Department has consistently provided pregnancy services, including comprehensive assessments of pregnant veterans, laboratory tests, prenatal screenings, ultrasounds, newborn care, pharmacy prescriptions during pregnancy and postpartum, education, and coverage for travel to obtain this care.[22] And in 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."[23] The Medical Benefits Package also provides coverage of certain fertility services, including in vitro fertilization treatment for eligible beneficiaries.[24] Thus, the Department has provided needed reproductive health care services for decades, pursuant to its authority under the 1996 Reform Act.

As the Department further found in 2022, 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. Section 106 of the VHCA makes clear that its restrictions on reproductive health care are only applicable to care provided pursuant to the Department's authority "under this section." When Congress subsequently passed the 1996 Reform Act, overhauling VA's system of care, it recognized a separate and distinct authority for the Department to provide care to veterans once the Secretary

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[20] 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)).
[21] Enrollment-Provision of Hospital and Outpatient Care to Veterans. 64 Fed Reg. 54207-10 (Oct. 6, 1999). https://www.govinfo.gov/content/pkg/FR-1999-10-06/pdf/99-25871.pdf
[22] VETERANS HEALTH ADMIN., DIRECTIVE 1330.03, MATERNITY HEALTH CARE AND COORDINATION (amended Feb. 7, 2025). https://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=9095.
[23] VETERANS HEALTH ADMIN., DIRECTIVE 1330.03, MATERNITY HEALTH CARE AND COORDINATION, at 3 (amended Feb. 7, 2025). https://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=9095.
[24] In vitro fertilization treatment. 38 U.S.C. § 17.380.

determined such care was "needed." Indeed, Congress has endorsed the Department's interpretation of its authority under the 1996 Reform Act. A few years ago, Congress passed the Deborah Sampson Act of 2020 to improve health care access and services to women veterans.[25] The law defined "health care" as "health care and services included in the medical benefits package provided by the Department" without reference to Section 106,[26] further reaffirming the Department's obligation, notwithstanding the VHCA, to provide needed care to the veterans that it has a duty to serve.

While the proposed rule declined to make a determination as to the continued validity of Section 106, it admitted that Congress' intent in 1996 may have been "to provide a new, full, and expansive set of laws governing authorization for VA care."[27] As detailed above, this reading is the one best supported by the legislative history and principles of statutory interpretation.

b. The Department acted consistent with its authority to determine what care is "medically necessary and appropriate" for CHAMPVA beneficiaries in the 2022 IFR and 2024 Final Rule.

In the 2022 IFR, the Department also expanded 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.[28] The medical care provided under CHAMPVA includes medical services that are "medically necessary and appropriate for the treatment of a condition"[29] and 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 Transformed Resources, Integrated Care, Affordable Reimbursement for Employees ("TRICARE") (Select) program.[30] Prior to the 2022 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.[31]

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[25] Deborah Sampson Act of 2020, Pub. L. No. 116-315, tit. V (codified as amended at 38 U.S.C. § 7310).
[26] Deborah Sampson Act of 2020, Pub. L. No. 116-315, tit. V (codified as amended at 38 U.S.C. § 7310 note).
[27] Reproductive Health Services, 90 Fed. Reg. 36415, 36416 (proposed Aug. 4, 2025), https://www.govinfo.gov/content/pkg/FR-2025-08-04/pdf/2025-14687.pdf.
[28] 38 U.S.C. § 1781(a) (authorizes the Department's secretary to provide specified "medical care" to CHAMPVA beneficiaries).
[29] 38 C.F.R. 17.270(b) (2025).
[30] 38 U.S.C. § 1781(b); *see* 32 C.F.R. §§ 199.1(r), 199.17(a)(6)(ii)(D). According to the Department of Defense, "Operated by the DHA [Defense Health Agency], TRICARE is designed to provide the integrated, high-quality care that millions of military families, past and present, deserve. As such, it offers one of the most comprehensive and affordable health benefits available to any American. Integrated health care is offered through military treatment facilities and through networks of civilian providers operated by civilian managed care support contractors in the United States and abroad. With 9.5 million beneficiaries, TRICARE would rank, if it was a civilian health insurer, among the 10 largest health plans in the nation." https://health.mil/About-MHS/MHS-Elements.
[31] IFR, 87 Fed. Reg. 55287, 55292 (effective Sept. 9, 2022) (codified at 38 C.F.R. pt. 17). https://www.govinfo.gov/content/pkg/FR-2022-09-09/pdf/2022-19239.pdf.

CHAMPVA had only permitted abortion in the case of life endangerment to the pregnant person,[32] falling short of the coverage provided by TRICARE (Select).

In 2022, the Department carried out its statutory obligation to provide the same or similar coverage under CHAMPVA and TRICARE (Select) when it extended coverage to abortion counseling and abortions in the case of rape, incest, and endangerment to the life or health of the pregnant person. The Department's reasoning for making this change was that it was "necessary and appropriate to protect a pregnant individual's health,"[33] particularly given the current abortion access crisis. The Department's current proposed rule would bring CHAMPVA coverage further out-of-step with care allowed under TRICARE (Select)—in violation of the Department's statutory duty to provide qualified veterans' loved ones with "same or similar" care as under TRICARE (Select).

Abortion bans harm the health of pregnant people, including those who care for and support our veterans. [34] In providing coverage of health care through CHAMPVA, the Department has an obligation to 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 would be failing in its statutory and ethical obligations to CHAMPVA beneficiaries by implementing this proposed rule.

c. The Department's regulations preempt conflicting state or local laws.

The proposed rule further mischaracterizes the 2022 IFR as an act of "federal overreach" that "create[ed] a purported Federal entitlement to abortion for veterans where none had existed before and without regard to State law."[35] Yet the proposed rule cites no authority to support this statement—because it cannot: the Supremacy Clause establishes that federal laws and regulations prevail over any conflicting state laws.[36]

This federal preemption authority has been established in this specific context. The 2022 IFR made clear that it would preempt conflicting state laws where those laws would prevent

[32] 10 U.S.C. § 1093.
[33] IFR, 87 Fed. Reg. 55287, 55292 (effective Sept. 9, 2022) (codified at 38 C.F.R. pt. 17). https://www.govinfo.gov/content/pkg/FR-2022-09-09/pdf/2022-19239.pdf.
[34] As of January 1, 2025, approximately 62.7 million women and girls lived under state abortion bans, and pregnant people in banned states are nearly twice as likely to die during pregnancy, childbirth, or shortly after, compared to pregnant people in states where abortion is not banned. GENDER EQUITY POL'Y INST. MATERNAL MORTALITY IN THE UNITED STATES AFTER ABORTION BANS 2 (2025), https://thegepi.org/maternal-mortality-abortion-bans/; *see generally* RACHEL YAVINSKI & MARK MATHER, ABORTION BANS LINKED TO SHARP RISE IN SEPSIS, INFANT DEATH, AND PREGNANCY-ASSOCIATED DEATHS, NEW RESEARCH SHOWS, POPULATION RESEARCH BUREAU (2025), https://www.prb.org/articles/abortion-bans-linked-to-sharp-rise-in-sepsis-infant-death-and-maternal-mortality-new-research-shows/.
[35] Reproductive Health Services, 90 Fed. Reg. 36415, 36416 (proposed Aug. 4, 2025), https://www.govinfo.gov/content/pkg/FR-2025-08-04/pdf/2025-14687.pdf..
[36] *See* U.S. CONST. art. VI, cl. 2.

health care professionals from "acting in the scope of VA authority and employment" [37] pursuant to statutory provisions authorizing such care. Indeed, the Department of Justice Office of Legal Counsel issued an opinion shortly after the promulgation of the 2022 IFR confirming that, pursuant to the Supremacy Clause, states may not impose civil or criminal liability on VA employees who provide or facilitate the provision of abortion care or related services in a manner authorized by federal law.[38]

Even outside of this specific context, the preemption of federal regulation over conflicting state law has been repeatedly reaffirmed. For example, the Department's own regulation at 38 C.F.R. § 17.419 states that "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."[39] Executive Order 13132 further provides that when there is no express preemption authority and a regulation conflicts with state law, agencies shall consider rulemaking as authorizing the preemption of state law.[40]

II. The Department erroneously asserts that abortion and abortion counseling are not needed care, while failing to substantiate this claim or acknowledge contradictory evidence, thus rendering the proposed rule invalid.

The determination in the proposed rule that abortion care is no longer a "needed" medical service is unfounded and inaccurate. The Department reaches this determination by disregarding its own prior factual findings to the contrary, ignoring the ample evidence put before it by the

[37] IFR, 87 Fed. Reg. 55287, 55294 (effective Sept. 9, 2022) (to be codified at 38 C.F.R. pt. 17); https://www.govinfo.gov/content/pkg/FR-2022-09-09/pdf/2022-19239.pdf.
[38] *Intergovernmental Immunity for the Department of Veterans Affairs and Its Employees When Providing Certain Abortion Services*, No. 46, at 1 (O.L.C. Sept. 21, 2022) (Schroeder, A.A.G.) https://www.justice.gov/olc/file/1553271/dl?inline.
[39] Interim Final Rule on Authority of VA Professionals to Practice Health Care, 85 Fed. Reg. 71838 (effective Nov. 12, 2020) (to be codified at 38 C.F.R. § 17).
[40] Exec. Order No. 13132, 64 Fed. Reg. 43255 (Aug. 10, 1999).

Center and other commenters in 2022,[41] and instead basing its finding now on factors that contravene its statutory obligation.

a. The proposed rule fails to address any of the Department's prior findings that abortions and abortion counseling are needed, rendering it arbitrary and capricious.

Notably absent from the proposed rule is any discussion of the evidence that the Department previously relied on to conclude that abortions and abortion counseling are indeed considered to be needed care.

In promulgating the 2022 IFR, the Department previously found that abortion care is needed when the life or health of the pregnant veteran would be endangered if the pregnancy were carried to term, and that abortion care is medically necessary and appropriate when the health of a pregnant CHAMPVA beneficiary would be endangered if the pregnancy were carried to term.[42] The Department relied on abundant evidence for this determination, including by citing research on rising maternal mortality rates in the U.S., which demonstrate that pregnancy and childbirth can result in physical harm and even death for pregnant individuals.[43] The Department also cited experts, including the American College of Obstetricians and Gynecologists, in observing that there are situations—including life-threatening conditions such as severe preeclampsia or newly-diagnosed cancer that requires prompt treatment—in which pregnancy termination is the only medical intervention that can preserve a patient's life or health.[44] The Department further underscored that veterans are at greater risk than the general population because of veterans' high rates of chronic medical and mental health conditions that may increase the risks associated with pregnancy.[45] The Department reaffirmed these factual findings in the 2024 Final Rule.[46]

In the 2022 IFR, the Department likewise found that when a pregnancy is the result of rape or incest, abortions were needed for veterans and CHAMPVA beneficiaries.[47] The Department cited to the severe health consequences associated with being forced to carry to term

[41] *See, e.g.*, NWLC comment at 10–15, https://downloads.regulations.gov/VA-2022-VHA-0021-56791/attachment_1.pdf; AAFP, ACOG, and ACOP comment 1–2, https://downloads.regulations.gov/VA-2022-VHA-0021-52290/attachment_1.pdf; PRH comment at 1–2, https://downloads.regulations.gov/VA-2022-VHA-0021-53088/attachment_1.pdf; MVA comment at 5–9, https://downloads.regulations.gov/VA-2022-VHA-0021-55985/attachment_1.pdf.
[42] IFR, 87 Fed. Reg. 55291–92 (effective Sept. 9, 2022) (to be codified at 38 C.F.R. pt. 17); https://www.govinfo.gov/content/pkg/FR-2022-09-09/pdf/2022-19239.pdf.
[43] *Id*.
[44] *Id*.
[45] *Id*.
[46] Final Rule, 89 Fed. Reg. 15465 (effective Apr. 3, 2024) (codified at 38 C.F.R. pt. 17); https://www.govinfo.gov/content/pkg/FR-2024-03-04/pdf/2024-04275.pdf.
[47] IFR, 87 Fed. Reg. 55291–92 (effective Sept. 9, 2022) (codified at 38 C.F.R. pt. 17); https://www.govinfo.gov/content/pkg/FR-2022-09-09/pdf/2022-19239.pdf.

a pregnancy that is the result of rape or incest, including serious traumatic stress and long-lasting psychological conditions.[48] The Department further noted that veterans are at an even heightened risk for these mental health consequences due to higher rates of sexual trauma as compared to their civilian peers, as well as their higher likelihood of having preexisting mental health conditions that would be compounded by being forced to carry an unwanted pregnancy to term.[49] The Department also reaffirmed these factual findings in the 2024 Final Rule.[50]

Moreover, the Department determined in 2022 that abortion counseling is needed care for veterans and is medically necessary and appropriate for CHAMPVA beneficiaries, reasoning that such counseling is essential to ensure that veterans and CHAMPVA beneficiaries can make informed decisions about their health care.[51] Again, the Department reaffirmed this finding in the 2024 Final Rule.[52]

Now, the Department does not address any of these prior findings in the proposed rule, neglecting its obligation to provide a detailed justification when it chooses to reverse the factual findings that underlay a prior policy.[53] Nor does the Department offer any acknowledgement that veterans and CHAMPVA beneficiaries may have structured their lives, intimate relationships, and health care decisions over the last several years in reliance on the availability of abortion care and abortion counseling through the Department.[54] The Department's utter failure to address the about-face reflected in the proposed rule or consider the reliance interests of its beneficiaries runs afoul of the Secretary's obligation to provide needed care and renders the proposed rule arbitrary and capricious.

b. Abortion care is needed health care, the denial of which can be devastating to pregnant people's lives, health, and economic security.

Even beyond what the Department specifically cited in the 2022 IFR and 2024 Final Rule, ample evidence makes clear that abortion is needed health care, as was put before the

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[48] *Id*.
[49] *Id*.
[50] Final Rule, 89 Fed. Reg. 15466 (effective Apr. 3, 2024) (codified at 38 C.F.R. pt. 17); https://www.govinfo.gov/content/pkg/FR-2024-03-04/pdf/2024-04275.pdf.
[51] IFR, 87 Fed. Reg. 55292-93 (effective Sept. 9, 2022) (codified at 38 C.F.R. pt. 17); https://www.govinfo.gov/content/pkg/FR-2022-09-09/pdf/2022-19239.pdf.
[52] Final Rule, 89 Fed. Reg. 15468-69 (effective Apr. 3, 2024) (codified at 38 C.F.R. pt. 17); https://www.govinfo.gov/content/pkg/FR-2024-03-04/pdf/2024-04275.pdf.
[53] *FCC v. Fox Television Stations, Inc.*, 556 U.S. 502, 515–16 (2009) ("[I]t is not that further justification is demanded by the mere fact of policy change; but that a reasoned explanation is needed for disregarding facts and circumstances that underlay or were engendered by the prior policy.")
[54] *Encino Motorcars, LLC v. Navarro*, 579 U.S. 211,221–22 (2006) (quoting *Fox Television Stations*, 556 U.S. at 515 (2009)) (noting that when an agency changes course, it "must be cognizant that longstanding policies may have 'engendered serious reliance interests that must be taken into account"); *see also Regents of the Univ. of Cal.*, 591 U.S. at 33 (holding that because the agency was "not writing on a blank slate . . . it *was* required to assess whether there were reliance interests, determine whether they were significant, and weigh any such interests against competing policy concerns").

Department by the Center and numerous other organizations and individuals who commented in support of the 2022 IFR.[55] There is broad medical consensus that abortion is an important component of comprehensive medical care and a safe, standard medical intervention that improves the lives, health, and well-being of those who need it.[56]

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

When a person is denied abortion care, there are well-documented life-long consequences to the pregnant person's physical and mental health. Women denied abortions report more life-threatening complications and chronic health conditions than those who receive abortion care.[57] These complications include chronic migraines, joint pain, gestational hypertension, eclampsia,[58] and postpartum hemorrhage.[59]

Being denied an abortion also negatively affects people's mental health[60] and is associated with elevated anxiety and stress levels, low self-esteem, and lower life satisfaction,[61] as well as more chronic headaches or migraines.[62] 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.[63] Of the key areas that influenced

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[55] *See, e.g.*, NWLC comment at 10–15, https://downloads.regulations.gov/VA-2022-VHA-0021-56791/attachment_1.pdf; AAFP, ACOG, and ACOP comment 1–2, https://downloads.regulations.gov/VA-2022-VHA-0021-52290/attachment_1.pdf; PRH comment at 1–2, https://downloads.regulations.gov/VA-2022-VHA-0021-53088/attachment_1.pdf; MVA comment at 5–9, https://downloads.regulations.gov/VA-2022-VHA-0021-55985/attachment_1.pdf.

[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 August 20, 2025); *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.").

[57] *Advancing New Standards in Reprod. Health, The Harms of Denying a Woman a Wanted Abortion Findings from the Turnaway Study 2*, UNIV. OF CAL., S.F., (2020), https://www.ansirh.org/sites/default/files/publications/files/the_harms_of_denying_a_woman_a_wanted_abortion_4-16-2020.pdf.

[58] *Id.*

[59] 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.

[60] 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. *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.

[61] 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.

[62] *Advancing New Standards in Reprod. Health, The Harms of Denying a Woman a Wanted Abortion Findings from the Turnaway Study 2*, UNIV. OF CAL., S.F., (2020), https://www.ansirh.org/sites/default/files/publications/files/the_harms_of_denying_a_woman_a_wanted_abortion_4-16-2020.pdf.

[63] 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.

their psychological well-being, many cited a lack of autonomy—such as being forced to delay termination of a pregnancy—as well as perceived stigma associated with abortion and reactions from friends and family.[64]

Being forced to carry an unwanted pregnancy to term also puts women at risk of dying during or shortly after childbirth. The U.S. has an alarmingly high maternal mortality rate that has been rising gradually for decades. The maternal mortality rate rose dramatically in 2020 and 2021, reaching a high of 32.9 deaths per 100,000 live births.[65] The maternal mortality rate declined slightly from 2021–2023, but as of 2023 (the most recent data available), the rate of maternal deaths is 18.6 per 100,000 live births (669 women), which is still above the pre-2020 high of 17.6 deaths per 100,000 live births.[66] This is especially disturbing when comparing data from other high income nations: in the U.S., the risk of maternal mortality is nearly three times higher than in Canada, more than four times higher than in the United Kingdom, and more than 1.5 times higher than in Chile—the high income country with the second highest mortality rate.[67] In the U.S., there is an increasing number of pregnant people with chronic health conditions, including hypertension and diabetes.[68]

Black and Native women are at a greater risk of pregnancy-related death, which is particularly concerning for the VA system because women veterans are disproportionately Black compared to non-veteran women (19 percent of women veterans are Black compared to 12 percent of non-veteran women).[69] Black women generally are 3.5 times more at risk of pregnancy-related death than white women.[70] In 2020, the rate of pregnancy-related deaths for Black and American Indian or Alaska Native women was more than three times greater than for white women.[71] These disparities increase by age and persist across education and income levels.[72] 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

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[64] *Id.*
[65] DONNA L. HOYERT, *Health E-Stat 100: Maternal Mortality Rates in the United States, 2023*, NAT'L CTR. FOR HEALTH STAT, (Feb. 2025), https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2023/Estat-maternal-mortality.pdf?ftag=MSF0951a18.
[66] *Id.*
[67] Munira Gunja et al., *Insights into the U.S. Maternal Mortality Crisis: An International Comparison*, COMMONWEALTH FUND, (June 2024), https://doi.org/10.26099/cthn-st75.
[68] *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).
[69] STEVEN GARASKY ET AL., WOMEN VETERAN ECONOMIC AND EMPLOYMENT CHARACTERISTICS, IMPAQ INT'L, U.S. DEP'T OF LABOR (2016), https://www.dol.gov/resource-library/women-veteran-economic-and-employment-characteristics-final-report.
[70] DONNA L. HOYERT, *Health E-Stat 100: Maternal Mortality Rates in the United States, 2023*, NAT'L CTR. FOR HEALTH STAT, (Feb. 2025), https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2023/Estat-maternal-mortality.pdf?ftag=MSF0951a18.
[71] Latoya Hill et. al., *Racial Disparities in Maternal and Infant Health: Current Status and Efforts to Address Them,* KFF, https://www.kff.org/racial-equity-and-health-policy/racial-disparities-in-maternal-and-infant-health-current-status-and-efforts-to-address-them/.
[72] 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.

preventable.[73] Overall, more than 80 percent of pregnancy-related deaths are preventable,[74] and a quarter of these deaths are due to mental health issues that include suicide or substance abuse,[75] an alarming statistic, especially when considering the high rates of suicide among veterans.

2. Denying someone an abortion threatens their economic security.

When people are denied the abortion care they seek, they can face devastating consequences to their 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.[76]

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.[77] Many veterans face financial stress that could be compounded by an unintended pregnancy: in 2023, nearly 1.2 million veterans lived below the FPL[78] and more than 1.8 million lived between the FPL and 200 percent of the FPL, likely living paycheck to paycheck.[79] Women veterans are more likely than men veterans to live below the poverty line and between the FPL and 200 percent of the FPL; in 2023, 8.2 percent of women lived below the FPL compared to 6.5 percent of men while 12.3 percent of women lived between the FPL and 200 percent of the FPL compared to 11.4 percent of men. Women veterans are at higher risk of experiencing homelessness compared to non-veteran women and are more likely to be single parents compared to men veterans;[80] they are also more likely to experience food insecurity compared to their male counterparts.[81] The majority of women seeking an abortion are already

[73] 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.
[74] CTR. FOR DISEASE CONTROL AND PREVENTION, Preventing Pregnancy-Related Deaths (Sept. 25, 2024) https://www.cdc.gov/maternal-mortality/preventing-pregnancy-related-deaths/index.html - cdc_program_profile_program_impact-what-factors-contribute-to-pregnancy-related-deaths
[75] 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.
[76] *Abortion in the USA: The Human Rights Crisis in the Aftermath of Dobbs*, AMNESTY INT'L, (Aug. 5, 2024), https://www.amnestyusa.org/wp-content/uploads/2024/08/Abortion_in_the_USA.pdf.
[77] 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).
[78] NWLC calculations using 2023 American Community Survey Table B21007 "Age by Veteran Status by Poverty Status in the Past 12 Months by Disability Status for the Civilian Population 18 Years and Over," data.census.gov.
[79] NWLC calculations using 2023 American Community Survey data accessed through IPUMS USA, University of Minnesota, www.ipums.org.
[80] DISABLED AM. VETERANS, WOMEN VETERANS: THE LONG JOURNEY HOME 7, 34 (2014), https://www.dav.org/wp-content/uploads/women-veterans-study.pdf.
[81] Tamara Dubowitz, *Food Insecurity Among Veterans*, RAND, (July 21, 2021), https://www.rand.org/pubs/perspectives/PEA1363-2.html.

parents, with six in ten having one or more children,[82] indicating an understanding of the immense commitment required to raise a child. A 2013 study found that 40 percent of women surveyed sought abortions because they were not financially prepared to support a child, while nearly 30 percent cited a need to focus on parenting their existing children.[83]

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.[84] This is especially true with respect to childbirth from unintended pregnancies.[85] 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.[86]

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[87] and adding not only travel expenses, but lodging and child care costs.[88] Oftentimes people need to take leave from work in order to travel long distances for multiple clinic visits,[89] 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.[90] These costs force many already struggling to

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[82] Katherine Kortsmit et al., *Abortion Surveillance – United States, 2019*, 70 MORBIDITY AND MORTALITY WKLY. REP. 1 (2021) http://dx.doi.org/10.15585/mmwr.ss7009a1.

[83] M Antonia Biggs et al., *Understanding Why Women Seek Abortions in the US*, 13 BMC WOMEN'S HEALTH 1, 6 (2013), https://bmcwomenshealth.biomedcentral.com/counter/pdf/10.1186/1472-6874-13-29.pdf.

[84] 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 E. BAKER ET AL., CTR. FOR AM. PROGRESS, THE MEDICAID PROGRAM AND LGBT COMMUNITIES: OVERVIEW AND POLICY RECOMMENDATIONS 6 (2016), https://ampr.gs/37m9Eq7.

[85] Christine Dehlendorf et al., *Disparities in Abortion Rates: A Public Health Approach*, 103 AM. J. PUB. HEALTH 1772, 1775 (2013), https://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.2013.301339?download=true ("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 14–16 (Mar. 2013), https://www.guttmacher.org/sites/default/files/report_pdf/social-economic-benefits.pdf.

[86] Dehlendorf et al., *supra* note 82 at 1775; SONFIELD ET AL., *supra* note 82, at 14–16 (reviewing studies that document how controlling family timing and size contribute to educational and economic advancements).

[87] 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*, 579 U.S. 582, 582–83 (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*, 591 U.S. 299, 336–37 (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. *Id.* at 338.

[88] *See* ALYSSA LLAMAS ET AL., GEO. WASH. UNIV. JACOBS INST. OF WOMEN'S HEALTH, PUBLIC HEALTH IMPACTS OF STATE-LEVEL ABORTION RESTRICTIONS: OVERVIEW OF RESEARCH & POLICY IN THE UNITED STATES 20–23 (2018), https://publichealth.gwu.edu/sites/default/files/downloads/projects/JIWH/Impacts_of_State_Abortion_Restrictions.pdf.

[89] 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* NAT'L WOMEN'S LAW CTR., STATES TAKE ACTION TO STOP DISCRIMINATION BASED ON REPRODUCTIVE HEALTH CARE DECISIONS 2 (2022), https://nwlc.org/wp-content/uploads/2022/03/NWLC_FactSheet_State-Laws-Agianst-Emplotment-Discrimination-Based-on-Reproductive-Health-Decisions-3.25.22.pdf.

[90] 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.

make ends meet to forgo paying for basic necessities—such as bills, food, and even rent—in order to pay for an abortion.[91] 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 "public records" (such as bankruptcy or eviction) on their credit reports after giving birth.[92] 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,[93] and, similarly, trans veterans who are more likely to live in poverty than their cisgender peers,[94] 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.[95] And it has only worsened following the Supreme Court's *Dobbs* decision, as states pass abortion bans that force clinics to close and hinder people from seeking the health care they need.[96]

c. Abortion care is needed health care for veterans in particular, due to the unique health risks they face stemming from their military service.

The proposed rule will have far-reaching effects on veterans across the country. Currently, the Veterans Health Administration ("VHA") is the largest integrated health care system in the U.S., with over nine million veterans enrolled in the program.[97] There are over two million women veterans living in the U.S., and the percentage of veterans who are women is predicted to rise dramatically—from four percent in 2000 to 18 percent in 2040. [98] This is in addition to the estimated one in five transgender people who is a service member or veteran,

[91] 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), https://www.whijournal.com/article/S1049-3867(13)00022-4/fulltext.
[92] *See generally* Sarah Miller et al., *The Economic Consequences of Being Denied an Abortion* (Nat'l Bureau of Econ. Rsch., Working Paper No. 26662, 2020), https://www.nber.org/system/files/working_papers/w26662/w26662.pdf.
[93] NWLC calculations using 2023 American Community Survey data accessed through IPUMS USA, UNIV. OF MINN., www.ipums.org. 6.5% of men veterans and 8.2% of women veterans lived in poverty in 2023.
[94] Janelle Downing et al., *Transgender and Cisgender Veterans Have Few Health Differences*, 37 HEALTH AFFS. 1160, 1161, 1166 (2018), https://www.healthaffairs.org/doi/epdf/10.1377/hlthaff.2018.0027.
[95] *See generally* SARAH JAVAID, NAT'L WOMEN'S LAW CTR., NATIONAL SNAPSHOT: POVERTY AMONG WOMEN & FAMILIES IN 2023 (2024), https://nwlc.org/wp-content/uploads/2024/12/National-Snapshot-Poverty-Among-Women-Families-in-2023-Accessible.pdf.
[96] More than 6.7 million Black women live in a state that is hostile to abortion access and nearly 2.7 million of these women experience economic insecurity. *See* Camille Kidd et al., *State Abortion Bans Threaten Nearly 7 Million Black Women, Exacerbate the Existing Black Maternal Mortality Crisis*, NAT'L P'SHIP FOR WOMEN & FAMILIES, (May 2024), https://nationalpartnership.org/report/state-abortion-bans-threaten-black-women/.
[97] *Veterans Health Admin.*, U.S. DEP'T OF VETERANS AFFS., https://www.va.gov/health/aboutVHA.asp (last visited Sept. 2, 2025).
[98] *Women Veterans Health Care Facts and Statistics*, U.S. DEP'T OF VETERANS AFFS., https://www.womenshealth.va.gov/materials-and-resources/facts-and-statistics.asp (last visited Sept. 2, 2025).

some of whom may need abortion care.[99] Given the prevalence of certain physical and mental health challenges among veterans, and because many of these health conditions are exacerbated by pregnancy or lead to poor pregnancy outcomes, it is particularly pernicious that the proposed rule would deny veterans abortions that are necessary to preserve their lives and health.

Many women veterans who receive VA health care have multiple medical conditions that can increase their risk of pregnancy complications.[100] For example, military deployment increases the risk of developing post-traumatic stress disorder, which in turn increases the risk of gestational diabetes, preeclampsia, and pre-term birth.[101] Veterans are also at greater risk of mental health issues due to their service: veterans are two times more likely to die by suicide than non-veterans,[102] 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.[103] Women veterans are nearly twice as likely to die by suicide as their non-veteran women counterparts.[104] Among women veterans, those of reproductive age have the highest suicide rates; additionally, reproductive health care settings may be crucial touchpoints for women veterans at risk of suicide.[105]

The current mental health crisis among veterans throws into sharp relief why abortion access is necessary: a 2018 study found that the high rates of mental health disorders among women veterans make them particularly susceptible to negative health outcomes associated with unintended pregnancy.[106] For pregnant veterans, mental health conditions are often compounded by pregnancy,[107] leading to poor pregnancy outcomes.[108] Veterans of reproductive age also have

[99] *Military & Veterans*, A4TE, https://transequality.org/issues/military-veterans (last visited Sept. 2, 2025).
[100] *Women Veterans and Pregnancy Complications*, U.S. DEP'T OF VETERANS AFFS., https://www.va.gov/HEALTHEQUITY/Women_Veterans_and_Pregnancy_Complications.asp (last visited Sept. 2, 2025).
[101] *Id.*
[102] *National Veteran Suicide Prevention Annual Report, Part 2 of 2: Report Findings*, U.S. DEP'T OF VETERANS AFFS. (Dec. 2024) at 8, 9, https://www.va.gov/HEALTHEQUITY/Women_Veterans_and_Pregnancy_Complications.asp.
[103] GOV'T ACCOUNTABILITY OFF., VETERANS' GROWING DEMAND FOR MENTAL HEALTH SERVICES (2021) at 1, https://www.gao.gov/assets/gao-21-545sp.pdf.
[104] *National Veteran Suicide Prevention Annual Report, supra* note 99, at 8, 9.
[105] Claire A. Hoffmire et al., *Suicidal Ideation and Suicide Attempts Among Women Veterans Using VA Reproductive Health Care: Prevalence and Associations with Fertility-, Pregnancy- and Parenting-related Factors*, 34 WOMEN'S HEALTH ISSUES 528 (2024), https://www.sciencedirect.com/science/article/pii/S1049386724000604.
[106] 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.
[107] 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 (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").
[108] *Fact Sheet: Maternal Mental Health*, POL'Y CTR. FOR MATERNAL MENTAL HEALTH, https://policycentermmh.org/maternal-mental-health-fact-sheet/ (last visited Sept. 2, 2025).

high rates of chronic medical and mental health conditions that may increase the risks associated with pregnancy [109] including PTSD.[110]

Moreover, because the treatment regimen for many of the conditions that veterans face cannot be received while pregnant, veterans are in particular need of access to abortion care and counseling. Take, for example, cancer. Almost 50,000 cases of cancer among veterans are diagnosed annually,[111] and, devastatingly, some veterans of the U.S. Armed Forces may have been exposed to substances, chemicals, and hazards during their military service that can lead to a higher risk for cancer than members of the general population.[112] Some studies have concluded that women veterans may have an increased breast cancer risk based on service-related exposures and post-traumatic stress disorder.[113] Many forms of cancer treatment, however, cannot be administered during pregnancy. Chemotherapy regimens are often incompatible with pregnancy[114] and may also increase the risk of fetal growth restriction, premature birth, and fetal death in the second and third trimesters.[115] Various chemotherapy drugs are also contraindicated for pregnancy—such as methotrexate, which is not appropriate for use during pregnancy due to a risk of fetal abnormalities and fetal death.[116] Further, hormone therapy, targeted drug therapy, and radiation therapy to an abdominal or pelvic area are not recommended during pregnancy because they are likely to harm the fetus, which limits treatment options for patients with cancers in these areas.[117]

If the proposed rule were to be finalized, accessing abortion care outside of the VA medical system would be particularly onerous for veterans and their loved ones. After the *Dobbs* decision, the barriers veterans face have increased dramatically, as local abortion providers close their doors across the country in response to state abortion bans and increased criminalization of

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[109] Colleen Judge-Golden et al., *Prior Abortions and Barriers to Abortion Access Reported by Pregnant Women Veterans,* 37 J. 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").
[110] Jonathan G. Shaw et al., *Post-traumatic Stress Disorder and Antepartum Complications: A Novel Risk Factor for Gestational Diabetes and Preeclampsia*, 31 PAEDIATRIC & PERINATAL EPIDEMIOLOGY 185 (2017).
[111] VA OFF. RSCH. AND DEV., VA RESEARCH ON CANCER, https://www.research.va.gov/topics/cancer.cfm#:~:text=Nearly%2050%2C000%20cases%20of%20cancer,and%20some%20soft%20tissue%20sarcomas (last accessed May 30, 2025).
[112] AMERICAN CANCER SOCIETY, U.S. MILITARY VETERANS & CANCER, https://www.cancer.org/cancer/veterans.html (last accessed Sept. 2, 2025).
[113] Kangmin Zhu et al*., Cancer incidence in the U.S. military population: comparison with rates from the SEER program* 18 J. CEBP (2009), https://aacrjournals.org/cebp/article/18/6/1740/66901/Cancer-Incidence-in-the-U-S-Military-Population.
[114] Kimia Sorouri et al*., Patient-Centered Care in the Management of Cancer During Pregnancy*, 43 AM. SOC. OF CLINICAL ONCOLOGY EDUC. BOOK (May 23, 2023), https://aacrjournals.org/cebp/article/18/6/1740/66901/Cancer-Incidence-in-the-U-S-Military-Population.
[115] T.E. Buekers et al*., Chemotherapy in Pregnancy*, 25 OBSTETRICS AND GYNECOLOGY CLINICS OF N. AM., 323 (1998), https://www.sciencedirect.com/science/article/abs/pii/S0889854505700073?via%3Dihub.
[116] Jamie Eske & Nancy Carteron, *How Does Methotrexate Affect Pregnancy?*, MED. NEWS TODAY (Mar. 24, 2022), https://www.medicalnewstoday.com/articles/325549.
[117] *Cancer During Pregnancy*, AM. CANCER SOC., https://www.cancer.org/cancer/managing-cancer/making-treatment-decisions/cancer-during-pregnancy.html (last accessed Apr. 30, 2024).

this essential health care.[118] The higher risk factors among the veteran community, including high rates of mental health disorders, make it unlikely that veterans will have the wherewithal to navigate the private health care system to obtain the care they need in a timely manner.

d. The Department wrongfully bases its determination of needed care on the number of individuals who have received abortions from VA since 2022.

Rather than address any of the vast medical evidence establishing abortion as a critical component of comprehensive reproductive health care—which, as noted above,[119] was submitted to the Department in comments in support of the 2022 IFR—the proposed rule asserts that abortion services are not needed care because the demand for these services over the last few years has been less than what it initially projected.[120] Not only is this interpretation of "need" irrelevant to the Department's statutory mandate, it also contradicts the Department's prior interpretation regarding quantification of need. And it is simply nonsensical.

As set forth above in Section I, the Secretary's determination regarding needed care is not boundless, but must be informed by medical judgment and its obligation to "promote, preserve, or restore the health of the individual."[121] Indeed, the focus on the health *of the individual* reflects that need must be determined on an individual, not a collective, basis. As such, the Department is responsible for providing needed care to *any* eligible beneficiary, regardless of how many other beneficiaries may need that care.

Contrary to the Department's assertion, the average number of veterans and CHAMPVA beneficiaries who have received abortions through VA—approximately 140 per year over the last several years—is not obviously low, given that abortion care as implemented by the 2022 IFR is only available to beneficiaries under certain exceptions. Regardless, in response to comments opposing the 2022 IFR on the grounds that life endangerment as a result of pregnancy is "rare," the Department previously took the position that "[e]ndangerment to even one veteran's life would be sufficient[.]"[122] And indeed, when only a relatively small number of VA patients requires treatment for a medical condition, the Department does not categorically deny

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[118] *See generally* RACHEL K. JONES, CANDACE GIBSON, JESSE PHILBIN, THE NUMBER OF BRICK-AND-MORTAR ABORTION CLINICS DROPS, AS US ABORTION RATE RISES: NEW DATA UNDERSCORE THE NEED FOR POLICIES THAT SUPPORT PROVIDERS, GUTTMACHER INST. (2024) https://www.guttmacher.org/report/abortion-clinics-united-states-2020-2024; MABEL FELIX, LAURIE SOBEL, & ALINA SALGANICOFF, CRIMINAL PENALTIES FOR PHYSICIANS IN STATE ABORTION BANS (2025), https://www.kff.org/womens-health-policy/criminal-penalties-for-physicians-in-state-abortion-bans/; Julie Rovner, *Abortion bans drive off doctors and close clinics, putting other health care at risk*, NPR (May 23, 2023), https://www.npr.org/sections/health-shots/2023/05/23/1177542605/abortion-bans-drive-off-doctors-and-put-other-health-care-at-risk.

[119] *See supra* at Section II(b).

[120] Reproductive Health Services, 90 Fed. Reg. 36415, 36416 n. 2 (proposed Aug. 4, 2025), https://www.govinfo.gov/content/pkg/FR-2025-08-04/pdf/2025-14687.pdf.

[121] *See supra* at Section I(a).

[122] 89 Fed. Reg. at 15465.

this care simply based on low demand. In fact, in 2018, the VA reportedly covered a mere 37 cases of carotid endarterectomy surgical procedures in asymptomatic patients. [123] Additionally, the VA covered only 182 cases of renal artery angioplasty and stenting procedures in 2018 among the entire population of VA enrolled veterans, at a cost of 1.8 million dollars.[124] Despite the low demand for coverage of these health care services among VA enrolled veterans, the care was indeed still covered by the VA, without exceptions. In the case of this proposed rule, however, the Department has singled out a specific health care service—abortion care—and is seeking to deny its beneficiaries that service under the arbitrary rationale that too few of them would use it. The Department fails to explain why abortion care should be subject to a "demand for care" standard when no other health care service is required to meet such a threshold to be covered by the VA.

What is more, this figure likely does not reflect the actual need or demand for these services. Demand for abortion services at the Department has likely been depressed by several factors, including various obstacles to care, both on a state level and federally, as well as beneficiaries' lack of knowledge regarding changes to coverage and care for abortion. The 2022 IFR was announced in a news release,[125] but its rollout lacked widespread public awareness and outreach efforts. Without adequate outreach and education regarding this coverage, it is unreasonable to conclude that the utilization rate in the first few years of implementation is necessarily representative of the utilization rate in future years, especially given increasing restrictions on abortion access at the state level that could create more demand within VA in later years. It is well-documented that VA beneficiaries and military women have faced, and continue to face various obstacles to abortion care, particularly in states that are hostile to abortion.[126]

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[123] A carotid endarterectomy for asymptomatic patients is a preventative surgical procedure to remove plaque from the carotid artery, reducing future stroke risk. Brian R. Chambers & Geoffrey Donnan, Carotid endarterectomy for asymptomatic carotid stenosis, COCHRANE LIB. (2005), https://pmc.ncbi.nlm.nih.gov/articles/PMC6669257/#:~:text=For%20most%20people%20with%20a,cause%20a%20stroke%20or%20death; Thomas R. Radomski, et al., *Use and Cost of Low-Value Health Services Delivered or Paid for by the Veterans Health* Administration, 182 JAMA INTERN. MED. 832 (2022) (providing that the VA covered 37 cases of carotid endarterectomy surgical procedures in asymptomatic patients in 2018), https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2794039.

[124] Renal artery angioplasty and stenting is a minimally invasive procedure used to treat narrowed kidney arteries, Cleveland Clinic, Renal Artery Stenting, https://my.clevelandclinic.org/health/treatments/14868-renal-artery-stenting (last viewed Sept. 2, 2025); Thomas R. Radomski, et al., *Use and Cost of Low-Value Health Services Delivered or Paid for by the Veterans Health* Administration, 182 JAMA INTERN. MED. 832 (2022) (providing that the VA covered 182 cases of renal artery angioplasty in 2018), https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2794039.

[125] VA News, *VA will offer abortion counseling and – in certain cases – abortions to pregnant Veterans and VA beneficiaries*, VA.GOV NEWS (Sept. 2, 2022), https://news.va.gov/press-room/va-will-offer-abortion-counseling-and-in-certain-cases-abortions-to-pregnant-veterans-and-va-beneficiaries/.

[126] Steve Walsh, *Faced with obstacles to abortion, military women have built their own support system,* NPR (Oct. 30, 2024), https://www.npr.org/2024/10/29/nx-s1-5162443/women-in-the-military-abortion-roe-v-wade#:~:text=Arana%20leads%20Sword%20Athena%2C%20an,the%20underlying%20problems%2C%20she%20said;%20https://www.nbcnews.com/news/us-news/female-veterans-criticize-gender-disparities-va-medical-system-rcna43948; Julie Tsirkin, *Female veterans criticize gender disparities in VA medical system,* NBC NEWS (Aug. 19, 2022), https://www.nbcnews.com/news/us-news/female-veterans-criticize-gender-disparities-va-medical-system-rcna43948.

Furthermore, the Department has not released any data regarding the number of VA patients who have sought abortion counseling, some of whom may not have ultimately received an abortion.

The *Dobbs* ruling undeniably created a climate of fear and uncertainty around abortion access across the country. As a result, veterans and their loved ones were and are likely hesitant to seek abortion services through their medical plans due to concerns about potential retaliation, prosecution, or stigma, especially in states where abortion has become heavily restricted. This chilling effect should not be dismissed when evaluating the need for abortion access. This is especially true for survivors of sexual assault, as a majority of sexual assaults go unreported,[127] and survivors may distrust the police or fear retaliation from known perpetrators.[128]

Additionally, newly established policies often take time to be fully integrated into practice. In September 2023, approximately one year after the 2022 IFR was implemented, the VA Office of Inspector General conducted a national review of VHA reproductive health services for veterans, finding that some VA facility leaders reported implementation challenges with the 2022 IFR, including concerns about potential legal repercussions, issues with availability of abortion resources, and a desire for ongoing national guidance and training.[129] Such implementation challenges may have led to delays or denials of care, forcing veterans or their dependents to seek care outside of VA. In short, the need for abortion care cannot be measured solely by initial service uptake within a three-year timeframe, during which such care was not only highly politicized but also being implemented for the first time, with limited efforts to ensure public awareness.

III. The proposed rule's exclusion of abortion in cases of rape and incest will harm vulnerable populations seeking care and is not justified by any federal policy.

The proposed rule would also explicitly rescind abortion care for survivors of rape and incest. The Department's suggestion that the proposed rule is nevertheless sufficient to protect the health and safety of its beneficiaries denies the realities that veterans, including survivors, contend with each day.

Women and gender minority veterans are at greater risk of sexual assault and intimate partner violence compared to their civilian counterparts. Devastatingly, one in three women

[127] NATIONAL SEXUAL VIOLENCE RESOURCE CENTER, STATISTICS, https://www.nsvrc.org/statistics (last visited Sept. 2, 2025.
[128] Jodie Muphy-Oikonen, et.al, *Unfounded Sexual Assault: Women's Experiences of Not Being Believed by the Police*, 37 J. INTERPERS VIOLENCE 8917, 8918 (2020) (providing that fear of retaliation or not being believed are among the various reasons why survivors do not report assault to law enforcement), https://pmc.ncbi.nlm.nih.gov/articles/PMC9136376/; Coreen Farris, et al., *Perceived Retaliation Against Military Sexual Assault Victims*, RAND CORP. (2021) (describing the frequency of retaliation against sexual assault victims in the military), https://www.rand.org/pubs/research_reports/RR2380.html.
[129] U.S. DEP'T OF VETERANS AFFAIRS, OFFICE OF INSPECTOR GEN., REPORT NO. VAOIG-22-03931-226 (Feb. 2024), https://www.vaoig.gov/sites/default/files/reports/2024-02/VAOIG-22-03931-226.pdf.

veterans report experiencing military sexual trauma.[130] 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.[131] One study revealed alarmingly high rates of sexual harassment and assault among female veterans using VHA services.[132] Research indicates that a significant proportion of post-9/11 women veterans accessing VHA reproductive health care—approximately 68.7%—screen positive for military sexual trauma, with 44.9% reporting experiences of military sexual assault. Considering these findings, it is particularly troubling that the proposed rule would explicitly rescind comprehensive health care access for survivors of sexual assault. The claim that the proposed rule adequately safeguards the well-being of veterans is fundamentally inaccurate given this data and threatens the recovery and mental health of those who have faced such traumatic experiences.

Women who are denied abortions, compared to women who are able to access abortion care, 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.[133] For the veteran and military community, this is especially troubling considering that the rate of spousal abuse in the military is twice as high as the rate among the national population,[134] and the transition to civilian life may continue or exacerbate intimate partner violence.[135]

The proposed rule does not contend with any of this evidence, which was presented to the Department in the Center's comment in support of the 2022 IFR,[136] nor does the Department otherwise explain its policy reversal. It does not even address the rape and incest exceptions with any specificity. On the contrary, the proposed rule simply cites abortion coverage restrictions in Medicaid, the Children's Health Insurance Program, TRICARE, and the Federal Employee Health Benefits Program as consistent with its terms. Each one of these federal programs,

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[130] *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 August 25, 2025).
[131] U.S. DEP'T OF VETERANS AFFAIRS, MILITARY SEXUAL TRAUMA (2021), https://www.mentalhealth.va.gov/docs/mst_general_factsheet.pdf.
[132] Lindsey L.Monteith, Julie A. Kittel, & Claire A. Hoffmire, *Military Sexual Trauma Among Women Veterans Using Veterans Health Administration Reproductive Health Care: Screening Challenges and Associations with Post-Military Suicidal Ideation and Suicide Attempts*, 38 J. INTERPERS. VIOLENCE 7578 (2023), https://journals.sagepub.com/doi/10.1177/08862605221145725 .
[133] 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).
[134] 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.
[135] 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.
[136] NWLC 2022 COMMENT IN RESPONSE TO INTERIM FINAL RULE, RIN2900-AR57 AT 9–10, https://nwlc.org/resource/nwlcs-public-comment-in-support-of-va-rule-on-abortion/#.

however, permits abortion access when the pregnancy is the result of rape or incest. By excluding the exceptions for rape and incest from the proposed rule, the Department has proposed a stricter abortion ban than that of any other federal agency. Thus, contrary to the Department's assertion that the proposed rule would align VA policy with that of other federal programs, the proposed rule would not in fact do so—a contradiction that demonstrates the arbitrariness of the Department's rationale. In contrast, in implementing the 2022 IFR, the Department found that lifting the complete exclusion on abortion at VA would promote parity across agencies, and that it was unconscionable for veterans to not have access to at least the same services they had through the Department of Defense following their transition to civilian life.[137] The Department fails to address the policy inconsistencies across federal agencies that would be reinstated if the proposed rule were to be finalized.

IV. The Department repeatedly contradicts itself with respect to the availability of a life endangerment exception in the Medical Benefits Package, rendering the rule arbitrary and capricious.

The proposed rule's assertion that the Medical Benefits Package will include an exception when the patient's life is endangered is riddled with contradictions, such that it is entirely unclear whether the exception in fact exists under the proposed rule.

On the one hand, the Department asserts that it has never understood its exclusion on abortions to prohibit providing care to pregnant women in life-threatening circumstances; yet, on the other hand, several paragraphs later, the Department states that "[p]rior to September 9, 2022, abortions and abortion counseling were excluded from the medical benefits package, *with no exceptions*."[138] Moreover, although the preamble states that, "[f]or the avoidance of doubt, the proposed rule would make clear that the exclusion for abortion does not apply 'when a physician certifies that the life of the mother would be endangered if the fetus were carried to term,'" the proposed amendment to the Medical Benefits Package does not include any such language. Because the preamble does not have the force of law, the life endangerment exception appears to be merely illusory. This inconsistency between the preamble's description of the proposed rule and the proposed rule itself renders the rule arbitrary and capricious.

The Department's own confusion around the life endangerment exception is further underscored by the Regulatory Impact Analysis ("RIA"), which summarizes the proposed rule by stating that "VA would exclude abortions and abortion counseling from the medical benefits

[137] 87 Fed. Reg. at 55293.
[138] 90 Fed. Reg. 36415, 36417 (emphasis added).

package and would exclude abortions, except when a physician certifies that the life of the mother would be endangered if the fetus were carried to term, and abortion counseling from CHAMPVA."[139] This language thus seems to clarify that the life exception would be available only to CHAMPVA beneficiaries.

To the extent that the Department does *not* intend to codify the life-saving exception for the Medical Benefits Package, it has failed to provide any explanation for the incongruence between the Medical Benefits Package and CHAMPVA. This differential treatment is especially puzzling given that the Department acknowledges that CHAMPVA's coverage of care that is "medically necessary and appropriate . . . is not different in any meaningful way" from the "needed" requirement under the Medical Benefits Package.[140]

If finalized as is, the proposed rule's inconsistencies will undoubtedly sow confusion among providers and patients. Health care providers are likely to be uncertain about what care is covered under the letter of the rule, leading to delayed care, denied care, and disparate care between veterans and CHAMPVA beneficiaries. Veterans who would qualify under the life endangerment exception may believe that the Department does not provide abortion care under any circumstances, thereby foregoing needed care or incurring significant costs to obtain abortion care outside the VA system.

The confusion surrounding this exception alone demonstrates that the Department would not succeed in obtaining any "benefits" it seeks through this proposed rule. The RIA claims that the proposed rule "explicates the boundaries on what health care would be included in or excluded from the medical benefits package and CHAMPVA benefits" and "would clarify the scope of health care coverage and limitations for both health care providers and beneficiaries, simplifying clinician-patient decision-making and administrative processes."[141] Yet as set forth above, the proposed rule does the precise opposite. If the Department proceeds with finalizing this rule, it must, at minimum, codify the exception for abortion care in cases of life-endangerment in the regulatory text and explicitly clarify wherever possible that VA providers should and must provide this care.

Even if the Department rectifies this grave oversight, however, a wealth of evidence, particularly from the past three years, shows that life exceptions to abortion bans are not

[139] DEP'T. OF VETERAN AFF.: OFF. OF REGUL. POL.Y & MGMT., REGULATORY IMPACT ANALYSIS OF RIN 2900-AS31(P) 2 (2025), https://www.regulations.gov/document/VA-2025-VHA-0073-0001.
[140] 90 Fed. Reg. 36415, 36417.
[141] DEP'T. OF VETERAN AFF.: OFF. OF REGUL. POL.Y & MGMT., REGULATORY IMPACT ANALYSIS OF RIN 2900-AS31(P) 2 (2025), https://www.regulations.gov/document/VA-2025-VHA-0073-0001.

sufficient to protect the lives of pregnant people.[142] Every state abortion ban currently being enforced has an exception for the life of the pregnant person. Yet pregnant people continue to suffer needlessly, and some have died, because they have nonetheless been denied care.[143] Life exceptions pressure providers to withhold care as a patient's health deteriorates, requiring a patient to be on the brink of death before a doctor can intervene. Even assuming the proposed rule does in fact include a life exception, such exception will not be adequate on its own to protect the lives and health of veterans.

The insufficiency of the proposed rule's purported life endangerment exception is made even clearer when considering the VA's statutory obligation to provide treatment for emergency medical conditions, including emergency pregnancy complications, mirroring the requirements under the Emergency Medical Treatment and Labor Act (EMTALA).[144] Pursuant to 38 U.S.C. § 1784A, a VA hospital with an emergency department must provide an "appropriate medical screening examination" to any individual who presents at an emergency department[145] and must provide "necessary stabilizing treatment" to any individual with an "emergency medical condition."[146] Notably, the statute defines an "emergency medical condition" to include one that, absent immediate medical attention, "could reasonably be expected to result in": (i) "placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;" (ii) "serious impairment to bodily functions;" or (iii) "serious dysfunction of any bodily organ or part."[147]

Consistent with that statutory obligation, VHA policies affirm that "[t]he ED must never turn away a walk-in individual or one who has arrived via ambulance; additionally, an MSE and, if applicable, stabilizing treatment or an appropriate transfer, must always be performed or provided, in accordance with the provisions of 38 U.S.C. § 1784A."[148] Likewise, VHA policies clarify that the intent of these requirements "is to prevent a facility from transferring a patient with an emergency medical condition . . . to another facility before the acute condition has been stabilized . . . . This includes proper stabilization of the pregnant patient and/or emergency delivery of the fetus/newborn if possible prior to transfer."[149] Accordingly, VA's EMTALA-

[142] Elizabeth Nash, *Focusing on Exceptions Misses the True Harm of Abortion Bans*, GUTTMACHER INSTITUTE (Dec. 12, 2022), https://www.guttmacher.org/article/2022/12/focusing-exceptions-misses-true-harm-abortion-bans.
[143] *Life of the Mother: How Abortion Bans Lead to Preventable Deaths*, PROPUBLICA, https://www.propublica.org/series/life-of-the-mother (last visited Sept. 2, 2025).
[144] 42 U.S.C. § 1395dd *et seq.*
[145] 38 U.S.C. § 1784A(a).
[146] 38 U.S.C. § 1784A(b).
[147] 38 U.S.C. § 1784A(e)(2)(A).
[148] VHA Directive 1101.14(1), Emergency Medicine, https://www.va.gov/VHAPUBLICATIONS/ViewPublication.asp?pub_ID=10205.
[149] VHA Directive 1094(1), Inter-Facility Transfer Policy, https://www.va.gov/VHAPUBLICATIONS/ViewPublication.asp?pub_ID=4311.

equivalent statute and its own policies require, at a minimum, the provision of stabilizing care—which may include an abortion, as discussed in Section II above—to a pregnant patient whose *health* is in serious jeopardy, not only when their life is endangered. The conflicting directives imposed on VA providers by this proposed rule versus other statutes and VHA policies are sure to result in confusion among VA providers and lower-quality pregnancy care at VA.

V. The RIA employs flawed methodology and is not consistent with the preamble to the proposed rule.

A review of the RIA casts even further doubt on the propriety of the Department's proposed rule, as the RIA—just like the proposed rule itself—contains various errors and inconsistencies.

The RIA's methodology for estimating the costs associated with this proposed rule, for example, focuses exclusively on the pregnancy care costs and newborn costs associated with increased births. This myopic view of the costs stemming from the proposed rule, however, severely underestimates the actual costs of the proposed rule by ignoring the long-term costs to individuals' health, economic security, and well-being from being denied abortion care, as detailed in Section II(b) above.

The RIA's calculations of the total budgetary impact of the proposed rule also underestimate the likely increase in births if the proposed rule were finalized. The RIA estimates that sixty percent of women veteran enrollees and CHAMPVA beneficiaries will still manage to obtain abortions outside of VA.[150] The Department explains that this figure is based on the portion of enrolled veterans who currently reside in states *without* "high levels of abortion restrictions." It is not clear, however, how the Department determined which states do or do not have "high levels of abortion restrictions."[151] For example, the RIA includes Arizona in a list of various states having "high levels of abortion restrictions," even though abortion is currently legal there, but excludes Florida and Georgia, which both ban abortion after six weeks gestation.[152] Notably, Florida has the third largest veteran population in the nation, behind

[150] DEP'T. OF VETERANS AFF.: OFF. OF REGUL. POL.Y & MGMT., REGULATORY IMPACT ANALYSIS OF RIN 2900-AS31(P) 5 (2025), https://www.regulations.gov/document/VA-2025-VHA-0073-0001.

[151] According to the Regulatory Impact Analysis, the list of states with high levels of abortion restrictions include: Alabama, Arkansas, Arizona, Indiana, Kentucky, Louisiana, Michigan, Mississippi, Missouri, North Dakota, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Utah, West Virginia, Wisconsin, and Wyoming, DEP'T. OF VETERANS AFF.: OFF. OF REGUL. POL.Y & MGMT., REGULATORY IMPACT ANALYSIS OF RIN 2900-AS31(P) 5 (2025), https://www.regulations.gov/document/VA-2025-VHA-0073-0001.

[152] N.Y. TIMES INTERACTIVE MAP: TRACKING ABORTION LAWS ACROSS THE COUNTRY, https://www.nytimes.com/interactive/2024/us/abortion-laws-roe-v-wade.html (last visited Sept. 2, 2025).

California and Texas.[153] The omission of states like Florida and Georgia suggests that far less than sixty percent of women veteran enrollees currently reside in states with abortion access.

The RIA's analysis also appears to assume, without justification, that every veteran who lives in a state without a "high level" of abortion restrictions will be able to access that care. But even where state laws do not restrict access, the cost of paying for abortion care out-of-pocket may still be prohibitive. The average cost of a first-trimester abortion in the U.S. is 550 dollars, which is simply more than many Americans can afford.[154]

Setting aside these methodological flaws, even the RIA's description of the proposed rule raises concerns for the ways in which it diverges in several respects from the preamble to the proposed rule. First, the RIA's Statement of Need attributes the basis for the proposed rule as ensuring that the Department "is appropriately prioritizing and addressing the urgent need to protect and preserve the lives of both the mother and unborn child."[155] It further notes a desire "to eliminate the risk of loss of life" and to "cease VA's provision of abortions when other health interventions may be possible which would preserve the health of both the mother and the unborn child."[156] Nowhere in the preamble, however, does the Department indicate that eliminating loss of life or preserving the lives and health of "both the mother and unborn child" are the rationales underlying the proposed rule. Second, the RIA's Statement of Need asserts that the proposed rule aligns with Executive Order 14182, Enforcing the Hyde Amendment.[157] However, the Department is not subject to the Hyde Amendment, and even if it were, as discussed above, the proposed rule would fail to align with the Hyde Amendment, which includes exceptions for rape and incest. Finally, as already noted above in Section IV, the RIA's summary of the proposed rule states that the life endangerment exception to the prohibition on abortion would apply only to CHAMPVA and not the Medical Benefits Package, contradicting language in the preamble that states otherwise.[158] Together, these inconsistencies and

[153] FLORIDA DEP'T. OF VETERANS AFFAIRS, FAST FACTS, https://www.floridavets.org/our-veterans/profilefast-facts/ (last visited Sept. 2, 2025).
[154] GUTTMACHER INST., ABORTION OUT OF REACH: THE EXACERBATION OF WEALTH DISPARITIES AFTER DOBBS V. JACKSON WOMEN'S HEALTH ORGANIZATION (2023), https://www.guttmacher.org/article/2023/01/abortion-out-reach-exacerbation-wealth-disparities-after-dobbs-v-jackson-womens (last visited Sept. 2, 2025).
[155] DEP'T. OF VETERANS AFF.: OFF. OF REGUL. POL.Y & MGMT., REGULATORY IMPACT ANALYSIS OF RIN 2900-AS31(P) 2 (2025), https://www.regulations.gov/document/VA-2025-VHA-0073-0001.
[156] *Id.*
[157] *Id.*
[158] DEP'T. OF VETERANS AFF.: OFF. OF REGUL. POL.Y & MGMT., REGULATORY IMPACT ANALYSIS OF RIN 2900-AS31(P) 2 (2025), https://www.regulations.gov/document/VA-2025-VHA-0073-0001.

contradictions between the RIA and the preamble are further indication that the Department did not engage in reasoned decision making here.

VI. Conclusion

Military service members undertake the ultimate sacrifice to serve and protect our country. When they return home from service—as with their civilian counterparts—they deserve quality, comprehensive, and equitable health care befitting those profound sacrifices. Yet the Department's proposed rule falls woefully short of its obligation to serve the needs of veterans and their loved ones. Abortion is health care, and throughout this proposed rule, the Department provides no basis in fact, law, or policy to conclude otherwise. We strongly urge the Department to withdraw this proposed rule.

We appreciate the opportunity to comment on the proposed 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 Jackii Wang, Senior Legislative Analyst at the National Women's Law Center at jwang@nwlc.org.