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October 10, 2022

Filed Electronically

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

Re: Vet Voice Foundation Comments in Support of RIN 2900-AR57– Interim Final Rule, Reproductive Health Services

Dear Sir or Madam:

On behalf of Vet Voice Foundation, we provide the following comments on RIN 2900-AR57–Interim Final Rule, Reproductive Health Services, published by the Department of Veterans Affairs ("VA") in the Federal Register, 38 C.F.R. Part 17, pages 55287–55296, on September 9, 2022. Vet Voice Foundation is a non-profit, non-partisan organization that seeks to empower veterans across the country to become civic leaders and policy advocates, harnessing the energy and drive of dedicated men and women who have fought for our country and putting it to work at home and in their communities on the important issues they face, including health care. This includes advocating for adequate and gender-specific health care for women veterans, who are the fastest growing population of veterans using Veterans Health Administration ("VA") services and account for 30% of new patients served by the VA.[1]

Vet Voice Foundation submits these comments in support of the Interim Final Rule. We fully support the action of the Secretary of Veterans Affairs ("Secretary") recognizing that abortion is health care, and therefore, expanding access to abortion care and counseling for veterans and for Civilian Health and Medical Program of the Department of Veterans Affairs ("CHAMPVA") beneficiaries.[2] His authority to enact the Interim Final Rule is indisputable, as demonstrated below in our analysis of the relevant statutory and regulatory provisions and the medical literature. In

[1] U.S. Dept. of Veterans Affairs, *Women Veterans Health Care* (May 25, 2022), https://tinyurl.com/5b2ejyhm.

[2] CHAMPVA is a health insurance program covering the spouses, widows, and children of certain veterans. *See* U.S. Dept. of Veterans Affairs, *Community Care, Frequently Asked Questions About CHAMPVA* (Oct. 27, 2021), https://tinyurl.com/2fkt8hzp.

fact, given the medical consensus concerning the importance of access to abortion care to the general health of pregnant individuals, and the mandate that the Secretary provide veterans with "needed" medical care, it would have been an abandonment of his duties not to act following the curtailment of abortion access in the wake of the decision in *Dobbs v. Jackson Women's Health Organization*, 142 S. Ct. 2228 (2022).

In addition, we urge the Secretary to act to the full extent of his legal authority by (1) revising the rule to authorize the VA to provide abortion care in *all* cases; (2) ensuring that VA facilities across the country provide CHAMPVA beneficiaries access to abortion care through the In-House Treatment Program; and (3) issuing guidance to VA facilities across the country to ensure that individuals who are not veterans or CHAMPVA beneficiaries—including civilians and active-duty service members—can nevertheless access emergency abortion care in appropriate circumstances.

The medical evidence and health care needs of veterans, their families, and their communities require these additional steps. The Interim Final Rule allows for abortions only where a medical professional determines that the life or the health of the pregnant individual would be endangered if the pregnancy were carried to term, or where the pregnancy is the result of an act of rape or incest. However, the medical evidence compels the enactment of a broader rule. In particular, pregnancy can present significant risks to the life and health of the pregnant individual, serious health complications can emerge suddenly and in individuals with no preexisting risks or conditions, and delaying abortion care increases the risk of complications.

Furthermore, the failure to secure access at VA facilities for abortion care for CHAMPVA beneficiaries would mean that CHAMPVA beneficiaries living in states with abortion bans will, in practice, be denied access to abortion care. And the failure to ensure that VA facilities across the country comply with their obligation to provide hospital and medical care to all individuals presenting with an emergency medical condition—including emergency abortion care—will put the lives of countless individuals in communities across the country at risk, including the lives of active-duty service members. The Secretary has the legal authority and moral obligation to act to secure access to these health care options.

I. The Secretary Has Broad Authority to Provide Abortion Care and Counseling to Covered Veterans

A. The Statutory Text Authorizes the Secretary to Provide Medical Care to Veterans that He Determines Is "Needed"

The Secretary acted well within the scope of his statutory authority in enacting the Interim Final Rule because the statute confers on him the power to determine what care is medically needed. The "analysis begins with the text"[3] of the relevant statute governing the duty to provide medical care to veterans. That duty is found in 38 U.S.C. 1710. For certain categories of veterans, the statute provides that the Secretary "shall furnish hospital care and medical services which the Secretary determines to be needed."[4] For other veterans, the statute provides that the Secretary

[3] *Merit Mgmt. Grp., LP v. FTI Consulting, Inc.*, 138 S. Ct. 883, 893 (2018).

[4] 38 U.S.C. 1710(a)(1)–(a)(2) (specifying that the Secretary "shall furnish hospital care and medical services that the Secretary determines to be needed" to "any veteran for a service-connected disability; and to any veteran who

"may" provide those services, subject to certain limitations, again guided by what services the "Secretary determines to be needed."[5] Thus, the statute makes the determination of need for care—which has been delegated by Congress to the Secretary—central to any inquiry regarding statutory authority for providing care by the VA.

The history and evolution of the statute further confirm that the authority to determine what care veterans need rests on the Secretary. Congress was intentional in centering the scope of the power conferred to the Secretary on this "need for care" determination. In 1996, Congress passed the Veterans' Health Care Eligibility Reform Act of 1996 ("1996 Act"), which made the availability of *all* medical care services for veterans turn on a single "need for care" criterion focusing on medical judgment rather than legal definitions.[6] Prior to that 1996 Act, Section 1710 only addressed eligibility for hospital, nursing, and domiciliary care.[7] It did not address outpatient medical services, which were instead covered by Section 1712.[8] That section authorized the Secretary to provide "such [ambulatory or outpatient] medical services as the Secretary determines are needed,"[9] but "require[d] the VA to apply at least four different legal tests to distinct veteran classifications"[10] using "medically uninterpretable"[11] standards. For instance, one provision required care where it would "obviate the need for hospital admission."[12] But in the 1996 Act,

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has a service-connected disability rated at 50 percent or more," and that the Secretary shall provide these services and may provide nursing home care to any veteran (1) "who has a compensable service-connected disability rated less than 50 percent or, with respect to nursing home care during any period during which the provisions of section 1710A(a) of this title are in effect, a compensable service-connected disability rated less than 70 percent;" (2) "whose discharge or release from active military, naval, air, or space service was for a disability that was incurred or aggravated in the line of duty;" (3) "who is in receipt of, or who, but for a suspension pursuant to section 1151 of this title (or both a suspension and the receipt of retired pay), would be entitled to disability compensation, but only to the extent that such veteran's continuing eligibility for such care is provided for in the judgment or settlement provided for in such section;" (4) "who is a former prisoner of war, who was awarded the medal of honor under section 7271, 8291, or 9271 of title 10 or section 491 of title 14, or who was awarded the Purple Heart;" (5) "who is a veteran of the Mexican border period or of World War I;" (6) "who was exposed to a toxic substance, radiation, or other conditions, as provided in subsection (e);" or (7) "who is unable to defray the expenses of necessary care as determined under section 1722(a) of this title") (footnote omitted).

[5] 38 U.S.C. 1710(a)(3) ("In the case of a veteran who is not described in paragraphs (1) and (2), the Secretary may, to the extent resources and facilities are available and subject to the provisions of subsections (f) and (g), furnish hospital care, medical services, and nursing home care which the Secretary determines to be needed.").

[6] Veterans' Health Care Eligibility Reform Act of 1996, Pub. L. No. 104-262, § 101(a)–(c), 110 Stat. 3182, 3178–79 (effective Oct. 9, 1996) [hereinafter 1996 Act]; 142 CONG. REC. H8771 (1996) (statement of Rep. Tim Hutchinson) ("The bill substitutes a single, streamlined eligibility provision—based on clinical need for care—for the complex array of disparate rules currently governing eligibility for hospital and outpatient care.").

[7] 38 U.S.C. 1710 (1996), *amended by* 1996 Act, *supra* n.6, § 101(a).

[8] *Id.* at 1712 (1996), *amended by* 1996 Act, *supra* n.6, § 101(c).

[9] *Id.* at 1712(a)(1) (1996).

[10] H.R. REP. NO. 104-690, at 4 (1996); *id.* (providing that "under section 1712(a), the VA 'shall furnish' comprehensive treatment to certain service-connected veterans, 'may furnish' such broad treatment to certain other classes of veterans, and either 'shall' or 'may' furnish treatment of more limited scope (to 'obviate' the need of hospital admission or to complete treatment begun during hospitalization) to still other groups of veterans").

[11] 142 CONG. REC. H8771 (1996) (statement of Rep. Tim Hutchinson).

[12] *Id.*; 38 U.S.C. 1712(5)(A) (1996).

Congress repealed Section 1712, and its confusing "legal tests," in favor of the single "need for care" determination.

Finally, the legislative history lends additional support to the conclusion that care provided to veterans will be determined by the Secretary based on a "need for care" determination. The congressional record accompanying the 1996 Act is clear that the purpose of the Act was to create this more streamlined and medically grounded criterion.[13] The House Report on the Act effectively summarizes Congress' view of what the 1996 Act meant to achieve: "While the new standard is a simple one, more importantly, it would employ 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."[14] The amendments would "establish medical need as the sole criterion of eligibility for VA hospital care and medical services."[15]

Thus, the statutory text is clear, and the legislative history confirms, that when analyzing whether the Secretary has the authority to provide veterans certain medical services—including the abortion care provided under the Interim Final Rule—the focus of the inquiry is the determination, delegated by Congress to the Secretary, of whether that care is medically needed. Courts agree, holding that "[e]xcept where the Act requires specific services or care for designated medical condition, the Secretary has broad discretion to determine the precise hospital or medical services to be supplied."[16]

In light of the clarity of the statutory text, this is not one of those "extraordinary cases" in which the so-called "major questions doctrine" would cast doubt on whether the Secretary has the authority to act to cover abortion care for veterans.[17] That doctrine applies only where the agency relies on ambiguous statutory text, as was the case in the *West Virginia v. Environmental Protection Agency* case decided by the Court this past Term.[18] Here, there can be no doubt that "Congress in fact meant to confer the power the agency has asserted,"[19] *i.e.* the determination that certain medical care is in fact "needed." Congress was crystal clear in that delegation: the statute charges the Secretary with providing veterans with "hospital care and medical services *which the Secretary determines to be needed*."[20] Nor is this a case in which the action by the agency constitutes a "transformative expansion in its regulatory authority."[21] To the contrary, the Secretary regularly makes determinations about the "need for care" in a variety of circumstances.

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[13] H.R. REP. NO. 104-690, at 13 (noting that the Act "substitute[s] 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"); *accord* 142 CONG. REC. H8771 (statement of Rep. Tim Hutchinson).

[14] H.R. REP. NO. 104-690, at 4 (emphasis added).

[15] *Id*. at 11.

[16] *E. Paralyzed Veterans Ass'n, Inc. v. Sec'y of Veterans Affs.*, 257 F.3d 1352, 1362 (Fed. Cir. 2001).

[17] *W. Virginia v. Env't Prot. Agency*, 142 S. Ct. 2587, 2608–09 (2022).

[18] *Id.* at 2609.

[19] *Id.* at 2608.

[20] 38 U.S.C. 1710(a)(1)–(a)(2) (emphasis added).

[21] *W. Virginia v. Env't Prot. Agency*, 142 S. Ct. at 2610.

Take, for instance, the decision to provide vaccines and other COVID-19 care to veterans.[22] No matter the controversies surrounding COVID-19 vaccines, no one doubts that the Secretary has the authority under the statute to decide whether such medical care is "needed." The same is true here. And notably, no matter the controversies surrounding the topic of abortion care, Congress was explicit in preserving the authority of the Secretary to provide this particular type of medical care. *See infra* Part I.D.

B. The Relevant Regulatory Scheme Authorizes the Provision of Medical Care that Promotes, Preserves, or Restores Health

The Secretary has determined that care is medically needed under 38 U.S.C. 1710 when that care would promote, preserve, or restore the health of the veteran—a standard that is easily met in the context of abortion care and counseling. The Secretary has enacted this definition of medically needed by exercising his power to "prescribe all rules and regulations which are necessary or appropriate to carry out the laws administered by the Department and are consistent with those laws."[23] Here, the Secretary has carried out the duty conferred upon him in 38 U.S.C. 1710 through regulation by creating the medical benefits package, 38 C.F.R. 17.38.[24]

That medical benefits package lists a variety of "basic care" and "preventative care" services for which enrolled veterans are eligible,[25] and that will be provided "only if it is determined by appropriate health care professionals that the care is needed to promote, preserve, or restore the health of the individual and is in accord with generally accepted standards of medical practice."[26] It defines what promotes, preserves, or restores health as follows:

> (1) ***Promote health.*** Care is deemed to promote health if the care will enhance the quality of life or daily functional level of the veteran, identify a predisposition for development of a condition or early onset of disease which can be partly or totally ameliorated by monitoring or early diagnosis and treatment, and prevent future disease.[27]
>
> (2) ***Preserve health.*** Care is deemed to preserve health if the care will maintain the current quality of life or daily functional level of the veteran, prevent the progression of disease, cure disease, or extend life span.[28]

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[22] U.S. Dept. of Veterans Affairs, Coronavirus FAQ: What Veterans Need to Know (Sept. 9, 2022), https://tinyurl.com/bdf6wbb6.

[23] 38 U.S.C. 501(a).

[24] *See* Enrollment—Provision of Hospital and Outpatient Care to Veterans, 64 Fed. Reg. 54,207, 54,210 (Oct. 6, 1999) ("Although the Veterans' Health Care Eligibility Reform Act of 1996 did not direct VA to create a medical benefits package, we believe that it is necessary under the requirements of the Administrative Procedure Act to inform affected individuals concerning the care that would or would not be provided to veterans enrolled in the VA healthcare system.").

[25] 38 C.F.R. 17.38(a)(1)–(a)(2).

[26] *Id.* at 17.38(b).

[27] *Id.* at 17.38(b)(1).

[28] *Id.* at 17.38(b)(2).

(3) ***Restoring health.*** Care is deemed to restore health if the care will restore the quality of life or daily functional level that has been lost due to illness or injury.[29]

As we address next, access to abortion care promotes, preserves, and restores health, such that it qualifies as medically needed care under 38 U.S.C. 1710.

C. The Secretary Has the Authority to Authorize *All* Abortion Care Under the Statute and Regulations

Taking the text of the statute, and its implementing regulations, it is clear that the Secretary is well within his authority to provide access to abortion care and counseling to veterans—and that authority extends to the provision of care for *all* abortion care, not just in cases where the life or health of the pregnant person would be endangered if the pregnancy were carried to term, or when the pregnancy is the result of rape or incest.

Here, abortion care and counseling easily satisfy the guidance that the VA has issued describing what it determines to be medically needed care—it is, as "determined by appropriate healthcare professionals," "the care [that] is needed to promote, preserve, or restore the health of the individual and is in accord with generally accepted standards of medical practice."[30] The medical evidence[31] overwhelmingly supports the conclusion that access to abortion care is essential to promoting, preserving, and restoring the health of the pregnant individual. The leading American medical organizations, including the American Medical Association and the American College of Obstetricians and Gynecologists, have made clear that "[r]eproductive health care is essential to women's overall health," and that "[a]ccess to abortion is an important component of reproductive health care."[32] The medical evidence also conclusively demonstrates that it is an extremely safe medical procedure,[33] and the procedure is incredibly common and integrated into mainstream healthcare practices, with over 860,000 abortions having been performed in the U.S. in 2017.[34] "Induced abortion is among the safest outpatient procedures performed in the United

[29] *Id.* at 17.38(b)(3).

[30] *Id.* at 17.38(b).

[31] The Secretary already cites much of that medical evidence in the publication of the Interim Final Rule. That medical evidence supports the decision of the Secretary to expand access to veterans and CHAMPVA beneficiaries. The additional medical evidence cited in these comments lends further support to that decision, and also supports the argument that the Secretary has the authority to cover *all* abortion care.

[32] Brief of Amici Curiae Am. Coll. of Obstetricians and Gynecologists, Am. Medical Ass'n, Am. Acad. of Family Physicians, Am. Acad. of Nursing, Am. Acad. of Pediatrics, Am. Ass'n of Pub. Health Physicians, et al. in Support of Respondents at 7, *Dobbs v. Jackson Women's Health Org.*, 142 S. Ct. 2228 (2022) (No. 19-1392), 2021 WL 4312120, at *7.

[33] National Academies of Sciences, Engineering, Medicine, *The Safety and Quality of Abortion Care in the United States*, 10 (Mar. 16, 2018), https://tinyurl.com/27wkbduw ("The clinical evidence clearly shows that legal abortions in the United States—whether by medication, aspiration, D&E, or induction—are safe and effective. Serious complications are rare.").

[34] Rachel K. Jones et al., *Abortion Incidence and Service Availability in the United States, 2017*, GUTTMACHER I., at 7 (2019), https://tinyurl.com/3ftbdey2.

States."[35] Legal abortion is also significantly safer than childbirth: it is substantially less likely to cause death than childbirth.[36]

Access to abortion care also promotes and restores health by enhancing the quality of life and daily functional level of individuals seeking these services. Individuals who are denied a wanted abortion experience more anxiety, lower self-esteem, and lower life satisfaction than those who received the wanted abortion.[37] Abortion care also prevents the health risks related to carrying an unwanted pregnancy to term, which includes the risk of post-birth hemorrhage and eclampsia.[38]

Access to abortion care also clearly preserves health. Areas that have limited access to abortion have significantly worse health outcomes, including higher morbidity and mortality rates.[39] Risk of death is fourteen times higher for people made to carry an unwanted pregnancy to term than for those who can secure safe and legal abortions.[40] Studies have also shown that having an abortion did not increase the likelihood of mental health symptoms, such as depression, anxiety, PTSD, or suicidality.[41]

Importantly, the medical literature is clear that pregnancy can pose significant health risks for *all* pregnant individuals, not just those with concomitant health conditions or those who experience complications. Many of these risks can be time-sensitive or emerge suddenly later in the pregnancy, and a health professional cannot always anticipate in early stages of pregnancy that, if carried to term, the pregnancy will pose a significant risk to the life or health of the pregnant individual.

For instance, pregnant individuals are at risk of deep venous thromboses (blood clots), a serious condition that can lead to pulmonary embolism or death.[42] Importantly, "pregnant women

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[35] Caitlin Gerdts et al., *Side Effects, Physical Health Consequences, and Mortality Associated with Abortion and Birth after an Unwanted Pregnancy,* 26 WOMEN'S HEALTH ISSUES 55, 58 (2016).

[36] Elizabeth G. Raymond et al., *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 OBSTETRICS & GYNECOLOGY 215, 216 (2012); Sam Rowlands, *Review: Misinformation on Abortion*, 16 EUR. J. CONTRACEPTION & REPROD. HEALTH CARE 233, 234–35 (2011).

[37] 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, 170 (2017); Biggs et al., *Does Abortion Reduce Self-Esteem and Life Satisfaction?*, 23 QUALITY OF LIFE RESEARCH 2505 (2014) (finding that women who received an abortion experienced higher self-esteem than women who were denied an abortion).

[38] Gerdts et al., *supra* n.35, at 58.

[39] Susheela Singh et al., *Abortion Worldwide 2017: Uneven Progress and Unequal Access*, GUTTMACHER I. (2018), https://tinyurl.com/3rtn3j6j; *see also* Center of Reproductive Rights, *Evaluating Priorities: Measuring Women's and Children's Health and Well-being against Abortion Restrictions in States, Vol. II* (2017), https://tinyurl.com/5dza6xdu.

[40] Raymond et al., *supra* n.36, at 215–19.

[41] Biggs *et al.*, *Women's Mental Health and Well-being 5 Years After Receiving or Being Denied an Abortion: A Prospective, Longitudinal Cohort Study*, *supra* n.37 at 177; U.C.S.F. Medical Center, Bixby Center for Global Reproductive Health, *The Mental Health Impact of Receiving vs. Being Denied a Wanted Abortion* (July 2018), https://tinyurl.com/jmphpy7s.

[42] Mayo Clinic, *Deep Vein Thrombosis* (June 11, 2022), https://tinyurl.com/4nhfd5pz.

are 5 times more likely to experience a blood clot compared with women who are not pregnant."[43] Dangerous conditions like gestational diabetes, which affects approximately 6% of pregnant individuals,[44] and hypertension disorders, which affect approximately 5-10% of pregnant individuals,[45] are unrelated to pre-existing conditions and manifest during the pregnancy.

Moreover, the risk of health complications from pregnancy increase as the pregnancy progresses. For example, gestational diabetes is generally not a concern before 24 weeks of pregnancy,[46] and preeclampsia usually manifests after 20 weeks of pregnancy.[47] By that time, the risk of complications from an abortion have increased substantially, as the risks increase as gestational age increases (*i.e.* as the pregnancy progresses). While legal abortion is among the safest procedures in medicine, delaying the wanted abortion until these pregnancy-related complications present themselves inherently increases the risk to the individual.[48] For example, whereas the risk of major complications for surgical abortions in the first trimester is only 0.16%, that risk more than doubles for abortions performed in the second trimester.[49]

Thus, because an unwanted pregnancy can pose significant risks to the life and health of pregnant individuals, because some dangerous conditions can manifest suddenly even in individuals without any preexisting risks, and because health risks increase the longer an individual is made to wait before they can get access to a legal abortion, access to *elective* abortion care is particularly important for the preservation of veterans' health from the outset. We therefore urge the Secretary, in the final rule, to expand access to abortion care to include elective abortions, without requiring that a health professional find that the life or health of the pregnant person is at risk if the pregnancy is carried to term.

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[43] Centers for Disease Control and Prevention, *Pregnant? Don't Overlook Blood Clots* (June 9, 2022), https://tinyurl.com/nhk42dxj.

[44] *See* Am. Coll. of Obstetricians & Gynecologists, *Practice Bulletin No. 190: Gestational Diabetes Mellitus*, 131 OBSTETRICS & GYNECOLOGY e49, e49 (2018), https://tinyurl.com/yubb3nvk ("7% of pregnancies were complicated by any type of diabetes and . . . approximately 86% of these cases represented women with [gestational diabetes].").

[45] Elisa Longhitano et al., *The Hypertensive Disorders of Pregnancy: A Focus on Definitions for Clinical Nephrologists*, 11 J. CLINICAL MED. 1 (2022), https://tinyurl.com/yc3v7xnz. Importantly, such hypertensive disorders are particularly dangerous, accounting for "approximately a quarter of maternal deaths and near misses." World Health Org., *WHO Recommendations on Antenatal Care for a Positive Pregnancy Experience*, at 40 (2016), https://tinyurl.com/r4t975bu.

[46] *See Practice Bulletin No. 190: Gestational Diabetes Mellitus*, *supra* n.44 at e49.

[47] *See Preeclampsia and High Blood Pressure During Pregnancy*, Am. Coll. of Obstetricians & Gynecologists, https://tinyurl.com/46u3eyzd.

[48] *See* Suzanne Zane et al., *Abortion-Related Mortality in the United States* 1998–2010, 126 OBSTETRICS & GYNECOLOGY 258 (2015), https://tinyurl.com/2j5tkuu6.

[49] *See* Ushma D. Upadhyay et al., *Incidence of Emergency Department Visits and Complications After Abortion*, 125 OBSTETRICS & GYNECOLOGY 175 (2015), https://tinyurl.com/2p8r6ju8.

D. The Veterans Health Care Act of 1992 Does Not Preclude the Secretary from Providing Abortion Care, and In Fact Congress Explicitly Preserved His Authority to Provide Such Care

Congress has been clear that the Secretary of Veterans Affairs has (1) broad authority to "prescribe all rules and regulations which are necessary or appropriate to carry out the laws administered by the Department and are consistent with those laws,"[50] and (2) must provide medical services that the Secretary determines are needed.[51] No law or other authority categorically prohibits the Secretary from providing abortion services. Absent such a law, the Secretary may provide abortion services that he determines are needed.[52]

i. Section 106 of the Veterans Health Care Reform Act of 1992 does not unilaterally preclude the VA from providing abortion or other listed services

Any suggestion that the Veterans Health Care Reform Act of 1992 ("1992 Act") universally prohibits the Secretary from providing abortion services relies upon a misreading of the statute and flouts express congressional intent. Parts of the 1992 Act were aimed at improving the health services provided to women veterans in particular, and thus Section 106 of the 1992 Act created a statutory note, 38 U.S.C. 1710 note, which states that the Secretary "may provide to women" pap smears, breast exams and mammograms, and general reproductive health care, "but not including *under this section* infertility services, abortions, or pregnancy care (including prenatal and delivery care), except for such care relating to a pregnancy that is complicated or in which the risks of complication are increased by a service-connected condition."[53]

The italicized text—"*under this section*"—is key: whereas Section 106 of the 1992 Act did not *guarantee* veterans access to infertility services, abortions, or pregnancy care, the Act did not *foreclose* such care if the Secretary deemed them "needed" under 38 U.S.C. 1710. In fact, to read the 1992 Act to foreclose such a power would read "under this section" out of the statute. And of course, the Supreme Court has recognized time and time again that courts have a "duty to give effect, if possible, to every clause and word of a statute."[54]

The legislative history accompanying the enactment of Section 106 further supports that reading. The joint explanatory statement issued by the Committees on Veterans' Affairs explained:

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[50] 38 U.S.C. 501(a).

[51] *Id.* at 1710(a)(1).

[52] *See id.* ("The Secretary . . . *shall* furnish hospital care and medical services which the Secretary determines to be needed . . . .") (emphasis added).

[53] *Id.* at 1710 note (Health Care Services for Women) (emphasis added).

[54] *Duncan v. Walker*, 533 U.S. 167, 174 (2001) (cleaned up); *see also Babbitt v. Sweet Home Chapter of Communities for a Great Oregon*, 515 U.S. 687, 698 (1995) (explaining its "reluctance to treat statutory terms as surplusage").

> The inclusion of the phrase "under this section" *underscores the intent of the Committees not to limit such authority as the Secretary may have* to provide any infertility services under Chapter 17.[55]

Thus, as written, the language "not including *under this section*" leaves room for the VA to provide infertility services, abortions, and pregnancy care through any number of other authorities, including authority in Chapter 17 of Title 38.

Notably, the Secretary has exercised that authority in the past without opposition or argument that he acted contrary to the 1992 Act—in providing comprehensive pregnancy care and infertility services. Specifically, the medical benefits package adopted in 1999 included coverage for pregnancy care, notwithstanding the language in Section 106 of the 1992 Act having limited such care to cases where "a pregnancy that is complicated or in which the risks of complication are increased by a service-connected condition."[56] And in 2017, the Secretary authorized the provision of in vitro fertilization ("IVF") treatment for veterans in certain cases, notwithstanding the exclusion of such care under Section 106 of the 1992 Act.[57] There is no argument that either form of care is foreclosed by the 1992 Act—it has been generally understood that although Section 106 did not itself require comprehensive pregnancy care and IVF coverage, the "under this section" language preserved the authority of the Secretary to provide such care if and when he deemed it "needed."[58]

In the end, had Congress intended to prohibit the Secretary from providing abortion services altogether, it could have done so. The resulting compromise language was clearly intended to leave intact the power delegated to the Secretary to make determinations about the need for medical care for veterans.

ii. Reading the 1992 Act as categorically precluding abortion and other services creates a conflict with the 1996 Act

In addition to the clear statutory text, and supporting legislative history, there is another reason why the 1992 Act cannot be read to preclude the authority of the Secretary to provide abortion care. That is that an interpretation of the 1992 Act that categorically precludes abortion care would be inconsistent with the plain meaning of the 1996 Act, which compels the Secretary—without reservation—to provide care the Secretary determines is needed.

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[55] Joint Explanatory Statement on H.R. 5193, 1992 U.S.C.C.A.N. 4186, 4189–90 (emphasis added).

[56] Reproductive Health Services, 87 Fed. Reg. 55,287, 55,289 (Sept. 9, 2022); *see also* 38 C.F.R. 17.38; U.S. Dept. of Veterans Affairs, *Maternity Care* (Sept. 22, 2022), https://tinyurl.com/2hda3pnr.

[57] 38 C.F.R. 17.380.

[58] The fact that Congress appropriated money for the Secretary, in his discretion, to use to provide IVF services confirms that he possessed the authority to provide such infertility care, notwithstanding the language of Section 106 of the 1992 Act. *See* Pub. L. No. 114-223, § 260, 130 Stat. 857, 897 (effective Sept. 29, 2016). Nowhere in that appropriations bill did Congress purport to repeal any part of the 1992 Act—because no such repeal was necessary. Instead, recognizing the pre-existing authority of the Secretary to provide care that he deemed "medically needed," Congress authorized the use of funds for those infertility services.

Reading the 1992 Act to create a categorical ban on some reproductive health care, including abortion care, would also be inconsistent with Congress' intent to focus on medical necessity as "the sole criterion of eligibility for VA hospital care and medical services."[59] The "need for care" test was meant to ensure "that medical judgment rather than legal criteria will determine when care will be provided and the level at which that care will be furnished."[60] Reading the 1992 Act as categorically precluding the listed medical services is in direct conflict with this goal, as it disregards medical judgment entirely in favor of legal criteria.

E. State Antiabortion Laws Do Not Limit the Availability of These Services at Federal VA Facilities Pursuant to Federal Law

The Secretary has the power to authorize the provision of abortion care at VA facilities even in states where abortion has been limited or banned following the *Dobbs* decision. To start, it is clear that under the Supremacy Clause, states cannot interfere with the actions of VA officials, including medical staff, as they carry out their duties under federal law. Moreover, the Secretary, in the exercise of his congressionally delegated power to enact "rules and regulations which are necessary or appropriate to carry out the laws administered by the Department,"[61] has explicitly preempted the application of conflicting state laws.

i. Supremacy Clause

The Supremacy Clause of the U.S. Constitution[62] provides federal officers immunity from "state prosecutions for actions reasonable and necessary in the discharge of their federal responsibilities."[63] The Supreme Court long ago interpreted this clause to mean that "the states have no power . . . to retard, impede, burden, or in any manner control, the operations of the constitutional laws enacted by congress to carry into execution the powers vested in the general government."[64] Just this year the Supreme Court again reaffirmed that the "Supremacy Clause generally immunizes the Federal Government from State laws that directly regulate or discriminate against it."[65] Simply put, "states may not impede or interfere with the actions of federal executive officials when they are carrying out federal laws."[66]

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[59] H.R. REP. NO. 104-690, at 11.

[60] *Id.* at 4.

[61] 38 U.S.C. 501(a).

[62] "This Constitution, and the Laws of the United States which shall be made in Pursuance thereof; and all Treaties made, or which shall be made, under the Authority of the United States, shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the Constitution or Laws of any State to the Contrary notwithstanding." U.S. Const. art. VI, cl. 2.

[63] *Wyoming v. Livingston*, 443 F.3d 1211, 1217 (10th Cir. 2006); *see also In re Neagle*, 135 U.S. 1, 75–76 (1890); *Ohio v. Thomas*, 173 U.S. 276, 284 (1899).

[64] *McCulloch v. Maryland*, 17 U.S. (4 Wheat.) 316, 436 (1819); *see also* Kate Sablosky Elengold et al., *The Sovereign Shield*, 73 STAN. L. REV. 970, 992–94 (2021).

[65] *United States v. Washington*, 142 S. Ct. 1976, 1982 (2022).

[66] *Wyoming v. Livingston*, 443 F.3d 1211, 1217 (10th Cir. 2006).

The Supreme Court has been clear that this intergovernmental immunity applies broadly. For instance, it has held that "even the most unquestionable and most universally applicable of state laws, such as those concerning murder, will not be allowed to control the conduct of a marshal of the United States acting under and in pursuance of the laws of the United States."[67] In that case, the Court held a U.S. Marshal who shot and killed a potential assassin of Supreme Court Justice Stephen Field was immune from state prosecution for murder.[68] And the doctrine has been applied "to assess state regulation of health, safety, environmental standards, and economic well-being."[69]

Thus, any attempt at state regulation of abortion services that prohibits federal agents from conducting their federal duties would be invalid under the Supremacy Clause. Put another way, however states want to regulate access to abortion services for state or other actors, when it comes to *federal VA employees acting pursuant to federal law*,[70] states may not impose civil or criminal liability for the performance of abortion services as authorized by the Interim Final Rule or any future final rule.[71]

Notably, following the issuance of the Interim Final Rule, the Office of Legal Counsel issued an opinion containing a thorough analysis of the relevant Supremacy Clause precedent, as well as an analysis of the legal authority supporting the Interim Final Rule. The Office of Legal Counsel similarly concluded that, given the intergovernmental immunity stemming from the Supremacy Clause, "states may not restrict VA and its employees acting within the scope of their federal authority from providing abortion services as authorized by federal law, including [the Interim Final Rule]. States may not penalize VA employees for providing such services, whether through criminal prosecution, civil litigation, or license revocation proceedings."[72]

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[67] *Johnson v. Maryland*, 254 U.S. 51, 56–57 (1920) (citing *In re Neagle*, 135 U.S. 1); *accord Kentucky v. Long*, 837 F.2d 727, 743 (6th Cir. 1988).

[68] *In re Neagle*, 135 U.S. 1.

[69] Elengold et al., *supra* n.64, at 992–94 (citing *Thomas*, 173 U.S. at 277–78, 283; *Johnson*, 254 U.S. at 55–57; *Hancock v. Train*, 426 U.S. 167, 168, 198–99 (1976); *Penn Dairies, Inc. v. Milk Control Comm'n*, 318 U.S. 261, 266, 269-71 (1943)).

[70] Various sections of Title 38 govern the appointment of VA employees and confirm their status as federal officers. *See, e.g.*, 38 U.S.C. 7306, 7401, 7405, 7406, 7408.

[71] The Assimilative Crimes Act, 18 U.S.C. 13—cited by some commenters as a source of liability for VA providers should they perform abortions otherwise prohibited under state law—has no applicability here. That statute provides: "Whoever within or upon [a federal enclave] is guilty of any act or omission which, although not made punishable by any enactment of Congress, would be punishable if committed or omitted within the jurisdiction of the State, Territory, Possession, or District in which such place is situated, by the laws thereof in force at the time of such act or omission, shall be guilty of a like offense and subject to a like punishment." *Id.* at 13(a). But this is not a case in which an offense has "not [been] made punishable" under federal law. Instead, here federal law explicitly *authorizes* the care being provided at VA facilities. As such, the Assimilative Crimes Act cannot be relied upon to argue that the actions of federal VA employees, acting pursuant to federal law, are subject to criminal penalties. Importantly, the Office of Legal Counsel recently issued an opinion analyzing this same question and reached this same conclusion. *See Application of the Assimilative Crimes Act to Conduct of Federal Employees Authorized by Federal Law*, 46 Op. O.L.C. __ (Aug. 12, 2022), https://tinyurl.com/z6mpyfss.

[72] *Intergovernmental Immunity for the Department of Veterans Affairs and Its Employees When Providing Certain Abortion Services*, 46 Op. O.L.C. __ (Sept. 21, 2022), https://tinyurl.com/2u9dw92p.

ii. Preemption

Here, the Secretary has also acted in accordance with his congressionally delegated duties to enact rules and regulations preempting the application of conflicting state laws to VA employees providing care pursuant to their federal duties. Specifically, in November 2020, the VA issued an Interim Final Rule, 38 C.F.R. 17.419(c), that preempts state laws that prohibit VA health care providers from providing services within the scope of their employment:

> Preemption of State law. Pursuant to the Supremacy Clause, U.S. Const. art. IV, cl. 2, and in order to achieve important Federal interests, including, but not limited to, the ability to provide the same complete health care and hospital service to beneficiaries in all States as required by 38 U.S.C. 7301, conflicting State laws, rules, regulations or requirements pursuant to such laws are without any force or effect, and State governments have no legal authority to enforce them in relation to actions by health care professionals within the scope of their VA employment.[73]

Under the clear text of this provision, any conflicting antiabortion state laws are explicitly preempted.[74]

* * *

Thus, under both the Supremacy Clause and the explicit preemption regulation adopted by the Secretary, any conflicting state laws banning or limiting access to abortion would be preempted.

II. The Secretary Has Broad Authority to Provide Coverage for Abortion Care and Counseling Under CHAMPVA Health Insurance

A. The Relevant Statutory and Regulatory Scheme Authorizes the Provision of Medical Care that is "Medically Necessary and Appropriate"

The CHAMPVA statutory and regulatory scheme similarly ground the care determination for insurance coverage by CHAMPVA on medical need, and thus also provide authority for the Secretary to have CHAMPVA provide coverage for abortion care and abortion counseling in *all* cases. This analysis again begins with the text of the relevant statutory and regulatory provisions.

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[73] 38 C.F.R. 17.419(c).

[74] The recent decision in *Texas v. Becerra*, No. 5:22-CV-185-H, 2022 WL 3639525 (N.D. Tex. Aug. 23, 2022)—where a federal district court found that the preemption statute in the Emergency Medical Treatment & Labor Act ("EMTALA") did not preempt Texas abortion laws—is inapposite. For starters, the preemption provision in EMTALA "do[es] not preempt any State or local law requirement, except to the extent that the requirement directly conflicts with a requirement of this section." 42 U.S.C. 1395dd(f). And the scope of care that EMTALA requires is narrower—requiring that physicians at hospitals receiving Medicare funds offer stabilizing treatment to patients who arrive with emergency medical conditions, 42 U.S.C. 1395dd(e)(1)(A)(i)–(iii). Simply put, the possible conflict between federal and state law that arises under EMTALA does not arise in the same circumstances as it does with the Interim Final Rule. In any event, another federal court has held that EMTALA preempts aspects of state law criminalizing abortion care. *See United States v. Idaho*, No. 22-CV-0329, 2022 WL 3692618, at *7–*15 (D. Idaho Aug. 24, 2022). The preemption of conflicting state abortion laws under EMTALA supports that the more sweeping preemption language in 38 C.F.R. 17.419(c) grants VA health providers affirmative license to provide complete care and services in the scope of their employment irrespective of contradictory state law or regulation.

Congress established the Civilian Health and Medical Program of the Department of Veterans Affairs ("CHAMPVA") through the Veterans Health Care Expansion Act of 1973.[75] Congress designed the insurance program to benefit the spouses, surviving spouses, and children of seriously disabled or deceased veterans who were not eligible for the existing coverage under the Department of Defense TRICARE[76] program.[77] The program was designed to provide a similar style of health insurance solution to TRICARE.[78]

The Veterans Health Care Expansion Act of 1973 required that the Secretary "provide for medical care in the same or similar manner and subject to the same or similar limitations as medical care is furnished to" TRICARE recipients.[79] The enacting regulations further provide that CHAMPVA benefits "cover allowable expenses for medical services and supplies that are *medically necessary and appropriate* for the treatment of a condition and that are not specifically excluded from program coverage."[80]

It is important to note that even before the Interim Final Rule, the Secretary (and the Secretary of Defense) had already determined that some abortion care was "medically necessary and appropriate." TRICARE already covers abortions "where the life of the mother would be endangered if the fetus were carried to term or in a case in which the pregnancy is the result of an act of rape or incest."[81] And CHAMPVA already provided coverage for abortions where the life of the pregnant individual would be at risk if the pregnancy were carried to term.[82] Those decisions were made well before the Interim Final Rule.

Like the "need for care" criterion for providing care to veterans under 38 U.S.C. 1710, the "medically necessary" criterion for provision of care to CHAMPVA beneficiaries is grounded in medical judgment. The American Medical Association ("AMA") defines medically necessary treatments as:

> Health care services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms in a manner that is: (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate in terms of type, frequency, extent, site, and duration; and (c) not primarily for the economic benefit of the

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[75] Pub. L. No. 93-82, 87 Stat. 179 (1973) (codified at 38 U.S.C. 1781 *et seq*.).

[76] TRICARE Select, the basic Department of Defense healthcare plan, was then known as the Civilian Health and Medical Program of the Uniformed Services ("CHAMPUS"). *See* Civilian Health and Medical Program of the Department of Veteran Affairs, 87 Fed. Reg. 41,594-02 (July 13, 2022) (to be codified at 38 C.F.R. pt. 17).

[77] *See* U.S. Dept. of Veterans Affairs, CHAMPVA benefits (Jan. 12, 2022), https://tinyurl.com/2bfpu5ax.

[78] *See* 119 Cong. Rec. S14769 (daily ed. July 26, 1973) (statement of Sen. Vance Hartke) (describing the CHAMPVA proposal as setting forth "independent [TRICARE]-type contract[s] with . . . private insurer[s]" except for situations where "VA facilities are not being fully utilized for the care of eligible veterans"); 119 Cong. Rec. H6193 (daily ed. July 17, 1973) (statement of Rep. Elwood Hillis) (describing CHAMPVA as "similar to" TRICARE).

[79] 38 U.S.C. 1781(b). TRICARE similarly requires provision of care that the Secretary of Defense deems "medically or psychologically necessary care." *See* 10 U.S.C. 1079(a)(12); 32 C.F.R. 199.2(b).

[80] 38 C.F.R. 17.272(a) (emphasis added).

[81] 10 U.S.C. 1093.

[82] 38 C.F.R. 17.272(a)(64)–(65) (1998).

> health plans and purchasers or for the convenience of the patient, treating physician, or other health care provider.[83]

And numerous major insurers define medical necessity as follows:

Insurance Provider	**Definition of 'medical necessity'**
Anthem	"Health care services or supplies that are a reasonable part of [patient] care."[84]
Cigna	"[H]ealth care services that a physician, exercising prudent clinical judgment, would provide to a patient" within generally accepted standards of medical practice.[85]
Humana	"A professional health service will be 'medically necessary' if it meets (at minimum) the following conditions: In accordance with nationally recognized standards of medical practice; Clinically appropriate; Not primarily for the convenience of the patient or provider; Not more costly than an alternative service; [and] Performed in the least costly site."[86]

In proposing amendments to CHAMPVA coverage in the past, the agency itself has been explicit that the amendments were needed to "permit coverage of [medical care] that [is] considered medically necessary and appropriate within the medical community and reflect[s] medical practice that is supported by current medical literature."[87]

B. The Secretary Has the Authority to Authorize Insurance Coverage of *All* Abortion Care Under the Regulations

Because the "medically necessary" determination for provision of medical services to CHAMPVA beneficiaries is similarly grounded in medical judgment, the reasons outlined above for supporting the provision of abortion care and counseling to veterans under the "need for care" determination in 38 U.S.C. 1710 apply with equal force here. *See supra*, Part I.C.

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[83] *Definitions of "Screening" and "Medical Necessity"*, AM. MEDICAL ASS'N (2016), https://tinyurl.com/yc44u6jf.

[84] *Glossary*, ANTHEM, https://tinyurl.com/yeys5pa2.

[85] *Medical Necessity Definitions*, CIGNA, https://tinyurl.com/fr82kvje.

[86] *Healthcare plan rules explained in plain language*, HUMANA, https://tinyurl.com/5xdeuajn.

[87] U.S. Dept. of Veterans Affairs, Semiannual Reg. Agenda, 46 (Nov. 24, 2008), https://tinyurl.com/2p9r47xs.

In addition, looking at the AMA definition for "medically necessity" set out above (as well as other industry definitions), it is clear that abortion care and counseling readily qualify as such "medically needed" care. To start, abortion care is generally accepted within the standards of medical practice. As noted above, the procedure is incredibly common and integrated into mainstream healthcare practices, with over 860,000 abortions having been performed in the U.S. in 2017.[88] The AMA recently "adopted policy recognizing that it is a violation of human rights" for governments to deny "safe, evidence-based reproductive health services, including abortion and contraception."[89] Simply put, abortion care is widely recognized in medical practice as "essential and medically necessary healthcare."[90]

Access to abortion care is also not a matter of convenience, which is the second prong of the AMA definition. As Justice Breyer explained in his dissent in *Dobbs*, individuals who are forced to carry an unwanted pregnancy face "significant personal or familial cost. At the least . . . the cost of losing control over their lives."[91] And losing access to abortion "not only . . . affect[s] the course of [a woman's] life" but also "alter[s] her 'views of [herself]' and her understanding of her 'place[] in society] as someone with the recognized dignity and authority to make these choices.'"[92] Access to abortion implicates interests much more fundamental than simple convenience—it "safeguards women's freedom and equal station."[93]

And, under the third prong of the AMA definition, there is no economic benefit motivating the performance of these procedures. In fact, the reality is that abortion clinics often face a mountain of costs—security details, higher rents, and budgets for legal fees—that some providers refer to as the "abortion tax."[94]

Given that abortion care so obviously qualifies as medically needed treatment, it is not surprising that major insurance providers cover elective abortions. For example, Anthem "allows reimbursement of induced abortions," including elective abortions, as a default.[95] And "[s]tandard Cigna benefit plans consider both elective and therapeutic abortion to be covered benefits."[96] The Secretary should construe elective abortions to be "medically necessary and appropriate" under CHAMPVA in order to align it more closely with other major insurance providers.

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[88] Jones, *supra* n.34, at 7.

[89] Kevin B. O'Reilly, *With Abortion Under Attack, Doctors Push Back on Criminalizing Care*, AM. MEDICAL ASS'N (June 14, 2022), https://tinyurl.com/mry7djje.

[90] Greer Donley et al., *The Legal and Medical Necessity of Abortion Care Amid the COVID-19 Pandemic*, 7 J. OF L. AND THE BIOSCIENCES 1, 2 (Apr. 29, 2020).

[91] 142 S. Ct. at 2319 (Breyer, J., dissenting).

[92] *Id.* at 2346 (quoting *Planned Parenthood v. Casey*, 505 U.S. 833, 851, 856 (1992)).

[93] *Id.* at 2350.

[94] Cynthia Koons et al., *Abortion Clinics Are Getting Nickel-and-Dimed Out of Business*, BLOOMBERG BUSINESSWEEK (Feb. 28, 2020), https://tinyurl.com/39sd2yf7.

[95] *Reimbursement Policy: Abortion*, ANTHEM BLUECROSS (July 13, 2020), https://tinyurl.com/28puy2ff.

[96] *Administrative Policy: Abortion*, CIGNA, https://tinyurl.com/bdhez5h2.

C. The Statutory Mandate that CHAMPVA Care Be "Same or Similar" to TRICARE Does Not Prevent the Secretary from Providing More Expansive Coverage

The Secretary is correct that the requirement that CHAMPVA care be the "same or similar" to that provided under TRICARE does not prevent the Secretary from adopting the Interim Final Rule here, or the more expansive final rule we urge him to adopt covering *all* abortion care, *see supra*. By using both "same" *and* "similar," the statutory text makes clear that perfect equivalency with TRICARE is not required. Reading 38 U.S.C. 1781 to require as much would read "similar" entirely out of the statute. But this "runs aground on the so-called surplusage canon—the presumption that each word Congress uses is there for a reason."[97] Here, the word "similar" signals that care need not be the *identical* to that provided under TRICARE, so long as the benefits offered to CHAMPVA beneficiaries are sufficiently alike.[98]

Notably, the agency has consistently read the "same or similar" mandate to allow for deviations in the care provided under CHAMPVA. Just recently the Secretary explained:

> The phrase "same or similar manner" does not require [TRICARE and CHAMPVA] to be administered in an identical manner. Rather, we broadly interpret this language as affording us needed flexibility to administer the program for CHAMPVA beneficiaries. For this reason, not every aspect of CHAMPVA will find a corollary in the [TRICARE] Plan.[99]

And in a proposed 2018 update to CHAMPVA, the VA noted that it will provide services not covered in TRICARE "when broadly interpreting [the mandate to provide same or similar care to TRICARE], [it] conclude[s] it lies within [its] discretion to determine that [the] benefit should be made available to all CHAMPVA beneficiaries."[100] Specifically, the VA proposed covering physical examinations for all CHAMPVA recipients, even though TRICARE limited coverage of those examinations to "certain dependents of Active Duty military personnel who are travelling outside the United States and for beneficiaries ages 5 through 11 who require such exams for school enrollment."[101] The VA explained that it did not "believe limiting the provision of annual physical examinations to only a few select groups," as TRICARE did, "was appropriate from a clinical perspective."[102]

Here, because TRICARE already covers abortions "where the life of the mother would be endangered if the fetus were carried to term or in a case in which the pregnancy is the result of an act of rape or incest,"[103] and because the Secretary is acting consistent with medical practice and judgment to cover care that he has deemed a "medical necessity," his expansion of abortion

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[97] *Advoc. Health Care Network v. Stapleton*, 137 S. Ct. 1652, 1659 (2017).

[98] Merriam-Webster Dictionary, "Similar", https://tinyurl.com/2brsvfc9 (defining similar as "having characteristics in common: strictly comparable; alike in substance or essentials").

[99] 87 Fed. Reg. 41,594-02 (July 13, 2022).

[100] 83 Fed. Reg. 2401 (Jan. 17, 2018) (to be codified at 38 C.F.R. pt. 17).

[101] *Id*.

[102] *Id*.

[103] 10 U.S.C. 1093.

coverage for CHAMPVA beneficiaries more than meets the statutory requirement that CHAMPVA coverage be "similar" to that provided under TRICARE. And this is true both under the Interim Final Rule and under the more expanded final rule we urge the Secretary to adopt.

D. VA Facilities Should Provide Abortion Care and Counseling to CHAMPVA Beneficiaries

To ensure that CHAMPVA beneficiaries are able to access the abortion care covered under the Interim Final Rule—and under the expanded final rule that we urge the Secretary to adopt, *see supra*—it is imperative that the Secretary exercise the full extent of his authority "to carry out such purposes [to provide medical care to CHAMPVA beneficiaries] through the use of such facilities not being utilized for the care of eligible veterans."[104] As noted above, unlike the direct care provided to veterans under 38 U.S.C. 1710, CHAMPVA functions as a health insurance program to "cover allowable expenses for medical services and supplies."[105] So it does not mandate that covered medical care be provided at VA facilities. The statute does, however, *authorize* such provision of care at VA facilities. It does so through the CHAMPVA In-House Treatment Initiative ("CITI"): treatment from a VA provider at a VA facility, on a resource-available basis.[106]

The Secretary must therefore ensure that VA facilities across the country—particularly in localities where abortion services are banned or restricted—fully participate in CITI so that CHAMPVA beneficiaries can have access to abortion services at their local VA facilities, immediately under the Interim Final Rule and in the future under an expanded final rule covering all abortion care. Otherwise, CHAMPVA beneficiaries will be required to travel out-of-state to secure necessary—and often time-sensitive—abortion care. And in practice, this will mean that many CHAMPVA beneficiaries will be unable to access the abortion care and counseling covered under the Interim Final Rule and under any expanded final rule.

III. The Secretary Has the Power to Provide Emergency Abortion Care to Persons with No Eligibility

Finally, in addition to the abortion services outlined above and in the Interim Final Rule, we urge the Secretary to issue guidance regarding the provision of emergency abortion care to individuals not otherwise eligible for services at VA facilities, including civilians and active-duty service members.[107] The statute grants VA the authority to "furnish hospital care or medical

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[104] 38 U.S.C. 1781(b).

[105] 38 C.F.R. 17.272(a).

[106] 38 U.S.C. 1781(b) ("In cases in which Department medical facilities are equipped to provide the care and treatment, the Secretary is also authorized to carry out such purposes through the use of such facilities not being utilized for the care of eligible veterans."). This authority is subject to capacity limitations. *See id.* And Medicare recipients are not eligible for care through the CITI program. *See* 83 Fed. Reg. 2398 (Jan. 17, 2018) ("With regards to CHAMPVA beneficiaries receiving care in VA medical facilities through CITI, we have historically interpreted section 1781(b) to mean that such care may be provided only if the CHAMPVA beneficiary is not also eligible for Medicare benefits.").

[107] A recent report by the Rand Corporation estimates "that 40 percent of active-duty service women in the continental United States will have no or severely restricted access to abortion services where they are stationed." Kyleanne M. Hunter et al., How the Dobbs Decision Could Affect U.S. National Security, RAND CORPORATION, 3

services as a humanitarian service in emergency cases" so long as the Secretary "charge[s] for such care and services at rates prescribed by the Secretary."[108] The statute further provides that

> In the case of a hospital of the [VA] that has an emergency department, if *any individual* comes to the hospital or the campus of the hospital and a request is made on behalf of the individual for examination or treatment for a medical condition, the hospital *must* provide for an appropriate medical screening examination within the capability of the emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition exists.[109]

Moreover, if an individual is determined to have an "emergency medical condition, the hospital must provide either—(A) within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition; or (B) for transfer of the individual to another medical facility in accordance" with certain guidance concerning the stabilization of patients.[110] The statute defines "emergency medical condition" as "a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of 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 . . . ."[111] In line with the statutory authority, the regulations recognize that the VA is authorized to provide "[e]mergency hospital care" even to "[p]ersons having no eligibility, as a humanitarian service,"[112] and as recently as this year, the VA issued a directive recognizing the duty of VA emergency rooms to treat an "individual who is not eligible for VA health care benefits" where he or she presents with an "emergency medical condition."[113]

Without a doubt, some pregnancy complications qualify as an "emergency medical condition" such that emergency abortion care is authorized—in fact, required—under the statute. For example, ectopic pregnancies, in which a fertilized egg attaches outside of the uterus, can rupture the fallopian tube and cause fatal bleeding. Approximately 2% of all pregnancies are ectopic pregnancies and can result in death without timely medical care.[114]

We therefore urge the Secretary to issue appropriate guidance to VA facilities across the country concerning the provision of emergency abortion care to pregnant individuals who would

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(Sept. 2022). Some of these active-duty service members may be stationed in areas where emergency abortion care would be restricted or nonexistent absent access to care at VA facilities.

[108] 38 U.S.C. 1784.

[109] *Id.* at 1784A(a) (emphasis added).

[110] *Id.* at 1784A(b).

[111] *Id.* at 1784A(e)(2)(A).

[112] 38 C.F.R. 17.43(b)(1).

[113] VHA Directive 1601A.02(3) (July 6, 2022).

[114] *See* Caitlin Gauvin et al, *Previously Asymptomatic Ruptured Tubal Ectopic Pregnancy at Over 10 weeks' Gestation: Two Case Reports*, CASE REPS. IN WOMEN'S HEALTH (Nov. 15, 2018), https://tinyurl.com/2p9cp48y.

not otherwise qualify for care at such facilities, including civilians and active-duty service members. Doing so—and thus ensuring that pregnant persons, no matter where they live, have access to a reliable abortion provider when a pregnancy complication presents an emergent risk to their life or health—would undoubtedly save countless lives.[115]

* * *

In sum, Vet Voice Foundation fully supports the move by the Secretary to provide abortion care and counseling to veterans and CHAMPVA beneficiaries where the life or health of the pregnant person would be endangered if the pregnancy were carried to term, and in cases where the pregnancy is the result of rape and incest. And because the medical evidence supports the conclusion that access to abortion care preserves, promotes, and restores health, we urge him to expand access in the final rule to cover abortion care in *all* cases. We also urge the Secretary to work with VA facilities across the country—particularly in states that have moved to restrict access to abortion care in the wake of *Dobbs*—to ensure that CHAMPVA beneficiaries can access abortion care at those VA facilities pursuant to the CITI program. And finally, we further urge the Secretary to issue guidance to VA facilities setting out that their duty to provide care for all individuals—including civilians and active-duty service members—who present with an emergency medical condition includes the duty to provide emergency abortion care.

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[115] Notably, although the Biden administration has issued clarifying guidance reaffirming that emergency abortion care remains available under federal law, *see* U.S. Dept. of Health and Human Services, Following President Biden's Executive Order to Protect Access to Reproductive Health Care, HHS Announces Guidance to Clarify that Emergency Medical Care Includes Abortion Services (July 11, 2022), https://tinyurl.com/z5e3txy5, since *Dobbs*, "emergency health care providers in states that ban abortion have had to make wrenching legal and ethical judgments before treating a pregnant woman whose health or life may be in peril," and pregnant women presenting with emergency medical conditions are being put in life-threatening circumstances. *See* Christine Vestal, *Some Abortion Bans Put Patients, Doctors at Risk in Emergencies*, PEW, Sept. 1, 2022, https://tinyurl.com/34sfttt5; *see also* Reena Diamante, *'Abortion saved my life': Texas Veteran Voices Support For VA Abortion Services Plan*, SPECTRUM NEWS 1, Sept. 20, 2022, https://tinyurl.com/mfw9c5ru (noting that "'[t]here are Texas women who've been turned away with life-risking conditions, because the hospital was worried that provided this care that they would be subject to criminal penalties . . .'").