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Submitted electronically via regulations.gov

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

Re: Comment on Proposed Rule: *Reproductive Health Services*, Docket No. VA-2025-VHA-0073

Dear Dr. Lieberman:

Minority Veterans of America (MVA) is a nationwide, nonpartisan non-profit that works to create belonging and advance equity and justice for the minority veteran community—more than 10 million veterans who are women, people of color, LGBTQI+, or non-religious/religious minority, many of whom have felt marginalized, unseen, or unheard during their time in military service and after. We strive to be the most diverse, inclusive, and equitable veteran-serving organization in the country and believe that by creating an intersectional movement of minority veterans, we can build a collective voice capable of influencing critical change. MVA provides that voice before Congress and agencies like the Department of Veterans Affairs (VA), on behalf of its thousands of members.

MVA's work also includes efforts to improve veterans' lives by offering resources and programs to help support veterans through social engagement, community connection, financial stability, and leadership development. This work puts us in contact with veterans—many from historically underserved populations—in need of accessible and affordable comprehensive reproductive healthcare services. The lived experiences of these veterans reflect their historical exclusion from and poor treatment by healthcare institutions, resulting in negative health outcomes.

MVA appreciates the opportunity to comment on VA's proposed rule on *Reproductive Health Services*, Docket No. VA-2025-VHA-0073 (the "Proposed Rule"), which would modify VA's medical benefits package by removing access to abortion care for veterans when the veteran's health would be endangered if the pregnancy was carried to term, and for veterans who became pregnant by rape or incest. The Proposed Rule would likewise eliminate access to any abortion counseling by VA providers. The preamble to Proposed Rule states that VA will continue to permit abortion care where a physician certifies that the life of the veteran would be endangered by the pregnancy, but it does not propose codifying that exception anywhere or explicitly permitting abortion counseling in those situations. The Proposed Rule similarly rolls back access to abortion and abortion counseling for beneficiaries of the Civilian Health and Medical Program of the VA (CHAMPVA), though it does propose codifying a life exception.

For the reasons that follow, MVA vehemently opposes the Proposed Rule, which will harm the health and well-being of the veteran community.

Veterans have a unique confluence of medical risks that make them particularly vulnerable to health complications during their pregnancies. Restricting their access to abortion care will only place the community at further risk. Restricting access to abortion care for veterans who become pregnant from rape will only retraumatize assault victims, likewise causing increased harm to veterans. And forbidding VA providers from offering abortion counseling will hamper access to necessary medical care and undermine veterans' trust in VA services.

MVA asks that VA withdraw the Proposed Rule, leaving access to abortion care in place when the life or the health of the pregnant veteran would be endangered if the pregnancy were carried to term, and for pregnancies that result from rape and incest, as currently permitted by the existing Rule.

A growing share of the veteran population are women who receive healthcare through VA.

Our nation's veterans have dedicated their lives to serving their country. That service comes with tremendous sacrifices, from spending extended periods far from their homes and families to risking their health, safety, and well-being. It also comes with catastrophic health consequences for veterans because of exposure to toxic substances, physical trauma from combat and training, and posttraumatic stress disorder (PTSD), depression, and anxiety. The United States has long recognized this sacrifice by providing "hospital care and medical services" to certain eligible veterans.[1] Veterans in turn rely on and value their VA healthcare to access providers who have a specialized understanding of military culture, particularly the unique service-connected health conditions so many veterans experience.

Women are the fastest growing group of veterans, with an estimated population of more than 2,000,000 women veterans in 2025.[2] Of the approximately 600,000 women veterans who access their healthcare through VA, half are of childbearing age.[3] The women who access their healthcare services through VA are racially and ethnically diverse, with over 43% belonging to a racial or ethnic minority group.[4]

Women are also increasingly likely to have a service-connected disability. Today, nearly three out of four women veterans accessing care through VA have a service-connected disability.[5] The numbers are higher for women of childbearing age: of women veterans who are 18 to 44 years old, 83% have a service-connected disability rating.[6]

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[1] 38 U.S.C. § 1710(a)(1) through (3).
[2] U.S. Dep't of Veterans Affairs (VA), *Women Veterans Health Care Facts and Statistics* (2022), https://perma.cc/6MN2-LK92.
[3] U.S. Dep't of Veterans Affairs, Office of Inspector General (VA OIG), *Review of Veterans Health Administration Reproductive Health Services* i (Sept. 28, 2023), https://perma.cc/GTH9-73J2.
[4] VA, *Women Veterans Health Care Facts and Statistics* (2022), *supra* note 2.
[5] Jessica Y. Breland et al., *Sourcebook: Women Veterans in the Veterans Health Administration. Volume 5: Longitudinal Trends in Sociodemographics and Utilization, Including Type, Modality, and Source of Care*, U.S. Dep't of Veterans Affairs 15 (June 15, 2024), https://perma.cc/GGP8-ED8B.
[6] *Id.*

The share of family members accessing their healthcare through CHAMPVA has likewise increased in recent years. Between FY2001 and FY2023, CHAMPVA enrollments grew by 629%, from 96,500 to 703,600 beneficiaries.[7]

Veterans are at significant risk of pregnancy complications that may require abortion care to protect their health, well-being, and future fertility.

Removing access to abortion care will cause tremendous harm in situations where the health of the pregnant veteran would be endangered if the pregnancy were carried to term. Veterans tend to have a constellation of health conditions that put them "at high risk for complications of pregnancy including severe maternal morbidity and pregnancy associated death," a troubling reality recognized by the Regulatory Impact Analysis (RIA) accompanying the Proposed Rule.[8] Forbidding access to abortion care when the health of the pregnant veteran is endangered will only cause further harms. The Proposed Rule ignores the significant data showing potential health consequences of carrying such pregnancies to term, including the data cited by the current Rule.[9]

Pregnancy in the United States can be dangerous. The United States ranks last in maternal mortality rates among high income countries, with a maternal mortality rate triple that of Sweden, Japan, the Netherlands, Germany, the United Kingdom, and France.[10] In 2023, the maternal mortality rate in the United States was 18.6 deaths for every 100,000 live births.[11] Black women are particularly vulnerable: the maternal mortality rate for Black women is more than three times the rate for white women.[12] Older women and women living in the deep South likewise have higher rates of maternal mortality.[13]

Severe maternal morbidity—"unexpected outcomes of labor and delivery that can result in significant short- or long-term health consequences"—is likewise on the rise in the United States.[14] Approximately 50,000 to 60,000 women each year are affected by severe maternal morbidity, with many cases being preventable.[15] Indicators of severe maternal morbidity include the need for blood transfusions and sepsis.[16] As with maternal mortality, Black women are more than twice as likely as white women to experience severe maternal morbidity.[17]

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[7] Sidath Viranga Panangala, Cong. Rsch. Serv., RS22483, *Health Care for Dependents and Survivors of Veterans* 2 (2024), https://perma.cc/7J8A-ULY5.
[8] U.S. Dep't of Veterans Affairs (VA), *Regulatory Impact Analysis for RIN 2900-AS31(P), Reproductive Health Services* 6 (July 30, 2025).
[9] *Reproductive Health Services*, 87 Fed. Reg. 55291–93 (Mar. 4, 2024).
[10] Eugene Declercq & Laurie C. Zephyrin, *Maternal Mortality in the United States, 2025*, The Commonwealth Fund (July 29, 2025), https://perma.cc/5SUG-6LMT.
[11] Donna L. Hoyert, *Health E-Stat 100: Maternal Mortality Rates in the United States, 2023*, Ctr. for Disease Control & Prevention (Feb. 2025), https://perma.cc/D33R-PN7S.
[12] *Id.*
[13] Declercq & Zephyrin, *supra* note 10.
[14] Ctr. for Disease Control & Prevention, *Severe Maternal Morbidity* (May 15, 2024), https://perma.cc/BNJ8-7GLT.
[15] Eugene Declercq & Laurie C. Zephyrin, *Severe Maternal Morbidity in the United States: A Primer*, The Commonwealth Fund (Oct. 28, 2021), https://perma.cc/Y7TH-3CCV.
[16] *Id.*
[17] *Id.*

These risks are particularly pronounced for veterans. Veterans have "high rates of chronic medical and mental health conditions that may increase pregnancy-associated morbidity."[18] Veterans with depression or PTSD—which impacts an estimated 24% of women veterans[19]—may be at increased risk for gestational diabetes and hypertensive disorders such as preeclampsia.[20] And pregnant veterans are more likely than the civilian population to experience maternal chronic hypertension, which is in turn associated with increased risk of adverse maternal outcomes, again including severe maternal hypertension and preeclampsia.[21] VA has reported that mental health conditions "are more common among pregnant veterans than non-pregnant veterans and pregnant women in the general population," which may increase the risk of suicide.[22] Many veterans also delay their choice to have children because of their military service, placing them at increased of adverse health outcomes because of their advanced maternal age.[23]

Veterans are likewise at significant risk for severe maternal morbidity, at an increasing rate. For VA-paid delivery hospitalizations, the severe maternal morbidity rate nearly doubled in recent years, from 93.5 per 10,000 hospitalizations in fiscal year 2011 to 184.6 per 10,000 in fiscal year 2020.[24] These risks are further compounded for Black and brown veterans. Because of underlying structural and societal inequities, these women face unacceptably high rates of maternal mortality and morbidity.[25] Black veterans face higher rates of maternal morbidity at every health stage when compared with white veterans.[26]

For pregnant veterans, abortion care may be necessary to prevent their health from further deteriorating. Take a pregnant veteran experiencing severe preeclampsia before viability. When

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[18] Colleen Judge-Golden et al., *Prior Abortions and Barriers to Abortion Access Reported by Pregnant Women Veterans*, 37 J. Gen. Intern. Med. 816, 816 (2022), https://perma.cc/Z3PT-CQYN; *see also* Breland et al., *supra* note 5, at 22 ("Coordinated and inclusive services are crucial given that many Veterans who use VHA often have intersecting characteristics associated with adverse pregnancy outcomes and severe maternal morbidity, such as belonging to a minoritized racial/ethnic group, advanced maternal age, or serious comorbidities like [PTSD]."); U.S. Dep't of Veterans Affairs & U.S. Dep't of Defense, *VA/DoD Clinical Practice Guideline For The Management Of Pregnancy* 12 (July 2023), https://perma.cc/9XAH-S9XQ ("Veterans might be at especially high risk for adverse pregnancy outcomes because the prevalence of comorbid conditions is higher among Veterans than among their civilian counterparts.").

[19] U.S. Dep't of Veterans Affairs, *How Common is PTSD in Veterans?* (2025), https://perma.cc/YFC2-4K8Q.

[20] U.S. Gov't Accountability Off. (GAO), *VA Should Improve Its Monitoring of Severe Maternal Complications and Mental Health Screenings* 10 (Jan. 2024), https://perma.cc/23CQ-QFRC.

[21] Ceshae C. Harding et al., *Maternal chronic hypertension in women veterans*, 59 Health Serv. Resch. 2 (2024), https://perma.cc/U5ZB-FR5M.

[22] GAO, *VA Should Improve Its Monitoring of Severe Maternal Complications and Mental Health Screenings, supra* note 20, at 10–11.

[23] Breland et al., *supra* note 5, at 22 (noting a quarter of VHA-covered deliveries "were in Veterans of advanced maternal age (35+ years old)" and recognizing advanced maternal age can be associated with adverse pregnancy outcomes).

[24] GAO, *VA Should Improve Its Monitoring of Severe Maternal Complications and Mental Health Screenings, supra* note 20, at 14.

[25] Judge-Golden et al., *supra* note 18, at 816.

[26] GAO, *VA Should Improve Its Monitoring of Severe Maternal Complications and Mental Health Screenings, supra* note 20, at 16.

severe preeclampsia is diagnosed before fetal viability, patients face "very high rates of maternal complications including pulmonary edema, renal insufficiency, eclampsia, admission to the intensive care unit, and even maternal death accompanied by very low chance of survival for the neonate."[27] Allowing abortion care only when a patient deteriorates to the point where her life is endangered is insufficient. If a patient is unable to obtain an abortion—the recommended treatment to protect her health—her health may continue deteriorating, causing long-term consequences for her well-being and future fertility, as well as impacting current family. Contrary to the conclusion of the Proposed Rule, these are "needed" medical services.

Under the Proposed Rule, a pregnant veteran would no longer be able to access this care through VA, or even counseling about her options when she faced the need. If she lives in a state with abortion restrictions, she will then be forced to travel out of state and find the requisite funds to travel for herself and any travel companions, for childcare, and the care itself, all in the midst of a health crisis. This will only cause unnecessary suffering for veterans and their families.

Veterans need access to abortion care and counseling for pregnancies that are the result of rape and incest.

Veterans are at elevated risk of experiencing sexual assault and rape, perhaps more so than any other population. Removing access to abortion care and counseling for veterans who become pregnant as the result of rape or incest risks is cruel and risks compounding acute mental health harms for veterans at a time when VA should be providing needed care. About one in three women veterans tell their VA healthcare provider that they experienced sexual harassment or assault while in the military.[28] Women veterans who experience sexual trauma in the military are more likely to experience PTSD and are at an increased risk of committing suicide.[29] Military sexual trauma is likewise associated with a range of medical conditions, including chronic pulmonary disease, liver disease, obesity, weight loss, and hypothyroidism.[30]

For veterans, the mental health consequences of sexual assault are magnified because of the military setting.[31] While still in service, victims are often forced to continue living and working with their assailants, increasing the prospect of revictimization and distress.[32] And pressure for unit cohesion may strongly encourage victims to "keep silent about their experiences, have their reports ignored, or are blamed by others for the sexual assault, all of which have been linked to poorer outcomes among civilian assault survivors."[33]

Veterans are at particular risk of experiencing repeat sexual assault following their service, also known as revictimization. Revictimization is "alarmingly common": for women who have been

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[27] Katrina Mark, *Abortion in women with severe preeclampsia and eclampsia prior to 24 weeks gestation*, 103 Contraception 420 (2021).
[28] U.S. Dep't of Veterans Affairs (VA), *Military Sexual Trauma*, https://perma.cc/6JKQ-MP6L.
[29] Rachel Kimerling et al., *The Veterans Health Administration and Military Sexual Trauma*, 97 Am. J. Pub. Health 2160, 2164 (Dec. 2007), https://perma.cc/H4XW-5B5B.
[30] *Id.* at 2163.
[31] *Id.* at 2160.
[32] *Id.*
[33] *Id.*

raped, over half experience more than one rape.[34] One study examining sexual revictimization among veterans found that 71% of their sample reported experiencing more than one rape in their lifetimes. Approximately 30.3% of women who were sexually assaulted during their military service also report sexual assault while a civilian.[35] Experiencing sexual revictimization places victims at increased risk of developing PTSD, and victims report greater general mental health symptoms.[36]

Abortion access and counseling are necessary to protect the metal health and well-being of veterans who become pregnant in these circumstances. Such pregnancies are all too common. The CDC has found that over three million women have experienced pregnancy resulting from rape during their lifetimes.[37] Being forced to carry such a pregnancy to term and give birth may compound the trauma stemming from the sexual assault, as well as compound existing mental conditions or cause new mental health consequences, such as anxiety, depression, or PTSD. That experience can be "shatter[ing]," as one lawyer described.[38] She represented a veteran who was raped during her military service and learned she was pregnant after leaving active duty.[39] She was unable to access abortion care through VA and couldn't otherwise afford to pay for an abortion, and was therefore forced to carry the pregnancy to term and put the child up for adoption.[40] The "trauma derailed her"[41]—an experience that will be shared by more veterans if the Proposed Rule is permitted to go into effect.

We encourage VA to continue to allow veterans to access abortion care and counseling in cases of rape and incest.

Eliminating access to abortion counseling may cause veterans to distrust their VA providers.

MVA is particularly concerned about the decision to eliminate access to abortion counseling entirely.

Eliminating counseling prevents providers from discussing the full panoply of potential medical care with their patients, meaning patients can't understand the full range of medical options available to them. This undermines veterans' confidence in their providers and medical care. The counseling restriction is particularly problematic when coupled with the exception in the Proposed Rule allowing for abortion care when the life of the pregnant patient would be endangered. In this way, the Proposed Rule appears to allow clinicians to provide life-saving abortion care without ever discussing that care with their patients.

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[34] Vanessa Tirone et al., *Examining the Impact of Sexual Revictimization in a Sample of Veterans Undergoing Intensive PTSD Treatment*, 36 J. Interpersonal Violence 23 (2020), https://perma.cc/KG4Y-57LK.
[35] Kimerling et al., *supra* note 29, at 2164.
[36] Tirone et al., *supra* note 34.
[37] Ctr. for Disease Control & Prevention, *Pregnancy Resulting from Sexual Violence* (Oct. 28, 2024), https://perma.cc/NVV5-CK65.
[38] Chelsea Donaldson, *We Cannot Let America Abandon Female Veterans*, TN.Y. Times (Aug. 25, 2025), https://perma.cc/93B9-5RYP.
[39] *Id.*
[40] *Id.*
[41] *Id.*

The removal of abortion counseling is likewise concerning for members still in service. Community-based Vet Centers offer counseling to servicemembers who have experienced military sexual trauma.[42] Those current servicemembers are currently able to access abortion care in instances of rape or incest through the Department of Defense.[43] Forbidding VA counselors from discussing abortion care with servicemembers who are permitted to access such care is nonsensical. VA's counseling rule should be consistent with DoD's.

The proposed exception for life-threatening pregnancies must be codified.

We appreciate that the Proposed Rule will allow for veterans to access abortion care in life-threatening situations. But MVA is concerned that failing to codify that exception in regulatory text will render the exception ultimately meaningless. As drafted, the Proposed Rule proposes removing language from the medical benefit package allowing access to abortion care when "[t]he life or the health of the pregnant veteran would be endangered if the pregnancy were carried to term." Without this language, the medical benefits package will not affirmatively allow for access to abortion care when the life of a pregnant veteran is endangered. While the Proposed Rule states that life-saving abortion care was permitted before the current Rule, that is contrary both to MVA's understanding and to prior statements saying that all abortion care was prohibited at VA.[44]

MVA is concerned that, without specifically codifying that life-saving abortion care is permitted, VA providers might hesitate to provide this care. Indeed, a VA Inspector General (IG) report states that providers were reluctant to provide care permitted by the current rule.[45] Reports of patients who were denied life-saving abortion care have become all too common since the *Dobbs* decision.[46] Medical research also confirms that delaying care is dangerous for patients.[47] MVA respectfully

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[42] U.S. Dep't of Veterans Affairs, *Military Sexual Trauma* (2025), https://perma.cc/2TTQ-WHZZ.
[43] 10 U.S.C. § 1093(a).
[44] Judge-Golden et al., *supra* note 18, at 816 ("The Veterans Affairs (VA) Health Administration does not cover or provide abortion under any circumstances—a policy more stringent than the federal standard, which allows for coverage in cases of rape, incest, or life endangerment."); Eleanor Bimla Schwarz et al., *Induced Abortion among Women Veterans: Data from the ECUUN study*, 97 Contraception 41 (2017), https://perma.cc/649H-5SD3 (noting that "current policy prohibits VA provision of abortion counseling or services, even when pregnancy endangers a Veteran's life").
[45] VA OIG, *Review of Veterans Health Administration Reproductive Health Services* 9–11, *supra* note 3.
[46] *See e.g.*, Lizzie Presser & Kavitha Surana, *A third woman has died under Texas' abortion ban as doctors reach for riskier miscarriage treatments*, ProPublica (Nov. 27, 2024); https://perma.cc/8FB5-FPA6; Jericka Duncan & Deanna Fry, *Family of Georgia mother who died after delayed abortion care says Amber Thurman should still be alive: "It was preventable"*, CBS News (Nov. 1, 2024), https://perma.cc/W6MK-KALD; Carter Sherman, *Texas woman died after being denied miscarriage care due to abortion ban, report finds*, The Guardian (Oct. 30, 2024), https://perma.cc/555H-72RC; Mary Tuma, *Texas women denied abortions for ectopic pregnancies demand federal investigation*, The Guardian (Aug. 13, 2024), https://perma.cc/UTQ9-2TB7; Amanda Seitz, *Dozens of pregnant women, some bleeding or in labor, are turned away from ERs despite federal law*, AP (Aug. 14, 2024), https://perma.cc/26XM-BTHT
[47] Ashley N. Battarbee et al., *Society for Maternal-Fetal Medicine Consult Series #71: Management of Previable and Periviable Preterm Prelabor Rupture of Membranes*, 231 Am. J. Obstetrics & Gynecology B2, B7 (2024); Anjali Nambiar et al., *Maternal Morbidity and Fetal Outcomes Among Pregnant Women at 22 Weeks' Gestation or Less with Complications in 2 Texas Hospitals After Legislation on Abortion*, 227 Am. J. Obstetrics & Gynecology 648, 649 (2022).

requests that, should it proceed with the Proposed Rule, VA amend 10 C.F.R. § 17.38 so that it continues to affirmatively allow for abortion care and counseling when the life of the pregnant veteran would be endangered if the pregnancy were carried to term.[48]

The Proposed Rule also limits examples of life-threatening circumstances where abortion care would be appropriate to "ectopic pregnancies or miscarriages." That list fails to account for the far-greater range of potential medical conditions and complications that could become life-threatening to a pregnant patient. A recent letter from the U.S. Department of Health and Human Services to health care providers discussing their obligations under Emergency Medical Treatment and Labor Act specifically highlighted "premature ruptures of membranes, trophoblastic tumors, and other similar conditions."[49] We call on VA to similarly recognize that abortion is permitted for any condition a physician identifies as life-threatening. –

Socioeconomic barriers will prevent veterans who are denied access to care because of the Proposed Rule from traveling to access abortion care.

The Regulatory Impact Analysis accompanying the Proposed Rule estimates that 60% of women currently eligible to receive abortion care under the existing rule will now seek abortions elsewhere. This estimate relies on the percentage of enrolled veterans who currently reside in states without "high levels" of abortion restrictions. But this ignores the fact that, too often, the determining factor in whether a pregnant person receives abortion care is not where they live, but what they can afford.[50]

Most private insurance companies do not cover abortion care, and many patients report difficulty affording their abortion.[51] Some patients report delaying or not paying other bills in order to cover their abortion care.[52] Patients who have challenges raising funds to cover the cost of abortion care are often forced to delay care until later in their pregnancies when the costs of abortion are even higher.[53] For low income individuals, the cost of an abortion can be catastrophic and requires borrowing money or seeking support from donation-based funds.[54] This includes many veterans. Veterans who receive healthcare from VA often are of lower socioeconomic status than those with private insurance and therefore face more substantial barriers to accessing abortion care.[55]

Similarly, veterans who live in states with abortion restrictions may be forced to travel long distances, and incur significant expenses for gas or airfare, for lodging and food for themselves and a needed companion, for any childcare, and for their medical care, on top of lost wages. But for any veteran, the cost of paying for even just healthcare out of pocket may be too much. For the

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[48] The Proposed Rule does expressly codify the life exception for CHAMPVA beneficiaries.
[49] Ltr. From Robert F. Kennedy, Jr. to Health Care Providers 3 (June 13, 2025), https://perma.cc/85T9-2CPB.
[50] Ushma D. Upadhyay, et al., *State abortion policies and Medicaid coverage of abortion are associated with pregnancy outcomes among individuals seeking abortion recruited using Google Ads: A national cohort study*, 274 Social Science & Med. 1 (2021), https://perma.cc/L3ZH-ZARU.
[51] *Id.* at 2.
[52] *Id.*
[53] *Id.*
[54] *Id.*
[55] Judge-Golden et al., *supra* note 18, at 816.

thousands of women veterans experiencing homelessness, the financial barrier is particularly acute.[56]

Low demand does not mean that abortion care is "not needed."

The Proposed Rule appears to suggest that abortion care is not needed because current demand for that care does not meet the estimates set forth in the existing rule.[57] That conclusion cruelly disregards the over 400 veterans or family members who have been able to access life or health saving medical care, or care because they were raped or experienced incest. It likewise fails to account for the necessary time investment to onboard and offer new forms of medical care, the hesitancy of VA providers to offer this care, and the knowledge of patients about this care.

It is important to recognize that the scope of care available to veterans under the existing Rule is extremely narrow. Indeed, the RIA accompanying the Proposed Rule recognizes that the actual number of abortions provided was "significantly lower" than the estimate, which "likely reflects that VA has strictly adhered to the limitations of the option of provision of abortion to only those for whom continuing the pregnancy to term would endanger the life or health of the veteran or VA beneficiary and those cases where pregnancy is the result of rape or incest."[58] Care under the existing Rule is being offered to eligible veterans in precarious situations; it is worth providing regardless of volume. Indeed, VA does not withdraw access to other forms of necessary medical care, such dental, simply because a smaller percentage of veterans use them.

Suggesting that care is not necessary because of the lower than anticipated volume also ignores the burden on VA facilities to launch new medical services. Before the existing Rule, VA did not offer any abortion care at its facilities. To implement the Rule, each VA facility had to develop and implement plans to offer care in-house or identify resources in the community to offer patient care. This is a time- and resource-intensive process. A VA IG report recognized that, six months after the effective date of the current IFR, some facility leaders "acknowledged uncertainties regarding resources and plans for providing this care."[59] And many veterans are likewise unaware that VA offers reproductive health services at all,[60] let alone access to abortion care. All of these realities contributed to so-called low demand.

Moreover, VA clinicians in states with abortion restrictions likewise were slow to offer these services because of concerns about adequate protection from restrictive state laws. Indeed, VA's Office of Inspector General recognized that "[d]espite protection offered by the federal Supremacy Clause, [VA] providers were concerned that performing abortions or abortion counseling would place them at risk for civil or criminal liability, or disciplinary action by state licensing boards. Leaders also shared concerns regarding the logistics of exercising federal supremacy and the degree of protection provided."[61]

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[56] Schwarz et al., *supra* note 44 (noting that experiencing housing instability is a significant predictor of veterans' need for abortion care).
[57] *Reproductive Health Services*, 90 Fed. Reg. 36416 (Aug. 4, 2025).
[58] VA, *Regulatory Impact Analysis for RIN 2900-AS31(P), Reproductive Health Services*, *supra* note 8, at 4.
[59] VA OIG, *Review of Veterans Health Administration Reproductive Health Services*, *supra* note 3, at 9.
[60] Lori M. Gawron et al., *Women's Health Provider Perspectives on Reproductive Services Provision in the Veterans Health Administration*, 116 South Med. J. 181 (2024), https://perma.cc/L4K3-9GLC.
[61] VA OIG, *Review of Veterans Health Administration Reproductive Health Services*, *supra* note 3, at ii.

The volume of services provided under the Rule thus far, therefore, likely does not reflect the need for services. Rather, it reflects the narrow category of patients eligible for these services and the time- and resource-intensive nature of offering new services, among other challenges.

Veterans will be driven away from accessing VA services.

VA should be the primary source of care a place where eligible veterans can receive treatment from providers that understand their complex medical needs. In recent years, VA has made great strides to create a more supportive and accessible environment to all veterans, particularly women veterans. Yet all too often, VA has given veterans reason to distrust the system. VA has struggled with long wait times to access care,[62] denial of claims, and failure to provide ample medical care to veterans struggling with suicidal ideation.[63] Veterans have also experienced sexual assault in VA facilities,[64] and one study found that one in four women veterans reported being harassed by male veterans in VA healthcare settings in the past year.[65] These failings drive veterans out of the VA system and into community care—or away from healthcare all together.

And new threats only magnify that distrust. Earlier this summer, VA amended its hospital bylaws to remove protections that explicitly prohibited discrimination based on patients' marital status or political views.[66] These changes, coupled with the anticipated departure of over 30,000 VA personnel this year alone,[67] will only chill access to vital medical care, drive providers to jobs outside VA, and increase veterans' distrust of the VA system.[68] Since the beginning of this fiscal year, VA has shown a net loss of 2,000 registered nurses, 1,300 medical assistants, 1,100 nursing assistants and licensed practical nurses, 800 doctors, 500 social workers and 150 psychologists.[69]

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The consequences of the Proposed Rule are certain: pregnant veterans will be denied access to needed medical care and they will experience both physical and mental health consequences. This harm can be avoided by leaving the existing Rule in place. MVA asks that VA do so, and continue to allow veterans to access abortion care when life or the health of the pregnant veteran would be endangered if the pregnancy were carried to term, or if the pregnancy is a result of rape or incest.

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[62] Patricia Kime, *A Decade After Scandal, VA Health Care May Be at Another Crossroads*, Military.com (April 12, 2024), https://perma.cc/3UF7-NGHZ.
[63] Kathleen McGrory & Neil Bedi, *How the VA Fails Veterans on Mental Health*, ProPublica (Jan. 9, 2024), https://perma.cc/24TQ-MGEG.
[64] Victoria Chamberlin, *After Alleged Sexual Assault, Veterans Say Officials Aren't Doing Enough To Make The D.C. VA Safe For Women*, WAMU (Jan. 17, 2020), https://perma.cc/7E3L-EJMV.
[65] Ruth Klap, *Prevalence of Stranger Harassment of Women Veterans at Veterans Affairs Medical Centers and Impacts on Delayed and Missed Care*, 29 Women's Health Issues 107, 112 (Mar. 2019), https://perma.cc/YQ4A-7NFA.
[66] Aaron Glantz, *'Profound alarm': US veterans agency roiled by fight over anti-discrimination provisions*, The Guardian (July 18, 2025), https://perma.cc/S5KT-UJKB.
[67] U.S. Dep't of Veterans Affairs, *VA to reduce staff by nearly 30K by end of FY2025* (July 7, 2025), https://perma.cc/9V52-5CF2.
[68] Glantz, *supra* note 66.
[69] Aaron Glantz, *US veterans agency lost thousands of 'core' medical staff under Trump, records show*, The Guardian (Aug. 11, 2025), https://perma.cc/XUL5-KY9S.

If you have any questions or would like to discuss the information in this comment, please contact Carrie Flaxman or Kaitlyn Golden, Democracy Forward Foundation, counsel for Minority Veterans of America, at cflaxman@democracyforward.org or kgolden@democracyforward.org.

Very respectfully,

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