

**Statement for the Record of a Coalition of Organizations Committed to Improving
Reproductive Health Care Access for Servicemembers and Veterans**

“Veterans’ Access to Reproductive Healthcare”

U.S. House of Representatives Committee on Veterans’ Affairs, Subcommittee on Health

July 1, 2020

Chairwoman Brownley, Ranking Member Dunn, and Members of the House Committee on Veterans’ Affairs, Subcommittee on Health:

The undersigned organizations respectfully submit the following statement for the record to the U.S. House of Representatives Committee on Veterans’ Affairs Subcommittee on Health. We appreciate the Subcommittee’s attention to the vital issue of reproductive health care access at the Department of Veterans Affairs. Women comprise approximately 10% of the total veteran community and are statistically the fastest growing cohort within that community.¹ Within that group, women of reproductive age between ages 18-44 are the fastest growing subset of new VA users.² Among the 1.6 million women who are veterans, 65% are white, non-Hispanic, 20% are Black, 9% are Latina, 3% are AAPI, and 1% are Native American.³

Military service is associated with unique risks to women’s reproductive health, including interruptions in preventive care, ongoing treatment or evaluation for conditions, such as menorrhagia and endometriosis, and increased rates of abnormal Pap test results, which may impact women veterans’ long term reproductive health and unique needs.⁴ Nonetheless, the Veteran’s Health Administration (VHA) has thus far failed to adequately provide for a number of reproductive health needs, including access to abortion, contraception, and assisted reproductive technology. By regulation, the VA’s medical benefits package specifically prohibits VA from providing abortion care and IVF services. Veterans also face cost barriers that most of the civilian population does not face, in the form of copays for contraception. VA’s failure to provide comprehensive basic health care, combined with a pervasive culture of sexual harassment at VHA facilities,⁵ presents significant barriers for women veterans to use the VA health care benefits they have earned. As our country continues to reel from the COVID-19 public health and economic crises, and as nationwide protests demand that our leaders address the pervasive racism that infects every one of our institutions, we strongly urge Congress and the VHA to promptly address these gaps in reproductive health care. Increasing access to timely,

¹ NAT’L CTR. FOR VETERANS ANALYSIS AND STATISTICS, U.S. DEP’T OF VETERANS AFFAIRS, THE PAST, PRESENT AND FUTURE OF WOMEN VETERANS 10 (2017), available at https://www.va.gov/vetdata/docs/SpecialReports/Women_Veterans_2015_Final.pdf.

² Sarah A. Friedman et al., *New women Veterans in the VHA: a longitudinal profile*. 21 WOMEN’S HEALTH ISSUES 103, 103-11 (2011) available at <https://pubmed.ncbi.nlm.nih.gov/21724129/>.

³ National Women’s Law Center calculations based on 2018 American Community Survey (ACS), using IPUMS USA, University of Minnesota, available at www.ipums.org.

⁴ AM. COLL. OF OBSTETRICIANS AND GYNECOLOGISTS COMM. ON HEALTH CARE FOR UNDERSERVED WOMEN, COMMITTEE OPINION NO. 547: HEALTH CARE FOR WOMEN IN THE MILITARY AND WOMEN VETERANS (Dec. 2012) 120 OBSTET GYNECOL 1538–42

⁵ Patricia M. Hayes, *VA: It’s our responsibility to end harassment*, VAntage Point (Aug. 15, 2019, 10:00 AM), <https://www.blogs.va.gov/VAntage/64559/va-our-responsibility-end-harassment/>.

comprehensive essential care, including contraception and abortion, has become ever more urgent and necessary in this time of crisis.⁶

The VHA was created to provide a full range of health care for veterans, in recognition of their sacrifice and service to the country. The VA does veterans a disservice by excluding or inadequately addressing many of their basic health needs. With the percentage of women veterans expected to grow by more than half in the next twenty years, the VA must take swift action to ensure that all veterans have comprehensive access to care, including access to abortion through the VHA and contraceptive equity with their civilian counterparts.⁷

I. Congress should take action to ensure equal coverage and access to contraception for veterans.

Contraception is basic preventive health care. The Affordable Care Act (ACA) already recognizes this. To reduce cost barriers to preventive care, the ACA requires all non-grandfathered group and individual plans to cover without cost-sharing all FDA-approved, female-controlled birth control methods and related education or counseling. However, the ACA does not extend to VA Care, and veterans must still pay a copay for their contraception.

Oral contraceptives are provided to approximately 24,000 female veterans every year.⁸ As mentioned above, women are the fastest-growing population of veterans accessing care through VHA, and female veterans are more likely to live in poverty than male veterans. Similarly, transgender veterans are more likely to live in poverty than their cisgender peers. Even a small copay can be prohibitive for some veterans struggling to make ends meet.⁹ Congress should take action to eliminate copays on contraception dispensed through VHA, allowing veterans the same contraceptive coverage as those who rely on private insurance coverage.

In addition, certain policy changes could increase consistent use of oral contraceptives and prevent unintended pregnancies in the veteran population.¹⁰ The experts are clear that the most effective way to prevent unintended pregnancy is by improving access to consistent, effective, and affordable contraception.¹¹ Like many insurance systems in the country, the VA currently distributes three-month supplies of birth control pills.¹² However, VA data indicate that 43% of

⁶ CTR. FOR REPROD. RIGHTS & COLUMBIA MAILMAN SCH. OF PUB. HEALTH, HEILBRUNN DEP'T OF POPULATION & FAMILY HEALTH, ABORTION IS ESSENTIAL HEALTHCARE: ACCESS IS IMPERATIVE DURING COVID-19 1 (2020), <https://reproductiverights.org/sites/default/files/documents/CRR%20Columbia%20COVID%2019%20Abortion%20FINAL.pdf>

⁷ VICTORIA L. ELLIOTT, CONG. RESEARCH SERV., IF11082, VETERANS HEALTH ADMINISTRATION: GENDER-SPECIFIC HEALTH CARE SERVICES FOR WOMEN VETERANS (Updated Feb. 2020) <https://crsreports.congress.gov/product/pdf/IF/IF11082>.

⁸ Ariana Puzzo, *Yearlong birth control supply for female vets could cut costs and unplanned pregnancies*, MILITARY TIMES (July 11, 2019), <https://www.militarytimes.com/veterans/2019/07/11/yearlong-birth-control-supply-for-female-vets-could-cut-costs-and-unplanned-pregnancies/>.

⁹ GUTTMACHER INST., EVIDENCE YOU CAN USE: INSURANCE COVERAGE OF CONTRACEPTION (2020) *available at* <https://www.guttmacher.org/evidence-you-can-use/insurance-coverage-contraception>.

¹⁰ Colleen Judge-Golden, Kenneth Smith, Maria Mor et al., *Financial Implications of 12-Month Dispensing of Oral Contraceptive Pills in the Veterans Affairs Health Care System*, 179 JAMA INTERN MED 1201, (2019) *available at* <https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2737751>.

¹¹ AM. COLL. OF OBSTETRICIANS AND GYNECOLOGISTS COMM. ON HEALTH CARE FOR UNDERSERVED WOMEN, COMMITTEE OPINION NO. 615: ACCESS TO CONTRACEPTION (Jan. 2015, reaffirmed 2017), <https://www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-opinion/articles/2015/01/access-to-contraception.pdf>.

¹² Kathleen Davis, *Study: VA Could Prevent Hundreds Of Unintended Pregnancies By Adjusting Birth Control Supplies*, 90.5 WESA (July 18, 2019) <https://www.wesa.fm/post/study-va-could-prevent-hundreds-unintended-pregnancies-adjusting-birth-control-supplies#stream/0>.

veterans who receive a three-month supply of oral contraceptives experience a gap of at least seven days or more between contraceptive refills over the course of a year.¹³ Such gaps leave veterans at risk of an unintended pregnancy. Recent research suggests that VHA could improve access to contraceptives and adherence to contraceptive methods, as well as prevent nearly 600 unintended pregnancies a year, by dispensing a 12-month supply of oral contraceptives.¹⁴ By the same reasoning, adherence in the use of contraceptive patches and rings would likely also improve with access to a 12-month supply. In fact, to improve access to contraception, 21 states (including D.C.) have enacted policies requiring insurers to increase the number of months for which they cover prescription contraceptives at one time—usually a 12-month supply.¹⁵

II. Veterans face unacceptable restrictions on abortion access.

Current VA regulations exclude all abortions and abortion counseling from the VA’s medical benefits package, making abortion unavailable in VHA facilities.¹⁶ Similarly, regulations governing CHAMPVA ban abortion, with only a single exception to permit life-saving abortions for certain eligible veterans’ dependents. Safe, legal abortion is a necessary component of women’s and transgender men’s health care.¹⁷ These dangerous policies disrupt continuity of care, and force veterans and their dependents to seek care outside the VHA system. This means veterans must delay access to time-sensitive care, pay for their care out of pocket, navigate a separate health care system and a maze of state-level abortion restrictions on their own. Female veterans are more likely to live in poverty than male veterans. Similarly, transgender veterans are more likely to live in poverty than cisgender veterans.¹⁸ Consequently, the cost of navigating and obtaining abortion care in the private health care market is likely to drive access out of reach for a significant number of veterans.

Compounding the barriers veterans face in accessing abortion care is the last decade’s unprecedented, coordinated attack on access to abortion care. Since 2011, state legislatures have passed more than 450 restrictions and bans on abortion care. These restrictions are designed to ensure that patients face insurmountable barriers and clinics are forced to shut their doors.¹⁹ In the United States, six states—Kentucky, Mississippi, Missouri, North Dakota, South Dakota and West Virginia—have only one clinic providing abortion.²⁰ Eighty-nine percent of counties in the United States do not have a single abortion clinic and some counties that have a clinic only provide abortion services on certain days of the week.²¹ In addition, many states require multiple,

¹³ *Id.*

¹⁴ *Id.*

¹⁵ Fact sheet: Coverage for an Extended Supply of Contraception, POWER TO DECIDE (May 2020) <https://powertodecide.org/what-we-do/information/resource-library/extended-supply-contraception>

¹⁶ 38 C.F.R. §17.38(e).

¹⁷ AM. COLL. OF OBSTETRICIANS AND GYNECOLOGISTS COMM. ON HEALTH CARE FOR UNDERSERVED WOMEN, COMMITTEE OPINION NO. 613: INCREASING ACCESS TO ABORTION (Nov. 2014, reaffirmed 2017) <https://www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-opinion/articles/2014/11/increasing-access-to-abortion.pdf>.

¹⁸ DISABLED AMERICAN VETERANS, *supra* note 24; *See also* Press Release, THE WILLIAMS INST. AT UCLA SCH. OF LAW, Transgender veterans as healthy as cisgender veterans, study finds (Jul. 11, 2018) *available at* <https://williamsinstitute.law.ucla.edu/press/trans-vets-health-press-release/>.

¹⁹ CTR. FOR REPROD. RIGHTS, *What if Roe Fell* (2019), <https://reproductiverights.org/what-if-roe-fell>

²⁰ Elizabeth Chuck, *Missouri begins hearing over Planned Parenthood clinic, state's lone abortion clinic*, NBC NEWS, Oct. 28, 2019, *available at* <https://www.nbcnews.com/news/us-news/missouri-begins-hearing-over-planned-parenthood-clinic-state-s-lone-n1072736>.

²¹ NAT’L P’SHIP FOR WOMEN & FAMILIES, BAD MEDICINE: HOW A POLITICAL AGENDA IS UNDERMINING ABORTION CARE AND ACCESS 13 (3rd ed. 2018), *available at*: <http://www.nationalpartnership.org/our-work/resources/repro/bad-medicine-third-edition.pdf>.

medically unnecessary provider visits or unnecessary medical services. These barriers both delay and prolong the time a patient must take to receive care.²²

When patients face delays in obtaining an abortion, for example due to denials of care, medically unnecessary restrictions or limited access to providers, the logistical and financial burdens they face multiply. On average, a patient must wait at least a week between when they attempt to make an appointment and when they receive an abortion.²³ Delays also have the effect of increasing the cost of an abortion. Abortion in the first trimester is substantially less expensive than in the second trimester, when the cost can more than double.²⁴ The rising cost of abortion as gestational age increases poses a profound challenge to the affordability of the procedure for lower-income women. And because fewer clinics offer second-trimester abortions, a patient who has been delayed into the second trimester will typically be required to travel farther to obtain an abortion, thereby incurring additional travel and related costs.²⁵ As a result, indirect referrals that result in a delay in care can significantly drive up the cost for a patient seeking abortion care.

Restrictions on abortion care fall the hardest on those who already struggle to access their basic needs. This includes low income women that cannot afford to make multiple trips to a provider, drive to clinics across or out of state, and pay out of pocket for abortion care. It includes those who already face tremendous inequality in health care, including in maternal health outcomes, particularly Black and Indigenous communities, as well as Latinx and AAPI communities.²⁶ Abortion restrictions also disproportionately harm those who live in rural areas, given the lack of providers and clinics in such areas; LGBTQ individuals, who already face barriers to reproductive health care;²⁷ and those who face intimate partner violence.²⁸ For veterans who are struggling in these various ways, our country should be doing everything to support and lift them up, not push them further down by restricting their reproductive health care, including abortion.

Given the substantial harm restrictions on abortion care cause, the Department of Veterans Affairs must rescind the regulations prohibiting abortion at VHA, and ensure its medical benefits package includes abortion and abortion counseling just as it does other pregnancy-related care.

²² See *id.* at 21-22; See also VIRGINIA DEPARTMENT OF HEALTH, REGULATIONS FOR LICENSURE OF ABORTION FACILITIES, PROPOSED REGULATION AGENCY BACKGROUND DOCUMENT 10, JAN. 8, 2013, available at http://townhall.virginia.gov/L/GetFile.cfm?File=C:\TownHall\docroot\58\3563\6315\AgencyStatement_VDH_6315_v2.pdf.

²³ See Lawrence B. Finer et al., *Timing of Steps and Reasons for Delays in Obtaining Abortions in the United States*, 74 CONTRACEPTION 334, 338-43 (2006) (The median is seven days, while the average is 10 days. Moreover, poorer women wait two to three days longer than the typical woman.).

²⁴ Rachel K. Jones et al., *Differences in Abortion Service Delivery in Hostile, Middle-Ground and Supportive States in 2014*, 28 WOMEN'S HEALTH ISSUES 215-16 (2018) available at [http://www.whijournal.com/article/S1049-3867\(17\)30536-4/abstract](http://www.whijournal.com/article/S1049-3867(17)30536-4/abstract).

²⁵ Rachel K. Jones & Jenna Jerman, *How Far Did US Women Travel for Abortion Services in 2008?*, 22 J. WOMEN'S HEALTH 706 (2013).

²⁶ NAT'L P'SHIP FOR WOMEN & FAMILIES, BLACK WOMEN'S MATERNAL HEALTH (2018), available at <http://www.nationalpartnership.org/our-work/resources/health-care/maternity/black-womens-maternal-health-issue-brief.pdf>; Roni Caryn Rabin, *Huge Racial Disparities Found in Deaths Linked to Pregnancy*, N. Y. TIMES (May 7, 2019), <https://www.nytimes.com/2019/05/07/health/pregnancy-deaths-.html>.

²⁷ AM. COLL. OF OBSTETRICIANS AND GYNECOLOGISTS COMM. ON HEALTH CARE FOR UNDERSERVED WOMEN, COMMITTEE OPINION NO. 586: HEALTH DISPARITIES IN RURAL WOMEN (Feb. 2014, reaffirmed 2016), <https://www.acog.org/-/media/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/co586.pdf?dmc=1&ts=20191112T0114132450>; BIXBY CTR. FOR GLOBAL REPROD. HEALTH, LGBTQ PATIENTS FACE DISCRIMINATION AND ERASURE WHEN SEEKING REPRODUCTIVE HEALTH CARE, <https://bixbycenter.ucsf.edu/news/lgbtq-patients-face-discrimination-and-erasure-when-seeking-reproductive-health-care> (last visited on Nov. 11, 2019).

²⁸ Women in abusive relationships who sought and obtained abortion care experienced a decrease in physical violence from the man involved in the pregnancy; women who sought but were denied care were not so fortunate. Women denied an abortion remain tethered to the abuser and at risk for continued violence, even if they end the romantic relationship. Pregnant women in abusive relationships are also at risk of being killed by their abusers. Sarah CM Roberts et al., *Risk of Violence from the Man Involved in the Pregnancy After Receiving or Being Denied an Abortion*, BMC MED., Sept. 2014, at 5; see also *id.* (women denied abortion were more likely to have sustained contact with the man involved in pregnancy); Deborah Tuerkheimer, *Conceptualizing Violence Against Pregnant Women*, 81 IND. L.J. 667, 672 (2006).

III. Conclusion.

By creating the VA Health Care system, the government took on a duty and responsibility to provide health care to all its veterans. Burdensome regulations and policies prevent VA Care from providing veterans with the evidence-based reproductive health services they need, and force VA health care providers to deny veterans care that most of the civilian population has access to. It can and must do better. The administration must rescind regulations restricting abortion care and counseling in VHA, and Congress should enact policies to improve contraceptive coverage and access for veterans.

Sincerely,

American Civil Liberties Union

American College of Obstetricians and Gynecologists

Center for Reproductive Rights

Guttmacher Institute

In Our Own Voice: National Black Women's Reproductive Justice Agenda

NARAL Pro-Choice America

National Women's Law Center

Planned Parenthood Federation of America

Power to Decide

Service Women's Action Network