September 3, 2025

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

Dear Dr. Lieberman,

On behalf of the American College of Obstetricians and Gynecologists, American Academy of Family Physicians, American College of Physicians, American Psychiatric Association, American Society for Reproductive Medicine, American Urogynecologic Society, and Society for Maternal-Fetal Medicine, we write to express our concern about the U.S. Department of Veterans Affairs' Reproductive Health Services Proposed Rule (the "Proposed Rule"). The Proposed Rule undermines clinicians' ability to give medical care based on their education, training and experience, and interferes with the patient-clinician relationship. Our organizations are concerned that the Proposed Rule will perpetuate harm against pregnant veterans and their families.

There are over 2 million women veterans, making them the fastest growing group in the veteran population.[i] Veterans have a unique set of risk factors associated with adverse pregnancy outcomes and severe maternal morbidity, making them more at risk for pregnancy complications.[ii] It is particularly important for clinicians treating veterans to understand their patients' history of service, and assess them for specific service-related health and reproductive health needs.[iii]

Abortion care is a component of comprehensive, evidence-based reproductive health care.[iv] Clinicians working with pregnant patients experiencing complications understand that abortion may sometimes be necessary to prevent severe health consequences or even death.[v] Those health consequences may include loss of uterus (and future fertility), seizures, stroke, and vital organ damage and failure.

Prohibiting abortion care when the health of the pregnant veteran is threatened is contrary to evidence-based medicine.

The Proposed Rule would prohibit abortion care in situations where a pregnant patient's health is endangered, despite allowing care when a patient's life is threatened. This does not reflect the practice of medicine. No clinical bright line necessarily defines when a condition transitions from merely health-threatening to life-threatening. Instead, clinicians rely on their medical training and expertise to evaluate their patients and make recommendations about the best course of treatment to ensure the best outcome for their patients.

Preterm prelabor rupture of membranes ("PPROM") provides one such example. PPROM occurs when the amniotic sac ruptures early, presenting a major maternal risk of infection, abruption, and sepsis.[vi] Patients who experience rupture of membranes prior to 22-24 weeks may deteriorate quickly and unpredictably, and the only sure way to halt this progression is an abortion.[vii] In cases of PPROM where pregnancies continue, rates of neonatal mortality and morbidity are high.[viii] Rather than offer this medically indicated care to a patient, the Proposed Rule would require a VA provider treating such a patient to wait until their patient's condition deteriorates to an arbitrary level before providing abortion care.

Delaying abortion care is dangerous. A 2022 study of Texas's abortion ban concluded that "expectant management of obstetrical complications" is associated with "significant maternal morbidity."[ix] According to the study, "[e]xpectant management resulted in 57% of patients having a serious maternal morbidity compared with 33% who elected immediate pregnancy interruption under similar clinical circumstances reported in states without such legislation."[x] The study documented a significant increase in maternal morbidity among patients with obstetrical complications who would have been promptly offered abortion care before the law but now cannot be offered such treatment until their physicians determined that an emergent condition poses "an immediate threat to maternal life."[xi] Delaying care may be particularly risky for veterans, who are at higher risk of certain factors associated with maternal mortality and morbidity than other patients.[xii] For veterans and their dependents, this potential harm is not restricted to states with abortion bans: the Proposed Rule applies to all care provided through the VA and covered by CHAMPVA, regardless of the state's abortion laws.

By forcing clinicians to delay care, the Proposed Rule fails to give appropriate weight to the expert medical judgment of clinicians who rely on their decades of training to provide appropriate medical care to their patients. Decisions regarding reproductive health care – like all medical decisions – should be made by patients in consultation with their clinicians based on the medical evidence. The Proposed Rule supplants that clinical judgment, which will only result in harm to the veterans that the VA is supposed to be serving. In so doing, the Proposed Rule is also contrary to clinicians' ethical obligations (both VA clinicians and the community providers serving veterans) to promote the well-being of others and to do no harm.

The Proposed Rule likewise undermines the patient-clinician relationship by barring clinicians from discussing the full range of potentially needed medical care with patients. A cornerstone of clinicians' ethical obligations is ensuring patient autonomy. Clinicians ensure patient autonomy through providing information about risks and benefits of potential courses of treatment and engaging in joint decision-making with their patients.[xiii] By banning abortion counseling in the VA, the Proposed Rule undercuts that patient autonomy. It also restricts clinicians from discussing the need for abortion care with their patients in situations where a patient's life is endangered, harming the patient's ability to fully understand the necessary medical care in a life-threatening situation.

The Proposed Rule will propagate patient and clinician confusion and lead to delayed care even when care may be technically permitted.

Our organizations are concerned that, if the VA chooses to proceed with the Proposed Rule, VA providers will be unclear about their ability to provide abortion care even when a patient's life is endangered. As currently drafted, the Proposed Rule proposes amending 38 CFR 17.38 to remove the language stating that "the 'medical benefits package' does not include the following: (1) Abortions, except when (i) The life or the health of the pregnant veteran would be endangered if the pregnancy were carried to term." The revised rule would instead state "the 'medical benefits package' does not include the following: (1) Abortions and abortion counseling." This revision does not incorporate the exception included in the Proposed Rule allowing for abortion care when the life of the pregnant veteran would be endangered. Our organizations are concerned that clinicians will be prevented from providing abortion care if the exception is not within the Code of Federal Regulations. VA providers in states with abortion bans already expressed low confidence that they would be supported in providing care under the current rule; removing the language permitting abortions when a patient's life is endangered will only create more uncertainty.[xiv]

The Proposed Rule further provides ectopic pregnancies and miscarriages as two examples where abortion care would be appropriate. These examples fail to capture the range of medical conditions that could endanger the life of a pregnant patient. It is impossible to create an inclusive list of medical conditions that could become life-threatening: the practice of medicine is complex and requires individualization for each unique patient.[xv]

Removing access to abortion care for veterans who are pregnant as the result of rape will perpetuate further harm.

Our organizations are troubled that the Proposed Rule will rescind access to abortion care for veterans who are pregnant as a result of rape or incest. Veterans have higher rates of military sexual trauma and intimate partner violence than other groups.[xvi] Access to abortion care and counseling is necessary to protect veterans' health and well-being if they become pregnant as the result of rape or incest. Being forced to carry such a pregnancy to term may compound the adverse impacts of the sexual assault, as well as any existing mental health conditions.

VA patients need access to effective treatment for miscarriage.

Our organizations are also concerned that, if the Proposed Rule is finalized, VA providers will no longer be able to access mifepristone and misoprostol to treat patients experiencing miscarriage. The most effective treatment for patients experiencing early pregnancy loss is mifepristone and misoprostol. We understand that prior to the current Rule, providers at the VA were unable to access this medication. We encourage the VA to formally recognize that patients will still have access to this basic and effective treatment.

***

Thank you for the opportunity to comment on the importance of the policies. We encourage the VA to rescind the Proposed Rule, and leave in place access to evidence-based reproductive health care for veterans and their families. If you have any questions or would like to discuss further, please contact the ACOG Government Affairs Department at govtrel@acog.org.

Sincerely,

American College of Obstetricians and Gynecologists
American Academy of Family Physicians
American College of Physicians
American Psychiatric Association
American Society for Reproductive Medicine
American Urogynecologic Society
Society for Maternal-Fetal Medicine

---

[i] U.S. Department of Veterans Affairs, *Women Veterans Health Care: Facts and Statistics* (2022), https://perma.cc/6MN2-LK92.
[ii] 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. Department of Veterans Affairs (June 2024), https://perma.cc/GGP8-ED8B.
[iii] Health care for women and gender-diverse active duty and reserve uniformed service members and veterans. Committee Statement No. 12. American College of Obstetricians and Gynecologists. Obstet Gynecol 2024;144:e144–e51.
[iv] American College of Obstetricians and Gynecologists*, Abortion Policy* (July 2025), https://www.acog.org/clinical-information/policy-and-position-statements/statements-of-policy/2025/abortion-policy.
[v] *See e.g.,* Prelabor rupture of membranes. ACOG Practice Bulletin No. 217. American College of Obstetricians and Gynecologists. Obstet Gynecol 2020;135:e80–97; Gestational hypertension and preeclampsia. ACOG Practice Bulletin No. 222. American College of Obstetricians and Gynecologists. Obstet Gynecol 2020;135:e237–60; Early pregnancy loss. ACOG Practice Bulletin No. 200. American College of Obstetricians and Gynecologists. Obstet Gynecol 2018;132:e197–207.
[vi] Prelabor rupture of membranes. ACOG Practice Bulletin No. 217. American College of Obstetricians and Gynecologists. Obstet Gynecol 2020;135:e80–97.
[vii] Sklar, Ariel et al., *Maternal morbidity after preterm premature rupture of membranes at <24 weeks' gestation,* American Journal of Obstetrics & Gynecology, Volume 226, Issue 4, 558.e1 - 558.e11.
[viii] Sorrenti, Sara et al., *Outcome of prelabor rupture of membranes before or at the limit of viability: systematic review and meta-analysis,* American Journal of Obstetrics & Gynecology MFM, Volume 6, Issue 6, 101370.
[ix] 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), https://tinyurl.com/5xtct689.
[x] *Id.*
[xi] *Id.* at 648-49. *See also* Grossman D, Joffe C, Kaller S, Kimport K, Kinsey E, Lerma K, Morris N, White K. Care Post-Roe: documenting cases of poor-quality care since the Dobbs decision. Advancing New Standards in Reproductive Health (ANSIRH), University of California, San Francisco, 2023; MacDonald A, Gershengorn HB, Ashana DC. The Challenge of Emergency Abortion Care Following the *Dobbs* Ruling. *JAMA*. 2022;328(17):1691–1692. doi:10.1001/jama.2022.17197.
[xii] Health care for women and gender-diverse active duty and reserve uniformed service members and veterans. Committee Statement No. 12. American College of Obstetricians and Gynecologists. Obstet Gynecol 2024;144:e144–e51.
[xiii] Informed consent and shared decision making in obstetrics and gynecology. ACOG Committee Opinion No. 819. American College of Obstetricians and Gynecologists. Obstet Gynecol 2021;137:e34–41.
[xiv] U.S. Department of Veterans Affairs, Office of Inspector General, *Review of Veterans Health Administration Reproductive Health Services* (Sept. 28, 2023), https://perma.cc/QJD2-64N3.
[xv] American College of Obstetricians and Gynecologists, *Understanding and Navigating Medical Emergency Exceptions in Abortion Bans and Restrictions* (Aug. 15, 2022), https://perma.cc/7XJR-URQ8.
[xvi] Health care for women and gender-diverse active duty and reserve uniformed service members and veterans. Committee Statement No. 12. American College of Obstetricians and Gynecologists. Obstet Gynecol 2024;144:e144–e51.