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October 11, 2022

The Honorable Shereef Elnahal
Under Secretary for Health
U.S. Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

RE: RIN 2900-AR57—Reproductive Health Services

Dear Under Secretary Elnahal:

On behalf of the physician and medical student members of the American Medical Association (AMA), I am writing to provide comments on the Department of Veterans Affairs (VA) Interim Final Rule (IFR) "RIN 2900-AR57— Reproductive Health Services." Within the IFR the VA is amending is medical regulations to allow for abortion counseling and abortions to be covered by VA health care and by Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA), in the case of rape, incest, or the life or health endangerment of the mother. The AMA recognizes that health care, including reproductive health services like abortion, is a human right. As such, the AMA recognizes the medical necessity of allowing for holistic reproductive care and supports the addition of these benefits within VA health care and CHAMPVA.

The VA is allowed to add abortion counseling and abortion care to its medical regulations

Prior to the IFR, the VHA did not provide abortions or abortion counseling.[1] This was in part due to the fact that the VA medical benefits package prohibited these services.[2] This previous VA probation on abortions, which did not cover abortion care in all circumstances, was more restrictive than Hyde Amendments, which provide exceptions for abortion care in the case of rape, incest, or life endangerment of the mother, in line with what the current IFR has implemented.[3]

This prohibition on abortion care for Veterans originated in Section 106 of the Veterans Health Care Act of 1992 (P.L. 102-585; Title 38 U.S.C. 1710 note) which allowed for "[g]eneral reproductive health care, including the management of menopause, but not including under this section infertility services, abortions, or pregnancy care (including prenatal and delivery care)."[4] However, since 1992, the VA has expanded the reproductive services it offers and now covers pregnancy care in its medical benefit

[1] https://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=5332.
[2] https://www.govinfo.gov/content/pkg/USCODE-2020-title38/pdf/USCODE-2020-title38-partII-chap17-subchapII-sec1710.pdf.
[3] https://www.govinfo.gov/content/pkg/PLAW-117publ103/pdf/PLAW-117publ103.pdf; see also https://crsreports.congress.gov/product/pdf/IF/IF12167.
[4] https://www.govinfo.gov/content/pkg/USCODE-2020-title38/pdf/USCODE-2020-title38-partII-chap17-subchapII-sec1710.pdf.

packages as well as some infertility services.[5] Moreover, Congress has included funding for Veterans in vitro fertilization services in annual appropriations language since FY2017.[6]

Moreover, since the inception of the 1992 law, a new governing law has been enacted. While the 1992 law limited VA care to hospital and outpatient care "needed for the care of a 'disability'" the Veterans' Health Care Eligibility Reform Act of 1996 (P.L. 104-262) modified and expanded these benefits. The 1996 Veteran's Health Care Eligibility Reform Act increased the services that Veterans are entitled to and requires the Secretary to "furnish hospital care and medical services…which the Secretary determines to be needed…."[7] With the expansion of care, via the 1996 law, the modern medical benefits package was created. At the creation of the benefits package, the VA stated that:

> The Secretary has authority to provide healthcare as determined to be medically needed. In our view, medically needed constitutes care that is determined by appropriate healthcare professionals to be needed to promote, preserve, or restore the health of the individual and to be in accord with generally accepted standards of medical practice. The care included in the proposed 'medical benefits package' is intended to meet these criteria.
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> Commenters asserted that infertility services, pregnancy and delivery, surgical implantation of penile prostheses, and membership in spas and health clubs should be included in the medical benefits package. As noted above, the medical benefits package would include care that is determined by appropriate healthcare professionals to be needed to promote, preserve, or restore the health of the individual and to be in accord with generally accepted standards of medical practice. Upon reconsideration, we conclude that pregnancy and delivery services (to the extent we have legal authority to provide such services) meet these criteria and should be included in the medical benefits package. We also conclude that membership in spas and health clubs does not meet these criteria and should not be included. Further, under these criteria, we have determined that reproductive sterilization, surgery to reverse voluntary sterilization, infertility services (other than in vitro fertilization), and surgical implantation of penile prostheses should not be excluded. Appropriate changes are made to the medical benefits package to reflect these determinations.[8]

"The primary function" of the VHA "is to provide a complete medical and hospital service for the medical care and treatment of veterans, as provided in" title 38 of the U.S. Code "and in regulations prescribed by the Secretary pursuant to" title 38.[9] According to the IFR, due to the extremely detrimental outcomes that can come from carrying out a pregnancy when a woman is physically at risk, the VA has determined that in the case of rape, incest, or the life endangerment of the mother abortion care is "needed".[10] As such, this justification, along with the expanded care provided for pregnancy and in vitro fertilization demonstrates that the VA can allow for medically needed abortion care under the 1996 law.

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[5] https://www.govinfo.gov/content/pkg/USCODE-2020-title38/pdf/USCODE-2020-title38-partII-chap17-subchapII-sec1710.pdf; See also https://www.law.cornell.edu/cfr/text/38/17.380.
[6] https://crsreports.congress.gov/product/pdf/R/R47191/2.
[7] https://www.congress.gov/104/plaws/publ262/PLAW-104publ262.pdf.
[8] https://crsreports.congress.gov/product/pdf/R/R47191/2.
[9] https://www.law.cornell.edu/uscode/text/38/7301.
[10] https://www.federalregister.gov/documents/2022/09/09/2022-19239/reproductive-health-services.

CHAMPVA is allowed to add abortion counseling and abortion care to its medical benefits

Pursuant to VA's statutory CHAMPVA authority, the Secretary "is authorized to provide" specified "medical care" to certain spouses, children, survivors, and caregivers of Veterans who meet specific eligibility criteria.[11] Prior to the IFR, CHAMPVA covered abortion counseling or abortion procedures if a physician certified that the life of the mother would be endangered if the fetus was carried to term.[12] However, prior to the IFR, CHAMPVA would not cover abortion care related to incest or rape. Yet, the exclusion of abortion care for incest and rape was not statutorily prohibited. Since the VA must provide "for medical care" under CHAMPVA "in the same or similar manner and subject to the same or similar limitations as medical care is" provided to individuals in the TRICARE (Select) program, and since TRICARE (Select) covers abortions for rape, incest, or when the life of the mother is endangered and provides counseling as part of their abortion care, the IFR correctly determines that this benefit expansion can be made under CHAMPVA.[13,14]

Physicians should be the head of abortion care teams to ensure the well-being of the patient

According to the IFR, the VA will provide Veterans with abortion care when a health care professional determines that such care "is needed to promote, preserve, or restore the health of the individual and is in accord with generally accepted standards of medical practice," including when the life of the mother would be endangered if the pregnancy was carried to term.[15] "Assessment of the conditions, injuries, illness, or diseases that will qualify for this care will be made by appropriate health care professionals on a case-by-case basis."[16] However, we urge the VA to ensure that only physician-led teams are making these critical determinations and that physicians remain the head of the health care team.

While all health care professionals play a critical role in providing care to patients, their skill sets are not interchangeable with those of fully educated and trained physicians. This is fundamentally evident based on the difference in education and training between the distinct professions. Physicians complete four years of medical school plus three to seven years of residency, including 10,000-16,000 hours of clinical training.[17] By contrast, nurse practitioners (NPs), complete only two to three years of education, have no residency requirement, and have only 500-720 hours of clinical training.[18] Moreover, the current physicians assistant (PA) education model is two years in length with only 2,000 hours of clinical care and no residency requirement.[19] Veterans expect the most qualified person—physician experts with unmatched training, education, and experience—to be making complex clinical determinations about the viability of their pregnancy.

It is more than just the vast difference in hours of education and training that matter, but also the difference in rigor and standardization between medical school/residency and NP and PA programs that

[11] https://www.law.cornell.edu/uscode/text/38/1781.
[12] https://crsreports.congress.gov/product/pdf/R/R47191/2.
[13] https://www.govinfo.gov/content/pkg/USCODE-2020-title38/pdf/USCODE-2020-title38-partII-chap17-subchapVIII-sec1781.pdf.
[14] https://tricare.mil/CoveredServices/IsItCovered/Abortions.
[15] https://www.ecfr.gov/current/title-38/chapter-I/part-17/subject-group-ECFRf01c7718f2a7e24/section-17.38#p-17.38(b).
[16] https://www.federalregister.gov/documents/2022/09/09/2022-19239/reproductive-health-services.
[17] https://www.ama-assn.org/system/files/scope-of-practice-physician-training.pdf.
[18] *Id*.
[19] https://college.mayo.edu/academics/explore-health-care-careers/careers-a-z/physician-assistant/.

matter and must be assessed. During medical school, students receive a comprehensive education in the classroom and in laboratories, where they study the biological, chemical, pharmacological, and behavioral aspects of the human condition. This period of intense study is supplemented by two years of patient care rotations through different specialties, during which medical students assist licensed physicians in the care of patients.[20] During clinical rotations, medical students continue to develop their clinical judgment and medical decision-making skills through direct experience managing patients in all aspects of medicine. Following graduation, students must then pass a series of examinations to assess their readiness for licensure. At this point, medical students "match" into a three-to-seven-year residency program during which they provide care in a select surgical or medical specialty under the supervision of experienced physician faculty. As resident physicians gain experience and demonstrate growth in their ability to care for patients, they are given greater responsibility and independence. NP programs do not have similar time-tested standardizations. For example, between 2010-2017, the number of NP programs grew by more than 30 percent, with well over half of these programs offered mostly or completely online, meaning less in-person instruction and hands-on clinical experience.[21] In addition, many programs require students to find their own preceptor to meet their practice hours requirement, resulting in variation among students' clinical experiences. This variation in preceptorship and lower educational standard creates difference in qualifications among NPs and leaves a large gap in the knowing-doing bridge which leaves NPs ill-prepared to handle the complexity of the clinical environment, inexperienced in teamwork, and lacking knowledge about patient care.[22] This difference in education highlights the lack of ability for these non-physician practitioners (NPPs) to make complex medical determinations on their own.

Therefore, it is imperative that the VA require that only physician-led teams make abortion care determinations in conformance with the standards of good medical practice.

Abortion Services and Counseling

The AMA supports the VA's actions to amend existing regulations to allow the VA to provide access to abortion counseling and in certain cases, abortions to pregnant veterans and VA beneficiaries (i.e., VA beneficiaries enrolled in CHAMPVA). Specifically, the VA will provide access to abortions when the life or health of the pregnant veteran would be endangered if the pregnancy were carried to term, or when the pregnancy is the result of rape or incest. The AMA strongly agrees that pregnant veterans and VA beneficiaries deserve to have access to such services, which is essential for preserving the life and health of veterans and VA beneficiaries. As noted in the preamble to the IFR, veterans of reproductive age have high rates of chronic medical and mental health conditions that may increase the risks associated with pregnancy, and lack of access to abortions can result in loss of future fertility, significant morbidity, or death. Since the *Dobbs* decision, the AMA has been very concerned about the impact of state bans on abortion on access to comprehensive reproductive services, including abortion. According to a new report from the Guttmacher Institute, 66 clinics in more than a dozen states have stopped providing abortions.[23]

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[20] https://medicine.vtc.vt.edu/content/dam/medicine_vtc_vt_edu/about/accreditation/2018-19_Functions-andStructure.pdf.

[21] David I. Auerbach, Peter I. Buerhaus, and Douglas O. Staiger. Implications of the Rapid Growth of the Nurse Practitioner Workforce in the US 10.1377/hlthaff.2019.00686 HEALTH AFFAIRS 39, NO. 2 (2020): 273–279.

[22] https://vdocument.in/closing-the-education-practice-gap-toward-nursing-education-according-to-the-survey.html?page=4.

[23] https://www.guttmacher.org/2022/10/100-days-post-roe-least-66-clinics-across-15-us-states-have-stopped-offering-abortion-care.

Thus, it is even more critical that the VA provide access to counseling about abortion and abortion services to veterans and CHAMPVA beneficiaries in those states where abortion has been banned.

The AMA strongly supports preserving access to evidence-based reproductive health care services, including fertility treatments, contraception, and abortion, and opposes any effort to undermine the basic medical principle that clinical assessments, such as *viability of the pregnancy* and safety of the pregnant person, are determinations to be made only by health care professionals with their patients (emphasis added). As such, the AMA recommends that the VA strengthen the IFR by specifically including an exception to allow abortions for fatal fetal abnormalities, and to acknowledge in the text of the rule that the exception allowing abortions for the "health" of the pregnant beneficiary includes the patient's mental health, in addition to physical health.

If you have any questions, please feel free to contact Margaret Garikes, Vice President, Federal Affairs, at margaret.garikes@ama-assn.org or 202-789-7409.

Sincerely,

James L. Madara, MD