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SUBCOMMITTEE ON HEALTH

Hearing on Veterans' Access to Reproductive Healthcare

Veterans' Access to Reproductive Healthcare: Enhance Equity Now

BY

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Chairwoman Brownley, Ranking Member Dunn, distinguished members of the Committee, thank you for the opportunity to discuss a topic I believe is of vital importance to the overall well-being of America's veterans: reproductive health is a core component of overall health.

Among women veterans ages 18–44, reproductive health issues are one of the top 10 reasons they seek care at the Department of Veterans Affairs (VA), the only demographic for which that is true.¹ Accordingly, I will focus my testimony primarily on reproductive health care for this population, while acknowledging that both men and older women also both need and deserve the highest quality full spectrum of care.² The high rate of reproductive health care-seeking among younger women veterans also demonstrates the fundamental importance of VA having providers who are knowledgeable about this domain of health—and its nuances among our population. For example, the high rate of post-traumatic stress disorder related to military sexual trauma among women veterans points to the urgency of being able to provide trauma-informed care, particularly during pelvic examinations.

In terms of reproductive health care for women veterans, there are areas of practice in which VA is excelling and truly leading the way; however, there are also matters of law and policy that demand change in order to provide equitable care to all women veterans.³

I. Areas of Success

Within VA, patients receive comprehensive and integrated care from a patient-aligned care team. To give an example of what this means, in the private sector my gynecologist and primary care provider used different electronic health records and I was responsible for keeping both up to date about health screenings conducted in the other setting. Conversely, all my VA providers have access to my complete health record, and they can easily collaborate if needed. VA also provides high-quality care, as further documented in the recently released Center for a New American Security (CNAS) working paper “Comparing VA and Non-VA Medical Centers.”⁴ This is true even on gender-specific measures: in fiscal year 2014, 88 percent of VA patients get cervical cancer screenings versus 74–76 percent of patients in the private sector and only 60 percent of Medicaid patients; when it came to breast cancer screening, 86 percent of VA patients got mammograms when recommended, compared to 69–74 percent in the private sector.⁵ Comprehensive health services available to women veterans today include primary, specialty, hospice/palliative, mental health, infertility, gynecology, and maternity care services, including seven days of newborn care; VA has trained over 7,000 providers and nurses through Women's Health Mini-Residency programs. Age-appropriate cancer screening rates are also higher among women assigned to Women's Health Primary Care Providers, emphasizing the need for care coordination; concerning, while still higher than in the civilian sector, these rates have declined in recent years.

In response to the increased number of women veterans of reproductive age receiving care at the VA, the agency created the maternity care coordinator (MCC) role in 2012. VA currently has 137 MCCs who serve pregnant women veterans in 140 medical facilities nationwide. MCCs develop relationships with a variety of VA providers and offices as well as non-VA community providers and support pregnant women veterans throughout pregnancy and into postpartum, a vital service that is being strained as the pandemic has forced many health care professionals to redirect their attention. Women veterans using VA for health care are also eligible for an array of benefits, ranging from preconception care to pregnancy support through seven days of newborn care, all managed by a dedicated maternity care coordinator. Nursing moms can receive not only a breast pump, but also nursing bras, nursing pads, nipple cream, and breast milk storage bags—extraordinary support that goes far beyond what I got from private insurance when my daughter was born.

To both enhance that support and spread the word about these benefits, while I ran the Center for Women Veterans (CWV), we supported the 2018 VA Nationwide Baby Shower. At 62 VA medical centers around the country, we sent

veteran families home with an array of free helpful items for mom and baby at little cost to government thanks to effective public-private partnerships.⁶ Many sites, like Hines VAMC in Chicago where I had the privilege of attending a shower, were also able to provide additional items including strollers, car seats, and more from local partners. Educational tables also provided training on infant CPR, proper car seat installation, VBA benefits, local resources, and more, meaning parents-to-be went home with both supplies and knowledge. Extensive media coverage around the country also raised awareness among many not yet enrolled in VHA healthcare about maternity benefits, fulfilling the second key goal of this initiative. These baby showers were an important part of our campaign to educate and encourage women to enroll in VA care, and I urge CWV to hold them annually nationwide in collaboration with VHA's Office of Women's Health and the Secretary's Center for Strategic Partnerships.

II. Room to Improve

While I laud VA's success in these key areas, there are three key areas in which VA has neglected to take action for so long that I now believe they require congressional attention: in vitro fertilization (IVF), contraception, and abortion.

IVF

Infertility affects roughly 12 percent of married women, but VA's medical benefits package specifically excludes provision of in vitro fertilization.⁷ Overriding this VA regulation, in 2016 Congress authorized VA to cover assisted reproductive technology for veterans and their spouses solely when a service-connected disability caused the infertility. As written and implemented, this authorization does not cover unmarried veterans, same-sex couples, those who cannot provide their own gametes, or veterans who are experiencing infertility for other reasons—including, for example, women who delayed pregnancy during military service due to previous policies that did not adequately support parenthood.

Rather than continue operating a complicated and limited program, VA should remove this outdated exclusion from the medical benefits package. IVF and other forms of assisted reproductive technology should be available to all veterans who are eligible for other types of VA infertility care, such as intrauterine insemination. Should the concern be related to the potential added cost of expanding this benefit to a wider array of veterans, cost could be reduced by following Quebec's lead and requiring single-embryo transfer in most cases, thus dramatically reducing the number of expensive and dangerous multiple births.⁸ Purposefully or not, this benefit is currently de facto discriminatory against LGBT veterans – an inequity that must be addressed.

Contraception

The Affordable Care Act required private health plans to cover contraceptives with no out-of-pocket costs. It also considered VA health care “minimum essential coverage” and did not make any significant changes to VA health benefits or out-of-pocket costs. Accordingly, VA can—and does—still charge many women veterans co-payments for birth control. Access to affordable contraceptives is an essential component of comprehensive health care for women, and since VA patients tend to be sicker and poorer than non-veteran patients, charging women veterans a co-payment that women using other types of care are not required to pay is particularly galling.

Representative Brownley has already introduced a bill that would prohibit VA from requiring payment for contraceptives from veterans, H.R. 3798, the Equal Access to Contraception for Veterans Act; I urge the House to vote on this bill promptly.⁹ CBO estimates collections of co-payments would be reduced by \$5 million over the time period from 2020–2025.¹⁰ However, this does not take into account the cost savings that would be delivered by reducing the number of unintended births. Previous research about cost savings from public provision of contraception due to reduction in expenses related to prenatal, delivery, and postpartum care has put savings to taxpayers of “\$4 for every \$1 spent on family planning.”¹¹ Accordingly, it is likely that—as with other public programs

as well as private insurance—rather than a cost to VA, there would be a net cost savings associated with eliminating co-payments to make birth control more accessible.

Abortion

Politicians have no place denying health coverage for abortion for people who are struggling financially. Yet, for decades, politicians opposed to reproductive health, rights, and justice have used the Hyde Amendment to block coverage of abortion for those enrolled in Medicaid for health care except for in cases of rape, incest, or life endangerment of the pregnant person. Over time, Congress and federal agencies expanded the scope of the Hyde Amendment to apply to other federal health care programs. Indeed, in some federal programs, the coverage was even less than that allowed by the Hyde Amendment. For example, until the Shaheen Amendment expanded coverage to victims of rape and incest was signed into law in 2013, for example, DoD only covered abortions when a pregnant woman's life was at risk.

VA's medical benefits package limits care even more narrowly than the Hyde Amendment, excluding abortions and abortion counseling with no exemptions. This means that women veterans are not able to get even the minimal abortion coverage available to any other women receiving health care through the federal government, including those using Indian Health Service, Medicare, TRICARE, the Peace Corps, Federal Employees Health Benefits Program, or in federal prisons. And it means that veterans, along with women who rely on these federal programs, have drastically less coverage than the vast majority of those who rely on private insurance for health care. This is an appalling inequity that must be addressed immediately.

Veterans who use VA for health care often face more significant health burdens and may be in financially precarious positions, particularly during this time of unprecedented economic crisis. However we feel about abortion, we should not deny health coverage for it to women veterans just because they are struggling financially, thus taking away their ability to make important personal decisions about their health and futures with dignity and respect. It is appalling that there is no coverage of abortion care or abortion counseling if a woman veteran has been raped and is seeking VA care for resulting PTSD. It is wrong that the VA provides no coverage for a veteran who is not ready to parent or is already parenting and makes the moral decision for herself that she does not want to carry a pregnancy to term. And it is wrong that there is no coverage of abortion care if a woman has pre-eclampsia or any of the other pregnancy-related conditions that are life-threatening. Not even for an ectopic pregnancy, which can result in uncontrollable bleeding and death if the fallopian tube ruptures. Under the language of VA's benefits, not only are VA providers prohibited from providing medically necessary care to their patients, they are barred from even providing abortion *counseling* to women—who, again, may be traumatized from rape or risking fatal complications.

Moreover, the complete lack of coverage of any abortion care means that a woman could leave active duty because she was sexually assaulted, and, expecting to receive the same level of care she could get in the military, walk into VA the next day as a veteran but no longer be able to access the care she and her provider agree is vital to her well-being. How is it just—or even possible—that because I am a veteran, my doctor would be prohibited from saving my life with a safe, simple procedure?

This issue has long been known. To give just one recently documented example, VA's Advisory Committee on Women Veterans recommended formally removing the exclusion of IVF and abortion from VA's medical benefits package in their 2016 report;¹² however, VA did not bother to provide an update on the status of these recommendations to the Congressionally-mandated committee,¹³ which was alluded to in its 2018 report.¹⁴ VA can and should act immediately to eliminate this exclusion and provide a full spectrum of health care to women veterans.

Absent VA action, the most effective way to resolve this issue for women veterans would be for Congress to pass the EACH Woman Act, lifting the discriminatory Hyde Amendment entirely and restoring abortion coverage for all

women, regardless of how we get our health care. At a minimum, however, the VA should immediately eliminate this potentially deadly component of VA's medical benefits package.

III. Conclusion

VA should be lauded for its exceptional rates of breast and cervical cancer screenings, ongoing efforts to improve the number of women's health primary care providers, and excellent maternity care coordination program—and it should ramp up efforts to raise awareness of its high-quality care for women veterans. However, VA's longstanding inaction on enhancing equity in access to IVF, contraception, and abortion makes it clear that Congress must act to address these gaps. Women veterans stepped forward to serve our nation at great risk to themselves. Now Congress must step forward and ensure that they can access the full spectrum of health care that they deserve.

¹ Department of Veterans Affairs, *Women Veterans in the Veterans Health Administration*, Vol. 4 (February 2018), 1–144, https://www.womenshealth.va.gov/WOMENSHEALTH/docs/WHS_Sourcebook_Vol-IV_508c.pdf.

² The Task Force should consider inquiring, for example, about rates of influenza vaccinations by gender in VA.

³ Note: The views in this statement are my own and should not be interpreted as representing any employer, current or former, including the U.S. government.

⁴ Jill Inderstrod and Shelley MacDermid Wadsworth, “Comparing VA and Non-VA Medical Centers,” (Center for a New American Security, May 2020), 1–16, <https://www.cnas.org/publications/reports/comparing-va-and-non-va-medical-centers>.

⁵ Kayla Williams, “State of Women Veterans: VA women's health care more proactive in some areas of care than private sector,” Vantage Point, October 12, 2016, <https://www.blogs.va.gov/VAntage/31833/state-of-women-veterans-va-health-care-more-proactive-for-women-in-some-area-of-care-than-many-civilian-facilities/>.

⁶ The list of participating sites and partners is available at <https://www.va.gov/womenvet/acwv/babyShower.asp>

⁷ 38 U.S.C. § 1, “Pensions, Bonuses, and Veterans' Relief,” 680,

<https://www.gpo.gov/fdsys/pkg/CFR-2014-title38-vol1/pdf/CFR-2014-title38-vol1-part17.pdf>.

⁸ Kathryn Doyle, “Insurance coverage of IVF may decrease multiple pregnancies,” Reuters, May 14, 2014, <https://uk.reuters.com/article/us-insurance-ivf-twins/insurance-coverage-of-ivf-may-decrease-multiple-pregnancies-idUKKBN0DU1EY20140514>.

⁹ U.S. House of Representatives, *Equal Access to Contraception for Veterans Act*, H.R. 3798, 116th Congress, 1st Session, <https://www.congress.gov/bill/116th-congress/house-bill/3798>.

¹⁰ Congressional Budget Office, *Cost Estimate: Equal Access to Contraception for Veterans Act*, (April 8, 2020), <https://www.cbo.gov/system/files/2020-04/hr3798.pdf>.

¹¹ U.S. Department of Health & Human Services, *The Cost of Covering Contraceptives Through Health Insurance*, (February 10, 2012), <https://aspe.hhs.gov/basic-report/cost-covering-contraceptives-through-health-insurance>.

¹² Department of Veterans Affairs, *Report of the Advisory Committee on Women Veterans*, (September 2016), <https://www.va.gov/womenvet/docs/acwv/acwvReport2016.pdf>.

¹³ Department of Veterans Affairs, *Advisory Committee on Women Veterans Meeting Minutes*, (December 2018), <https://www.va.gov/ADVISORY/docs/Minutes-WomVetMay2018.pdf>.

¹⁴ Department of Veterans Affairs, *Report of the Advisory Committee on Women Veterans*, (September 2018), <https://www.va.gov/ADVISORY/docs/ReportWomVetSep2018.pdf>.