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BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON VETERANS' AFFAIRS

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LEGISLATIVE HEARING

THURSDAY, JUNE 12, 2025

SUBCOMMITTEE ON HEALTH,
COMMITTEE ON VETERANS' AFFAIRS,
U.S. HOUSE OF REPRESENTATIVES,
Washington, DC.

The subcommittee met, pursuant to notice, at 2:15 p.m., in room 360, Cannon House Office Building, Hon. Mariannette Miller-Meek [chairwoman of the subcommittee] presiding.

Present: Representatives Miller-Meek, Bergman, Murphy, Van Orden, Kiggans, Hamadah, King-Hinds, Brownley, Cherfilus-McCormick, Dexter, Conaway, and Morrison.

OPENING STATEMENT OF MARIANNETTE MILLER-MEEKS, CHAIRWOMAN

Ms. MILLER-MEEKS. This legislative hearing of the Subcommittee on Health will now come to order. Without objection, the Chair may declare a recess at any time. Given that votes have been moved to 3 o'clock, we will, in all likelihood, declare a recess. I would like to welcome all members and witnesses to today's hearing. We have 12 important legislative proposals to consider here today. It is important to note that not all of the proposals will move forward in the legislative process, but many will. Congress is responsible for ensuring U.S. Department of Veterans Affairs (VA) stewards its resources effectively. Many of my colleague's bills would optimize the VA's funding, talent, and capital. Other bills reinforce VA's mission to care for veterans in mental and physical health.

I am grateful to Representative Hamadeh for introducing the Health Professional Scholarship Program (HPSP) Improvement Act. One of the greatest resource drains at the VA is the broken student-to-employee pipeline. The VA loses untold investments in student clinicians by offering scholarships in exchange for employment commitments only for the VA not to keep its end of the deal. Students are consistently unemployed for months before the VA gives them a position. These students have been driven to the point where they cut their losses with the VA and seek jobs elsewhere at great financial cost to them and an opportunity cost to the VA. Representative Hamadeh's bill would help end this unacceptable dilemma.

The Representing Our Seniors at VA Act by Representative Kiggins would improve the Geriatric and Gerontology Advisory Committee. Under current law, there is no requirement for input from State veterans homes, even though these homes are key part-

ners in serving aging veterans. Representative Kiggins's bill would fix this oversight by making sure these homes have a seat at the committee table.

The Veterans Patient Advocacy Act by Representative Moolenaar would increase the rural footprint for VA patient advocates. I know all too well how veterans in rural areas struggle to obtain care from the VA. I firmly support the bill's goal to have patient advocates accessible to rural veterans. I think we can all agree that we can always do more to ensure that VA's resources must keep evolving to reach veterans where they live.

The Territorial Response and Access to Veterans Essential Life Care (TRAVEL) Act by Representative King-Hinds would also help our veterans living in remote areas. This bill would require a 1-year billet for VA physicians at U.S. territories like the Northern Mariana Islands. Health care is not easy to come by in these remote parts of the world. This bill would place VA practitioners in the right places at the right times.

Representative McGuire's bill, the VA Data Transparency and Trust Act, tackles the unending reporting requirements at the VA and replaces them with a comprehensive and unified report on outcomes and metrics to improve VA programs. The laws today incentivize a system where consultants can create a cottage industry to broker reports, which diverts precious time and money away from VA's mission and only makes oversight more difficult. Congress has gained little from the manner in which it has received information from the numerous current VA reporting requirements. Representative McGuire's bill would pull in the reins and improve outcomes for veterans.

My bill, the Fisher House Availability Act, would make lodging in Fisher Houses more accessible for service members and their families. Fisher House Foundation is a nonprofit dedicated to providing lodging for veterans and service members in need. The VA owns most Fisher Houses. We know that service members and their families can stay at Fisher Houses whenever they get care from the VA. However, a recent agency interpretation prohibits them from using VA-owned Fisher House when receiving non-VA care, even though we all know there is more than enough room to house them. This bill does not displace veterans or veterans' families. It is important to know it would simply ensure that service members have access to available lodging. I am thankful to the Fisher House Foundation for supporting this bill, and I am proud to sponsor it.

Representative Luttrell's bill, the Service Dogs Assisting Veterans (SAVES) Act, picks up where the popular Puppies Assisting Wounded Servicemembers for Veterans Therapy (PAWS) Act left off. This bill covers the cost for service dogs that provide veterans with mental and physical assistance. The therapeutic benefits of service dogs are well established. I thank Representative Luttrell for his efforts to improve the availability of service dogs for veterans in need.

Representative Dunn's bill would align nonsmoking policies at Veterans Health Administration (VHA) with most medical facilities in America. Currently, there is no protection in law against smoking at VHA facilities. As a physician, I know how important it is

to make sure that patients breathe clean air when they receive care at the VHA facility. This bill would ensure that.

Finally, a bill introduced by Dr. Murphy would create a pilot program to build on existing research into Post-Traumatic Stress Disorder (PTSD)-related inflammation and cellular stress. The continued prevalence of PTSD in our veteran population requires us to continue finding new and innovative ways of screening and diagnosing PTSD. The research from this pilot program could help equip VA with the tools for preventive rather than reactive care for PTSD.

Again, these bills optimize VA and reinforce its mission to care for veterans' mental and physical health in exchange for their service in uniform. I now yield to Ranking Member Brownley for any opening remarks you may have.

OPENING STATEMENT OF JULIA BROWNLEY, RANKING MEMBER

Ms. BROWNLEY. Thank you, Madam Chair, and thank you to our witnesses for making the time to be here. I understand we will have votes, as the Chairwoman said, that could interrupt us this afternoon. I will keep my remarks brief to allow us to get to everyone's testimony. While Committee Democrats appreciate and are not opposed to the intent of many of the Republican bills on today's agenda, we would like to see some changes and improvements on some of these bills. I hope we will be able to work together collaboratively with our majority colleagues to make these improvements through the committee markup process and put forth the best possible legislation to support our veterans.

I am pleased we are considering three Democratic bills today, including my bill, the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) Children's Care Protection Act. I first introduced this bill in 2019, and it has long been a priority for numerous veteran service organizations and organizations serving caregivers and survivors. CHAMPVA provides health care coverage for spouses and dependent children of veterans with permanent and total service-connected disabilities and for the surviving spouses and children of veterans who have died from service-connected disabilities.

When the Affordable Care Act (ACA) was signed into law in 2010, it required private-sector health plans to allow children to stay on their parent's insurance until they are 26 years old. However, this ACA mandate was not extended to military or veteran health coverage. This inequity was addressed for TRICARE in 2011, but to date, we have not extended parity to the CHAMPVA program. It is long past time to right this wrong. I am glad we will have a chance to hear directly from a caregiver, Ms. Caira Benson, about what this legislation would mean for her and her family. I look forward to working with the VA to learn how we can address the department's concerns and ensure that caregivers and their families have the support that they deserve.

To that end, I also appreciate that we are considering Representative Morelle's bill, H.R. 2148, The Veteran Caregiver Reeducation, Reemployment, and Retirement Act. This legislation will provide VA and other agencies additional authorities to support veteran

caregivers as they transition out of VA's program of comprehensive assistance for family caregivers. The sacrifices caregivers make, including for their own earning potential and financial security, are immense, and we must support them by ensuring they have the tools and the resources they need. I know Ms. Benson will also provide powerful testimony in support of Representative Morelle's bill.

Finally, I know Congresswoman Budzinski will be here to discuss her own legislation, the VA Mental Health Outreach and Engagement Act, so I will briefly just say that I also support her bill. This legislation will ensure that VA conducts regular outreach and offers consultations to assess the needs of veterans with service-connected disability ratings for mental health conditions. We know that veterans who are connected with VA care have better health outcomes and lower risk of suicide than veterans who are not connected. I am glad Congresswoman Budzinski's bill will allow more eligible veterans to engage with VA care.

I look forward to hearing from all of our witnesses today. With that, Madam Chair, I will yield back.

Ms. MILLER-MEEKS. Thank you, Ranking Member Brownley. We have a full agenda today, so I will be holding everyone to 3 minutes per bill to ensure we can move in a timely manner. In accordance with Committee Rule 5(e), I ask unanimous consent that Representative Luttrell from Texas be permitted to participate in today's subcommittee hearing. Without objection, so ordered.

I now recognize Representative Murphy for 3 minutes to speak on his bill.

STATEMENT GREG MURPHY

Mr. MURPHY. Thank you, Chairwoman Miller-Meeks and Ranking Member Brownley, for holding this meeting today. My bill, H.R. 3886, the Veterans PTSD Screening Act, is being discussed at today's hearing. You know, we talk a lot about mental health with our veterans, especially with PTSD and Traumatic Brain Injury (TBI), and anything that we can do to move the needle. I have been obviously a big fan of hyperbaric oxygen therapy, but any other thing that we can do to move the needle is critical in how we are trying to help the veterans who have kept us free.

I am going to talk a little bit about something called Ribonucleic Acid (RNA), RNA sequencing. Deoxyribonucleic Acid (DNA) is in our body, and DNA is a constant thing in our body. RNA rather changes with different experiences, with different memories, et cetera, in our brain. What we have found and has been well documented is the ability to measure RNA sequencing, either microRNA or something called long digital RNA, in different assays. These have become a predicting point to determine levels of stress within the body. Where compared to controls, those who have experienced PTSD have a markedly different pattern of RNA. What this bill is going to do is going to direct the VA to study this RNA sequencing in five separate veterans' VINs. I think it is going to be critical as we put our armamentarium, as our toolbox gets bigger and bigger as technology advances, that this will be a great tool.

Now, caveats. We do not want to ever deny care based upon what is found with RNA sequencing. We also do not want to make this

as a single modality. We have to have a holistic approach to PTSD. Being able to monitor just this one single variable really helps us, but it is not going to be the sole object for doing this.

The science is growing. We are actually using this in some VAs right now, as been modeled in some VAs right now and is being modeled in other places, trauma centers, et cetera. I think we are seeing as technology increases, especially with AI, that we are going to be able to use all these new different tools to help our veterans, those who have experienced PTSD, and hopefully come up with a cure 1 day. If not, be able to monitor, to diagnose, and to monitor treatment as we treat our veterans.

I will ask for appreciation and I would love us to bring the vote to committee. Thank you, Madam Chairwoman. I yield back.

Ms. MILLER-MEEKS. Thank you, Representative Murphy. The Chair now recognizes Representative Budzinski for 3 minutes to speak on her bill.

STATEMENT OF NIKKI BUDZINSKI

Ms. BUDZINSKI. Thank you, Chairwoman Miller-Meeks, and thank you to Ranking Member Brownley. I appreciate this for giving me the opportunity to speak on my bill, H.R. 3863, the VA Mental Health Outreach and Engagement Act, which would expand VA's outreach to veterans about mental health services. I also want to thank my Republican colleague, Mr. Edwards, for co-leading this bipartisan bill.

As a member of the Veterans Affairs Committee, I have heard from veterans unaware of where to turn for support and care for the invisible wounds of war. We must support our veterans and provide them with the knowledge and resources to prosper following their service to our Nation. My bill would ensure we are proactively reaching out to veterans with mental health-related service-connected disabilities and connecting them with the care that they need. Navigating the VA should never be a burden, and this bipartisan legislation would help to make it easier for veterans to get the mental health care that they have earned.

I am also here today to speak in support of H.R. 3767, the Health Professional Scholarship Program Improvement Act. I want to thank my colleague on the committee, Congressman Hamadeh, for his leadership and bipartisan collaboration on this bill. VA's Health Professional Scholarship Program supports the students pursuing healthcare careers while connecting VA with talented staff. When program participants graduate, they are often met with delays in receiving a contract. Amid Veteran Health Administration staffing shortages, we need solutions to address this inefficiency. This legislation would streamline the path for HPSP participants to start working full-time, making it easier for veterans to get the care that they need.

For both of these bipartisan bills, I am committed to working with my colleagues on both sides of the aisle, the VA and Veterans Service Organizations (VSO), to ensure we are continuing to improve healthcare for our Nation's veterans. Thank you very much for the time, and I yield back.

Ms. MILLER-MEEKS. Thank you, Representative Budzinski. The Chair now recognizes Representative King-Hinds for 3 minutes to address her bill.

STATEMENT OF KIMBERLYN KING-HINDS

Ms. KING-HINDS. Thank you, Chairwoman Miller-Meeks and Ranking Member Brownley, for the opportunity to speak on my bill, H.R. 3400, The Territorial Response and Access to Veterans Essential Life Care Act, or the TRAVEL Act of 2025 for short, which aims to provide much-needed medical care to the United States territories.

My home, the Northern Mariana Islands, has one contracted part-time doctors who sees and cares for hundreds of veterans who are spread across three islands. Which means if a veteran needs specialized medical care, he or she must travel to Guam, Hawaii, or the continental United States for health care. This is not only acceptable, it is offensive to the people who have served our country. Veterans should not have to pay upfront for air travel, book appointments across the globe, or forego medical care entirely because there are no nearby accessible doctors.

Our Nation's heroes have worked hard and sacrificed so much to provide for us. We owe medical care to our veterans. We are indebted for their service. The very least we can do is to ensure they can go to a cardiologist or a neurologist when they need it. It is my hope that the TRAVEL Act will begin to address the medical desert that veterans face every day in the Northern Mariana Islands and all across the territories.

This bill, once passed, will create a program similar to Doctors Without Borders. Veterans' Affairs, who supports this bill, will send doctors to the territories for periods of up to 1 year so they can practice specialized medical care on Island. It will not bring the status of medical care for veterans in my district up to par with care available in the continental United States, but every little bit, any sort of improvement will help, and this bill does that.

I ask and urge all of my colleagues in the House of Representatives to stand behind me as I advocate for our heroes across our territories. Thank you, Madam Chair. I yield my time back.

Ms. MILLER-MEEKS. Thank you very much, Representative King-Hinds. The Chair now recognizes Representative Luttrell for 3 minutes to speak on his bill.

STATEMENT OF MORGAN LUTTRELL

Mr. LUTTRELL. Thank you, Madam Chairwoman and Ranking Member Brownley, for inviting me to speak on the Service Dogs Assisting Veterans Act. This legislation is an important step forward toward improving access to service dogs for our veterans. This pilot program gives the Secretary the authority to award competitive grants to nonprofits that provide service dogs to assist veterans who need them most.

We are talking about men and women who have borne the weight of war, many of them returning from a theater of combat with invisible wounds. Nearly one in five veterans from those conflicts live with post-traumatic stress, post-traumatic stress disorder, or other cognitive issues. Over 450,000 veterans have suf-

fered at least one traumatic brain injury over the past two decades. These are not just numbers. These are warriors now battling depression, anxiety, addiction, joblessness, and homelessness. Right now, we are losing an estimated 17 to 22 veterans a day to suicide. This is absolutely a national crisis.

Service dogs are more than companions. They are a life changing—they are life changing. They assist veterans. They assist veterans in regaining a sense of normalcy and control. They support those living with post-traumatic stress and traumatic brain injury and also assist vets dealing with mobility issues, vision loss, and hearing impairments. These dogs help our veterans live independently and stay active and re-engage with their families and their communities. This program is about giving back to those who never hesitated to serve. It is a step toward healing and toward honoring the promise we made to our veterans.

Cost is one of the biggest hurdles veterans must jump over when it comes to service dogs. I am pleased that this legislation would enable veterans to gain access to highly trained service dogs at no cost. Ensuring our veterans have access to the biggest resources is a team sport. The SAVES Act team is comprised of dedicated members from across the political spectrum working to make this bill a reality. We also count numerous veterans organizations who are ready to execute and provide our veterans with highly trained service dogs who will make their life better.

I would like to thank this committee and Ranking Member McGarvey for their assistance. Thank you, and I yield back.

Ms. MILLER-MEEKS. Thank you, Representative Luttrell. The Chair asked—in accordance with Committee Rule 5(e), I asked unanimous consent that Representative McGuire from Virginia be permitted to participate in today's committee subcommittee hearing. Without objection, so ordered. The Chair now recognizes Representative McGuire for 3 minutes to speak on his bill.

STATEMENT OF JOHN MCGUIRE

Mr. MCGUIRE. I need a little teammate teamwork for my SEAL brother. Thank you, Madam Chair. We would not have a country without our men and women who risk their life or give their life. For all of our men and women, our veterans, thank you. Ranking Member Brownley, thank you as well. For the opportunity to speak on my bill, H.R. 3643, the Virginia Data Transparency and Trust Act, which I was proud to introduce with my good friend, the chairman of the full committee, Chairman Mike Bost of Illinois. Information and access to reliable and accurate data are necessary to all industries and government agencies. Nowhere is this need more apparent or more important than the Department of Veterans Affairs.

Over the past 10 years, the VA's budget has increased by nearly 220 percent while the daily suicide rate has remained flat, with 18 veterans committing suicide each day, with some experts believing that number might be higher. We also cannot forget that last November, the Department of Veterans Affairs made egregious mistakes and its accountant and budgeting practices, and they came to Congress last summer asking for additional funds or else veterans would lose their benefits. This resulted in a $3 billion stop-

gap spending bill that was rushed through Congress to ensure veteran benefits could continue, only for us to learn months later that there was no shortfall at all. Clearly, Congress needs to have better oversight of how the VA spends taxpayer funds and where they spend it.

Currently, the department provides Congress with a wide range of reports but falls short of providing timely and accurate reports conducted by other agencies, such as the Department of Defense (DOD), with regard to TRICARE and the Center for Medicare and Medicaid Services. My bill would require that the VA provide an annual comprehensive report that would provide Congress and congressional support agencies with the necessary information to provide proper and clear oversight while allowing for greater visibility of veterans needs and the usage of certain programs. Without comprehensive and useful data, Congress cannot make informed decisions about veterans' healthcare, disability compensation or program funding. This bill modernizes the way the VA handles data, bringing it in line with other major Federal agencies' best practices.

I would like to thank Chairwoman Miller-Meeks for allowing me the time to speak and be impart on this important legislation today. I will yield back the balance of my time.

Ms. MILLER-MEEKS. Thank you, Representative McGuire. Seeing no other members here to speak on their bills, as is our practice, we will forego a round of questioning for the members. For those off committee members who are here, you may remain to ask questions of our witnesses if you have time.

I now invite our first panel to the table. Thank you. Joining us today is Dr. Antoinette Shappell with support from Dr. Ilse Wiechers. Dr. Shappell is Deputy Assistant Undersecretary for Health and Patient Care Services at VHA. Dr. Wiechers is Deputy Executive Director of the Office of Mental Health and Suicide Prevention at VHA.

Dr. Shappell, you are now recognized for 5 minutes to prevent the department's testimony.

STATEMENT OF ANTOINETTE SHAPPELL

Dr. SHAPPELL. Thank you. Chairwoman Miller-Meeks, Ranking Member Brownley, and members of the subcommittee thank you for inviting us to discuss several bills affecting Veterans Affairs programs and services. My name is Dr. Antoinette Shappell, and I currently serve as the Deputy Assistant Undersecretary for Health for Patient Care Services. I am joined today by Dr. Ilsa Wiechers, Deputy Executive Director for the Office of Mental Health.

While VA's detailed views on each of the bills are included in my written statement, I will briefly highlight some of the bills. First, H.R. 785, the Representing Our Seniors at VA Act. VA supports the intent and has already appointed a member of the National Association for State Veteran Homes to the Gerontology Advisory Committee in 2024. We have some concerns with the legislation as written.

Next is H.R. 1404, the CHAMPVA Children's Care Protection Act of 2025, which would extend CHAMPVA benefits for children until

age 26. CHAMPVA is a medical care benefit for dependents of certain veterans similar to DoD's TRICARE. However, VA does not support this bill because we believe this coverage up to age 23 is sufficient for our beneficiary population. VA is concerned that the bill would require resources that could otherwise be used to support patient care.

VA agrees with the intent of H.R. 2068, the Veterans Patient Advocacy Act. The bill aims to ensure rural veterans can access patient advocates. VA has expanded advocacy options for veterans, such as local advocates, online platforms, and the VA Hotline to meet veterans' needs. VA has concerns with some of the bill's provisions.

The Veteran Caregiver Reeducation, Reemployment, and Retirement Act, H.R. 2148, proposes several changes. It extends CHAMPVA benefits for 180 days for primary family caregivers after their designation ends, offering a necessary transition time for seeking alternative health care coverage. The bill also suggests employment assistance and compensation, including training for caregivers. VA supports Section II of the bill, subject to appropriations. We generally support Section III of the bill, subject to appropriations. However, we do have some concerns with the certain provisions and would appreciate the opportunity to discuss these concerns with the committee.

The Service Dogs Assisting Veterans ACT, or the SAVES Act, H.R. 2605, requires the VA to establish a pilot program to provide service dogs to eligible veterans. VA supports this but recommends clarifying the bill's language for effective use of funds. We also propose aligning terminology with existing VA definitions. We do have concerns about including traumatic brain injury and post-traumatic stress disorder in the criteria, given insufficient evidence of service dogs' effectiveness for PTSD.

Additionally, H.R. 3400, the TRAVEL Act, proposes assigning traveling VA physicians to territories and possessions in the U.S. VA supports this with amendments to clarify the bonus eligibility and coordination of care, ensuring physicians provide care where it is needed. We agree with the intent to expedite the employment process for healthcare professions. However, we do not support the bill seeking to expedite VA employment for health professional scholarship program participants within 90 days.

VA supports the VA Data Transparency and Trust Act, which requires VA to submit detailed reports and create a data-sharing system for researchers. However, we recommend amendments to focus on desired topic areas to avoid complex and resource intensive implementation.

The Fisher House Availability Act of 2025 aims to extend lodging benefits at Fisher Houses. VA supports this, provided amendments to clarify eligibility for service members and dependents, ensuring the bill's language aligns with current practices.

We strongly support the bill banning smoking in all VHA facilities.

VA supports the intent of the draft bill, directing VA to conduct a study on RNA sequencing to diagnose PTSD. We do have concerns with several of the bill's provisions and would appreciate the opportunity to discuss our concerns with the committee.

VA supports the VA Mental Health Outreach and Engagement Act. Support is subject to amendments and the availability of appropriations. We would appreciate the opportunity to discuss amendments with the committee and provide technical assistance.

This concludes my statement. We are happy to answer any questions you or other members of the subcommittee may have. Thank you.

[THE PREPARED STATEMENT OF ANTOINETTE SHAPPELL APPEARS IN THE APPENDIX]

Ms. MILLER-MEEKS. Thank you for your testimony, Dr. Shappell. Your full written statement will be entered into the record.

As is my typical practice, I will reserve my time until all of the members have had a chance to ask their questions, especially with pending votes coming. I now recognize Ranking Member Brownley for 5 minutes for any questions she may have.

Ms. BROWNLEY. Thank you, Madam Chair. Dr. Shappell, thank you for being here. In your testimony, your written testimony, anyway, you say that the—that VA opposes the CHAMPVA because it is not an insurance plan. Is that correct?

Dr. SHAPPELL. Yes.

Ms. BROWNLEY. If you could answer just a couple of questions for me, just yes—yes or no. The first one, does CHAMPVA have cost-sharing requirements like deductibles and co-pays?

Dr. SHAPPELL. I would need to that for the record.

Ms. BROWNLEY. Well, I can say that it does for the record. Are there any limitations to the services and supplies covered by CHAMPVA?

Dr. SHAPPELL. I would also take that one for the record.

Ms. BROWNLEY. It does. Does CHAMPVA use a formulary?

Dr. SHAPPELL. I believe so, but I can get specifics for the record.

Ms. BROWNLEY. Well, I can tell you that it does. Does CHAMPVA have any prior authorization requirements for services like mental health and substance use treatment?

Dr. SHAPPELL. I believe so, but I can—I can——

Ms. BROWNLEY. I can tell you—say that it does. Is CHAMPVA considered credible coverage for the purposes of the ACA's mandate that individuals have health insurance coverage?

Dr. SHAPPELL. CHAMPVA is a benefit, but it is not an insurance policy per se.

Ms. BROWNLEY. Well, the point that I am trying to make here is that all the questions that I just asked you, the answers are yes. Then, of course, you say that it is not a health insurance policy, but it certainly sounds like one. It has, you know, the questions that I just asked you were sort of almost like a checklist for insurance policies. It just seems to me that CHAMPVA—you say it is not a health insurance policy. I say it certainly appears to be one. As the old saying goes, if it walks like a duck and swims like a duck and quacks like a duck, it is probably a duck.

DoD's TRICARE program was not affected by the ACA either. However, Congress created the TRICARE Young Adult program in 2011 to provide health care for qualified young adults ages 21 to 26 who are unmarried and not eligible for an employer-sponsored health plan. Why is VA advocating for the dependents and survivors of service-disabled veterans to be treated differently and less

than TRICARE beneficiaries? This legislation would create that long-standing inequity.

In her testimony on behalf of the Elizabeth Dole Foundation, Mrs. Benson suggests that our committee should use its oversight authority to improve the administration of the CHAMPVA program. I certainly agree. She recounts the incredible number of hurdles she has to overcome in getting services covered, getting claims paid, and even simply getting VA to process the paperwork to recertify her child's status as a college student. Yes, I mean paperwork because CHAMPVA is still operating, in my most humble opinion, in the dark ages with paper-based forms and a month's long backlog in processing the mail.

Dr. Shappell, 7 weeks ago today, committee staff submitted a few simple questions to VHA regarding academic enrollment recertification requirements for CHAMPVA beneficiaries. We have yet to receive a response despite our attempts to follow up. Can I have your assurance that we will receive answers to these questions within the next week, which will make it more than 2 months since we requested the information?

Dr. SHAPPELL. Thank you. I do not have a timeline right now, but I can assure you that I will work with my colleagues in our Office of congressional Legislative Affairs to ensure you have a response.

Ms. BROWNLEY. You cannot state at a timeline? Not a week, not 2 weeks, not a month, not 3 months?

Dr. SHAPPELL. Not at this time.

Ms. BROWNLEY. I yield back.

Dr. SHAPPELL. Thank you.

Ms. MILLER-MEEKS. Thank you, Representative Brownley. The Chair now recognizes representative Dr. Murphy for 5 minutes for any questions he may have.

Mr. MURPHY. I am going to hold off and pass on questions. I will come back later. Thank you.

Ms. MILLER-MEEKS. The Chair now recognizes Representative King-Hinds for any questions she may have.

Ms. KING-HINDS. just have a couple of questions. I was reading over your comments on the proposed TRAVEL Act, and first of all, thank you for the support. Section, the proposed section 7415B proposes to require traveling physicians to coordinate with non-departmental medical providers to the extent necessary to ensure high-quality and coordinated care. How do you foresee the VHA implementing this program?

Dr. SHAPPELL. Thank you. I am going to pass that to Dr. Wiechers.

Dr. WIECHERS. We would actually like to work with the committee to better understand what the intent is in that section so that we can have some clarity on what care coordination entails.

Ms. KING-HINDS. Okay, great.

Dr. WIECHERS. That we could make a plan together.

Ms. KING-HINDS. I would love to have that conversation with you. Just one other quick question. There was some objections with regards to, I think I want to say, section—the pay, section 7415. I know that there are some concerns about the budget and the lan-

guage with regards to the retention bonus, which is included in the legislation. I just wanted to bring this up for situational awareness.

Right now, the Commonwealth of the Northern Mariana Islands (CNMI), in general, is having a hard time recruiting healthcare professionals just for regular care. I think that is a direct result of, you know, just the difference in the quality of life that is here on the mainland as it relates to back in the territories. I will give you an example. I am really excited that he is introducing the SAVES Act, which would, you know, allow for the VA to provide service care or service animals. We do not have a vet. That is one of the biggest challenges is that you do have these professionals who want to relocate there. Transporting your pets to the CNMI right row costs around $10,000. You know, it is cost-prohibitive, right? We do not have a mall, we do not have a shopping center, any type of major shopping center. Our only movie theater has just recently closed down. I would like to have a conversation with you with regards to the challenges as it relates to recruitment and retention for people coming out to the territories.

Dr. WIECHERS. Absolutely. We would be happy to engage in a conversation with you about that. I think the technical amendment suggestion is just to ensure that the language and the authorities that we have related to bonus eligibility line up appropriately. Absolutely understand the importance of being able to recruit high quality providers to be able to come to the islands and to help with the health care for our veterans there.

Ms. KING-HINDS. All right, thank you. I yield my time.

Ms. MILLER-MEEKS. Thank you. If I can, I will remind our witnesses to speak a little louder. The Chair now recognizes Representative Bergman, General Bergman, for any questions he may have.

Mr. BERGMAN. Thank you, Madam Chair, and thank you to everybody who is here because we are all trying to do the right thing for the right reasons. The question is, how do we figure out what the right reasons really are and what the priorities are? We are in an oversight position here. You are the, you know, we are the higher headquarters that send you money and resources to do the mission. We want to know how the mission is going, okay? I appreciate the honesty in your testimony.

One specific question here as it relates to H.R. 3767, as it relates to the Health Professional Scholarship program. I am not going to go into details of what each—whether you are a psychiatrist, a nurse practitioner, pharmacist, how many of those scholarships, so the Health Professional Scholarship program, are providing scholarships for certain specialties. I will just say if you do not have the answer, you can take it for the record. Why is the VHA plan for Fiscal Year 2026 eliminating the PA, Physician's Assistance, Health Professional Scholarship Program for returning veteran medics and corpsmen? Do we have any detail of that? I do not want—I do not want to play gotcha here, but I want to give you the opportunity to answer the question based upon what you know.

Dr. SHAPPELL. Thank you. I will pass that to Dr. Wiechers.

Dr. WIECHERS. I am going to have to take that for the record, sir. I do not have an answer for you today, but I will get an answer for you.

Mr. BERGMAN. Well, the reality is here we need all different medical special, you know, proficiencies, specialties. It would seem to me that when we have veteran medics and corpsmen that are already, for lack of a better term, in most cases, battle-tested, we would want to make sure that we continue to develop their expertise and their ability to serve other veterans. This is a medical specialty that we need to continue to move forward. This cannot be, you know, the—not that I would get specific, but there is an ongoing discussion between nurse anesthetists and anesthesiologists. That is—we have been dealing with that for a very, very long time, and there is room for both. The question is, who supervises who, who has charge of patient care, et cetera, et cetera. As we continue to look at the healthcare system of the future and physician's assistance, as they might migrate into the VA system, and maybe they go out into community care, which the vast majority of veterans are looking for care in the community. Physician assistant in the world in which we live is a great step forward.

With that, Madam Chair, I yield back.

Ms. MILLER-MEEKS. Thank you, General Bergman. The Chair now recognizes Dr. Conaway for any questions he may have for 5 minutes.

Mr. CONAWAY. Hi. Thank you, Madam Chair, for recognizing me for a few moments to make a statement and answer some questions. We are, I am assuming I just walked in, we are on 3643, right? No. Oh. What is that? Okay. I just wanted to take a moment to discuss H.R. 3643, the VA Data Transparency and Trust Act. It aims to reauthorize a congressionally mandated report that expired in 2022 and significantly expands the number of elements that the VA is required to report. Dr. Shappell, does the VA have the personnel and resources necessary to compile, calculate, and report this data?

Dr. SHAPPELL. Thank you. VA does support this bill, subject to amendments. Right now, as written, the report is very broad and would require a significant amount of time and resources to fully understand what is desired. We would appreciate the opportunity to meet with the committee to narrow the focus of the specific topics.

Mr. CONAWAY. I agree with the importance of transparency in this bill and strongly believe data points from the VA are essential for Congress to effectively conduct its oversight responsibilities. I would. You have just said that you have some concern about the breadth of the report, but I must say that I am concerned about what is lacking, specifically how many staff are retiring, resigning or leaving the VA, along with their specific job titles. I am also concerned about what is going on with new hires and what their titles are. It sounds like you would not be able to provide—you do not believe the VA, excuse me, is in a position to provide this data. We think, I think, and I think, I hope, I am joined by everyone here, believes it is important to understand what is going on with the staffing levels in the VA and that it has the appropriate personnel and adequate numbers of personnel to complete its very important mission. Certainly, what is going on with hiring and staffing, et cetera, would be important to our oversight function. What are

your thoughts on—on the things I suggest needed to go into the bill?

Dr. SHAPPELL. Thank you. Thank you for the question. That the resources that would be needed to collect and report on this data could potentially divert from health care and benefits delivery, but we do not have a cost estimate at this time. We would really appreciate the opportunity to meet with the committee to fully understand what is really desired and needed so that we can come up with a better plan to move forward.

Mr. CONAWAY. Well, then I would ask then, do you know why—and of course, you are supposed to know the answer to these questions before we ask them. You know, it is, my notes say, of course, this report ceased a couple of years ago. Do you have an explanation for why that happened?

Dr. SHAPPELL. I do not know. I was not in my current position at that time. I would be happy to take that for the record and provide a response for you.

Mr. CONAWAY. Well, I would just say that we know that staffing and the ability to fully staff the various departments within the VA plays an enormous role in the quality of care that is delivered to our veterans. Gathering these data points would allow us to better understand how we can support the VA and ensuring they provide the high-quality care that veterans deserve. Do you agree? Or that staffing levels have an important impact on the. On the outcomes that we expect from the VA and that our veterans need the VA to produce for them and their care?

Dr. SHAPPELL. Yes, I do believe that the veterans need the VA. However, I can assure you that the VA has worked with the White House and the Office of Personnel Management to exempt more than 300,000 positions from the hiring freeze and early retirement incentives or deferred resignation program. We, the Department, is committed to ensuring that we have the best employees in place to serve our veterans and the services that they need.

Mr. CONAWAY. Thank you, Doctor. Madam Chair, I yield back.

Ms. MILLER-MEEKS. Thank you, Dr. Coleman. The Chair now recognizes Representative Luttrell for 5 minutes for any questions you may have.

Mr. LUTTRELL. Thank you, Madam Chairwoman. Dr. Shappell, H.R. 2605, the SAVE Act, I think I heard you say that the Department of Veterans Affairs does not support a portion of that because of the given service—it says that the service dogs do not provide effectiveness for post-traumatic stress disorder?

Dr. SHAPPELL. Yes.

Mr. LUTTRELL. I want you to read that statement out of your notes. Make sure that I heard it right.

Dr. SHAPPELL. The Service Dogs Assisting Veterans Act, or the SAVES Act, H.R. 2605, requires the VA to establish a pilot program to provide service dogs for eligible veterans. VA supports this but recommends clarifying the bill's language for effective use of funds. We also propose aligning terminology with existing VA definitions. We do have concerns about including traumatic brain injury and post-traumatic stress disorder criteria in the—in the criteria given insufficient evidence of service dogs' effectiveness.

Mr. LUTTRELL. Insufficient evidence that service animals assist veterans with post-traumatic stress disorder. That is the opinion of the Department of Veterans Affairs?

Dr. SHAPPELL. Yes, and I am going to pass this over to Dr. Wiechers.

Mr. LUTTRELL. Have at it.

Dr. WIECHERS. All right. Thank you, sir, for the question. The evidence does not support any——

Mr. LUTTRELL. What evidence?

Dr. WIECHERS. There is a study that was conducted.

Mr. LUTTRELL. One study. One study.

Dr. WIECHERS. That is——

Mr. LUTTRELL. The VA is basing that claim that you just threw at me off of one study.

Dr. WIECHERS. I would like——

Mr. LUTTRELL. I would be very careful in the waters that you are going to swim in with me right now——

Dr. WIECHERS. I am, sir.

Mr. LUTTRELL [continuing]. because I have been studying this for an extremely long period of time. One thing that I do know, and I talked to hundreds of veterans that have post-traumatic stress disorder and post-traumatic stress and traumatic brain injury with service animals, and they say this is a life-changing event for them. It is the opinion off of one study in the Department of Veterans Affairs to say that that is ineffective?

Dr. WIECHERS. We have a method in the existing regulations that we have around access to service dogs for mental health mobility dogs for veterans with PTSD and TBI. That is what we are speaking to.

Mr. LUTTRELL. You are differentiating between a service animal and a therapy animal?

Dr. WIECHERS. I am speaking to a mental health mobility dog. Mental health mobility service dog, which can be provided for patients with PTSD and TBI. It is a—sir, I agree with you.

Mr. LUTTRELL. In the language——

Dr. WIECHERS. I agree with you.

Mr. LUTTRELL [continuing]. in front of you, I need to add that subtext in there to make this thing?

Dr. WIECHERS. I would like to work with you to make sure we have language that aligns with the definitions we have that allow for the access when it is appropriate clinically for veterans with PTSD or TBI who have a mental health mobility disability. We have a method we need to align language, sir.

Mr. LUTTRELL. Well, I can assure you, if it does not happen today, within the next couple of days, you need to be in my office and make sure that it is absolutely the way that it needs to be because this is something I am not walking away from because I adamantly disagree with what you are saying. Since you are speaking for the VA, you do not want to go to war with me over this.

Dr. WIECHERS. I do not.

Mr. LUTTRELL. There is a room full of veterans sitting behind you that I am sure going to be on my side.

Dr. WIECHERS. I understand. I am committed to working with you and making sure we get the language that works so that we can ensure access to the service dogs through this pilot program.

Mr. LUTTRELL. This is the conversation that most likely should have happened before you are sitting in front of the committee in an open hearing.

The VA has expressed concerns that the Fisher House Availability Act will create an adverse interference that providing lodging to some service members is prohibited by law. On what legal authority does VA base its concern? If these concerns were alleviated, would VA support allowing DoD use of excess capacity in VA Fisher House residences?

Dr. SHAPPELL. Thank you. Yes, so VA does support this proposed bill. We would like to work with the committee on some technical assistance. We do want to support service members and their beneficiaries.

Mr. LUTTRELL. Madam Chairwoman, I yield back.

Ms. MILLER-MEEKS. Thank you, Representative Luttrell. The Chair now recognizes, again, Dr. Murphy for any questions you may have. Okay. The chair now recognizes herself for any questions she may have. They are calling for votes, so I am going to be very, very brief so we can try to complete this panel before we recess and then come back for the next panel.

Dr. Shappell, in your testimony, you state that due to the ambiguity of current law, active-duty service members, and I think this is getting to the point Mr. Luttrell was making, and their beneficiaries are being turned away even though the Fisher House Foundation is willing and able to support them if there is availability. Can you explain why my bill is necessary to clarify congressional intent and correct this error?

Dr. SHAPPELL. Currently, the current law does not allow for TRICARE beneficiaries to stay in the Fisher home. VA does support this and does want to provide equitable access for our military families, but we do need to have it codified in law.

Ms. MILLER-MEEKS. Dr. Shappell, Congress often encounters difficulty getting timely information on performance outcomes and spending. I know that the VA spends countless hours preparing numerous and disparate reports for Congress. Would the VA support a centralized, publicly accessible data platform, as Congressman McGuire's bill proposes, to streamline oversight and increase public trust?

Dr. SHAPPELL. Thank you for your question. I would have to take that back for the record, ma'am.

Ms. MILLER-MEEKS. Thank you very much. The other questions I will have, I will submit for the record in order for time. There is still 421 votes, so I think we have a few minutes. On behalf of this subcommittee, I want to thank you for your testimony and for joining us here today. You are now excused. We are going to wait a moment for the second panel to come to the witness table.

Thank you very much. Welcome, everyone, and thank you for your participation today. The staff and I are watching votes very carefully. I am hoping to push through to get through at least one of our testimoneys, and we can at least introduce the panel.

On our second panel today, we have Dave Coker, President of the Fisher House Foundation, Randy Johnson, Marine Corps veteran, member of The Veterans of Foreign Wars of the U.S. (VFW) Post 3457, and constituent of Representative King-Hinds. Cole Lyle, Director of the Veterans Affairs and Rehabilitation Division at the American Legion. John Schmitt, Chief Executive Officer (CEO) of iExpressGenes. Caira Benson, a caregiver fellow, testifying on behalf of the Elizabeth Dole Foundation. Mr. Coker, you are now recognized for 5 minutes.

STATEMENT OF DAVID COKER

Mr. COKER. Thank you, Chairwoman Miller-Meeks, and good afternoon to the members of the committee. My name is David Coker, and I have the privilege of serving as President of Fisher House Foundation.

The Fisher House Program was founded in 1990 by Zachary Fisher, a private citizen and patriotic philanthropist who believed that no military family should ever struggle to be by their loved one's side during a medical crisis. He built the first Fisher Houses at the National Naval Medical Center and Walter Reed Army Medical Center. The vision was simple but powerful: to create a home away from home for families traveling to be with a loved one receiving care.

The Fisher House program has now grown into a network of 100 Fisher Houses located at Department of Defense hospitals and VA medical centers across the country and overseas. Because of the special mission of supporting both military and veteran families, it is fitting that the 100th Fisher House, to be dedicated next month, is located at the James A. Lovell Federal Health Care Center, the only fully integrated DoD and VA Medical center in the country.

Each home is now built through the generous support of the American public and donated to the Veterans Affairs or the military service it serves. To date, Fisher Houses have offered more than 12 million nights of lodging and saved families more than $650 million in out-of-pocket costs. When we gift a Fisher House to the Army, Navy, Air Force, or Veterans Affairs, our goal is to support these families in their time of greatest need. We know that having a loved one present improves recovery. Family members serve as caregivers and advocates and are a tremendous source of strength. We believe they are essential to the healing process and that every veteran and service member deserves to have their loved one by their side.

Of the 100 Fisher Houses, more than half support VA medical centers. In 2024, the VA Fisher Houses served more than 24,000 veteran families spanning all eras and generations.

Last fall, guidance was published which changed the way VA Houses operate. It directed that only families of veterans receiving VA-directed care were eligible for the support Fisher Houses provide. Even when rooms are available, families that have historically been welcomed must now be turned away. Last year, the occupancy rate at the VA Fisher Houses across the country was 53 percent. We would ask that if a room was available, consideration should be given to support the family of an eligible DoD beneficiary.

The Fisher House supporting the Washington DC VA Medical Center is on the same campus as the Children's National Hospital, the National Rehabilitation Hospital, and the Washington Hospital Center. Last year, occupancy at that house was 22 percent and could have easily accommodated families receiving care at one of those facilities.

The world-renowned Paley Orthopedic and Spine Institute is located near the Fisher House, supporting the Thomas H. Corey VA Medical Center in West Palm Beach, Florida. 27 military children were referred to them for life-changing care last year. Today, their families are no longer eligible to stay in the Fisher House.

There are three Fisher Houses at the DeBakey VA Medical Center in Houston, adjacent to the Texas Medical Center and MD Anderson. Last year, the occupancy rate was 63 percent. Again, because of this guidance, military families will be turned away.

The bipartisan Fisher House Availability Act of 2025 would restore the flexibility that the VA Fisher House Managers once had, allowing the families of active-duty service members and other eligible beneficiaries to stay on a space-available basis while preserving the priority access for veterans. This change will not reduce access for veterans. It simply allows these homes already built, already staffed, and already serving, to do what they were intended to do: keep families of our Nation's heroes together in the hardest moments of their lives.

This bill is consistent with the Memorandum of Understanding between the Secretary of Defense and Secretary of Veterans Affairs titled, Strengthening Our Partnership and Service to Those Who We Serve, and it will provide one more way for the two departments to work together to support both the military and veterans' communities.

On behalf of the Fisher House Foundation and the tens of thousands of families we have the privilege of serving each year, I want to thank the sponsors of this bill and all of you for your support of our Nation's service members, veterans, and their loved ones. Thank you for the opportunity to speak today. I welcome any questions.

[THE PREPARED STATEMENT OF DAVID COKER APPEARS IN THE APPENDIX]

Ms. MILLER-MEEKS. Thank you, Mr. Coker. Mr. Johnson, you are now recognized for 5 minutes.

STATEMENT OF RANDY JOHNSON

Mr. JOHNSON. Thank you. Chairwoman Miller-Meeks, Ranking Member Brownley, and members of this committee. My name is Randy Johnson. I am a resident of the Northern Mariana Islands, a veteran of the United States Marine Corps. For the past decade, I have had the privilege of assisting fellow veterans in the Northern Marianas, helping them navigate the VA system and access the benefits they earn through their service. I have traveled nearly 8,000 miles to be here today to speak in support of H.R. 3400, The Territorial Response and Access to Veterans' Essential Lifecare, known as the TRAVEL Act, introduced by our delegate, Congresswoman Kimberlyn King-Hinds. This is a good bill.

In the Northern Marianas, we do not have a VA medical center. We do not have consistent access to specialty care or mental health services. When veterans need more than basic care, we are often told to leave the island, traveling thousands of miles, paying out of pocket, and spending weeks away from our families. The TRAVEL Act helps to change that. It allows the Department of Veterans Affairs to send traveling VA physicians into remote communities like ours. Instead of forcing the veteran to chase care across oceans, this bill brings care to the veteran. That is the right direction.

I am here to voice my support for the TRAVEL Act, but I also came this distance to give voice to the hundreds of veterans who could not be here. Veterans who serve this country with honor, who, like me, are not asking for special treatment. We are asking for what we would have received if we lived anywhere else in the United States.

We are the only place in the Nation where a veteran can call home but have no access to community-based outpatient clinicians (CBOC). No CBOC at all. Veterans from every conflict, past and present, have been told that if they want the full range of care they have earned, they cannot live at home. Veterans seeking care at home see one doctor on Tuesdays and Thursdays. Dr. Ada has done a great job, but only—but there is only one such—only so much one person can do. Her office has one VA registered nurse, a veteran herself, but if she needs care or takes a much-needed vacation, there is no one left to keep pace.

Decisions on care, travel, and benefits happen in Guam or Hawaii. Resources come from Guam or Hawaii. When those places are struggling or overloaded, we cannot reasonably expect them to prioritize our needs.

What we want, and what I believe we have earned, is the right to live in the country that we fought for, in the community we fought for, and to have our services speak for itself. We should not have to choose between access to care and being with home with our families. We stood the watch. We answered the call. That should be enough.

I served in Iraq. I saw combat. I received a Purple Heart for it. I traveled here by choice. Many veterans are forced to travel simply to receive the care they need. That should not be the case.

In the Northern Marianas, I have served alongside and advocated for generations of veterans, those who fought in Vietnam, Panama, Iraq, and Afghanistan. All of them returned home to a system still not built to meet their needs.

As I made my way here, I thought the—thought of the Vietnam veterans in their 70's and 80's who served our Nation even before our islands were formally part of this country. They have spent a lifetime fighting for benefits that only trickled in slowly over decades. Now, even in their later years, they are still being asked to travel off island for basic, sometimes life-sustaining care. I think of how difficult this travel is for them. I thought of the Gulf War veterans who opened a new chapter in America's military history but returned to the same old gaps in care and support. I thought of my generation, those who served in Operation Iraqi Freedom and Enduring Freedom. We served with commitment. We returned home

with hope. We still face the same cycle of delay, denial, and distance.

Of this generation of new veterans, I am proud to be part of a group that is organizing to support one another directly. Project Buddy Check 670 is an example of that effort. It reflects our belief that care for veterans does not always come in the form of a pill or prescription, but sometimes it comes from another veteran picking up the phone, checking in, and listening. Project Buddy Check is a reminder that veterans seeking care that treats us as people, not just patients. When even ordinary care is far to reach, how can we expect a system to provide the mental health and holistic support for our veterans who truly need?

Generations of veterans have answered the call from our islands. I know the challenges we face are difficult to address, but again, we stood the watch. We bore the burden. That should be enough. It is time the system answered back.

H.R. 3400 is a strong start. I respectfully ask this committee to support it and continue advancing policies that bring real access, real dignity to every veteran, no matter where they live. Thank you for your time and for your unwavering commitment to those who serve.

[THE PREPARED STATEMENT OF RANDY JOHNSON APPEARS IN THE APPENDIX]

Ms. MILLER-MEEKS. Thank you, Mr. Johnson, and thank you for your long duration of travel to get here. Mr. Lyle, you are now recognized for 5 minutes.

Mr. LUTTRELL. Madam Chairwoman, they called votes. I do not know if you, just——

Ms. MILLER-MEEKS. Yes, sir. There is 327 people left to vote.

Mr. LUTTRELL. I have never missed a vote time.

Ms. MILLER-MEEKS. Sir, you may be excused if you want to be excused. I am sorry. Mr. Lyle.

STATEMENT OF COLE LYLE

Mr. LYLE. Well, thank you, Chairwoman Miller-Meeks, Ranking Member Brownley, distinguished members of the subcommittee, on behalf of National Commander James A. LaCoursiere Jr., and the 1.5 million dues-paying members of the American Legion, thank you for the opportunity to testify today discussing pending legislation that directly impacts the lives and well-being of American veterans.

Today, the American Legion supports nearly all the bills under consideration because they reflect a bipartisan commitment to improving mental health outcomes, suicide prevention, addressing provider shortages, and safeguarding the dignity of those who have worn the uniform.

First, H.R. 785, the Representing Our Seniors at VA Act. This bill appropriately recognizes the vital role that State veterans homes play in long-term care. As the average age of our veteran population reaches 75 this year, this legislation would add a representative from the National Association of State Veterans Homes (NASVH) to the Geriatrics and Gerontology Advisory Committee. With over 169 homes now operating under NASVH, this change is both timely and necessary.

Second, the VA Data and Transparency and Trust Act is a good step toward improving VA reporting on health care and benefits. By expanding access to underlying data and requiring disaggregation by gender, age, geography, and condition, this legislation enhances oversight, fosters collaboration, and enables evidence-based improvements in care delivery. We support the bill with amendments to clarify definitions like "reliance" on VA care and minimize administrative burden while urging the inclusion of data on caregivers, survivors, and emerging chronic conditions.

We also offer strong support for H.R. 3400, the TRAVEL Act, which would authorize temporary VA physician assignments to U.S. territories like Puerto Rico and Guam. With physician shortages reaching crisis levels in these areas, this legislation brings us closer to healthcare equity for veterans, no matter where they live.

Further, we commend the draft legislation directing VA to study RNA sequencing as a diagnostic tool for post-traumatic stress. While this technology should never be used as the sole basis for compensation decisions, it holds promise for advancing diagnostic precision and developing targeted therapies. We must embrace science without losing sight of the holistic nature of invisible wounds.

Workforce development also remains a priority. That is why we support the bill establishing employment timeframes for Health Professional Scholarship Program participants, a commonsense measure to address critical shortages and ensure VA retains its pipeline of trained professionals.

On caregiver support, H.R. 2148 expands transitional health care and provides stipends for career re-licensure, recognizing the sacrifices caregivers make. These steps help veterans remain in-home settings at a fraction of the cost of institutional care and ensure caregivers can reenter the workforce with dignity and purpose.

Finally, H.R. 2605, the SAVES Act, would establish a grant program to expand access to service dogs through accredited nonprofits. VA's own research continues to confirm that veterans paired with service dogs experience reduced post-traumatic stress symptoms, decreased suicidal ideation, and improved quality of life. The VA itself offered a FOX Grant to a service dog organization.

Anyone who owns a dog will tell you they can be therapeutic. You do not need research. When fingers meet fur, magic happens. I know from personal experience, having previously benefited from a service dog named Kaya (phonetic), the profound power a specially trained dog can have in a veteran's life. This is why I helped author the original PAWS Act of 2016, and Kaya and I spent years advocating for its passage before she passed. The compromised version passed in 2021. The SAVES Act builds on this effort and more closely aligns to the text of the original PAWS Act than the compromised version that ultimately passed.

I cannot overstate the power passage and implementation of this bill would have on veteran suicide prevention and improved mental health outcomes. Because of Kaya, I earned a bachelor's and a master's degree. I have a beautiful 2-year-old son. I sit here today, as a veteran advocate in the largest division for the largest veterans service organization in the country because of my service dog.

Chairwoman Miller-Meeks, Ranking Member Brownley, thank you for the opportunity to testify, and I stand ready to answer your questions.

[THE PREPARED STATEMENT OF COLE LYLE APPEARS IN THE APPENDIX]

Ms. MILLER-MEEKS. Thank you very much, Mr. Lyle. My apologies to the witnesses and those who are here. Due to the vote that has already been called in the House, the subcommittee will stand in recess subject to the call of the chair. I expect to reconvene 10 minutes after the start of the last vote. There are 5 votes.

[Recess]

Ms. MILLER-MEEKS. Welcome back. I am sorry. Mr. Schmitt.

STATEMENT OF JOHN SCHMITT

Mr. SCHMITT. Good afternoon, Chairwoman Miller-Meeks and Ranking Member Brownley and members of the subcommittee. Thank you for the opportunity to testify today.

I want to begin not with the science, but with the intention behind the science. Because when it comes to the lives of veterans, as one myself, I believe that intention matters.

In 2010, the founder of iXpressGenes, Dr. Joe Ng, molecular biologist and professor at the University of Alabama, Huntsville, was at a routine faculty meeting. Tragedy struck when a colleague pulled a handgun out of her purse and murdered three people in front of him. Joe fortunately survived, but in the aftermath, he watched this spectrum of resilience occur among his peers. Joe asked the question that would change everything, could trauma have an immunological component? That question set us on a path to transform trauma care forever.

I met Dr. Ng in 2018. I am John Schmitt. I am a CEO of iXpressGenes and a two tour Iraq combat veteran, having served over 20 years in the Army. When Joe and I crossed paths, I was still in uniform. I was trapped in a culture of silence. Like many of my peers and contemporaries, because of the risk to my career, I could not admit I was unraveling, depressed, anxious, and increasingly suicidal. That journey for me has turned into a mission. Today I testify not just as a veteran and a CEO, but as a survivor advocating for the science to help me heal, and I hope will help millions of others.

While in uniform, I earned a degree in microbiology and immunology from Vanderbilt University School of Medicine. It was a fateful step, one that quietly equipped me to understand the science and the application of the technology that I stand before you advocating for.

Together, our team at iXpressGenes has developed groundbreaking blood tests using the power of RNA transcriptome analysis, the Trauma Autoimmune Indicator, or TAI as we call it. It identifies inflammation caused by trauma, detectable before symptoms even surface, to empower prevention, enable early intervention, and inform effective treatments for best possible outcomes.

The TAI test reads RNA transcription, how the body's genes are responding right now in real time, creating potential for limitless therapeutic strategies never before possible. Unlike genetics, which only tell us what might happen, RNA tells us what is happening

and this matters. This matters because it is the kind of inflammation that we detect, is the root cause for the oxidative stress and the neuroinflammation that crosses the blood-brain barrier and contributes to the anxiety, depression, and other hallmarks of PTSD. This lab developed test is already available commercially through our lab in Huntsville, Alabama. It is low cost, it is scalable, and it is incredibly precise.

With the VA, we are not starting from scratch. With our partnerships at VA Birmingham over the last 2 years, we have already demonstrated powerful results. In fact, as our key clinical research collaborators put it, "Its high sensitivity, specificity, and translational relevance position it as an exceptional tool for clinical use. Given the clarity and consistency of the data it provides, I strongly advocate for its broader adoption and urge that it be rapidly prioritized for clinical validation to support improved patient outcomes."

PTSD and trauma-related illness have long been treated based on symptoms and subjective reporting. Now with RNA transcriptome analysis, we can assess it objectively for the first time, offering a novel approach for diagnosing, treating, and even preventing trauma-induced disease.

Today there is a promising patchwork of powerful therapies: mindfulness, contrast therapy, Eye Movement Desensitization and Reprocessing (EMDR), neurofeedback, ketamine-assisted psychotherapy, and even psychedelics. It is a choose-your-own adventure landscape for our veterans because we have lacked an objective compass. TAI is that objective compass and we can use it to validate the effectiveness of all of these modalities and track clinical progress in real time. We are not starting from scratch here either. We have already partnered with groundbreaking technology companies using hyperbaric oxygen to virtual reality with exceptionally promising early results.

The VA has long pioneered technologies that went on to change the world. Let this be the next chapter, ushering in a new standard of precision mental health that is proactive, data driven, and lifesaving. iXpressGenes is a company born out of tragedy, led by those who have lived the realities of trauma and built for a world finally ready to confront it. Let us lead the transformation of trauma care. Our veterans deserve it, and so does every other American still waiting for their suffering to be seen, understood, and treated with precision. The opportunity is massive and, as you know, the need is urgent and only growing. Now the science is ready. Let us transform trauma care together forever.

Thank you for your time and I welcome your questions.

[THE PREPARED STATEMENT OF JOHN SCHMITT APPEARS IN THE APPENDIX]

Ms. KING-HINDS. [Presiding.] Thank you, Mr. Schmitt. I now recognize Ms. Benson for 5 minutes.

STATEMENT OF CAIRA BENSON

Ms. BENSON. Members of the committee, thank you for inviting me to testify today. As the wife and caregiver of a severely injured and ill combat veteran, it is my honor to speak to some proposed legislation that could lessen the burden of each of our caregiving

families face every day. I care for my husband Eric, who deployed twice to Iraq as a combat engineer. My husband suffered multiple traumatic brain injuries during his years in service and is considered by VA to be permanently and totally disabled and unable to work. He is wheelchair-dependent, struggles cognitively, suffers from migraines and blackouts, and is visually impaired.

I am also mom to five amazing kids, three of whom have needed specialized care over the years. The day my husband was awarded permanent and total status, my children and I became eligible for CHAMPVA. I breathed a sigh of relief knowing that we, too, would have appropriate healthcare.

In 2021, one of my children began attending college and needed monthly medications. We mailed the required certification paperwork, but when we went to fill the prescriptions, we found CHAMPVA was inactive. I called, sat on hold for 4 hours, and learned CHAMPVA's central mail facility was 6 months behind on opening mail. Horrifyingly, CHAMPVA began requiring semester certifications in 2023 with no option to expedite activation for medical best interest.

Since 2023, my child has suffered from lapsed coverage between semesters due to the certification process in CHAMPVA's archaic mail system. Winter and summer break became a mix of timing medication pickups prior to coverage loss, and paying out of pocket for any therapies or doctors' visits. This outdated system ensured my child was without insurance from November 2024 to May 2025. Caregivers need CHAMPVA fixed beginning with ensuring our children who have already given up so much do not have to worry over the loss of coverage upon their 18th birthday or due to an archaic certification process.

H.R. 1404, the CHAMPVA Children's Care Protection Act, would allow coverage until age 26, eliminating these egregious situations. It would align coverage with civilian insurers and the age at which dependents must begin to use their VA Chapter 35 education benefits. It also recognizes the true nature and sacrifice of youth caregivers by allowing them to support the need—or support their needs as they transition from caregiving into adulthood.

I understand at VA's recent testimony VA indicated they oppose this bill due to the nature of CHAMPVA, arguing that it is a medical service and not an insurance product. CHAMPVA provides explanation of benefits, approves or denies diagnostic and medical treatment codes, and remits payment for enrollees to providers for services. CHAMPVA even has out-of-pocket maximums, deductibles, co-pays, and a medication formulary with tiered pricing.

Every year, enrollees receive a 1095B attesting to the fact that CHAMPVA counts as minimum essential coverage under the Affordable Care Act. I admit I am a layperson, but this feels like every other insurance product I have ever received through an employer. While I am here to support extending CHAMPVA coverage to age 26, I implore this committee to use its oversight authority to improve the system itself so our families can use it to find appropriate care. To help you understand the challenges, let me explain what using CHAMPVA is like.

In 2019, one of our children was hospitalized and needed a residential facility. I was told to find a facility that would take CHAMPVA without the guidance of a provider network. I called over 20 facilities that were TRICARE approved to see if they had a bed available or could add my child to their wait list. All but one turned me down immediately. The reason? Prior authorization under CHAMPVA since January of that year was taking upward of 6 to 9 months. The one residential facility that did agree to treat our child had a stipulation. We were to sign $110,000 promissory note upon admission and the chance CHAMPVA refused authorization and payment.

Another of my children needed specialized therapy which was completed in 2021. In 2023, the provider called me to let me know they had finally received payment from CHAMPVA, almost 27 months later. Unlike its TRICARE counterpart, CHAMPVA has no contracted network of providers and no published fee schedule. CHAMPVA processes the majority of provider and enrollee claims using a single traditional mail center, lengthening the time between claim submission, processing, and reimbursement.

Filing and retaining providers willing to file it in my area—I am sorry, filing and retaining pay for services has become so cumbersome that the number of providers willing to file it in my area dropped to two practices, neither containing a pediatrician.

Once again, I am paying out of pocket for basic routine and pediatric care. I have stopped filing for reimbursement myself due to the burden of the process. It is one more bureaucratic fight caregivers like me do not need. Yet I know another fight looms on the horizon.

Not long ago, I firmly realized, like so many other caregivers, I would likely become a survivor. Having given over a decade to being a caregiver, I was situated to outlive my veteran with no retirement, no active work credits, and almost no life insurance for my family's financial security. I am not alone. Mozella Richardson Kamara, a 2025 Dole caregiver fellow from Delaware, studied for many years to become a civil engineer, but left her job to care for her veteran husband. Like myself, Mozella made this choice to ensure immediate well-being of her husband and sacrifice their own long-term professional goals and retirement potential for the benefit of the veteran.

According to a recent Research and Development (RAND) report, military connected caregivers saved this Nation in healthcare costs by providing a minimum of $119 billion in unpaid care. In exchange, we face this harsh reality: when our caregiving ends, many of us will be financially destitute. Caregivers like Mozella and me, we need you to pass H.R. 2148, the Veteran Caregiver Reeducation, Reemployment, and Retirement Act. This bill will not fix the entirety of the problem, but it is a valuable first step in ensuring caregivers can begin to plan for retirement and establish safety nets of their own. More immediately, it will provide caregivers financial security by allowing for reentry—work reentry programs and paying for relicensure in careers like teaching and engineering.

Again, I am honored to be here at the request of the Committee and the Elizabeth Dole Foundation. To truly support the veteran,

we must support the caregivers, survivors, and families who bear the burden of the war that continues to rage at home.

I thank you for your time and attention and I look forward to your questions.

[THE PREPARED STATEMENT OF CAIRA BENSON APPEARS IN THE APPENDIX]

Ms. KING-HINDS. Thank you very much, Ms. Benson. Thank you to all of you for your very insightful testimony.

I now recognize Ranking Member Brownley for 5 minutes.

Ms. BROWNLEY. Thank you, Madam Chair.

Ms. Benson, thank you for being here. I think you and I think alike when it comes to the CHAMPVA bill and you certainly have my commitment to continue to work hard on this. You know, I introduced this back in 2019, so it has been something that I have been trying to work on for a long time. I can tell you before I even got to Congress there were a couple of members who have carried this bill. For a very long time we have been trying to fight for some kind of parity and healthcare. We will continue that fight.

I agree with you that we need more committee oversight of the program. Again, I commit to you to make sure that that happens. Hopefully, you can join us again in another hearing and I certainly would encourage Dr. Miller-Meeks to help me in that process. I think we should try very hard to encourage the VA Office of Inspector General and the Government Accountability Office to assist us in this effort to drill down.

About 18 months ago, VA's Office of Integrated Veteran Care began an initiative to modernize what it calls the Family Member Programs, which included CHAMPVA. You are smiling. They planned to implement additional Information Technology (IT) systems to administer the program and move away from a paper-based process. Have you noticed any improvements in the last 18 months as far as hold times when you call the CHAMPVA call center or processing times when you submit paperwork?

Ms. BENSON. I want to thank you for your commitment and the question. I actually called this morning and when I called at opening, the hold time was an hour and a half, which is not bad. They did now offer——

Ms. BROWNLEY. Which is not bad?

Ms. BENSON. I am used to 4 to 6 hours with CHAMPVA. They did offer callback service now, which was new. I called May 21. I was here in town and spoke with another caregiver who was having similar recertification issues and she was able to get through. They told her they were opening mail from January.

Ms. BROWNLEY. Tell me about the paper process.

Ms. BENSON. The paper process, I understand that there is—I actually just spoke with another caregiver whose wife is pregnant and diabetic. They are trying—well, I am sorry, the veteran, his wife is pregnant, diabetic. They are trying to get her CHAMPVA turned on. They went to go submit through the online portal, which is down. There is a fax number which has been disconnected.

Ms. BROWNLEY. A fax number?

Ms. BENSON. Yes, ma'am, a fax number. That was the expedition process that we had always used in the past.

Ms. BROWNLEY. I have not seen a fax machine in a long time. I guess I should go over to the VA perhaps to see one.

Ms. BENSON. Yes. I can tell you that the way we were able to turn on my daughter's insurance was that I called, I instituted a VHA executive inquiry. That executive inquiry allowed us to upload the documentation and bypass the mail system. The ability to turn it on once that is uploaded is instantaneous.

Ms. BROWNLEY. Is what?

Ms. BENSON. Instantaneous.

Ms. BROWNLEY. Instantaneous.

Ms. BENSON. I do not understand why we are on a mail paper system when no other provider, including other government medical benefits are. That is the best answer I have is that, no, I have not seen an improvement at all.

Ms. BROWNLEY. I had a feeling that that was going to be your answer, but I wanted it for the record, so thank you for that. You know, in addition to the Children's Care Protection Act, what should we prioritize in terms of oversight or legislation to improve the CHAMPVA program for your family and for other families?

Ms. BENSON. My belief is, again, wonderful question, my belief is the statute is outdated.

Ms. BROWNLEY. Yes.

Ms. BENSON. The statute is very outdated. We have been a very small constituency, 737,000, of those only about 408,000, according to the congressional Report that was done in October of last year, are actually users. We have to at least bring it up to the standard that is TRICARE, who has a contract, who has providers. It is impossible for me to go to a provider and say, you may or may not be paid Medicaid rates. Would you please accept this? The only mandated acceptors are hospitals and urgent cares.

Ms. BROWNLEY. Hospitals and what?

Ms. BENSON. Urgent cares.

Ms. BROWNLEY. Oh, and urgent cares.

Ms. BENSON. To the VA's point today that they are worried that the money that this would cost would take away from healthcare of the veteran, I argue we are healthcare. Every caregiver, every youth caregiver, we provide billions in healthcare for our veterans. We save lives every day. We are the front lines. We are providing that. In exchange, we are left without our own care for ourselves because caregiving is stressful and destroys our own health. Our children, who are higher special needs rates, are left without coverage and it is impossible to find coverage. We are, as you said earlier, we are so behind even TRICARE, and it is egregious.

Ms. BROWNLEY. It is egregious. I agree with you.

My time is up. I also hope that the VA begins the process of instituting the Elizabeth Dole Bill, because that, too—well, I should not say that, too, but that will be helpful and supportive of you as a caregiver to your husband and certainly to your children as well. I really enjoyed working with the Elizabeth Dole Foundation to have that section in the bill that takes care of our caregivers.

Thank you for your husband's service. Thank you for your service and helping him.

With that, I yield back.

Ms. MILLER-MEEKS. [Presiding.] Thank you, Ranking Member Brown.

The chair now recognizes Representative King-Hinds for any questions you may have.

Ms. KING-HINDS. First of all, I want to say thank you to each and every one of you for coming here and providing your testimony and sharing your insights with regards to different legislations that are before us. Time is money and traveling is very costly, so I definitely appreciate it.

I want to start off first by saying thank you to TSL Foundation for supporting my very own constituent, Mr. Randy Johnson, who has made the 8,000-mile trek here to Washington, DC, to amplify the voices of the veterans across the territory, specifically the Commonwealth of the Northern Mariana Islands. I want to focus my questions today to further flesh out some of the challenges that the veterans in the CNMI face by asking a couple of questions to Mr. Johnson.

Just for the record, prior to a few—up to about 3 months ago, you were employed by the district office by my predecessor and then the first couple months during my tenure serving as a community caseworker, basically serving our veterans. In your experience there, what are the three areas of concerns that are frequently raised by the vets who come and seek help at the office?

Mr. JOHNSON. Thank you for your questions. The veterans seek travel. They have difficulty with travel, mainly, to their appointments. A lot of times the veterans have to pay out of pocket. The veteran from Tinian and Rota traveling to Saipan have to pay out of pocket to travel to go see the VA doctor on Saipan. If they have to get further care, they have to go through BeniTravel, which is on Guam, and a lot of times BeniTravel will not issue the tickets immediately for them and sometimes it may take up to a couple of days, right, even before their appointment schedule. At that point, sometimes the veteran is stressed and was worried if they have to cancel or postpone their appointments and seek alternative care or alternative means by either fundraising for the necessary funds to travel or taking up personal loans. A lot of veterans on those islands are on fixed incomes and so filing for reimbursement with the VA sometimes can be difficult.

I know a lot of our veterans are old school, so they would rather talk to somebody in person. Communicating with the VA is difficult on Guam because they are also working with their VA veterans on Guam. Our veterans are stuck with having to wait on calls sometimes or not get through and that poses a difficult challenge for them as well.

Ms. KING-HINDS. All right. Tell us just a little bit, just so that the committee has an idea, what the cost of travel is for vets, for example, from Rota or Tinian——

Mr. JOHNSON. Yes. The travel——

Ms. KING-HINDS [continuing]. and what all that entails.

Mr. JOHNSON. Yes. The travel between the interislands can run up a couple hundred dollars round trip, and that is just the veteran him-or herself. Oftentimes veterans are uncomfortable traveling by themselves so they would pay for their spouse or caregiver and that comes out of pocket, and then they would have to file for reim-

bursement. Fortunately, I have not heard of delay in that reimbursement. I would have to assume that there has been delays because that was an issue during my employment during my—the last delegate-under Delegate Sablan. That was something that we had tried to close gaps with the reimbursement because a lot of these veterans do not just have a single appointment on Guam or Hawaii, they have multiple appointments. While they are waiting for the reimbursement, they have to push back their next appointment at times.

Ms. KING-HINDS. In terms of specialized care, what are the areas of needs do you foresee being something that will fulfill some of the medical requirements that are needed on the ground?

Mr. JOHNSON. Yes. The one thing that been highlighted during discussions recently is the chiropractic care. I do know some veterans that do travel to Guam for chiropractic care, including myself in the past. Those tickets can, round trip, run between $300 to $580 through United Airlines and that is just the airline itself. Then, also, you are considering the overnight stay because there is only one flight leaving to Guam daily. Those can add up significantly for a veteran.

Ms. KING-HINDS. All right, thank you.

I yield back the balance of my time. Thank you, Chair.

Ms. MILLER-MEEKS. Thank you, Representative King-Hinds.

I now recognize myself for 5 minutes for questions.

Mr. Lyle, can you share with us how veterans around the country would benefit from Congressman Luttrell's SAVES Act?

Mr. LYLE. Thank you for the question, Chairwoman Miller-Meeks. Obviously, in my opening statement, I testified that I have a large, extensive personal experience with this as an end user of a service dog.

As somebody who has advocated and heard from other veterans for years, you know, I think there is a misconception that service dogs, at least at the VA, service dogs should be viewed simply as clinical tools. I think they also serve as a powerful backstop to veteran suicide because when you are in that point, that critical crisis point, you feel unloved, you feel alone, and you look down at the dog and you say, I cannot leave the dog, and the dog would miss me. Right? It provides a sense of purpose that pills and therapy simply just will not ever do.

I was a little upset to hear the study that the VA cited, which I am very familiar with. The study, in my mind, was set up to fail because the control group was emotional support animals, not somebody that did not have a service dog altogether. The study, even though I feel it was set up to fail, still showed positive results for reduced post-traumatic stress symptoms, depression, anxiety, any number of different things.

In my long history of advocating for this, the amount of veterans that have reached out to me and said, you know, I saw your story and it prompted me to get my own dog, and if I had not had the dog, I would have killed myself, is just super powerful testimony to that end.

Ms. MILLER-MEEKS. Thank you. Mr. Coker, would you mind sharing firsthand accounts of servicemembers and their families'

inability to access your facilities due to the current policy and how my legislation would help prevent this from occurring again?

Mr. COKER. You know, the VA medical centers have such a tremendous affiliation with academic medical centers, and so often we believe that both within the DOD health system and VA health system, you have world-class healthcare. Sometimes the treatments need to be so specialized, and when you do not have a safe, comfortable environment for your family to be there, you worry about do I max out the credit cards? Or you decide I am going to accept what time I have left, and I will just forego treatment so that we can be together. That is not a decision that a military member should have to make.

Ms. MILLER-MEEKS. Thank you very much. Ranking Member Brownley, would you like to make any closing remarks?

Ms. BROWNLEY. I have no closing remarks, but I thank you for bringing the witnesses here today and reviewing all of these bills and look forward to continuing to mark them up and move them forward.

Ms. MILLER-MEEKS. I want to also thank our witnesses and then again apologize for the 90-minute delay on recess as we had to go vote.

On behalf of the subcommittee, I want to again thank all of you, the witnesses and the members, for being here today. I look forward to working with you and the Ranking Member to address the issues facing our veterans.

The complete written statements of today's witnesses will be entered into the hearing record. I ask unanimous consent that all members have 5 legislative days to revise and extend their remarks and include extraneous material.

Hearing no objection, so ordered.

This hearing is now adjourned.

[Whereupon, at 4:44 p.m., the subcommittee was adjourned.]

A P P E N D I X

PREPARED STATEMENTS OF WITNESSES

Prepared Statement of Antoinette Shappell

STATEMENT OF
ANTOINETTE V. SHAPPELL, M.D.
DEPUTY ASSISTANT UNDER SECRETARY FOR HEALTH
FOR PATIENT CARE SERVICES
VETERANS HEALTH ADMINISTRATION (VHA)
DEPARTMENT OF VETERANS AFFAIRS (VA)
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON HEALTH
U.S. HOUSE OF REPRESENTATIVES
ON

PENDING LEGISLATION

June 12, 2025

Chairwoman Miller-Meeks, Ranking Member Brownley, and other Members of the Subcommittee, thank you for inviting us here today to present our views on several bills that would affect VA programs and services. Joining me today is Dr. Ilse Wiechers, Deputy Executive Director, Office of Mental Health.

H.R. 785 Representing our Seniors at VA Act

This bill would amend 38 U.S.C. § 7315(a), which generally requires VA to establish a Geriatrics and Gerontology Advisory Committee (the Advisory Committee). The bill would require consultation with the President of the National Association of State Veterans Homes (NASVH) with respect to matters concerning such association. It would further require the Advisory Committee to include one representative of NASVH who holds a professional license in nursing home administration.

VA supports the intent of this bill but cites concerns.

VA fully supports the participation of a NASVH representative on the Advisory Committee, but we do not believe this bill is necessary because, in 2024, VA appointed a member of NASVH to the Advisory Committee. We also believe the bill, as written, creates unnecessary ambiguity regarding who (the Secretary or the Under Secretary for Health) is consulting with the President of NASVH and on what issues (on appointment of members generally, only on matters concerning NASVH, or on the appointment of members concerning NASVH).

We caution that legislating membership of the Advisory Committee could restrain VA's ability to adapt to evolving circumstances in the future. We also have concerns with the language that would apparently subject the appointment of all members of the Advisory Committee, at least with respect to matters concerning NASVH, to the consultation requirements of the NASVH President. While the term consultation is not

defined, this could constrain the Secretary's authority to appoint members and would be inconsistent with other laws regarding Federal Advisory Committees.

VA revised the Advisory Committee's charter in 2024 to permit the Secretary to appoint a representative; the bill would restrict the Secretary's appointment flexibility to a NASVH representative whose skill sets may not provide the best fit for the Committee given its membership composition.

VA does not believe this bill would result in any appreciable costs.

H.R. 1404 CHAMPVA Children's Care Protection Act of 2025

This bill would amend 38 U.S.C. § 1781 to allow a child to be eligible to receive medical care benefits under VA's Civilian Health and Medical Program (CHAMPVA) until the age of 26. VA's CHAMPVA program is primarily for dependent spouses and children of certain Veterans, provided they do not qualify for Department of Defense's (DoD) TRICARE program for dependents. In the absence of a CHAMPVA-specific definition, CHAMPVA relies on the definition of "child" that is codified in 38 U.S.C. § 101 and applicable to other VA benefits available to a child. Generally speaking, a child reaches the age of majority when the child attains 18 years of age. Some exceptions exist, namely for a child who, before attaining the age of majority, became permanently incapable of self-support, or who after reaching the age of majority is pursuing a course of instruction at an approved education institution up until the age of 23 years.

VA does not support this bill.

VA is not subject to the Patient Protection and Affordable Care Act (PPACA), as CHAMPVA is not a health insurance plan. Rather, it is a medical care benefit grounded in statute. No provision of the PPACA amends the title 38 definition of "child" which states that the age of majority is 18. Because CHAMPVA operates like a health insurance plan, there has been a lot of confusion and disputes over who can be covered.

This bill would extend a child's eligibility for CHAMPVA up until the age of 26, thereby aligning the age criterion for CHAMPVA eligibility with that applicable to health insurance dependent care coverage consistent with the PPACA. It would, however, be a greater benefit than found in plans covered by the TRICARE Young Adult Program because this extended eligibility would be regardless of a child's marital status.

CHAMPVA is required by law to provide medical care to CHAMPVA beneficiaries in the same or similar manner as that which is provided to TRICARE dependents, and subject to the same or similar limitations as TRICARE. TRICARE provides premium based (to offset the cost to DoD) extended medical coverage for a young adult up until the age of 26 (provided the child is unmarried and meets certain other requirements such as ineligibility for employer-sponsored health insurance based on the young adult's own employment). Nonetheless, an unmarried child between the ages of 18 and 23 who

is pursuing a course of instruction at an approved educational institution is eligible for CHAMPVA medical benefits only up until the child's 23rd birthday. VA believes this benefit coverage up to age 23 is sufficient for our beneficiary population. VA is also concerned that the bill would require resources that could otherwise be used to support patient care.

The Department does not currently have a cost estimate for this bill; however, by providing coverage to dependents up to the age of 26 under CHAMPVA, this bill would significantly increase costs for VHA.

H.R. 2068 Veterans Patient Advocacy Act

This bill would amend 38 U.S.C. § 7309A to require VA to ensure that rural Veterans may access the services of patient advocates, including, to the extent practicable, with respect to assigning patient advocates to rural community-based outpatient clinics. VA would have to implement this requirement within two years of enactment. Not later than two years from enactment, the Comptroller General would have to submit a report to Congress evaluating this implementation.

VA supports the intent of this bill, subject to amendments and the availability of appropriations.

Over the last few years, the role of the patient advocate has expanded because of the enactment of the Comprehensive Addiction and Recovery Act of 2016 (P.L. 114-198), the VA MISSION Act of 2018 (P.L. 115-182), the Johnny Isakson and David P. Roe, M.D. Veterans Health Care and Benefits Improvement Act of 2020 (the Isakson-Roe Act; P.L. 116-315), the Veterans COMPACT Act of 2020 (P.L. 116-214), and the Honoring our PACT Act of 2022 (P.L. 117-168).

VA's goal is to ensure the Patient Advocacy Program is responsive to Veterans' needs based on evidence of what those needs are and strongly recommends continued examination of data analytics from VA facilities to determine how best to proceed in this area. Currently, Veterans can contact a local patient advocate by phone at their local VA medical facility, including in rural areas. Veterans who wish to speak with someone in person can contact the Nursing Supervisor (or designee) to listen to and address their needs. VA also provides Nationwide service through the Ask VA online platform, which allows Veterans to access patient advocacy services at any time; the VA Hotline (855-948-2311) also remains available 24 hours a day, 7 days a week. Hotline staff document concerns and refer them to local patient advocates for review and resolution. VA believes these current options are sufficient to address patients' needs.

While the bill would provide VA 2 years to implement, it would also require the Comptroller General to report within 2 years of enactment on VA's implementation. Given the time it takes to draft and publish a report, the Comptroller General's report could very well reflect information that does not reflect VA's progress by the implementation deadline.

VA does not currently have a cost estimate for this bill.

H.R. 2148 Veteran Caregiver Reeducation, Reemployment, and Retirement Act

Section 2 of the bill would amend 38 U.S.C. § 1781, which authorizes the CHAMPVA program, to allow VA to provide medical care under CHAMPVA to designated primary family caregivers eligible for CHAMPVA during the 180-day period following the removal of such designation unless the individual was dismissed from the program for fraud, abuse, or mistreatment. Notwithstanding any other provision of law, individuals would not be eligible during this 180-day period if they were entitled to hospital insurance benefits under Part A of the Medicare program during that period.

VA supports this section, subject to the availability of appropriations.

Primary family caregivers provide extensive and direct care and support for Veterans with service-connected disabilities; many often face significant constraints that limit their ability to maintain regular employment and, consequently, employer-sponsored health insurance. The 180-day extension of CHAMPVA benefits, as proposed in this bill, would allow these caregivers a necessary transitional period to seek alternative health coverage without facing an abrupt interruption in their medical care.

VA does not have a cost estimate for this section.

Section 3 of the bill would make several amendments to 38 U.S.C. § 1720G, which generally establishes the Program of Comprehensive Assistance of Family Caregivers (PCAFC) under subsection (a). Specifically, section 3(a) of the bill would add a new subsection (e) to § 1720G regarding employment assistance for individuals designated as a primary provider of personal care services under the PCAFC. VA would have to provide to such individuals reimbursement of fees associated with certifications or re-licensure necessary for such employment; no-cost access to VA training modules for purposes of gaining credit for continuing professional education requirements; and, in consultation with DoD and the Department of Labor (DoL), access to employment assistance under DoD's Military OneSource program, DoL's Veterans' Employment and Training Service if they are eligible, and such VA programs as VA determines appropriate. Such individuals would have access to this assistance while participating in PCAFC and during the 180-day period following the date on which the individual is no longer participating in PCAFC, unless the individual was dismissed for fraud, abuse, or mistreatment. The maximum lifetime amount that could be reimbursed for an individual for fees associated with certifications or re-licensure necessary for employment would be $1,000.

Section 3(b) would amend the benefits available to primary family caregivers to allow VA to use agreements (instead of only contracts) for financial planning services (including retirement planning services) and legal services. It also would make such assistance available during the 180-day period following the date on which the primary family caregiver is no longer participating in PCAFC, unless the family caregiver was dismissed for fraud, abuse, or mistreatment, such instruction, preparation, training, and support as VA considers appropriate to assist the caregiver in transitioning away from caregiving.

Section 3(c) would further amend the benefits that could be furnished through contracts or agreements to include assistance returning to the workforce upon the discharge or dismissal from PCAFC unless the family caregiver was dismissed for fraud, abuse, or mistreatment.

Section 3(d) would expand the counseling available to family caregivers (not just the primary family caregiver) to include bereavement counseling and support following the death of the eligible Veteran.

Section 3(e) would require VA, in partnership with DoL and no later than 1 year after enactment, to complete a study on the feasibility and advisability of conducting a returnship program for individuals who are or were designated as a primary family caregiver to assist such individuals in returning to the workforce. Not later than 180 days after completing this study, VA would have to submit a report to Congress on the study.

Section 3(f) would require VA, not later than 1 year after enactment, to complete a study on barriers and incentives to hiring individuals who were primary family caregivers at VA facilities to address staffing needs. Within 180 days of completing this study, VA would have to submit a report to Congress on the study.

VA supports this section in general, subject to the availability of appropriations, but cites concerns.

VA appreciates the Committee's interest in expanding support for caregivers of Veterans by offering assistance when they transition out of Caregiver Support Programs and into the workforce or retirement. VA also appreciates the ability to provide bereavement counseling after a Veteran dies, as this loss can be especially difficult for family caregivers who have dedicated their lives to caring for the Veteran.

VA supports some of the requirements under section 3; however, we do have concerns with certain provisions and would appreciate the opportunity to speak with the Committee to address them. We also recommend meeting with DoL as well.

VA does not have a cost estimate for this section.

Section 4 of the bill would require the Comptroller General to submit to Congress a report assessing VA's efforts to support family caregivers under the PCAFC in transitioning away from caregiving, either by assisting those individuals with retirement planning or returning to work.

VA defers to the Comptroller General on this section.

VA does not have a cost estimate for this section.

Section 5 of the bill would require VA, in consultation with the Department of the Treasury and the heads of other relevant entities, to submit to Congress a report on the feasibility and advisability of establishing an individual retirement plan (as defined in section 7701(a)(37) of the Internal Revenue Code of 1986, or similar retirement plans) for family caregivers under the PCAFC or permitting such family caregivers to join an already established pathway to retirement savings.

VA supports this section, subject to amendments and the availability of appropriations.

Providing a pathway to retirement savings acknowledges the critical role that family caregivers play in the health and well-being of Veterans. It also demonstrates a commitment to supporting those who make substantial personal and financial sacrifices in the service of their loved ones. We appreciate the intent behind this section, but it would not grant VA any new authority. VA can already work with the Department of the Treasury and other entities to better understand the feasibility of establishing individual retirement plans for family caregivers under PCAFC. We would appreciate the opportunity to talk with the Committee about its intended outcomes to determine if legislation is needed.

VA does not have a cost estimate for this section, but as this would only require a report to Congress, we do not anticipate any appreciable costs.

H.R. 2605 Service Dogs Assisting Veterans Act (SAVES Act)

Section 2(a) of this bill would require VA, not later than 24 months after the date of enactment, to establish a 5-year pilot program under which VA would award grants, on a competitive basis, to nonprofit entities to provide service dogs to eligible Veterans. Section 2(b) would provide that, to be eligible to receive a grant, nonprofit entities would have to submit to VA an application at such time, in such a manner, and containing such commitments and information as VA may require. Applications would have to include a proposal for the provision of service dogs to eligible Veterans, including how the entity would communicate with VA to ensure an increasing number of service dogs are provided to Veterans; applicants would also have to include a description of training

and services provided by the entity, as well as the qualifications of the entity (including documentation that the entity has experience in training dogs as service animals).

Under section 2(c), VA would have to award a grant to each non-profit entity for which VA has approved an application. VA and the entity would have to enter into an agreement containing such terms, conditions, and limitations as VA determines appropriate. The maximum grant amount VA could award to a non-profit entity under this section would be $2 million. VA would have to establish intervals of payment for the administration of each grant awarded under this section.

Under section 2(d), grantees would have to use the grant amounts to plan, develop, implement, or manage (or any combination thereof) one or more programs that provide service dogs to eligible Veterans. VA could establish a maximum amount for each grant awarded under this section to cover administrative expenses. VA also could establish other conditions or limitations on the use of grant amounts.

Under section 2(e), grantees would have to notify each Veteran that receives a service dog through the grant that the dog is being paid for, in whole or in part, by VA, and they would have to inform such Veterans of the benefits and services available from VA for the Veteran and service dog. Grantees could not charge a fee to a Veteran receiving a service dog through the grant.

Under section 2(f), VA would have to provide to each Veteran who receives a service dog through a grant a commercially available veterinary insurance policy for the service dog, and, if VA provides such a veterinary insurance policy to a Veteran, VA would have to continue to provide the policy without regard to the continuation or termination of the pilot program.

Under section 2(g), VA could provide training and technical assistance to recipients of grants under this section.

Under section 2(h), VA would have to establish oversight and monitoring requirements as appropriate to ensure grants are used appropriately, and VA could take actions as necessary to address any issues identified through the enforcement of such requirements. VA could require each grantee to provide reports or written answers to specific questions, surveys, or questionnaires as VA determines necessary.

Section 2(i) would define terms for purposes of this Act. The term “eligible veteran” would be defined to mean Veterans who have a covered condition. The term “covered condition” would mean any of the following: blindness or visual impairment; loss of use of a limb, paralysis, or other significant mobility issue, including mental health mobility; loss of hearing; posttraumatic stress disorder (PTSD); traumatic brain injury (TBI); and any other disability, condition, or diagnosis VA determines, based on medical judgment, that it is optimal for the Veteran to manage the disability, condition, or diagnosis and live independently through the assistance of a service dog. The term “service dog” would mean any dog that is individually trained to do work or perform

tasks that are for the benefit of a Veteran with a disability, condition, or diagnosis described above and directly related to the disability, condition, or diagnosis of the Veteran.

Section 2(j) would authorize to be appropriated $10 million for each of the 5 consecutive fiscal years following the fiscal year in which the pilot program is established.

VA supports this bill, subject to amendments and the availability of appropriations.

VA provides benefits for service dogs for eligible Veterans who have been diagnosed with a visual, hearing, or substantial mobility impairment (including mental health mobility) when the VA clinical team treating the Veteran for such impairment determines, based upon medical judgment, that it is optimal for the Veteran to manage the impairment and live independently through the assistance of a trained service dog. See 38 C.F.R. § 17.148(b). VA provides a commercially available veterinary insurance policy for service dogs, as well as payments for travel expenses associated with obtaining a dog if the Veteran is eligible for beneficiary travel under 38 U.S.C. § 111 and 38 C.F.R. part 70 and if pre-approved for such benefits.

While not involving the provision of service dogs, since February 2022, VA has been implementing the Puppies Assisting Wounded Servicemembers for Veterans Therapy Act (P.L. 117-37), which requires VA to conduct a pilot program to provide canine training to eligible Veterans diagnosed with PTSD as an element of a complementary and integrative health program for such Veterans. Service dogs provide essential support for many Veterans.

We appreciate that the bill generally focuses on creating a more direct connection in the legislation between grant funds and the provision of service dogs to eligible Veterans, but we believe this could be clearer. Specifically, in section 2(d), the bill would require grantees to use funds "to plan, develop, implement, or manage (or any combination thereof) one or more" programs that provide service dogs to eligible Veterans. Allowing the use of funds to plan a program that provides service dogs, but which ultimately does not provide service dogs, is not an ideal use of funds. We recommend the bill simply state that grantees would use funds to provide service dogs to eligible Veterans. In VA's experience, Veterans can wait between 1 and 3 years between when a dog has been recommended by VA and when a Veteran has been fully paired with a service dog that has graduated training. VA believes the grants provided under this authority could help increase the supply of service dogs to reduce this delay. In any grant program, but particularly in the case of service dog training, it is essential to ensure that funds are properly used.

Several provisions in the bill raise concerns. First, VA recommends clearly aligning the definition of service dog under this section with VA's existing definition in regulations. Second, VA is concerned about the list of disabilities that was presented in

the bill. Specifically, the inclusion of TBI, for which a Veteran may already otherwise qualify based on having a significant mobility issue, and PTSD, as there is no substantial evidence to date that service dogs provide improvements in functioning and quality of life for Veterans with PTSD as compared to emotional support dogs. VA recommends striking these provisions. We note, similar to the discussion above regarding Veterans with TBI qualifying for a service dog when they have a significant mobility issue, Veterans with PTSD can receive a service dog on the same basis. Further, VA recommends including additional language that would ensure clear authority for the administration of a grant program. Finally, we note that the current bill expands eligibility to all Veterans (presumably those who meet the requirements of 38 U.S.C. § 101), not just Veterans enrolled in VA health care. This would complicate administration of this program.

We also note that this proposal would likely require dedicated staff in a new office to administer this program.

VA does not have a cost estimate for this bill.

H.R. 3400 Territorial Response and Access to Veterans' Essential Lifecare Act (TRAVEL Act of 2025)

Section 2(a) would add a new 38 U.S.C. § 7415, regarding traveling physicians. Proposed section 7415(a) would authorize VA to assign a physician appointed under 38 U.S.C. § 7401(1) to serve as a traveling physician for a maximum of 1 year. Such traveling physician(s) would provide health care to Veterans residing in the territories or possessions of the United States at Department facilities in such territories or possessions (including American Samoa, Guam, the Commonwealth of the Northern Mariana Islands, the Commonwealth of Puerto Rico, the U.S. Virgin Islands, and any other U.S. territory or possession).

Proposed section 7415(b) would require the traveling physicians to coordinate with non-Department medical providers to the extent necessary to ensure high quality and coordinated care for Veterans receiving hospital care and medical services.

Proposed section 7415(c) would require VA to provide to the traveling physicians, in addition to pay under 38 U.S.C. § 7431 (which generally governs VHA physician pay), a relocation or retention bonus that is substantially similar to one offered under sections 5753 and 5754 of title 5, U.S.C., as the Secretary considers appropriate.

Section 2(b) would make a clerical amendment.

VA supports this bill, subject to amendments and the availability of appropriations.

VA supports section 2 if amended to modify the current text to reference VA's bonus authority under title 38 and remove the reference to retention bonuses offered under 5 U.S.C. § 5754.

VHA physicians are eligible to receive recruitment or relocation bonuses and retention allowances under 38 U.S.C. § 7410(a), which requires payment of these incentives in a manner consistent with the authorities described in 5 U.S.C. §§ 5753 and 5754. By aligning the incentive authority under 38 U.S.C. § 7410(a), these payments would be excluded from the total compensation limit in 38 U.S.C. § 7431(e)(4). A retention bonus may not be an appropriate incentive mechanism due to the statutory requirement for the agency to determine that an employee is likely to leave Federal service (or to take a different Federal position in limited cases).

Current VA policy in VA Handbook 5007, Pay Administration, allows for the authorization of relocation incentives for temporary workplace changes of 120 days or more, not to include when an employee remains in temporary duty travel status. In accordance with VA Handbook 5007, an employee must also have a rating of record of at least "Fully Successful" for the position held immediately before the temporary workplace change and physically relocate to a different geographic area to receive a relocation incentive. Edits to VA policy may be required to ensure traveling physicians would be eligible for relocation incentives. Service agreements would generally be required in accordance with policy and the proposed legislation as drafted.

VA welcomes the opportunity to work with the Committee on technical assistance to clarify such bonus eligibility and required coordination of care, as well as a technical amendment to clarify the traveling physician would not necessarily provide care in each and every possession or territory.

VA does not have a cost estimate for this bill.

H.R. 3643 VA Data Transparency and Trust Act

Section 2(a) of this bill would amend 38 U.S.C. § 7330B, which required VA to submit a report to Congress, between 2018 and 2022, including three defined elements. These reports were, on average approximately 40-50 pages in length. The proposed amendments would re-establish, for a period of 5 years, and significantly expand these reporting requirements by requiring VA to report on 24 distinct elements, many of which would contain a number of sub-elements. The bill would also require VA to develop and carry out a data sharing system to grant access to researchers who meet certain criteria regarding data security and protection established by VA in regulations. Data access by these researchers would be limited to aggregated, anonymized data for Veterans and individuals receiving health care furnished by VA. VA would have to consider the Centers for Medicare & Medicaid Services Qualified Entity Program (also known as the Medicare Data Sharing for Performance Measurement Program) in developing the new data sharing system. VA would have to ensure that data available through such data sharing system includes each type of data available under the Medicare Data Sharing

for Performance Measurement Program, data on enrolled Veterans, data on health care visits at VA facilities, and data on insurance claims submitted to VA for care furnished at non-VA facilities.

Section 2(b) would create a new section 7735 in title 38, U.S.C., that would require reporting of data in the Annual Benefits Report of the Veterans Benefits Administration (VBA) on 15 elements for similarly detailed data as required by subsection (a) for VHA. Proposed § 7735(b) would establish a similar data sharing system requirement as described above.

VA supports this bill, subject to amendments and the availability of appropriations.

While VA agrees with the transparency this bill would require, the level of necessary detail would make implementation very complex and resource intensive. Given the nuances of VA operations and data systems, VA recommends the bill focus on the desired topic areas for inclusion in the reports in lieu of mandating specific metrics that may not meet the drafter's intent.

VA also has concerns with a number of the specific reporting requirements in the bill. To satisfy some of these, VA would need additional and regular updates regarding income, education level, and military service for Veterans. Some of the provisions refer to VA as a health insurance plan or as receiving health insurance claims, which are not accurate. VA also recommends clarifying the requirement to provide data on the average amount of compensation paid to Veterans for non-service-connected disabilities; we believe this is intended to refer specifically to benefits under 38 U.S.C. § 1151, which authorizes VA to award compensation for a qualifying disability (as if the disability were service-connected) resulting from hospital care, medical or surgical treatment, or examination furnished by VA; VA may also award compensation if the disability was proximately caused by the provision of training and rehabilitation services provided by VA as part of an approved vocational rehabilitation training, or in compensated work therapy.

Further, VA is concerned about the availability of information technology (IT) systems necessary to facilitate the data exchanges required to satisfy all of the requirements of this bill, specifically with agencies whereby a data sharing exchange platform is not already established with VA. This could require additional time and resources before VA could implement. VA also recommends amending the requirement for data on re-evaluations of disability ratings to begin from the date on which the data are first available. Limitations in existing systems could present challenges in providing requested information more than 25 years old.

As written, this bill would mandate the release of granular data on Veterans' health and benefits to Congress and establish a system allowing eligible researchers to access anonymized individual-level data. While this initiative can hold great promise for fostering innovation and improving the quality of care and benefits for our Veterans, it

also presents significant privacy challenges. While the bill intends to ensure data released would be anonymized, providing the detail required at an individual level makes robust anonymization very difficult. VA recommends the requirement for individual level data be removed, permitting the use of aggregated data that would provide detail without impacting Veterans' privacy. Retaining the individual-level data requirement would necessitate robust access restrictions to prevent users from deanonymizing the underlying data.

VA additionally requests that the bill include wording to acknowledge the expanded data sharing from other Federal agencies that would be required for this level of reporting, including details on income and dependents that would require expansion of data provided by the Department of Treasury.

VA has other technical amendments and comments on this bill.

VA believes this bill would result in significant additional costs, although VA does not have a cost estimate at this time. The resources needed to collect and report these data would divert from health care and benefits delivery.

H.R. XXXX Fisher House Availability Act of 2025

This bill would amend 38 U.S.C. § 1708, which allows VA to furnish certain persons with temporary lodging in a Fisher house or another appropriate facility. Specifically, it would amend § 1708(a) to remove the condition that temporary lodging be in connection with the examination, treatment, or care of a Veteran under chapter 17 or in connection with benefits administered by VA. It would also amend § 1708(b), which defines which persons can receive lodging under subsection (a). It would add two new cohorts, both on a space-available basis: covered beneficiaries that must travel a significant distance to receive care or services at a non-VA facility, and members of the family of a covered beneficiary that provide the equivalent of familial support for such beneficiary. The bill would amend what is currently § 1708(e) (but would be redesignated as subsection (d)) to require that VA's regulations would have to include provisions establishing criteria for persons considered to be accompanying a Veteran or covered beneficiary, and to establish criteria for providing access to temporary lodging facilities on a space-available basis to the two new cohorts of eligible individuals under § 1708(b), as revised. Finally, the bill would define the term "covered beneficiary" to mean a beneficiary under chapter 55 of title 10, U.S.C., other than beneficiaries under 10 U.S.C. § 1074(a), which refers to certain members of the uniformed services (based on the definition of that term in 10 U.S.C. § 1072(5) and 10 U.S.C. § 1074(a)); it would also amend the definition of "Fisher house" to include a reference to the Fisher House Foundation, Inc., as well.

VA supports this bill, subject to amendments.

VA supports allowing Fisher Houses to provide lodging, on a space available basis, to Service members who receive care at VA facilities and their families. VA has

adopted this posture through VHA Directive 1107, Department of Veterans Affairs Fisher Houses and Other Temporary Lodging (October 19, 2023), but current law is ambiguous in this respect, and the bill's proposed changes would not clearly include all Service members who may receive care at a VA facility. We are concerned that if Congress amended current law to include certain individuals, but not all Service members, this could create an adverse inference that providing lodging to other Service members is prohibited by law. We also recommend amendments to ensure the eligibility for lodging for dependents of both Veterans and Service members is the same or comparable.

We also note that the bill has technical issues that need to be addressed, particularly concerning the proposed amendments to section 1708(a), where the bill would refer to removing a phrase that appears in two different places without clearly stating which phase would be amended.

Additionally, we recommend the bill be amended to expressly authorize VA to provide lodging at Fisher Houses to Service members who receive care at VA facilities and their families. VA has adopted this posture through VHA Directive 1107, Department of Veterans Affairs Fisher Houses and Other Temporary Lodging (October 19, 2023), but we are concerned that if Congress amended current law to include other individuals, but not Service members, this could create an adverse inference that providing lodging to Service members is prohibited by law. VA would welcome the opportunity to provide technical assistance to address these concerns.

VA does not have a cost estimate for this bill.

H.R. XXXX Prohibiting Smoking in Facilities of the Veterans Health Administration

This bill would repeal section 526 of P.L. 102-585 and amend 38 U.S.C. § 1715 to prohibit any person (including Veterans, patients, residents, employees, contractors, or visitors) from smoking on the premises of any VHA facility. The bill would prohibit the use of cigarettes, cigars, pipes, and any other combustion or heating of tobacco, as well as the use of any electronic nicotine delivery system, including electronic or e-cigarettes, vape pens, and e-cigars. The prohibition would apply to any land or building that is under VA's jurisdiction, under the control of VHA, and not under the control of the General Services Administration.

VA strongly supports this bill.

Legislation to prohibit smoking on the premises of any VHA facility will ensure that VA can provide a smoke-free health care environment. Currently, there are more than 4,000 local or State, territorial, or commonwealth hospitals, health care systems and clinics, and at least four national health care systems (Kaiser Permanente, Mayo Clinic, SSM Health Care, and CIGNA Corporation) in the United States that have adopted 100% smoke-free policies that extend to all their facilities, grounds, and office

buildings. Absent this legislation, VHA patients, health care providers and visitors may not have the same level of enduring protection from the hazardous effects of secondhand smoke exposure as do patients and employees in these other systems. Currently, approximately 12.7% of Veterans enrolled in VA health care are smokers. Many of the non-smokers are also older Veterans who may be at higher risk for cardiac or other conditions that may make them even more vulnerable to the cardiovascular events associated with secondhand smoke.

As with other health care systems, VA believes its Veteran patients and employees have a right to be protected from secondhand smoke exposure when seeking health care or working at a VA facility. For Veteran smokers who are inpatients, nicotine replacement therapy is available. VA also offers tobacco cessation programs and resources for Veterans and employees. VA notes that it would support an exception for ceremonial uses of tobacco within limited parameters set by the Secretary in coordination with federally recognized tribes, consistent with Indian Health Service tobacco policy. VA recommends including an effective date to facilitate implementation.

VA estimates that this bill would not result in any costs because it is consistent with current policy.

H.R. XXXX Study on RNA Sequencing to Diagnose PTSD in Veterans

This bill would require VA, acting through the Center for Innovation for Care and Payment (CICP) and within 120 days of enactment, to conduct a study to determine whether ribonucleic acid (RNA) sequencing could be used to effectively diagnose Veterans with inflammation or cellular stress, symptoms of PTSD. VA would have to carry out the study in medical facilities in five Veterans Integrated Service Networks (VISN). The study would have to terminate on September 30, 2027. Not later than September 30, 2028, VA would have to submit a report to Congress containing the results of the study.

VA supports the intent of this bill, subject to the availability of appropriations, but cites concerns.

VA supports efforts to expand work in this critical research area. However, VA cites concerns with this proposed legislation because, at the current time, such a study would be premature given the state of the science. There is not sufficient scientific evidence to indicate that clinically useful information would result from such a study. Additionally, we have concerns with codifying research approaches or methodologies, as this bill would do, and we note this research could be conducted with current authority. We also note the timeline for this bill would be too short to produce scientifically valid results. Further, the CICP would not be the appropriate entity to carry out this study. We would appreciate the opportunity to discuss current research efforts in this area and how legislation might support these.

VA does not have a cost estimate for this bill.

H.R. XXXX Providing for a Time Frame for Employment in VA of Participants in the Health Professionals Scholarship Program (HPSP)

This bill would amend 38 U.S.C. § 7616 by adding a subsection (d) to require VA to appoint Health Professional Scholarship Program (HPSP) participants in a full-time clinical position at a VA facility within 90 days of course completion.

VA does not support this bill.

VA agrees with the intent to expedite the employment process for health care professionals. However, VA does not support the bill because it would not allow VA to consider the various hiring considerations inherent in health care occupations or current operational constraints.

The proposed 90-day timeframe does not accommodate the various requirements across health care professions. For instance, certain health care professions necessitate the completion of licensure, certifications, internships, or residencies before the health care professional can be appointed to their respective position. A one-size-fits-all approach does not reflect the variability in preparation and does not align with VA qualification standards across the various health care occupations.

There are many instances in which the hiring of individuals within 90 days of completing HPSP is not possible. For example, VHA Qualification Standards for Physicians require graduates to complete a residency training, approved by the Accreditation Council for Graduate Medical Education, American Osteopathic Association, or other residencies which the local Medical Staff Executive Committee deems appropriate. Once residency training is complete, individuals must pass the United States Medical Licensing Examination or Comprehensive Osteopathic Medical Licensing Examination. Upon receiving licensure, in some cases, VA requires an additional physician board certification for those overseeing medical students or physician residents (including fellows), or faculty status with an affiliated medical school. For registered nurses, VHA Qualification Standards require graduates to pass the National Council Licensure Examination and maintain an active, current, full and unrestricted license. Additionally, VHA Directive 1077, VHA Registered Nurse Transition-to-Practice Residency Program, requires those with one year of professional experience serve in a residency program for one year before they can operate in a full-time clinical capacity position. In each of these examples, VA would be unable to comply with the proposed 90-day hiring requirement due to critical mandatory steps to obtain requisite licensure, certification, and experience.

VA does not have a cost estimate for this bill.

H.R. XXXX VA Mental Health Outreach and Engagement Act

This bill would amend 38 U.S.C. § 1167 related to mental health consultations to clarify that the current subsection (a) would refer only to initial mental health consultations. This statute requires VA, not later than 30 days after the date on which a Veteran submits to VA a claim for compensation under chapter 11 for a service-connected disability relating to a mental health diagnosis, to offer the Veteran a mental health consultation to assess the mental health needs of, and care options for, the Veteran. VA is required to offer such a consultation without regard to any previous denial or approval of a claim for a service-connected disability relating to a mental health diagnosis for the Veteran and to ensure the Veteran offered a mental health consultation can elect to receive such consultation during the 1-year period beginning on the date on which the consultation is offered (although VA can provide a longer time period if appropriate).

This bill would insert a new subsection (b) that would require VA, not less frequently than annually, with regard to a Veteran who is receiving compensation under chapter 11 for a service-connected disability relating to a mental health diagnosis, to offer a mental health consultation to assess the mental health needs of, and discuss other mental health care options for, the Veteran. VA would also have to conduct annual outreach to each such Veteran regarding the availability of mental health consultations and other mental health services from VA. Current subsections (b) and (c) would be redesignated as subsections (c) and (d), respectively.

This bill also would make technical corrections to 38 U.S.C. § 1167 related to mental health consultations to instead be codified at 38 U.S.C. § 1169. It would also make amendments to the table of contents to reflect this change.

Finally, the bill would require the Comptroller General to submit to Congress a report on the effect of the amendments made by this section. This report would need to include the number of Veterans who received mental health consultations under the newly-designated § 1169(b)(1) and outreach under § 1169(b)(2). It would also need to include whether Veterans reported barriers to seeking consultations and such barriers, if any.

VA supports this bill, subject to amendments and the availability of appropriations.

In particular, VA supports the technical corrections as this would provide clarity to the U.S. Code. However, VA only partially supports the substantive amendments this bill would make, subject to amendments and the availability of appropriations. VA currently offers an annual screening to enrolled Veterans for commonly occurring mental health conditions. Veterans who screen positive receive further evaluation and treatment, if they are willing to engage in care. In the first quarter of FY 2025, 73% of Veterans receiving compensation under chapter 11 for a service-connected disability

relating to a mental health diagnosis were enrolled in VA health care and receive the annual mental health screenings described above.

Instead of requiring annual offers of mental health consultations to those Veterans receiving compensation as described above, VA believes it would be more appropriate only to conduct annual outreach to such Veterans advising them of VA mental health services and how to access them. Veterans who elect to enroll, or to seek care without enrolling (if eligible), would receive a mental health assessment as part of an initial appointment. If mental health needs are identified, the Veteran would also receive information about treatment goals and options. This would connect Veterans directly to existing mental health services, and every VA health care facility must screen Veterans requesting mental health services for urgent needs and immediately address them.

VA would appreciate the opportunity to discuss other technical issues with the Committee regarding current 38 U.S.C. § 1167 (regarding mental health consultations) and section 2068 (regarding mental health consultations for Veterans entering Homeless Programs Office programs). VA has been working to implement these authorities since their enactment, but we believe Congress could facilitate this implementation with additional revisions to these statutes.

VA does not have a cost estimate for this bill.

Conclusion

This concludes my statement. We would be happy to answer any questions you or other Members of the Subcommittee may have.

Prepared Statement of David Coker

Thank you, Chairwoman Miller-Meeks, and good afternoon to the members of the Committee.

My name is David Coker, and I have the privilege of serving as President of Fisher House Foundation.

The Fisher House program was founded in 1990 by Zachary Fisher, a private citizen and patriotic philanthropist who believed that no military family should ever struggle to be by their loved one's side during a medical crisis. He built the first Fisher Houses at the National Naval Medical Center and Walter Reed Army Medical Center. The vision was simple but powerful: to create a home away from home for families traveling to be with a loved one receiving care.

The Fisher House program has now grown into a network of 100 Fisher Houses located at Department of Defense hospitals and VA medical centers across the country and overseas. Because of the special mission of supporting both military and veteran families, it is fitting that the 100th Fisher House, to be dedicated next month, is located at the Captain James A. Lovell Federal Health Care Center—the only fully integrated DoD and VA medical center in the country.

Each home is now built through the generous support of the American public and donated to the VA or the military service it serves. To date, Fisher Houses have offered more than 12 million nights of lodging and saved families more than $650 million in out-of-pocket costs.

When we gift a Fisher House to the Army, Navy, Air Force, or VA, our goal is to support families in their time of greatest need. We know that having a loved one present improves recovery. Family members serve as caregivers, advocates, and a tremendous source of strength. We believe they are essential to the healing process—and that every veteran and service member deserves to have their loved one at their side.

Of the 100 Fisher Houses, more than half support VA medical centers. In 2024, VA Fisher Houses served more than 24,000 veteran families—spanning all eras and every generation.

Last fall, guidance was published which changed the way VA houses operate. It directed that only families of veterans receiving VA-directed care were eligible for the support Fisher Houses provide. Even when rooms are available, families that have historically been welcomed must now be turned away.

Last year, the occupancy rate at VA Fisher Houses across the country was 53 percent. We would ask if a room was available; consideration should be given to support the family of an eligible DoD beneficiary.

The Fisher House supporting the Washington DC VA Medical Center is on the same campus as the Children's National Hospital, the National Rehabilitation Hospital, and Washington Hospital Center. Last year, occupancy at that house was 22 percent and could easily accommodate families receiving care at one of the other hospitals.

The world-renowned Paley Orthopedic and Spine Institute is located near the Fisher House supporting the Thomas H. Corey VA Medical Center in West Palm Beach, Florida. 27 military children were referred to them for life-changing care last year, but today their families are no longer eligible to stay in the Fisher House.

There are three Fisher Houses at the DeBakey VA Medical Center in Houston, Texas adjacent to the Texas Medical Center and MD Anderson. Last year, the occupancy rate was 63 percent, and again, because of this guidance, military families will be turned away.

The bipartisan Fisher House Availability Act of 2025 would restore the flexibility that VA Fisher House managers once had, allowing families of active-duty service members and other eligible beneficiaries to stay on a space-available basis, while preserving the priority access for veterans.

This change will not reduce access for veterans. It simply allows these homes—already built, already staffed, already serving—to do what they were intended to do: keep families of our Nation's heroes together in the hardest moments of their lives.

This bill is consistent with the Memorandum of Understanding between the Secretary of Defense and the Secretary of the VA—Strengthening our Partnership in Service to those we Serve, and it will provide one more way for the two departments to work together to support both the military and the veteran communities.

On behalf of Fisher House Foundation and the tens of thousands of families we have the privilege of serving each year, I want to thank the sponsors of this bill and all of you for your support for our Nation's service members, veterans, and their loved ones. Thank you for the opportunity to speak today. I welcome your questions.

Prepared Statement of Randy Johnson

Thank you, Chairman Bost, Ranking Member Takano, and members of this Committee.

My name is Randy Johnson. I am a resident of the Northern Mariana Islands, a veteran of the United States Marine Corps, and for the past decade I have had the privilege of assisting fellow veterans in the Northern Marianas, helping them navigate the VA system, and access the benefits they earned through their service.

I have traveled nearly 8,000 miles to be here today to speak in support of H.R. 3400, the Territorial Response and Access to Veterans' Essential Lifecare Act, known as the TRAVEL Act, introduced by our delegate, Congresswoman Kimberlyn King-Hinds.

This is a good bill. In the Northern Marianas, we do not have a VA medical center. We do not have consistent access to specialty care or mental health services. When veterans need more than basic care, we are often told to leave the island, traveling thousands of miles, paying out of pocket, and spending weeks away from our families.

The TRAVEL Act helps to change that. It allows the Department of Veterans Affairs to send traveling VA physicians into remote communities like ours. Instead of forcing the veteran to chase care across oceans, this bill brings care to the veteran. That is the right direction.

I am here to voice my support for the TRAVEL Act. But I also came this distance to give voice to the hundreds of veterans who could not be here. Veterans who served this country with honor, who, like me, are not asking for special treatment. We are asking for what we would receive if we lived anywhere else in the United States.

We are the only place in the Nation where a veteran can call home but have no access to a Community Based Outpatient Clinic. No CBOC at all. Veterans from every conflict, past and present, have been told that if they want the full range of care they have earned, they cannot live at home.

Veterans seeking care at home see one doctor, on Tuesdays and Thursdays. Dr. Ada has done a good job, but there is only so much one person can do. Her office has one VA Registered Nurse, a veteran herself. But if she needs care, or takes a much-needed vacation, there is no one left to keep pace.

Decisions on care, travel, and benefits happen in Guam or Hawaii. Resources come from Guam or Hawaii. And when those places are struggling or overloaded, we cannot reasonably expect them to prioritize our needs.

But what we want, and what I believe we have earned, is the right to live in the country we fought for, in the community we fought for, and to have our service speak for itself. We should not have to choose between access to care and being home with our families. We stood the watch. We answered the call. That should be enough.

I served in Iraq. I saw combat. And I received the Purple Heart for it. I traveled here by choice, but many veterans are forced to travel simply to receive the care they need. That should not be the case.

In the Northern Marianas, I have served alongside and advocated for generations of veterans, those who fought in Vietnam, Panama, Iraq, and Afghanistan. All of them returned home to a system still not built to meet their needs.

As I made my way here, I thought of the Vietnam veterans in their 70's and 80's who served our Nation even before our islands were formally part of this country. They have spent a lifetime fighting for benefits that only trickled in, slowly, over decades. Now, even in their later years, they are still being asked to travel off-island for basic, sometimes life-sustaining care. I think of how difficult this travel is for them.

I thought of the Gulf War veterans who opened a new chapter in America's military history, but returned to the same old gaps in care and support.

And I thought of my own generation, those who served in Operation Iraqi Freedom and Enduring freedom. We served with commitment. We returned home with hope. But we still face the same cycle of delay, denial, and distance.

Of this new generation of veterans, I am proud to be part of a group that is organizing to support one another directly. Project Buddy Check 670 is an example of that effort. It reflects our belief that care for veterans does not always come in the form of a pill or a prescription. Sometimes, it comes from another veteran picking up the phone, checking in, and listening.

Project Buddy Check is a reminder that veterans seeking care that treats us as people, not just patients. But when even ordinary medical care is so far out of reach, how can we expect the system to provide the mental health and holistic support our veterans truly need?

Generations of veterans have answered the call from our islands. I know the challenges we face are difficult to address. But again, we stood the watch. We bore the burden. That should be enough. It is time the system answered back.

H.R. 3400 is a strong start. I respectfully ask this committee to support it and to continue advancing policies that bring real access and real dignity to every veteran, no matter where they live. Thank you for your time, and for your unwavering commitment to those who served.

Prepared Statement of Cole Lyle

TESTIMONY
OF
COLE LYLE
DIRECTOR
VETERANS' AFFAIRS AND REHABILITATION DIVISION
THE AMERICAN LEGION
BEFORE THE
HOUSE COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON HEALTH
LEGISLATIVE HEARING
ON
"PENDING LEGISLATION"

JUNE 12, 2025

EXECUTIVE SUMMARY

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Chairman Miller-Meeks, Ranking Member Brownley, and distinguished members of the subcommittee, on behalf of National Commander James A. LaCoursiere Jr., and more than 1.5 million dues-paying members of The American Legion, we thank you for the opportunity to offer our written testimony regarding proposed legislation.

The American Legion is guided by active Legionnaires who dedicate their time and resources to serve veterans, service members, their families, and caregivers. As a resolutions-based organization, our positions are directed by more than 106 years of advocacy and resolutions that originate at the post level of our organization. Every time The American Legion testifies, we offer a direct voice from the veteran community to Congress.

H.R. 785: Representing Our Seniors at VA Act

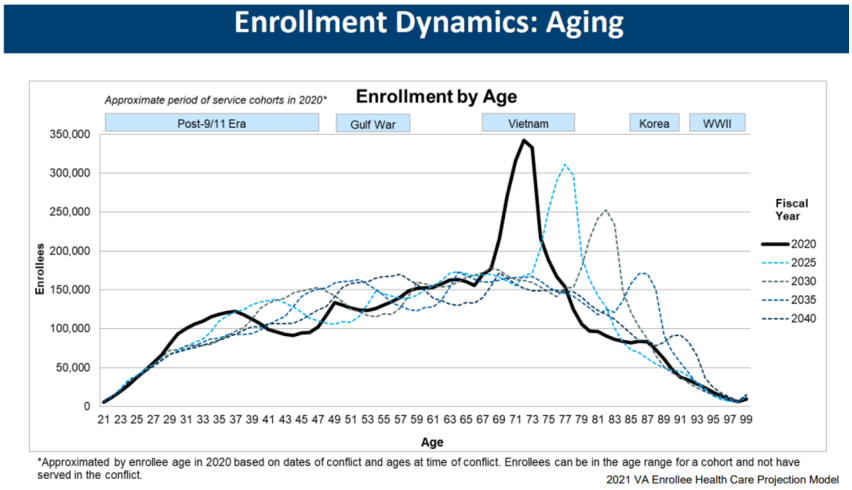
To amend title 38, United States Code, to include a representative of the National Association of State Veterans Homes on the Geriatrics and Gerontology Advisory Committee of the Department of Veterans Affairs.

Representing Our Seniors at VA Act modifies the membership structure of the Department of Veterans Affairs (VA) Geriatrics and Gerontology Advisory Committee (GGAC). This committee, appointed by the Secretary of Veterans Affairs upon recommendation from the Under Secretary for Health, is legally required to be composed of individuals "who have demonstrated interest and expertise in research, education, and clinical activities related to aging." Existing law also mandates the inclusion of at least one representative from a national veteran service organization. This bill will add to that framework by granting a seat on the GGAC to a representative of the National Association of State Veterans Homes (NASVH), selected in consultation with the President of the NASVH.

State Veterans Homes are long-term care facilities which provide a range of services to eligible veterans and their families. While owned and operated by individual states, these facilities are certified and partially funded by the VA. According to the U.S. Government Accountability Office (GAO), 14,500 veterans resided in 153 State Veterans Homes in 2021, which accounted for

approximately half of VA long-term care facilities.[1] As of 2024, all of the now 169 State Veteran Homes held membership in NASVH.[2] These homes are a cornerstone of the nation's care infrastructure for aging veterans, and NASVH is well-positioned to speak on their behalf.

The urgency of strengthening geriatric care at the VA is clear. A 2021 VA care projection model (see figure below) illustrates the demographic surge of Vietnam-Era veterans.



As shown in this figure, in 2025 the average (mode) age of the veteran population is 77 years old and this is the same age the National Center for Health Statistics reports to be the average age for residents of long-term care facilities.[3] As these veterans age, the cost to care for them will continue to increase with projected costs doubling by 2037, and recommendations of the Geriatrics and Gerontology Advisory Committee will become more critical.[4] The VA and the nation itself must be prepared to care for these heroes.

Through Resolution No. 20: *Home and Community-Based Services and Veteran Choice to Age In Place*, The American Legion supports veteran choice in where they age, and the only way to ensure

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[1] U.S. Government Accountability Office. *VA Health Care: Improved Oversight of State Veterans Homes Would Help Better Ensure Quality of Care*. GAO-23-105167. Washington, DC: U.S. Government Accountability Office, 2023. https://www.gao.gov/products/gao-23-105167

[2] Harries, Ed. *Statement of Ed Harries, President, National Association of State Veterans Homes, on Draft Legislation to Include a Representative of NASVH on the Geriatric and Gerontology Advisory Committee*. Hearing before the Subcommittee on Health of the House Committee on Veterans' Affairs, 118th Cong., 2nd sess., September 11, 2024. https://docs.house.gov/meetings/VR/VR03/20240911/117591/HHRG-118-VR03-20240911-SD004.pdf.

[3] Centers for Disease Control and Prevention. *National Post-acute and Long-term Care Study: 2020 Data on Nursing Home Residents by Age and Length of Stay*. Atlanta: U.S. Department of Health and Human Services, 2022. https://www.cdc.gov/nchs/data/npals/NHresident-age-lengthofstay-2020-508.pdf.

[4] U.S. Government Accountability Office. *VA Health Care: Veterans' Use of Long-Term Care Is Increasing, and VA Faces Challenges in Meeting the Demand*. GAO-20-284. Washington, DC: U.S. Government Accountability Office, February 2020. https://www.gao.gov/assets/gao-20-284.pdf

this is a robust advisory system for VA Gerontology. The VA and the nation itself must be prepared to care for these heroes.

The American Legion supports H.R. 785 *as currently written*.

H.R. 2068: The Veterans Patient Advocacy Act

To amend title 38, United States Code, to improve the assignment of patient advocates at medical facilities of the Department of Veterans Affairs, and for other purposes.

There are currently 4.7 million rural and highly rural veterans across the United States.[5] The VA's Office of Rural Health (ORH) estimates that 2.8 million rural veterans are enrolled in and rely on the VA's health care system.[6] The American Legion believes that patient advocates are vital in serving rural veterans and supports all efforts to ensure they are appropriately assigned and staffed. A September 2024 VA OIG report found a patient advocate failed to assist a veteran due to an overwhelming workload,[7] and found VA needed to enhance the operation of the Patient Advocate Program, providing three recommendations to resolve the issue.

The American Legion applauds efforts to improve the assignment of patient advocates, as this directly impacts our membership. Legionnaires like Sergeant John Tedford in Arizona shared that despite his 90% service-connected disability rating, he waited over a year for a medical appointment due to the multitude of dead-end paths.[8] Through the System Worth Saving Program visits, The American Legion has actively sought and provided recommendations to the VA regarding enhancements to the patient advocate program which align with the OIG's September 2024 recommendations.

The American Legion supports initiatives to advocate for veterans and improve access to care for rural veterans through better staffing and communication, as outlined in Resolution No. 75: *Department of Veterans Affairs Rural Health Care*. The American Legion believes that veterans deserve timely medical services regardless of where they live and should have access to advocates who can help them secure appropriate healthcare. Furthermore, the American Legion backs staffing measures ensuring patient advocates are present in all VA medical centers, as stated in Resolution No. 115: *Department of Veterans Affairs Recruitment and Retention*. Patient advocates are crucial for veterans, particularly those in rural areas, and the Legion supports the VA's efforts to develop and implement staffing models that address these needs.

The American Legion supports H.R. 2068 *as currently written*.

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[5] U.S. Department of Veterans Affairs, "Office of Health Equity" Access to Care Among Rural Veterans - Office of Health Equity, https://www.research.va.gov/topics/rural_health.cfm

[6] U.S. Department of Veterans Affairs, "Office of Rural Health" "https://www.ruralhealth.va.gov/"Office of Rural Health Home, https://www.ruralhealth.va.gov/.

[7] U.S. Department of Veterans Affairs, Office of Inspector General, *Leaders Failed to Address Community Care Consult Delays Despite Staff Advocacy*, June 2025, https://www.vaoig.gov/reports/hotline-healthcare-inspection/leaders-failed-address-community-care-consult-delays-despite.

[8] American Legion. "Only Hope For Some." *The American Legion*, 2025. https://www.legion.org/information-center/news/your-words/personal-experiences/only-hope-for-some.2025.

H.R. 2605: Service Dogs Assisting Veterans (SAVES) Act

To require the Secretary of Veterans Affairs to award grants to nonprofit organizations to assist such organizations in carrying out programs to provide service dogs to eligible veterans, and for other purposes.

The SAVES Act would establish a grant program at the VA to allow Assistance Dogs International (ADI)-accredited nonprofits to competitively apply for awards to train more service dogs to assist veterans. This is a different approach than the PAWS for Veterans Therapy pilot program, as it inherently recognizes the dog itself as a mental prosthetic rather than the act of training as a therapy. This legislation appropriates money towards the program, and recognizes that more disabilities than PTSD can be positively affected with use of a service dog.

VA has provided service dogs to veterans since 1958, with the program originally created to support blind veterans.[9] The program has been expanded over time to provide service dogs to veterans with a variety of physical and mental disabilities. The VA has approved organizations that they work through to provide service dogs for veterans, and a recent recipient of the SSgt. Parker Gordon FOX Grant Program is a service dog organization.

VA research shows that veterans who receive a service dog have an average 3.7-point drop in PTSD symptoms, and veterans who receive service dogs have less suicidal ideation and improved mental health than those paired with emotional support dogs.[10] It was further identified that veterans with service dogs are noted to have lower depression, higher quality of life, and increased social functioning than veterans on the waiting list for service dogs.[11]

The American Legion supports the SAVES Act through Resolution No. 134: *Service Dogs for Injured Service Personnel and Veterans with Mental Health Conditions.* Many individuals suffering from PTSD and other mental health disorders refuse to seek treatment because of the stigma surrounding mental health, so it is critical that these alternative treatments are accessible. The American Legion further supports this bill through Resolution No. 262: *Department of Veterans Affairs Provide Service Dog Allowance*, which supports all maintenance requirements for the upkeep and care of service dogs.

The American Legion supports providing veterans who need a service or guide dog with the appropriate resources to support their healing process. Service animals are just as vital to veterans with physical and mental impairments as prosthetic body parts are heavily relied on by veterans for Activities of Daily Living. The American Legion supports this bill in order to ensure that veterans continue to receive the care that they deserve.

The American Legion supports H.R. 2605 *as currently written*.

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[9] Richard Weinmeyer, " Service Dogs for Veterans with Post Traumatic Stress Disorder," AMA Journal of Ethics Health Law, June 2015, Accessed April 13, 2023, https://journalofethics.ama-assn.org/article/service-dogs-veterans-posttraumatic-stress-disorder/2015-06.

[10] National Academies of Sciences, Engineering, and Medicine. 2021. *Letter Report on Review of Department of Veterans Affairs Monograph on Potential Therapeutic Effects of Service and Emotional Support Dogs on Veterans with Post Traumatic Stress Disorder*. Washington, DC: The National Academies Press. https://doi.org/10.17226/26039.

[11] O'Haire, M.E. & Rodriguez, K.E. (2018). *Preliminary Efficacy of Service Dogs as a Complementary Treatment for Posttraumatic Stress Disorder in Military Members and Veterans.* Journal of Consulting and Clinical Psychology. Retrieved from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5788288/

H.R. 3400: The Territorial Response and Access to Veterans' Essential Lifecare (TRAVEL) Act

To amend title 38, United States Code, to authorize the Secretary of Veterans Affairs to assign physicians of the Department of Veterans Affairs to temporarily serve as traveling physicians in the territories and possessions of the United States, and for other purposes.

In addition to the 50 U.S. states and the District of Columbia, the VA provides benefits to veterans in the five U.S. territories, which includes the Pacific territories of American Samoa, Guam, and the Commonwealth of the Northern Mariana Islands (CNMI), as well as the Caribbean territories of the Commonwealth of Puerto Rico and the U.S. Virgin Islands (USVI). Many veterans live in these territories, but VA care and benefits can be challenging to deliver for various reasons. In recent years, the Caribbean Island of Puerto Rico has faced multiple crises—including Hurricanes Maria and Irma—that devastated the infrastructure and threatened the island's public health system, and 50% of Puerto Rico's physicians have left the island since 2009.[12]

A 2024 GAO Report indicated that VA efforts have not sufficiently addressed veterans' access to care challenges in the territories. For example, due to VA's eligibility criteria for its travel benefits program, as of March 2024, freely associated states (FAS) and a large portion of territory veterans do not qualify for VA travel benefits.[13] This critical need must be addressed with new and creative solutions.

The American Legion published an article on November 17, 2023, stating veterans in Puerto Rico deserve the same support as those living in mainland United States. Department Commander Carmen Rosario further stated, "The American Legion commits to bringing opportunities like town halls to veterans so they can receive the same treatment as their counterparts living in the States". [14]

This legislation seeks to improve health care access, including specialized medical services, for veterans residing in U.S. territories and other underserved areas. This legislation will allow the Secretary to assign a physician to serve as a traveling physician for a period of not more than a year, at Department facilities in the American territories (Samoa, Guam, the Commonwealth of the Northern Mariana Islands, the Commonwealth of Puerto Rico, the Virgin Islands of the United States) and any other territory or possession of the United States. Moreover, the traveling physician shall help coordinate with non-Department medical providers to ensure high quality and coordinated care for veterans receiving hospital care and medical services. To help incentivize physicians to enter this program, the Secretary shall also provide a relocation or retention bonus like the relocation and retention bonus offered under sections 5753 and 5754 of title 5, respectively.

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[12] Howard, Jeannie. "Residency Programs Address Unique Access to Care Challenges." *VA News*, December 8, 2023. https://news.va.gov/126531/residency-programs-address-care-challenges/.
[13] U.S. Government Accountability Office. *Veterans Affairs: Actions Needed to Improve Access to Care in the U.S. Territories and Freely Associated States*. GAO-24-106364. Washington, DC: U.S. Government Accountability Office, May 23, 2024. https://www.gao.gov/products/gao-24-106364.
[14] The American Legion. "Legion, VA and Congress Listen to Puerto Rican Veterans' Concerns at Town Hall." *The American Legion*, November 17, 2023. https://www.legion.org/information-center/news/veterans-benefits/2023/november/legion-va-and-congress-listen-to-puerto-rican-veterans-concerns-at-town-hall.

The opportunity for a short-term assignment outside of the continental US could be very attractive to current employees and improve retention, and could also be an incentive for recruiting new providers who are seeking the opportunity to work abroad or in underserved areas.

The American Legion supports this legislation through Resolution No. 46: *Department of Veterans Affairs (VA) Non-VA Care Programs.*

The American Legion supports H.R. 3400 *as currently written*.

DRAFT: To amend title 38, United States Code, to prohibit smoking on the premises of any facility of the Veterans Health Administration, and for other purposes.

To amend title 38, United States Code, to prohibit smoking on the premises of any facility of the Veterans Health Administration, and for other purposes.

According to VA Directive 1085.01, it is VHA policy that all VHA health care facilities be smoke-free for employees effective October 1, 2019. This includes eliminating all designated smoking areas for employees. The VA made these changes based on the security hazards related to smoking on VHA health care facility grounds, scientific evidence regarding the adverse health effects of secondhand and thirdhand smoke exposures, and their impact to patient safety and direct patient care.[15]

The tobacco epidemic is a major public health challenge that accounts for more than 8 million deaths worldwide annually. A quarter of these deaths are among nonsmokers who were exposed to secondhand smoke.[16] This is concerning as three out of ten U.S. veterans use tobacco, a much higher rate than non-veterans across all age groups, and numbers are higher among active-duty service members.[17]

A comprehensive review of literature published by July 2022 concerning the adverse impacts of secondhand smoke (SHS) continues to cause harm to nonsmokers, who are disproportionately children and women. This review conservatively estimates that SHS increases the risk of heart disease by 8%, increases the risk of stroke by 5%, and increases the risk of both Type 2 diabetes and lung cancer by 1%.[18]

This legislation amends Section 1715 of title 38 to read that no person, including any veteran patient, resident, employee of the Department, contactor, or visitor may smoke on the premises of any facility of the Veterans Health Administration. This includes electronic or e-cigarettes, vape pens, and e-cigars. The term VA facility is defined as any land or building, including any medical

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[15] U.S. Department of Veterans Affairs. "Smoke-Free VA Health Care Facilities." Last modified August 14, 2019. https://www.va.gov/health/smokefree/.
[16] Garg, Suneela, and Akash D. Sharma. "Secondhand smoke: an unintended public health concern." *Indian Journal of Community and Family Medicine* 8, no. 2 (2022): 81-85.
[17] Brown, David W. "Smoking prevalence among US veterans." *Journal of general internal medicine* 25 (2010): 147-149.
[18] Flor, Luisa S., Jason A. Anderson, Noah Ahmad, Aleksandr Aravkin, Sinclair Carr, Xiaochen Dai, Gabriela F. Gil et al. "Health effects associated with exposure to secondhand smoke: a Burden of Proof study." *Nature medicine* 30, no. 1 (2024): 149-167.

center, nursing home, domiciliary facility, outpatient clinic, or center that provides readjustment counseling under the jurisdiction of the Department of Veterans Affairs.

Existing Executive Order 13058, "Protecting Federal Employees and the Public from Exposure to Tobacco Smoke in the Federal Workplace," bans smoking in front of air intake ducts and allows agency heads to evaluate the need to restrict smoking to protect workers and visitors from environmental tobacco smoke. Furthermore, EO13058 bans smoking in courtyards and within 25 feet of doorways on GSA-controlled properties.

As the overwhelming body of research concludes use of tobacco products and secondhand exposure to tobacco is detrimental to the health and wellness of veterans, and this bill would codify existing norms, the American Legion supports the bill via Resolution No. 377: *Quality of Life*.

The American Legion supports the draft legislation *as currently written*.

DRAFT: The VA Data Transparency and Trust Act

To amend title 38, United States Code, to improve the annual reports submitted to Congress with respect to the Veterans Benefits Administration and the Veterans Health Administration, and for other purposes.

The VA Data Transparency and Trust Act aims to enhance the annual reports submitted to Congress by the Veterans Benefits Administration (VBA) and the Veterans Health Administration (VHA). The bill also mandates the underlying data used in these reports be available to independent researchers certified by the Secretary. For a period of five years, this bill expands the reports to cover major chronic conditions, the service era and branch of affected veterans, as well as disaggregated data by age and gender and various costs associated with such care.

This legislation builds upon the existing high-quality reports produced by VBA and VHA, including the Annual Benefits Report (ABR) and the National Veteran Suicide Prevention Annual Report, which have provided congress and Veteran Service Organizations (VSO) with insight into the health of veterans. These reports promote accountability and foster more rigorous oversight and collaboration with Congress and the veteran community. The Data Sharing System proposed by this legislation would allow a new level of scientific collaboration, yet unseen in veterans' policy or health research.

While this legislation takes significant steps to improve transparency and collaboration, further enhancements would strengthen its impact:

Recommendation 1

This bill proposes a significant expansion to public VA reporting that results in both transparency and increased administrative burden. To reduce duplication and administrative burden, VA should be explicitly authorized to incorporate existing data from active products such as The Annual Report on the Steps Taken to Achieve Full Staffing Capacity, The Agency Financial Report, The Advisory Committee on Homeless Veterans Annual Report, and other various Advisory Committee reports.

Recommendation 2

Section § 7330B(b)(14)(A)(iii)–(v) seeks to quantify veterans who are "reliant" on VA care, but the term "reliant" is not defined within the bill and may be interpreted in multiple ways. For example, veterans with complex chronic conditions may be reliant due to the specialized care the VA provides, while others may be considered reliant simply because the VA is their sole health care provider. Still others may rely on the VA for specific services, such as polytrauma care. We recommend this section be amended to clarify the category of reliance whether volume of care, exclusivity, severity of care, clinical dependency or some other metric.

Recommendation 3

Considering the current conversation around VA staffing and the prospect of a reduction in force, The American Legion strongly supports the bill's requirements to report on physician staffing, including their specialties, pay, and bonuses.[19] While the VA Workforce Dashboard currently captures portions of this information, additional physician-specific reporting on an annual basis would enhance transparency. We recommend that the report also include the functional role of the physicians, such as whether they provide direct care in specialty or primary care, or serve in vital non-clinical roles such as policy, research, education, or administration.

Recommendation 4

The proposed legislation pertaining to major chronic conditions should be further disaggregated by type of cancer and cardiovascular disease. Each cancer experienced by a veteran is personal and unique, and broad categories do not reflect the diversity of veteran health needs. While it is impractical to report every possible subtype, a prioritized list of conditions determined by the Secretary in consultation with relevant advisory councils could ensure reporting is meaningful and feasible. As independent bodies representing the veteran community and clinical experts, these councils should have a meaningful role in determining which conditions are reported.

Recommendation 5

In addition to the four chronic conditions listed, a fifth category should be added:

a. "(E) Any additional chronic condition identified by the secretary that;
    i. disproportionally affects the veteran community; or
    ii. has a major effect on the veteran community;"

This language would encourage flexibility by the report authors to bring attention to emerging issues.

Recommendation 6

The rates of chronic conditions reported in §7330B(b)(2) should be contextualized through comparison to the rates of such conditions experienced by the US veteran population versus the rates experienced by the US civilian population. A comparison to the general veteran community

[19] U.S. Department of Veterans Affairs. "Reduction in Force." *Workforce Optimization Hub*. Accessed June 5, 2025. https://department.va.gov/workforce-optimization-hub/reduction-in-force/.

and the civilian population will not only better direct VA and community care but also illuminate which conditions should be studied further for possible connection to service.

Recommendation 7

While state of residence is included in the ABR, this data is not currently mandated, and no rurality metric is reported, yet the VA reports drive time accounts for 51% of community care referrals.[20] To better direct care, it is recommended State Level Data and some metric of rurality be included in the VBA report expansion.

Recommendation 8

The VA's mission includes caregivers and survivors, yet current VBA reporting excludes these groups. The same demographic data collected for veterans should be reported for:

- Survivors receiving Dependency and Indemnity Compensation (DIC)
    - Disaggregation by age is particularly important for survivor data, as survivors who are 55 and older are eligible to marry without loss of benefits.
- Caregivers enrolled in the Program of Comprehensive Assistance for Family Caregivers (PCAFC).
- Caregivers enrolled in the Program of General Caregiver Support Services (PGCSS).
- For DIC recipients the cause of the veteran's death (e.g., enemy action, cancer, accident, cardiovascular event, suicide) should be included.
- For PCAFC and PGCSS participants, the service-connected conditions of the veteran they support should be reported.

Recommendation 9

For all benefit programs, data on reason for severance from the program would benefit both advocacy and delivery of services. When the reason for severance is death of the veteran, as is often the case for PCAFC and PGCSS, data should be further separated by cause of death.

The improved demographic collection produced by this bill is supported by The American Legion Resolution No. 6: *Minority Veterans* and Resolution No. 147: *Women Veterans.* The suggested changes to geographic data collection are supported by Resolution No. 119: *Support More Service Programs Benefiting the Rural Veteran.* Improved data collection for caregivers is supported by Resolution No. 18: *Comprehensive Supports for Caregiver Support Program.* Improved collection of survivor demographics is historically supported by The American Legion, including recent testimony by Executive Director Mario Marquez on similar legislation, such as the Honoring Our Promise Act.[21] The disaggregation of cancer and cardiovascular conditions, and the proposed Data Sharing System, is supported by several resolutions including Resolution No. 239: *Support Research about Breast Cancer* & Resolution No. 127: *Prostate Cancer Research and Treatment.*

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[20] Peabody, Hillary, and Michael A. Pappas. *VHA Community Care Growth Trends*. Presented in March 2024 by the Office of Integrated Veteran Care, U.S. Department of Veterans Affairs. Acting Assistant Under Secretary for Health (AUSH) and Acting Deputy AUSH for Integrated Veteran Care, respectively.

[21] Marquez, Mario. "Statement for the Record." Testimony before the House Committee on Veterans' Affairs, Subcommittee on Economic Opportunity, March 29, 2022. https://docs.house.gov/meetings/VR/VR09/20220329/114539/HHRG-117-VR09-Wstate-MarquezM-20220329-U1.pdf

The American Legion applauds the VA for its leadership in producing high-quality, evidence-driven reports and commends Congress for seeking to expand the VA's tools for transparency, collaboration, and scientific partnership.

The American Legion supports this draft legislation *with amendments*.

DRAFT: To direct the Secretary of Veterans Affairs to conduct a study to determine whether RNA sequencing can be used to effectively diagnose PTSD in veterans.

To direct the Secretary of Veterans Affairs to conduct a study to determine whether RNA sequencing can be used to effectively diagnose PTSD in veterans.

This draft legislation directs the Secretary of Veterans Affairs, through the Center for Innovation for Care and Payment, to study the feasibility of using RNA sequencing to diagnose post-traumatic stress disorder (PTSD) within five Veteran Integrated Service Networks.

The American Legion recognizes the advancements in PTSD diagnosis as a critical component of our Be The One mission to prevent veteran suicide. As part of our commitment, The American Legion has interviewed experts on RNA expression as a diagnostic tool for PTSD and is cautiously optimistic on the implications of this emerging technology.

Unlike DNA, which remains constant throughout an individual's life, RNA can change based on lived experiences. Trauma, particularly from combat and other life-threatening situations, can alter RNA expression, changes which may result in the persistent re-experiencing of traumatic memories which interfere with daily life. Recent studies suggest these molecular changes can be detected through RNA sequencing, making them no less measurable than other wounds of war.

RNA sequencing only requires a small vial of blood and is no different than a cholesterol test from the perspective of a patient.[22] RNA degenerates quickly but can be used if stabilized within 72 hours at a medical facility, making this technology possible for home care without specialized equipment.[23]

Beyond diagnostics, RNA-based detection offers additional innovations. By identifying the physiological contributors of PTSD, new targeted therapies could be developed. In addition, emerging research suggests RNA diagnostics may be used as a leading indicator for symptoms, offering clinicians real-time feedback on the effectiveness of treatment even before symptoms improve or worsen.[24]

The VA has been an industry leader in the biological markers of PTSD, with groundbreaking studies at the Michael E. DeBakey VA Medical Center,[25] the Richard L. Roudebush VA Medical

[22] The American Legion and IXpressGenes. *Meeting to Discuss PTSD Diagnostic Research Using RNA Sequencing.* April 28, 2025.
[23] Ibid
[24] Dean, Kelsey R., et al. "Multi-omic Biomarker Identification and Validation for Diagnosing Warzone-Related Post-Traumatic Stress Disorder." *Molecular Psychiatry* 25 (2020): 3337–3349. https://doi.org/10.1038/s41380-019-0496-z
[25] Ibid

Center,[26] and the William Jennings Bryan Dorn Veterans Medical Center, among others.[27] This bill would bring a concerted and collaborative effort for the VA to not only pursue RNA as a diagnostic tool, but produce a report to congress to improve follow-up legislative efforts.

As with any emerging technology, concerns of potential misuse must be included in development and implementation. Even if research proves RNA sequencing to be a valuable diagnostic tool, it should never be used as the sole basis for determining service connection for PTSD. The psychological impact of military service is holistic and cannot be reduced to a single biologic marker. This technology may be most appropriately applied to track ongoing treatment, or in cases where traditional diagnostic methods yield inconclusive results, such as when a veteran is reluctant to engage with a clinician or presents atypical symptoms.

Another potential misuse could be denying claims on the basis a veteran is predisposed to PTSD. This could occur if blood tests are completed both before and after service, showing biological markers for PTSD existed before the trauma. While individuals who experience traumatic events in childhood may be susceptible to developing PTSD in adulthood, trauma related to service only occurs because our country has asked these brave men and women to step into harm's way.[28] The presence of predisposition does not diminish the real, service-related nature of their suffering.

The American Legion supports this legislation through Resolution No. 16: *Furthering Research Pertaining to Traumatic Brain Injury (TBI), Chronic Traumatic Encephalopathy (CTC), and Post Traumatic Stress Disorder (PTSD)*.

The American Legion supports the draft legislation *as currently written*.

DRAFT: To amend title 38, United States Code, to provide for a time frame for the employment in the Department of Veterans Affairs of participants in the Health Professionals Scholarship Program, and for other purposes.

To amend title 38, United States Code, to provide for a time frame for the employment in the Department of Veterans Affairs of participants in the Health Professionals Scholarship Program, and for other purposes.

The recruitment and retention of medical providers has always been a struggle in the VA medical system. 96% of the nation's medical schools including 151 of 157 Liaison Committee on Medical Education (LCME)-accredited allopathic schools and 35 of 37 Commission on Osteopathic College Accreditation (COCA)-accredited osteopathic medical schools are affiliated with VA.[29]

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[26] U.S. Department of Veterans Affairs. "Posttraumatic Stress Disorder (PTSD)." *Office of Research & Development*. Last updated June 24, 2022. https://www.research.va.gov/topics/ptsd.cfm.
[27] Bam, Marpe, Xiaoming Yang, Elizabeth Ellen Zumbrun, Yin Zhong, Mitzi Nagarkatti, Prakash Nagarkatti, and others. "Dysregulated Immune System Networks in War Veterans with PTSD Is an Outcome of Altered miRNA Expression and DNA Methylation." *Scientific Reports* 6, no. 1 (2016): 31209. https://doi.org/10.1038/srep31209.
[28] Herika Cristina da Silva et al., "The Role of Childhood Cumulative Trauma in the Risk of Lifetime PTSD: An Epidemiological Study," *Psychiatry Research* 336 (June 2024): 115887, https://doi.org/10.1016/j.psychres.2024.115887
[29] U.S. Department of Veterans Affairs, Office of Academic Affiliations, Health Professions Education Statistics: Academic Year 2021–2022 (Washington, DC: U.S. Department of Veterans Affairs, 2022), https://www.va.gov/oaa/docs/OAACurrentStats.pdf.

Medical professionals learn critical skills at VA facilities during their medical education, and they take these skills to the public sector and flourish. The VA has developed many programs that will encourage medical professionals to remain and work at the VA upon graduation.

This bill would ensure medical professionals in certain fields of critical need, determined by the Secretary, would be guaranteed employment at VA for one year of every year in the HPSP. Acceptance into the program is based on limited eligibility requirements and successful completion by participants would fill critical gaps in areas of high demand for VA. Further, it provides a measure of predictability for HPSP participants to make financial and logistical preparations before their first job with VA.

The American Legion has consistently supported the VA's recruitment and retention measures. The Health Professionals Scholarship Program Improvement Act of 2025 is endorsed through Resolution No. 115: *Department of Veterans Affairs Recruitment and Retention,* which supports recruitment and retention challenges that the VA has who are providing direct health care to our nation's veterans. The American legion further supports this legislation through Resolution No. 237: *The American Legion Policy On Nurse Recruitment and Retention,* which supports education assistance programs for nursing staff.

The American Legion supports the draft legislation *as currently written*.

DRAFT: The Fisher House Availability Act

To amend title 38, United States Code, to direct the Secretary of Veterans Affairs to make temporary lodging facilities of the Department of Veterans Affairs available for certain TRICARE beneficiaries on a space-available basis, and for other purposes.

The Fisher House Foundation was created by Zachery and Elizabeth M. Fisher in 1990.[30] The original project cost 20 million dollars to provide temporary, comfortable homes for families of hospitalized military personnel, the most notable of which is at Walter Reed Medical Center in Bethesda, MD.[31] When one of these homes reaches capacity, the Fisher House Foundation has an additional resource called Hotels for Heroes, providing accommodations for service members, family, and close friends closer to a medical facility.[32] Taken together, these programs house 1,400 military and veteran families on a nightly basis in the U.S. and abroad.

This bill seeks to expand this capability by making temporary lodging facilities on VA campuses available to certain TRICARE beneficiaries when the covered beneficiary must travel a significant

[30] Zachary Fisher - Builder, Philanthropist, Patriot - Fisher House Foundation https://fisherhouse.org/about/our-history/zachary-fisher/.
[31] Fisher House Foundation, "Fisher House Foundation is On the Road to 100." Sept 28, 2022. https://fisherhouse.org/stories/articles/fisher-house-foundation-is-on-the-road-to-100/.
[32] Fisher House Foundation, *Hotels for* Heroes. https://fisherhouse.org/programs/hotel-for-heroes/.

distance to receive care at a non-VA facility. This will be given on a space-available basis. Military and veteran family members with patients that are being treated at a military or VA hospital are currently eligible to stay at a Fisher House or utilize the Hotels for Heroes program.[33]

This bill codifies this directive into law and will help to ensure the Fisher House programs are allowed to help veterans, service members, and their families as originally intended. The American Legion supports this legislation through Resolution No. 18: *Comprehensive Supports for Caregivers Support Program*.

The American Legion supports the draft legislation *as currently written*.

H.R. 1404: The CHAMPVA Children's Care Protection Act

To amend title 38, United States Code, to increase the maximum age for children eligible for medical care under the CHAMPVA program, and for other purposes.

Children of 100% service-connected disabled veterans qualify for a 75%/25% cost-sharing health plan known as the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA). However, 38 U.S.C. §101 mandates that a dependent (other than a helpless child) covered under CHAMPVA loses eligibility if (a) the dependent turns 18, unless enrolled in an accredited school as a full-time student; (b) the dependent, who has been a fulltime student, turns 23 or loses full-time student status; or (c) the dependent marries.[34] This legislation seeks parity with DOD's TRICARE Young Adult plan (TYA), by extending coverage to age 26 regardless of marital status. Additionally, notwithstanding the subsection c(i) and (iii) of section 101(4)(a) of title 38, proposed bill language goes further to seek parity with the *Patient Protection and Affordable Care Act* (ACA), by also extending eligibility regardless of student status.

As such, The American Legion supports H.R. 1404 through Resolution No. 21: *Expanding Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) Coverage*, which urges Congress to enact legislation which seeks parity between the Department of Defense and the Department of Veterans Affairs programs when providing services to widows and dependents to include making health-care coverage available for a dependent child until 26 years of age, regardless of the dependents' marital status.

The American Legion supports H.R. 1404 *as currently written*.

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[33] Lange, Katie, U.S. Department of Defense," Fisher Houses Offer Free Stays, Comfort to Ailing Families, Vets" May 10,2023. https://www.defense.gov/News/Feature-Stories/Story/Article/3391501/fisher-houses-offer-free-stays-comfort-to-ailing-military-families-vets/

[34] U.S. Library of Congress. CRS, Health Care for Dependents and Survivors of Veterans: Answers to Frequently Asked Questions. April 21, 2021, https://sgp.fas.org/crs/misc/RS22483.pdf.

H.R. 2148: The Veteran Caregiver Reeducation, Reemployment, and Retirement Act

To expand medical, employment, and other benefits for individuals serving as family caregivers for certain veterans, and for other purposes.

The Veteran Caregiver Reeducation, Reemployment, and Retirement Act provides essential follow-on support for caregivers enrolled in the Program of Comprehensive Assistance for Family Caregivers (PCAFC). This bill recognizes the sacrifice of family caregivers, many of whom leave their careers to care for critically ill veterans and offers a path to reenter the workforce with dignity after their service.

Section 2 continues health care coverage for caregivers who lose eligibility for the program because their veteran has either improved and is no longer in need of the program or has passed away. This provision allows a six-month transition period while the caregiver seeks healthcare through employment or the marketplace.

Section 3 establishes a modest stipend of $1,000 for caregivers to fund professional re-licensure or continuing education. PCAFC caregivers often provide 24-hour support for their veterans, in some cases delivering over 80 hours per week of care.[35] This level of responsibility greatly hinders career prospects, with 16% of veteran caregivers reporting a reduction in work hours or leaving the workforce entirely.[36] This stipend ensures caregivers seeking gainful employment, many of whom have professional experience and in positions of public trust, are able to smoothly transition into their next chapter of life.

Sections 4 and 5 require follow-up reports to assess the effectiveness of transitional and reemployment support and to identify additional interventions to improve the caregiver program.

Although there is no formal Congressional Budget Office (CBO) score for this legislation, these provisions are likely to modestly increase the PCAFC expenditures. More importantly, it may increase enrollment by reducing financial hurdles for professionals considering the program.

According to the CBO, CHAMPVA coverage for typical caregivers cost approximately $2,700 per year in 2017, or about $1,350 for a six-month extension.[37] If extended to all 57,000 caregivers enrolled in PCAFC, this would represent a meaningful expansion to the program.[38] However, without additional VA data on caregiver turnover and healthcare utilization, a precise cost estimate of this expansion is not possible.

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[35] Ramchand, Rajeev, Sarah Dalton, Tamara Dubowitz, Kelly Hyde, Nipher Malika Andrew R. Morral, Elie Ohana, and Vanessa Parks. Hidden Heroes Emerging from the Shadows: America's Military and Veteran Caregivers. RRA3212-1. RAND Corporation, 2024. www.rand.org/t/RRA3212-1

[36] Ibid

[37] Congressional Budget Office, Cost Estimate for S. 2921, Veterans First Act (Washington, DC: Congressional Budget Office, October 24, 2016), accessed May 16, 2025, https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/costestimate/s2921.pdf

[38] U.S. Department of Veterans Affairs, 2023 Annual Report: Caregiver Support Program (Washington, DC: U.S. Department of Veterans Affairs, 2024), accessed May 16, 2025, "https://www.caregiver.va.gov/docs/2024/CSP_Annual_Report_2023-Final.pdf"https://www.caregiver.va.gov/docs/2024/CSP_Annual_Report_2023-Final.pdf.

In contrast, we can assess the value of PCAFC relative to institutional care. The PCAFC, including stipends and caregiver healthcare, cost an average of $18,300 per year for 2015 and 2017 according to the CBO.[39,40] While this information is dated, there is no evidence recent changes to the program via the *Elizabeth Dole 21st Century Healthcare and Benefits Improvement Act* and the *MISSION Act* have raised costs to a level comparable to institutional settings. By comparison, in 2017 VA reimbursed State Veterans Homes at a rate of $397 per day for severely disabled veterans,[41] which cost the VA $145,000 per veteran, per year. That same year, the average daily cost of VA-operated nursing homes was $1,222, or $445,000 per veteran annually.[42]

While not direct comparisons, PCAFC is more cost effective than institutional care and veterans prefer it. Enhancing the program's attractiveness to licensed professionals by covering the modest cost of re-credentialing will help more veterans remain at home at a fraction of the cost of institutionalization in long-term facilities.

The American Legion supports this legislation through Resolution No. 18: *Comprehensive Supports for Caregiver Support Program,* where the members of American Legion specifically called for follow-on supports for caregivers transitioning out of caregiver support programs, and Resolution No. 20: *Home and Community-Based Services and Veteran Choice to Age In Place*, which calls on improvements to programs which enhance a veterans choice of where to age.

This legislation is a fiscally prudent investment in veteran health and caregiver reintegration, and it honors the service and sacrifice of both veterans and those who care for them.

The American Legion supports H.R. 2148 *as currently written*.

DRAFT: The VA Mental Health Outreach and Engagement Act

To amend title 38, United States Code, to direct the Secretary of Veterans Affairs to furnish annual mental health consultation to certain veterans, and for other purposes.

This legislation amends section 1167 of Title 38, directing the Secretary to reach out to veterans who are receiving compensation for a service-connected disability relating to a mental health diagnosis no less frequently than once per calendar year, with no presumption the consultation necessitates a reevaluation of the disability compensation determination.

The bill requires a GAO review outlining the implementation of the program and, most importantly, list any barriers to veterans seeking mental healthcare from VA.

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[39] Congressional Budget Office, Cost Estimate for H.R. 5674, VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018 (Washington, DC: Congressional Budget Office, May 14, 2018), accessed May 16, 2025, https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/hr5674.pdf

[40] Congressional Budget Office, Cost Estimate for S. 2921, Veterans First Act (Washington, DC: Congressional Budget Office, October 24, 2016), accessed May 16, 2025, https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/costestimate/s2921.pdf

[41] Congressional Budget Office, Cost Estimate for H.R. 5674, VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018 (Washington, DC: Congressional Budget Office, May 14, 2018), accessed May 16, 2025, https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/hr5674.pdf.

[42] U.S. Department of Veterans Affairs, HERC Inpatient Average Cost Data, Health Economics Resource Center, accessed May 16, 2025, https://www.herc.research.va.gov/include/page.asp?id=inpatient

The American Legion supports this legislation through Resolution No. 17: *Continuum of Care and Mental Health Supports* which calls for VA to conduct a consistent follow-on continuum of care in any setting for any veteran suffering from mental health illnesses, and for the Department of Defense and VA to better coordinate and collaborate their mental health outreach programs to address the stigma in seeking mental health care.

The American Legion supports the draft legislation *as currently written*.

CONCLUSION

Chairman Miller-Meeks, Ranking Member Brownley, and distinguished members of the subcommittee, The American Legion thanks you for your leadership and for allowing us the opportunity to provide feedback on legislation.

The American Legion looks forward to continuing this work with the Committee and providing the feedback we receive from our membership. Questions concerning this testimony can be directed to Logan Barber, Legislative Associate, at lbarber@legion.org.

Prepared Statement of John Schmitt

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Testimony of John Schmitt
CEO, iXpressGenes
Before the House Committee on Veterans' Affairs
Subcommittee on Health
June 12, 2025, at 2:15 p.m. ET

Good afternoon Chairwoman Miller-Meeks, Ranking Member Brownley, and Members of the Subcommittee. Thank you for the opportunity to testify today.

I want to begin today not with science, but with intention behind the science—because when it comes to the lives of veterans, as one myself, I believe intention matters.

In 2010, the founder of iXpressGenes, Dr. Joe Ng—a molecular biologist and professor at the University of Alabama in Huntsville—was in a routine faculty meeting. Tragedy struck when a colleague pulled a handgun from her handbag and murdered three people in front of him. Joe fortunately survived but in the aftermath, he witnessed a haunting spectrum of resilience among his colleagues.

Joe asked a question that would change everything: *Could trauma have an immunological component?* And that question set us on a path to transform trauma care forever.

I met Dr. Ng in 2018. I'm John Schmitt, CEO of iXpressGenes and a two-tour Iraq combat veteran having served over 20 years. When Joe and I crossed paths, I was still in uniform—trapped in a culture of silence. Like many of my peers, because of the risk to my career, I could not admit I was unraveling. Depressed, anxious, and increasingly suicidal.

That journey for me has turned into a mission. Today, I testify not just as a veteran and a CEO, but as a survivor advocating for the science that helped me heal and I hope will help millions of others.

While in uniform, I earned a degree in microbiology and immunology from Vanderbilt University School of Medicine. A fateful step—one that quietly equipped me to understand the science and application of the technology I stand before you advocating for. Together, our team at iXpressGenes has developed a groundbreaking blood test using the power of RNA transcriptome analysis—the Trauma Autoimmune Indicator, or TAI™. It identifies inflammation caused by trauma—detectable *before* symptoms even surface to empower prevention, enable early intervention, and inform effective treatment for best possible outcomes.

The TAI™ test reads RNA transcription—how the body's genes are responding right now, in real time creating potential for limitless therapeutic strategies never before possible. Unlike genetics which tell us what might happen. RNA tells us what *is* happening.

This matters. Because the kind of inflammation we detect is the root cause for the oxidative stress and neuroinflammation crossing the blood-brain barrier and contributes to anxiety, depression, the hallmarks of PTSD. This lab developed test is already available commercially through our lab in Huntsville, Alabama. It's low-cost, scalable, and precise.

With the VA, we are not starting from scratch. With our partnership at the VA in Birmingham, we've already demonstrated powerful results. In fact, as our key clinical research collaborators put it:

> *"Its high sensitivity, specificity, and translational relevance position it as an exceptional tool for clinical use. Given the clarity and consistency of the data it provides, I strongly advocate for its broader adoption and urge that it be rapidly prioritized for clinical validation to support improved patient outcomes."*

PTSD and trauma-related illness have long been treated based on symptoms and subjective reports. But now, with RNA transcriptome analysis, we can assess it objectively—offering a novel approach for diagnosing, treating, and even preventing trauma-induced disease.

And today there is a promising patchwork of powerful therapies—mindfulness, contrast therapy, EMDR, neurofeedback, ketamine-assisted psychotherapy, or even psychedelics. But it's a "choose your own adventure" landscape for our veterans because we have lacked an objective compass.

TAI™ is that compass. We can use it to validate effectiveness of these modalities and track clinical progress. We are not starting from scratch here either and have already partnered with groundbreaking technology companies from hypobaric oxygen to virtual reality with exceptionally promising early results.

The VA has long pioneered technologies that went on to change the world. Let this be the next chapter—ushering in a new standard of precision mental health care that is proactive, data-driven, and life-saving.

iXpressGenes is a company born out of tragedy, led by those who've lived the reality of trauma, and built for a world finally ready to confront it. Let's lead the transformation of trauma care. Our Veterans deserve it—and so does every American still waiting for their suffering to be seen, understood, and treated with precision.

The opportunity is massive—The need is urgent and growing—But now, the science is ready.

Let us transform trauma care—together.

Thank you.

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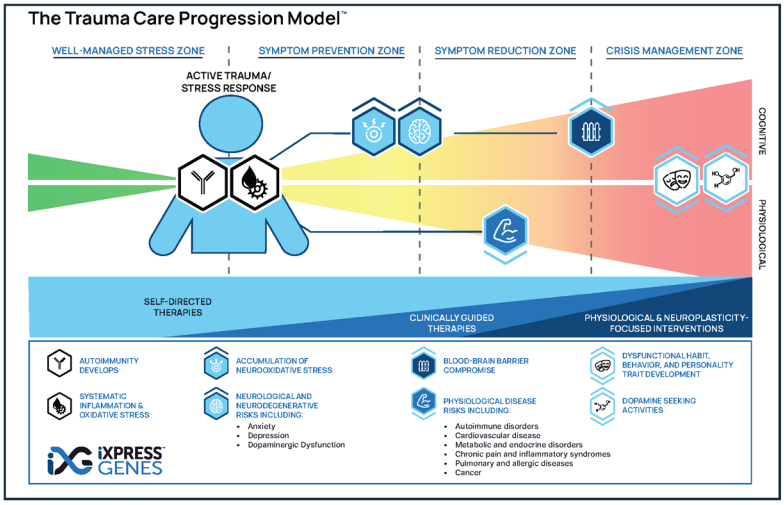
Trauma Autoimmune Indicator™ Test: A Peripheral Biomarker-Based Assessment of Chronic Stress and Neurocognitive Risk

Introduction

Chronic psychological trauma and unresolved stress are increasingly recognized as key contributors to systemic inflammation, oxidative stress, and long-term neurological dysfunction. At $225 retail, the Trauma Autoimmune Indicator™ (TAI) test offers a novel, low-burden, precise, scalable, and low-cost method for assessing an individual's biological response to chronic stress using a panel of validated blood-based expressed gene biomarkers. This approach identifies early indicators of unresolved systemic inflammation and blood-brain barrier compromise— a state in which the brain's protective barrier becomes abnormally permeable, allowing potentially harmful substances to enter neural tissue. By identifying these biological changes before the onset of overt disease, the TAI™ test supports proactive health interventions aimed at preserving cognitive function and overall well-being. Integrating advances from immunology, neurobiology, and psycho-neuroendocrinology, the TAI™ test translates decades of peer-reviewed research into a practical tool for preventive medicine and brain health optimization.

TAI™ Testing: The Trauma Care Progression Model™

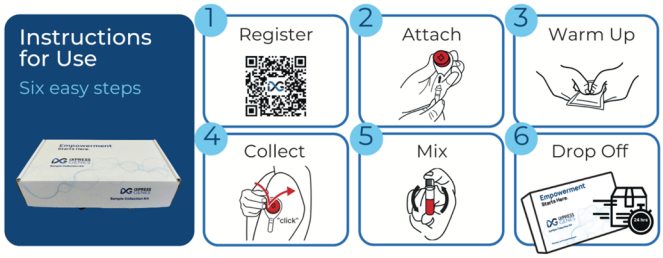
The TAI™ test supports a wholistic model along a trauma continuum that is being developed by iXpressGenes to help provide global clinical context of trauma-induced disease and the underlying physiology it detects.



DISCLAIMER: iXpressGenes Inc. is not a licensed medical provider and does not diagnose, treat, or prescribe for any disease or condition. The TAI™ test is a laboratory-developed test intended for investigational and informational purposes only. All interpretations, risk indicators, or recommendations provided by iXpressGenes are derived from peer-reviewed scientific literature and are not a substitute for professional medical advice, diagnosis, or treatment. Clinical decisions should always be made by a qualified healthcare professional based on the full context of a patient's history, symptoms, and clinical findings. Patients should consult their physician or licensed healthcare provider before making any medical decisions based on test results.

Blood Collection

The TAI ™ test requires a standard peripheral blood draw, which can be performed in-clinic or at home using a validated self-collection kit. For clinical settings with on-site phlebotomy, venipuncture samples are collected in EDTA tubes. Alternatively, for simplicity, remote testing, or self-directed collection, the Tasso+ Kit or Red Drop device we employ enables patients to collect a capillary blood sample from the upper arm in a user-friendly, sterile device. This method supports decentralized testing models for greater accessibility. All collected samples are shipped or collected by courier and processed in the iXG CLIA-approved laboratory located in Huntsville, Alabama.



Explanation of Results

Analytes Evaluated: IL6, TNF-α, IL-1β, IL-8, MCP-1, CRP, IL-10, IFN-γ, IL-17, CD163, NOS2, TGF-β, COL1A1, HMOX1, COX-2, NLRP3, Caspase-1, Cytochrome C, and LDH

In addition to detailed test results that can be used for clinicians to conduct individualized research for their patients, the TAI™ test delivers a simplified discussion falling in one of four categories which compliment the Trauma Care Progression Model™ to aid in interpretation and clinical action:

- **Non-inflammatory** Neither systemic nor neuroinflammatory markers are elevated. Immune and barrier functions appear well-regulated. This seems to represent a balanced physiological state. There is no evidence of chronic stress physiology or neurovascular compromise. Preventive strategies are recommended to maintain this resilience.

- **Chronic Stress and Inflammation Present** Systemic inflammation and oxidative stress present, but no compromise blood–brain barrier (BBB) disruption appear to be present. Literature reports have associated similar profiles with unresolved psychological or physiological stress manifesting through elevated pro-inflammatory and oxidative markers. The immune system is persistently activated, which, if unaddressed, may predispose to future neuroinflammatory risk and lead to cognitive dysfunction such as anxiety and depression.

- **Blood–Brain Barrier (BBB) Compromise** Biomarkers are present consistent with systemic inflammatory load and potential blood–brain barrier disruption. Literature reports have associated similar profiles with historical trauma, infection, or injury. Although the immune system may not currently be in a complete pro-inflammatory state, the barrier between brain and blood is impaired, potentially allowing immune or toxic insults to enter the central nervous system.

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- **Chronic Stress, Inflammation, and BBB Compromise** Biomarkers consistent with both chronic systemic inflammation and potential blood–brain barrier (BBB) permeability.

Trends over time can inform trajectory and treatment response. A shift towards a non-inflammatory state supports therapeutic success; conversely while rising profiles may flag imminent relapse or unresolved biological trauma, even in the absence of self-reported symptoms.

Potential Use Cases

The TAI™ test is designed to be applied across a range of clinical environments, enabling early detection, tailored treatment, and preventive interventions:

- **High Stress Occupations**: Occupational health providers and clinicians working with veterans, active-duty military, or public safety professionals can utilize the TAI™ test for proactive identification of unresolved physiological stress before the onset of functional decline or psychiatric decompensation. Elevated inflammatory markers can guide early interventions such as structured rest, behavioral health referral, or anti-inflammatory treatments to preserve performance and long-term cognitive resilience.
- **Family Medicine and Primary Care**: In routine annual checkups, TAI™ serves as a screening tool for identifying patients with subclinical inflammation who may be at elevated risk for stress-related comorbidities such as cardiovascular disease, autoimmune disorders, or neurodegenerative conditions. Its use in asymptomatic individuals offers a proactive approach to lifestyle or pharmacological interventions before disease manifests.
- **Psychiatrists and Trauma Therapists**: In behavioral health settings, the TAI™ test provides an objective physiological measure to complement subjective symptom reporting. Elevated biomarkers can validate trauma exposure in patients with PTSD, generalized anxiety, or major depression. This data can help guide pharmacotherapy choices, monitor inflammation-related treatment resistance, and provide reassurance to patients that their symptoms have a measurable biological basis.
- **Self-Insured Employers and Occupational Health Clinics**: TAI™ can be deployed in workplace wellness programs to detect chronic stress in high-risk roles or demanding environments. Early identification of biologically stressed employees enables targeted wellness interventions that improve productivity, reduce burnout, and lower downstream healthcare costs by mitigating inflammation-driven disease before it develops.
- **Monitoring Treatment Efficacy**: For mental health providers and integrative care teams, serial use of TAI™ can measure the biological impact of therapy. Effective interventions may reduce cytokine and oxidative stress markers even before subjective improvement is evident. This is particularly important in conditions like PTSD or depression where patients often experience a lag between biological recovery and symptom relief. TAI™ can inform adjustments to treatment plans based on objective data.
- **Relapse Prevention and Early Intervention**: For patients with a prior history of trauma or chronic stress, the TAI™ test offers a sensitive tool for monitoring recurrence. As these individuals are primed for exaggerated immune responses to renewed stress, TAI™ can detect inflammatory reactivation before cognitive or emotional deterioration is clinically apparent. This enables preemptive interventions—such as therapy intensification or pharmacologic support—to halt the trajectory toward relapse.

Supporting the Evolving Modalities of Trauma Care

In addition to evidence based nutritional supplementation to support recovery, there is a rapidly expanding field of trauma recovery modalities—from traditional cognitive therapies to emerging

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neurophysiological interventions such as MDMA-assisted psychotherapy, ketamine infusions, hyperbaric oxygen therapy, and psychedelic-based treatments like psilocybin and ibogaine. While many of these approaches show promise, they often lack broad clinical acceptance due to limited objective validation outside of controlled trials. The TAI™ test offers a powerful tool to help bring these therapies into the mainstream by providing measurable and objective, biologically based markers of immune activation, oxidative stress, and blood–brain barrier integrity. By demonstrating physiological change in response to treatment—regardless of the modality—TAI can support evidence-based adoption, guide individualized care, and help clinicians, researchers, and innovators validate the effectiveness of new and integrative approaches in a way that resonates across disciplines.

Conclusion

As the clinical landscape of trauma recovery continues to evolve, the need for objective, biologically grounded data has never been greater. The TAI™ test offers healthcare professionals a practical, science-based tool to assess the physiological impact of unresolved stress—providing a clearer picture of the body's inflammatory and neuroimmune status when patient symptoms may be vague, delayed, or absent altogether. By translating complex immune and oxidative markers into a clear interpretive framework, TAI™ supports personalized treatment decisions grounded in measurable biology rather than subjective reporting.

Notably, the TAI™ test does not prescribe any specific therapeutic path, but rather serves as a diagnostic compass—helping clinicians identify when more support may be needed, when treatment is taking effect, or when early intervention could prevent relapse. Whether you practice mindfulness-based interventions, trauma-informed cognitive therapies, or are exploring the role of physiologically focused and neuroplasticity-oriented modalities such as MDMA-, psilocybin-, ketamine-, or ibogaine-assisted psychotherapy, the TAI™ test offers a unifying biomarker-based foundation to inform care across approaches. This includes integrative strategies such as targeted nutritional interventions, which modulate inflammation and oxidative stress and support brain health through diet.

This test complements—not replaces—clinical judgment, therapeutic alliance, and patient-reported outcomes. As the field of trauma recovery moves toward a more integrated biopsychosocial model, tools like TAI help bridge disciplines by contributing objective, actionable insights into an otherwise invisible biological burden.

At its core, the TAI test is a clinical tool to support evidence-based, individualized care—and a step toward transforming trauma care forever.

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Prepared Statement of Caira Benson

Chairwoman Miller-Meeks, Ranking Member Brownley, Members of the House Committee on Veterans' Affairs, thank you for inviting me to testify today. As the wife and caregiver of a severely injured and ill combat veteran, it is my honor to speak to some proposed legislation that could lessen the burden each of our caregiving families face every day.

Veteran family caregivers are a group of people who have been tempered in the fires of a war many will never see and even fewer will understand. We are forged stronger every day we fight for appropriate care for our loved ones.

I care for my husband, Eric, deployed twice to Iraq between 2003–2006, spending roughly over 20 months in combat zones. I immediately noticed things were off upon his return home, but I was told not to worry. It was only "expected reintegration stress." By 2007, my husband's "reintegration stress" would ensure he couldn't feel his legs when he ran. He was quickly put on a permanent profile, meaning he was unable to carry out a mission due to medical conditions that had not stabilized, and, due to deployment readiness policies at the time, my husband was separated from the Army with no medical board and no financial security.

We would spend the next decade fighting for understanding of his injuries as well as proper diagnosis and treatment while often facing the worst-case scenario. Initial screens for Traumatic Brain Injury (TBI) were non-existent or misunderstood; the Veterans Health Administration (VHA) originally told me my husband's IQ was too high to have suffered TBI, despite all evidence to the contrary. By 2010, my husband needed full-time care, and I would have to step down from my position as an executive director at a non-profit. It would take us until 2018 to formally diagnose my husband's multiple TBIs, despite a clear record of evidence. It would take another year to figure out his case was complicated by toxic encephalopathic process, most likely due to chemical exposures. The two conditions, mingling together, started a path of neurological degeneration that cannot be stopped.

Today, Eric is considered by the Department of Veteran Affairs (VA) to be permanently and totally disabled and unable to work. He is wheelchair dependent, struggles cognitively, suffers from migraines and blackouts, and is visually impaired. I care for him full-time and am enrolled in the VA's Program for Comprehensive Assistance for Caregivers (PCAFC). His TBI care is considered complex enough it is managed by a university specialty neurological team.

You should know I am also mom to five amazing children, three of whom have needed specialized care over the years. The day my husband was awarded permanent and total status, my children and I became eligible for the Civilian Health and Medical Program of the Department of Veteran Affairs (CHAMPVA). CHAMPVA is medical coverage offered to dependents and survivors of eligible veterans, mainly those with 100 percent permanent and total disabilities. CHAMPVA is also offered to caregivers through PCAFC. I breathed a sigh of relief knowing that we, too, would have appropriate health care for our needs.

However, in 2021, one of my children began attending college prior to their 18th birthday and needed monthly medications. We mailed the certification paperwork, but, when I went to fill prescriptions, I found out CHAMPVA was inactive. I called CHAMPVA, sat on hold for 4 hours, and was told that CHAMPVA's central mail facility was 6 months behind opening mail. Because my child was on medications that would cause permanent damage if terminated without tapering, I was offered an expedited process to certify and activate the CHAMPVA coverage within 7 days via fax. We used the same method to certify coverage in 2022. However, in the fall of 2023, coverage lapsed again when certifications began to be required on a semester basis instead of a yearly basis, compounding the mail-in timeframe dilemma. Horrifyingly, CHAMPVA agents relayed to me that CHAMPVA had terminated the ability to expedite certifications in the fall of 2024.

My child, who is in therapies and on daily medications, suffered from lapsed coverage between semesters—even over Christmas break—due to the way certification was completed. CHAMPVA's archaic mail system, often months behind in opening mail, complicated the ability to maintain coverage. Winter break and summer break became a mix of timing medication pickups prior to coverage loss and paying out of pocket for any therapies or doctor's visits. Indeed, until last month, my child, who was enrolled in school, had been without insurance since November 2025, had been paying out of pocket for meds and therapies, and had an unpaid ER bill sent to collections. However, it wasn't a miracle in the mail room that finally activated the CHAMPVA coverage; it was an executive inquiry within VHA.

I have another child who graduated high school this past May. With licenses and certificates in hand, my child desires to work instead of going to college. However, this child knows that within the next 6 months, their CHAMPVA coverage will dis-

appear unless they enroll in college or trade school. Can you imagine the pressure on this 17-year-old who worked day in and day out to finish high school and attain a drone pilot's license within 3 years to meet their goals? This child who has given up so much to aid me in the care of their father, who has suffered the trauma of watching their father's degeneration, and who has been devastated over the lack of appropriate care for both their father and their siblings—tell me, how do I tell my child that the system meant to help us has spectacularly failed once more?

Caregivers like myself and our families need CHAMPVA fixed and that begins with ensuring our children, who have already given so much, don't have to worry over loss of coverage upon their 18th birthday or suffer from lapse of coverage due to an archaic certification process by passing H.R. 1404, *The CHAMPVA Children's Care Protection Act*. This legislation would help alleviate these egregious situations by authorizing CHAMPVA eligibility automatically through age 26, allowing us to forgo the constant bureaucracy, which makes using the benefit a challenge. It also recognizes the true nature and sacrifice of these young caregivers by allowing them the support they need to transition from caregiving into adulthood while having their medical and mental health needs supported during key years. Allowing the younger dependents coverage until age 26 is crucial and aligns with not only private, civilian insurers but also the age limit CHAMPVA eligible dependents CHAMPVA must begin to use their VA Chapter 35 Dependent's Education Assistance.

I understand in VA's testimony to the Senate Veteran Affairs Committee on May 21, 2025, VA indicated they opposed this bill due to the nature of CHAMPVA, arguing that it is a medical service and not an insurance product.

However, the industry, the Federal Government, and, more often than not, VA treat CHAMPVA as an insurance product. For instance, like those covered by Medicaid, Medicare, or TRICARE, my family may not take part in the drug cost reduction programs offered to patients on fixed or low incomes due to our eligibility for CHAMPVA. If we choose to shop for insurance through the Health Care Marketplace, CHAMPVA enrollees are not eligible for either financial assistance nor advance premium tax credits. Every year, CHAMPVA enrollees receive a 1095-B attesting to the fact that CHAMPVA counts as minimum essential coverage under the Affordable Care Act. Finally, even VHA states that CHAMPVA is only available to caregivers enrolled in PCAFC when they have no other health insurance.

CHAMPVA provides explanations of benefits (EOB), approves and denies diagnostic codes, approves and denies medical treatment codes, and remits payment for enrollees to providers for approved services rendered by the medical community. CHAMPVA even has out-of-pocket maximums, deductibles, copays, and a medication formulary with tiered pricing. I admit I am a lay person, but this feels like every other insurance product I have ever received through an employer.

While I'm here to support extending CHAMPVA coverage to age 26, I also ask that this Committee use its oversight authority to improve the system itself so our families can find appropriate medical care.

To help you understand the challenges, let me explain what using CHAMPVA is like. In 2019, when one of our children was hospitalized and needed movement to a residential facility, I was told to find a facility that would take CHAMPVA, as there was no facility nor provider network available under CHAMPVA. I called over 20 TRICARE approved facilities to see if they had a bed available or could add my child to their waitlist. All but one turned me down immediately. The reason – prior authorizations under CHAMPVA since January of that year were taking upwards of 6–9 months. The one residential facility that did agree to treat our child had a stipulation – we were to sign a $110,000 promissory note upon admission in the chance CHAMPVA refused authorization and payment. Later during treatment, I would be told that CHAMPVA had ordered a discharge within 24 hours, even though our child had not completed their treatments. Only intervention by a VHA executive, finding the preauthorization form in the mail room, enabled necessary continued hospitalization approval.

Another of my children needed specialized therapy during 2020 and 2021. The physician didn't routinely take CHAMPVA, but, wanting to help us, agreed to see us and bill CHAMPVA. Our child completed her therapy in 2021. In 2023, I received a call from the physician's office. They had finally received payment from CHAMPVA with the exception of one therapy session, which I would have to pay for myself. I gladly paid and asked about the delay; the account manager relayed that she'd had to mail-in everything and simply wait. Because CHAMPVA has no provider contracts or a published fee schedule, the provider only had a ballpark estimate of what their payment would be until the claim was returned. Due to the mail-in claims system, lack of automation, and lack of published fee schedule, providers must wait inordinately long periods of time for payment, and that payment is a rel-

ative unknown until it is received. I can't think of a better scenario to discourage provider participation.

As I mentioned above, CHAMPVA has no contracted network of providers or facilities. It has no published fee schedule to share with potential providers. It processes the majority of claims using paper sent through a mail-in center, lengthening the time between physician or enrollee submission, claim processing, and enrollee reimbursement. CHAMPVA processes certifications, coverage additions, and changes of information through mail – using a single mail center in Colorado for all 737,000 enrollees. While an online portal currently exists for initial applications only, its functionality varies.

Providers who have agreed to take CHAMPVA often have mixed messaging – hospitals can file electronically, but most providers I've spoken to must file by mail. Some are told to file with the mail-in center in Colorado, while others are told to file directly with the local VAMC Community Care Network (CCN). Filing and retaining pay for services has become so cumbersome that the number of providers willing to file it in my area, which is last year's fastest growing county in the United States, dropped to 2 practices outside hospitals and urgent cares. Neither practice willing to file CHAMPVA contains a pediatrician.

Once again, I'm paying out-of-pocket for basic, routine, and pediatric care. I've stopped filing for reimbursement myself due to the burden of the process, including diagnostic codes which may or may not be covered and long pay times.

My understanding is that CHAMPVA falls under VHA's Office for Integrated Veteran Care (IVC), which also runs VHA's CCN. If that is true, why could VA not use the existing CCN structure to provide for network providers, a published fee schedule, and electronic claims submissions? It seems that it would be far more efficient, reduce the burden on VA and providers, and better meet the medical best interest of our veterans' dependents and caregivers.

As a wife and caregiver, I have fought every day for appropriate care for my husband and for my children. Yet, I know another fight looms on the horizon.

Not long ago, I firmly realized, like so many other caregivers, I would eventually become a survivor. Having given over a decade to being a sandwich caregiver, I am situated to outlive my veteran with almost no retirement, no active work credits, and almost no life insurance for my and my family's financial security.

Because we have fought so long for appropriate care and ratings, my family has financially suffered. I left my growing career in non-profit administration at the age of 30. What I had saved in retirement until that point was cashed out to pay for emergent medical care for my family. We have struggled, but survived, for over a decade on only disability income. The severity of my husband's injuries, like so many others, makes him uninsurable for life insurance.

I am not alone. Mozella Richardson Kamara, a 2025 Dole Caregiver Fellow from Delaware, studied for many years to become a civil engineer, but left her job to care for her veteran husband who suffers from many service-connected disabilities, both neurological and physical. Like myself, Mozella made this choice to ensure the immediate well-being of her husband, and, out of love, sacrificed her own long-term professional goals and retirement potential for the benefit of her family and service-connected veteran husband.

According to a recent RAND report, commissioned by the Elizabeth Dole Foundation and released in September of last year, military-connected caregivers save this Nation billions in healthcare costs by providing a minimum of $119 billion in unpaid care. In exchange, we face this harsh reality—when our caregiving ends, most of us will be financially destitute.

As this harsh reality was revealed, I started planning what I could. I used my Chapter 35 Dependents Educations Assistance to finish a terminal degree remotely, all while caring for both my husband and our children. Once I graduated, I overhauled my resume and began seeking any kind of contract work so that I had some earned income. That earned income allowed me to finally contribute some small amount to a retirement plan. It's too little, too late, but it is something more than 0.

With the growth of remote work, I eventually began searching for full-time work so that I could once again have work credits to pay toward Social Security and pay toward student loans. Employers are not designed to be caregiver friendly, even with their remote employees. I found an employer willing to be flexible with me, and I excelled at my job. Unfortunately, I had to resign recently because my salary would not entirely cover the cost of care for my husband while I worked. I loved my work, I had stellar performance reviews, but I was working at a net negative after expenses.

Like Mozella, I have once again put aside my own personal and professional goals to care for those who need me. But caregivers like Mozella and me, we need you

to pass H.R. 2148, *The Veteran Caregiver Reeducation, Reemployment, and Retirement Act*.

This bill won't fix the entirety of the problem, but it is a valuable first step in ensuring caregivers can begin to establish safety-nets of their own. It will begin the process and hopefully eventually allow caregivers like Mozella and me to contribute to a retirement fund. More immediately, it will provide caregivers financial security by allowing for returnships, or other possible work-rentry program, and paying for re-licensure in careers like teaching and engineering, ensuring caregivers like Mozella experience fewer obstacles to returning to work.

It is a truth that 1 day, every caregiver will stop caregiving, either through the veteran's improvement or their passing. As a thankful nation, we should ensure veteran caregivers do not end up in poverty simply because they ensured their veteran had appropriate care due to the wounds, illnesses, and injuries sustained while serving their nation.

Again, I am honored to be here at the request of the Committee and the Elizabeth Dole Foundation. I am ever thankful that Senator Elizabeth Dole led the charge to build a remarkable non-profit that ensures caregivers like me are seen, accepted, supported, and encouraged. Senator Dole gave caregivers a voice so we are heard in places such as this Committee room. Every day, caregivers carry out the work of caring for, as President Lincoln said, those who have borne the battle. To support the veteran, we must also support the caregivers, survivors, and families who bear the burden of the war that continues to rage at home.

I thank you for your time and attention, and I look forward to your questions.

STATEMENTS FOR THE RECORD

Prepared Statement of Joseph Morelle

Chairwoman Miller-Meeks, Ranking Member Brownley, thank you for the opportunity to submit this statement for the record in support of H.R. 2148, the *Veteran Caregiver Reeducation, Reemployment, and Retirement Act*. I also want to express my deep appreciation to my colleague and co-lead, Representative Juan Ciscomani, for his partnership on this vital bipartisan legislation.

Every day, thousands of family caregivers across the country make extraordinary sacrifices to care for our Nation's veterans. They put their careers on hold, deplete savings, and forgo personal goals to ensure their loved ones receive the care and dignity they deserve. When those caregiving duties come to an end—whether through recovery, transition to other care, or the passing of a veteran—these caregivers are often left to navigate a difficult and uncertain path forward, without the tools or support they need to rebuild their lives.

H.R. 2148 seeks to change that. This legislation would require the Department of Veterans Affairs to provide family caregivers with practical and meaningful support as they transition into the next chapter of their lives. This includes employment assistance, retirement planning, bereavement counseling, and reimbursement for professional certification or re-licensure fees. It would also require VA to study the barriers caregivers face when reentering the workforce, grant access to existing employment services, and evaluate the feasibility of establishing a retirement savings mechanism tailored to their unique circumstances.

These are not luxuries—they are long overdue acknowledgments of the economic and emotional toll that caregiving can take. This legislation will empower caregivers to regain their footing and reclaim their futures. It is a step toward honoring the quiet service they provide behind the scenes and recognizing that their well-being is essential to our broader commitment to veterans and their families.

Finally, I want to extend my heartfelt thanks to the many caregivers across America whose strength and selflessness make this bill necessary. Your stories, your sacrifices, and your advocacy have shaped this legislation. It is my hope that H.R. 2148 is just the beginning of a broader national effort to support you in the same way you have supported our veterans.

Thank you.

Prepared Statement of Paralyzed Veterans of America

Chairwoman Miller-Meeks, Ranking Member Brownley, and members of the subcommittee, Paralyzed Veterans of America (PVA) appreciates this opportunity to share our views on some of the legislation before the subcommittee today. PVA members, veterans who have acquired a spinal cord injury or disorder (SCI/D), experience the breadth of VA care and benefits in unique ways due to their injuries and illnesses. We welcome the chance to share how some of these bills might impact our members.

H.R. 1404, the CHAMPVA Children's Care Protection Act

The Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) is a comprehensive healthcare program for the spouse or widow(er) and children of an eligible veteran. Through CHAMPVA, VA shares the cost of certain healthcare services and supplies with eligible beneficiaries. It may also provide benefits to the Primary Family Caregiver through the Program of Comprehensive Assistance for Family Caregivers (PCAFC). Coverage for children under CHAMPVA currently expires when they turn 18 unless they are full-time students. In this case, they continue to receive coverage until they turn 23, stop attending school full-time, or get married. However, for most Americans with health insurance, their adult

children can remain on their plan until age 26 with no separate premium, as mandated in the Patient Protection and Affordable Care Act (ACA) (P.L. 111–148). CHAMPVA and the military's TRICARE programs were not affected by the ACA, so they required separate congressional action to extend these benefits to children up to age 26. This discrepancy was addressed for TRICARE in 2011 and the CHAMPVA Children's Care Protection Act would fix this for VA's CHAMPVA program.

The delay in making this change to CHAMPVA has adversely impacted several of our members. Take PVA member Amy and her husband for example. She served honorably in the U.S. Marine Corps before an SCI/D cut her military service short. Her husband served in the Marine Corps as well, but injuries he sustained in Operation Desert Storm curtailed his military career, too. Both have 100 percent disability ratings from the VA. Their two boys have severe immune deficiencies that were caused by their parents' exposure to hazards during their military service. As a result, the boys require weekly plasma infusions to keep them alive. These infusions cost thousands per month, and they cannot afford to pay for them out of pocket. They rely on CHAMPVA to provide this life-saving care and suffered tremendous angst when their oldest child turned 18. Fortunately, he became well enough with the infusions that they were able to keep him in school and CHAMPVA until he turns 23 in March 2026. The younger child is currently 17 but he has additional comorbidities that may not allow him to do the same. The family is straining under the pressure that the lack of action from Congress has put on them and unless legislation like this is passed, there is a very real possibility that both children will age out of the program next year.

The VA testified in opposition to the companion measure to this bill at a May 1, 2025, Senate Veterans' Affairs Committee hearing. The witness correctly stated that CHAMPVA was not affected by the ACA, but we disagree with VA's assertion that it is not health insurance because it clearly functions like it. For example, certain types of care and services require preauthorization. This approval is extremely important, and the failure to obtain it may result in denial of the claim. Also, providers must be properly licensed in their State to receive payment from CHAMPVA, and they cannot be on the Medicare exclusion list. To be reimbursed, providers must file a claim, using diagnosis and procedure codes that all other healthcare plans follow.

The Congressional Research Service (CRS) which advises Congress on programs like this seems to agree. In its October report to Congress on VA healthcare programs for dependents and survivors, CRS stated, "CHAMPVA is primarily a health insurance program where certain eligible dependents and survivors of veterans receive care from private sector healthcare providers. The program is administered by the Veterans Health Administration (VHA), Assistant Under Secretary for Health (AUSH) for Integrated Veteran Care, Office of Integrated Veteran Care (IVC). The law (38 U.S.C. §of veterans, 1781) requires CHAMPVA to provide for medical care in the same or similar manner and subject to the same or similar limitations as medical care is furnished to certain dependents and survivors of active duty and retired members of the Armed Forces under [the Department of Defense (DOD) TRICARE program]." [1]

DOD's TRICARE program wasn't affected by the ACA either, but Congress created the TRICARE Young Adult program in 2011 which provides health care for qualified young adults aged 21 to 26 who are unmarried and not eligible for an employer-sponsored health plan. Our government should not deem veterans' dependents and survivors less worthy than civilians for support. Those who are eligible for CHAMPVA should be able to retain their healthcare coverage until their 26th birthday just like those in private and Federal healthcare plans. We urge Congress to correct this inequity as soon as possible.

H.R. 2148, the Veteran Caregiver Reeducation, Reemployment, and Retirement Act

The VA's PCAFC was established by Congress in 2010 to support family caregivers who play a critical role in caring for and supporting veterans severely injured in the line of duty following 9/11. Occasionally, changes have been made to improve the program's support of veterans. Such changes include those in the VA MISSION Act of 2018, which authorized VA to offer PCAFC to caregivers for veterans of all eras.

Still, the program does not consider that many caregivers are forced to reduce their work hours, take unpaid leave, or leave the workforce entirely to provide care.

[1] Health Care for Dependents and Survivors of Veterans, October 16, 2024

They sacrifice wages, retirement savings, and financial stability to care for those they love. The time away from their jobs creates gaps in their resumes and many lose the employment certifications they previously held. When their loved one either passes away or returns to independent functioning, caregivers need to return to the workplace and must face these issues. Also, those who were relying on CHAMPVA for their health care lose this coverage within 90 days of leaving PCAFC through the death or discharge of the veteran. Members in other insurance programs have 180 days to transition their health insurance benefits.

This bill seeks to strengthen the PCAFC by addressing these, and other common problems that many caregivers face. Provisions in the bill would provide former caregivers with bereavement counseling, funding to renew their professional certifications, and the ability to participate in employment assistance programs like Military OneSource or the Department of Labor's, Veterans' Employment and Training Service. It also directs studies on the possibility of allowing caregivers to make contributions to Social Security and other types of existing retirement accounts, the feasibility of caregivers being allowed to participate in a Department of Labor returnship program, and the possibility of the VA incorporating former caregivers into the VA workforce as personal care attendants, enabling the VA to lessen staff shortages. Last, it gives caregivers who are not Medicare eligible the option to keep their CHAMPVA coverage for 180 days, if they need it.

Caregivers are often the most important component of rehabilitation and maintenance for veterans with catastrophic disabilities. As a result, their welfare directly affects the quality-of-care veterans receive. We strongly support this bill and urge Congress to pass it quickly.

Discussion Draft, the Fisher House Availability Act of 2025

Beneficiaries of active-duty service members often travel far from home to receive care through DOD's TRICARE program. Often their appointments don't end until late in the day which then requires them to drive extended distances home at night. This bill would allow VA to provide temporary lodging to a covered beneficiary or a family member of a covered beneficiary on a space available basis. If VA has available space and there is no cost to the department, PVA can support this legislation.

Discussion Draft, to provide for a timeframe for the employment in the Department of Veterans Affairs of participants in the Health Professionals Scholarship Program

The Health Professionals Scholarship Program (HPSP) provides financial assistance to students in various healthcare disciplines, aiming to meet VA workforce needs. Participants must complete their education and meet qualification requirements before employment, with the program requiring an 18-month service obligation for each year of support. The current law does not have a provision guaranteeing graduates of the HPSP a job at the VA following completion of their training. PVA supports this draft bill which requires VA to offer each participant a contract for full-time employment at the VA facility with the greatest need for their specialty within 90 days of their course completion date.

Discussion Draft, the VA Mental Health Outreach and Engagement Act

PVA supports passage of the VA Mental Health Outreach and Engagement Act. The VA suicide report clearly states that veterans who are not enrolled and engaged with the VHA are more likely to die by suicide. As we work to reduce the number of veteran suicides, the most common sense first step is to conduct proactive outreach to veterans receiving compensation for a service-connected mental health condition who are not accessing VA mental health services. By conducting intentional outreach to a vulnerable population, the department could not only increase enrollment in VA mental health programs, but ultimately, it may move the needle on curbing the number of veteran suicides.

Discussion Draft, the VA Data Transparency and Trust Act

The House and Senate Veterans' Affairs Committees are responsible for moving legislation expanding, curtailing, or fine-tuning existing laws relating to health care and benefits for veterans, certain dependents, and eligible survivors. The committees also have oversight responsibility of the department, which means monitoring and evaluating the operations of the VA. So, if the committees find that VA is not administering laws as Congress intended, or if emerging needs of veterans are identified, it is addressed through the hearing process and legislation. To fulfil this role, the committees need timely and accurate information, but in recent years, VA has been unable to provide either. We strongly believe that VA should be able to produce timely and accurate reports to Congress and respective oversight bodies so

the committees can ensure the department is providing the benefits and services that veterans have earned and deserve.

We support the VA Data Transparency and Trust Act which requires the department to provide Congress with annual reports detailing how VA benefits are delivered, who is using them, and how well the system is performing while still safeguarding veterans' privacy. This would help the committees ensure VA programs are properly funded, operating efficiently, and most importantly, meeting the needs of the veterans they were intended to serve.

H.R. 2605, the Service Dogs Assisting Veterans ("SAVES") Act

Service dogs provide invaluable assistance to disabled veterans with the greatest support needs, allowing them to live more independent lives in their communities. PVA supports the SAVES Act, which requires the VA to establish a competitive grant program to fund nonprofit organizations that provide service dogs to veterans with a variety of disabilities, such as mobility or vision impairments or PTSD. Nonprofit organizations would be required to submit an application to the Secretary that includes a description of the training that will be provided by the organization to eligible veterans; the training of dogs that will serve as service dogs; the aftercare services that the organization will provide for the service dog and eligible veteran; the plan for publicizing the availability of service dogs through a marketing campaign; and the commitment of the organization to have humane standards for animals. Passage of this legislation will increase veterans' access to service dogs and their independence.

Discussion Draft, the Territorial Response and Access to Veterans' Essential Lifecare Act or the TRAVEL Act of 2025

Thousands of veterans who are residents of U.S. territories or reside on islands in the Pacific face significant challenges in seeking medical care. In May 2024, the Government Accountability Office issued a report that found these veterans often experienced "unique and substantial barriers" that veterans in the United States do not encounter when seeking medical services from the VA.[2] PVA supports this proposed legislation, which authorizes the department to utilize traveling physicians to provide needed health care to veterans residing in these areas.

Discussion Draft, the Representing our Seniors at VA Act of 2025

State Veterans Homes play a crucial role in providing care and support for those who have served this Nation in uniform. These facilities are designed to meet the unique needs of veterans, offering a range of services tailored to their medical and emotional well-being. For many veterans and their families, these homes represent a vital resource for long-term care, rehabilitation, and companionship. They play an outsized role in VA's ability to provide skilled nursing and long-term care for veterans. PVA supports including a representative of the National Association of State Veterans Homes on the VA's Geriatrics and Gerontology Advisory Committee.

H.R. 2068, the Veterans Patient Advocacy Act

PVA supports the Veterans Patient Advocacy Act, which seeks to ensure there are an adequate number of patient advocates at VA medical facilities. Patient advocates are highly trained professionals who can help resolve veterans' concerns about any aspect of their healthcare experience, particularly those concerns that cannot be resolved at the point of care. They help to ensure access to care by listening to any questions, problems, or special needs that a veteran has and working to resolve them. PVA supports passage of the Veterans Patient Advocacy Act with the understanding that VA may need additional resources to assign patient advocates to rural community-based outpatient clinics.

PVA would once again like to thank the subcommittee for the opportunity to submit our views on some of the bills being considered today. We look forward to working with you on this legislation and would be happy to take any questions for the record.

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[2] GAO–24–106364, VETERANS AFFAIRS: Actions Needed to Improve Access to Care in the U.S. Territories and Freely Associated States

Information Required by Rule XI 2(g) of the House of Representatives

Pursuant to Rule XI 2(g) of the House of Representatives, the following information is provided regarding Federal grants and contracts.

Fiscal Year 2025

Department of Veterans Affairs, Office of National Veterans Sports Programs & Special Events—— Grant to support rehabilitation sports activities—$502,000.

Fiscal Year 2023

Department of Veterans Affairs, Office of National Veterans Sports Programs & Special Events——Grant to support rehabilitation sports activities—$479,000.

Fiscal Year 2022

Department of Veterans Affairs, Office of National Veterans Sports Programs & Special Events——Grant to support rehabilitation sports activities—$ 437,745.

Disclosure of Foreign Payments

Paralyzed Veterans of America is largely supported by donations from the general public. However, in some very rare cases we receive direct donations from foreign nationals. In addition, we receive funding from corporations and foundations which in some cases are U.S. subsidiaries of non-U.S. companies.

Prepared Statement of Gold Star Spouses of America, Inc.

Chairwoman Miller-Meeks, Ranking Member Brownley, and distinguished members of the House Committee on Veterans Affairs, Subcommittee on Health,

Gold Star Spouses of America, Inc. appreciates the opportunity to submit this statement for the record as the Committee considers several important legislative proposals aimed at improving the lives of veterans and their families. As an organization dedicated to advocating for the needs, dignity, and recognition of surviving military spouses and their families, we are encouraged by the Committee's ongoing commitment to addressing inequities and modernizing policies that directly affect our community.

We write today to express our strong support for the CHAMPVA Children's Care Protection Act (H.R. 1404), introduced by Ranking Member Julia Brownley. This legislation would extend eligibility for health care coverage under the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) to children of disabled veterans up to age 26, aligning CHAMPVA with current standards established by the Affordable Care Act and the Department of Defense's TRICARE program.

Currently, children enrolled in CHAMPVA lose eligibility at age 18, or at 23 if enrolled in school. This is in stark contrast to families covered under private insurance or TRICARE, who benefit from dependent coverage through age 26. As a result, children of disabled or fallen veterans are too often forced off health coverage at a critical stage, while pursuing higher education or beginning their professional lives. This disparity is not only unjust; it places unnecessary financial and emotional strain on families who have already endured great sacrifice in service to our country.

Surviving families deserve the same respect, stability, and support afforded to others across the Federal health care system. By extending CHAMPVA eligibility, this legislation honors the full scope of a veteran's service and ensures their children are not treated as second-class dependents under Federal policy. We urge the Committee to advance this bill and address this longstanding inequity.

Gold Star Spouses of America stands ready to work alongside Congress to strengthen the systems that support surviving families. We remain committed to ensuring the promise made to those who serve, that their families will not be forgotten, is fully upheld.

Thank you for your consideration of this statement and for your steadfast dedication to veterans and their loved ones.

Gold Star Spouses of America, Inc.

Gold Star Spouses of America is a national nonprofit organization dedicated to supporting the surviving spouses of military service members and veterans who have made the ultimate sacrifice in defense of our country. Our mission is to provide meaningful support, advocacy, education, and a sense of community for Gold Star families. Through our programs, we work to ensure that the needs of these spouses and their families are heard, addressed, and prioritized by policymakers at the Federal, State, and local levels.

GSSA is listed as an approved resource in the National Resource Directory (NRD.gov) and has been approved by the Department of Defense as a resource on Military OneSource and in the "Days Ahead" binder for all active-duty losses.

GSSA is also recognized by the Department of Veterans Affairs for volunteer opportunities within the department's Center for Development and Civic Engagement.

Prepared Statement of National Association of Veterans' Research and Education Foundations

The National Association of Veterans' Research and Education Foundations (NAVREF) is the national nonprofit organization representing over 75 VA-affiliated nonprofit research and education corporations (NPCs), established by Congress [38 U.S.C. §§7361–7366] to support the VA's medical and scientific research enterprise. Since 1992, our community has facilitated clinical trials, engaged private sector and academic partners, and advanced groundbreaking discoveries that improve the health and lives of veterans.

VA Data Transparency and Trust Act

We commend the intent behind the VA Data Transparency and Trust Act to improve transparency and trust in VA data. However, we have concerns about the scope and quality of data that would be accessed and reported if the legislation were enacted. Specifically, the bill calls for medical services data as defined by 38 U.S.C. §1701, which may not fully capture the complexity of veteran care and research activities at VA. For example, a veteran receiving medical care for diabetes at VA could also be enrolled in an **industry-sponsored** diabetes study at the same VA medical center, but those treatment protocols are not traditionally accounted for the same way as a "medical service" is. This segmentation risks incomplete or skewed reporting, limiting the full picture of veteran care and research. We urge Congress and VA stakeholders to carefully consider these nuances to ensure transparency efforts accurately reflect the scope of veteran care and research and ultimately, keep VA accountable on all aspects of the integrated health care system.

RNA Sequencing to Diagnose PTSD Bill

NAVREF fully supports the direction of the proposed legislation directing the VA to study whether RNA sequencing can effectively diagnose inflammation or cellular stress symptoms related to PTSD in veterans. This initiative aligns with ongoing VA research efforts to explore innovative molecular diagnostics and precision medicine approaches that could improve mental health diagnosis and treatment. Several VA-affiliated nonprofits are actively engaged in PTSD research, and NAVREF's membership stands ready to collaborate with the VA and congressional committees by sharing expertise, supporting study implementation, and facilitating connections with research programs. We also encourage the legislation to be inclusive of the VA Million Veteran Program and direct it to use its resources and data to engage in this initiative.

NAVREF appreciates the opportunity to provide input on these important legislative efforts. We look forward to working closely with Congress and VA leaders to help refine policies and support research that advances veterans' health and well-being.

Prepared Statement of National Association of State Veterans Homes

Chairwoman Miller-Meeks and Ranking Member Brownley:

As President of the National Association of State Veterans Homes (NASVH), I'm pleased to offer our strong support for H.R. 785, the Representing our Seniors at

VA Act of 2025, legislation to include a member of NASVH on VA's Geriatrics and Gerontology Advisory Committee (GGAC). This legislation is a commonsense effort to ensure that the experience and expertise of a State Veteran Home (SVH) leader is a part of VA's long term care planning.

As you may know, NASVH is an all-volunteer organization dedicated to promoting and enhancing the quality of care and life for the veterans and families in our Homes through education, networking, and advocacy. Today there are 172 VA-recognized State Veterans Homes across the Nation operating 166 skilled nursing care programs, 47 domiciliary care programs, and 3 adult day health care (ADHC) programs. NASVH is the only organization representing their collective interests, and our membership continues to grow as new Homes seek VA recognition.

With over 30,000 authorized State Home beds providing a mix of skilled nursing and domiciliary care, SVHs provide approximately half of all federally supported institutional long-term care for veterans yet consume less than 20 percent of VA's total budget for veterans' long term nursing home care. Having a permanent seat for a NASVH member would add a critical voice commensurate with the leading role that State Veterans Homes play in meeting veterans long term care needs.

The GGAC was first authorized by Public Law 102–40 in 1991 to advise VA on all matters pertaining to geriatrics and gerontology, and was charged with three specific tasks:

1. Evaluate the operation and effectiveness of VA's Geriatric Research Education and Clinical Centers (GRECCs);

2. Assess the demand for long term care by veterans and VA's capability to provide high quality geriatric and extended care services; and

3. Assess the current and projected needs for veterans' long term care services and VA's activities and plans to meet such needs.

H.R. 785 would require the appointed NASVH member to be a licensed nursing home administrator, which would provide a different perspective from the clinicians, researchers, and academics on the GGAC. Historically, there have been few, if any, GGAC members with direct experience leading or overseeing nursing homes, and particularly not ones focused on the care of aging and disabled veterans.

For more than a decade, NASVH had proposed a number of highly qualified leaders for membership on the GGAC, however none had been chosen until last year. Among the arguments that some VA officials had made against a NASVH member was that State Home administrators were not "experts" and that the GGAC already had sufficient expertise. However, the vast majority of GGAC members have never run a nursing home, nor worked directly on issues related to aging and disabled military veterans and their unique medical and social challenges.

We were pleased last fall when then-VA Secretary McDonough and Under Secretary Elnahal agreed to add a NASVH member, however we were disappointed to learn that the NASVH member would be a "non-voting" member of the GGAC. We were told that a NASVH member would have a conflict of interest, since State Veterans Homes receive funding from VA, even though many current and past members of the GGAC have worked for organizations or companies that have an interest in Federal policies related to long term care.

For example, the GGAC's immediate past Chairman, David Gifford, was the Chief Medical Officer for the American Health Care Association (AHCA), which lobbies on behalf of thousands of nursing homes, overwhelmingly private ones. Most of these nursing homes receive significant Federal funding through the Center for Medicare and Medicaid Services (CMS), and many also have contracts with VA for the care of veterans. Yet, Dr. Gifford was able to successfully lead the GGAC and manage his dual roles in conformity with Federal ethics rules.

While NASVH receives no funding from VA or any Federal agency, if a member of NASVH appointed to the GGAC also works for a State Veteran Home, then that member would certainly recuse themselves appropriately, in the same manner as other GGAC members whose jobs, organizations, and companies are impacted by Federal funding, grants, and policies.

Madame Chairwoman, State Veterans Homes can and must play a greater role in meeting the needs of aging veterans and their caregivers in partnership with VA and other Federal agencies. One way to strengthen that partnership is to ensure that NASVH and its members are engaged when VA is discussing, evaluating and making plans to improve the access to and quality of long-term care for our Nation's aging and disabled veterans.

NASVH fully endorses H.R. 785 and looks forward to continuing to work with Congress and VA to ensure that veterans have greater access to a full spectrum of long-term care options, whether at home or in nursing homes. Adding the experi-

ence and expertise of a NASVH member will not only benefit the GGAC but will also improve the lives of America's heroes.

Prepared Statement of Quality of Life Foundation

Thank you Chairman Miller-Meeks, Ranking Member Brownley, and distinguished members of the Committee for allowing us to emphasize and advocate for H.R. 2148, the Veteran Caregiver Re-education, Re-employment and Retirement Act (Veteran Caregiver 3R Act). This bill is deeply personal to my organization, Quality of Life Foundation, and to me personally as a caregiver to a veteran who withdrew from the VA's Program of Comprehensive Assistance for Family Caregivers (PCAFC). I'd like to thank Congressmen Ciscomani and Morelle, as well as Senator Moran, and former Senator Sinema for taking my words in the SVAC hearing in March 2022 to heart when I said VA's family caregivers, without the safety nets in this bill, will fall into poverty upon leaving their caregiving roles. I will leave the facts and statistics of caregivers' financial contributions and lost income to others. Today, I want to tell you why this legislation is personal to me and why I feel it necessary to advocate so strongly for it.

In 2009, Wounded Warrior Project invited myself and 19 other Post 9/11 military veteran caregivers to the Hill, to tell our stories to lawmakers about why Congress should create the VA's Caregiver Support Program, a component of which, the Program for Comprehensive Assistance for Family Caregivers (PCAFC), would provide a stipend for those caregivers whose role prevented us from maintaining a position in the workforce. When I arrived in DC in July 2009, my husband was on his third hospitalization since returning from Iraq in February 2007. During those years, I had tried to maintain my 13 year teaching career while raising two young children and caring for him, but it was impossible to simultaneously teach well and to caregive well. And, honestly, there is no room in either role, teacher or caregiver, for anything less than well.

In May 2009, I made the decision to give up my financial independence and professional identity in order to become "just a caregiver." At the time, not only did I hold teaching licenses in two states, but I also held my National Board Of Professional Teaching Standards certificate. This certificate offered me a substantial salary boost to my teacher salary and is something only 141,000 teachers nationwide have achieved. The last day of that school year in June 2009 saw me shifting from providing the majority of my family's income to providing none of it.

That shift was substantial and provided the reason it was so important for me to advocate for family caregivers in the summer of 2009. I gave up my job voluntarily to care for my husband, but, in doing so, I lost my professional identity, my financial independence which contributed to my family's financial well-being, and my long-term retirement savings' stability. Additionally, I had no idea how long I would have to support my veteran through caregiving nor the long-lasting effects that it would have on my retirement savings.

In 2009, I came to the Hill with high hopes for the creation of a program that would provide me, a caregiver, an income, allowing me to make a monetary contribution to my family and relieve the financial pressure we felt after losing my teaching income. I also had hopes of having my role as caregiver validated as an important part of my husband's recovery, not just another role that was expected of me. When the Caregivers and Veterans Omnibus Health Services Act of 2010 was signed into law on May 5, 2010, I was excited to see a program that I had supported through legislation come into fruition.

However, as the years have gone by, PCAFC has become a reality along with regulations and a few oversights. As a person who worked on helping PCAFC come into existence, I find it imperative that I, as Advocacy Director of Quality of Life Foundation's Wounded Veteran Family Care Program, and a caregiver, lead the efforts in fixing those oversights, for the caregivers that advocated for that original legislation and all the caregivers that have come before and will come after us.

As a teacher, I had to renew my licenses with continuing education credits, some of which can be earned by teaching in the classroom and others through taking classes or going to conferences. I held on to my State licenses for 15 years, but did eventually give them up. It made little sense to keep them, when there was no end in sight to my caregiving. In addition to my regular State teaching licenses, The National Board of Professional Teaching Standards certification that I had taken such pains to earn in addition to my State licenses was lost as it could only be renewed by actually being in the classroom.

Had I chosen to return to the classroom, here's what would have happened: I would have needed to renew my license. Depending on the State, I would be teaching on daily substitute pay until my full license was restored by earning enough continuing education credits. Not only would that path mean teaching days be paid with extremely low wages on which to support myself, it also meant I would have to bear the cost of the renewal of my licenses which could add up to thousands of dollars depending on the State requirements, including any college classes or seminars. That is not a cost caregivers can support if they have lost their income from caregiving, nor will that cost be realistically covered by the 3-months of stipend paid when the caregiver exits PCAFC.

H.R. 2148, the Veteran Caregiver Re-education, Re-employment, and Retirement Act would grant $1000 per caregiver for those who wish to renew licenses or certifications upon leaving the Caregiver Program and returning to the workplace. H.R. 2148 would institute a program which is a mirror of a program that already exists in DOD for military spouses that must relocate due to their spouses receiving orders. In reality, many of our caregivers will never return to the workplace, either because their veterans never recover fully enough for them to do so or because they will end caregiving well past retirement age. But for those caregivers who must return to the workforce due to the death of their care recipients during their pre-retirement years, this money would be essential.

The bill would study expanding returnships to caregivers. Returnship programs are already supported by the Department of Labor. Returnships are opportunities for companies to hire Americans returning to work after being out of the workplace for a period of at least 2 years. The best way to think about returnships are to think of Robert De Niro's character in the movie The Intern. Technically he wasn't an intern; he was a return. This type of returnship program would allow caregivers to become current on workplace skills while using the vast knowledge they have from their prior careers and leveraging the skills they have learned from caregiving, such as superb organizational skills and ability to prioritize multiple tasks. Some companies, i.e. Goldman Sachs and Wells Fargo, and State governments, such as Utah and Vermont, have returnship programs already established.

The VA remains in a shortage of workers to meet demand, and the Veteran Caregiver 3R Act would study whether caregivers discharged from PCAFC could be used to fill gaps within the VA workforce, either through roles leveraging prior professional skillsets or as non-medical attendants. Either way, leveraging the wealth of experience, knowledge, and skill sets of caregivers exiting PCAFC could be a way to fill apparent gaps in VA's workforce while also providing economic stability to caregivers having to return to the workforce.

Another component of this bill offers transition assistance to caregivers who are either transitioning from caregiving back to the workforce or into caregiver "retirement," the later stages of life where it is no longer beneficial for caregivers or their care recipient to have care from the person designated as the family caregiver.

But what future exists for caregivers without retirement income options? Truly, this is the most important component of this bill to me. It solves a crisis that currently keeps me up at night. For many years, I was not able to contribute to a retirement fund due to lack of earned income in my home. Any year that I worked part time, I made a contribution to my personal individual retirement account, though there were many years it was not funded or underfunded due to limited income and the inability to contribute. At 51, I have about one-third of the retirement savings that I should have at this time, and I am running out of time to catch up on those contributions.

I am one of the lucky ones. I was old enough to have made some retirement contributions, and I have been able to return to work in a job that uses all of my teaching experience and my knowledge of caring for an injured veteran.

Unfortunately, that is not the case for many of the caregivers I advocated with on the Hill in 2009. Many of them have been caregivers since 2005. They are looking at 20 years with no contributions to Social Security or individual retirement accounts. There is no safety net for them if they are injured while providing care for their loved one. If their spouses pass away now, with them in their early 40's to mid 50's, they will have to go back into the workplace after more than 20 years out of the workforce. They will have no retirement savings, and they will have to move into jobs that are at a lower pay level than their peers of the same age due to their lack of work experience. This severely limits their ability to save for retirement in their personal retirement accounts and their income from Social Security. In addition, the Social Security spousal benefit will not be an option for them because their spouses stopped contributing to Social Security at an extremely young age; meaning the potential spousal benefit would be extremely low, if it existed at all. These care-

givers should not be forced into a low retirement income because they chose to care for their loved one and save the VA and taxpayers money.

As caregivers, we simply want to be able to have a way to contribute to and fund our own retirement savings and income so that we do not to fall into poverty because we chose to care for our veterans at home. Please allow us the pathway to do this. Such a pathway could be created by creating special caregiver IRA's which would allow taxation at the withdrawal period and not at the contribution period. Other options are Thrift Savings Plans like those offered to troops.

While I am extremely grateful that I was able to be a part of the creation of the VA's PCAFC, I would also like to be a part of the fixing issues that were not even considered when the legislation creating the program was drafted. None of us knew this would be a potential lifelong role. We did not think about returning to the workforce if our care recipient passed away. None of us thought about retirement at the ages of 20 or 30, and none of us thought about having to transition from caregiving for our veteran to possibly needing to "retire" from caregiving and ourselves be cared for and how that would be funded. But today, at 40 and 50 years of age, we are thinking of that. And what we see is frightening—we don't have easy pathways to returning to the workforce or retiring. Some of us have no pathway to return to the workforce or retire.

Veteran Caregiver Re-education, Re-employment, and Retirement Act is our plea to Congress to help us address these issues. It allows us to create our own long-term safety nets through re-employment or funding retirement. As a caregiver for a veteran, and as an advocate for caregivers of veterans, I would ask you to please pass H.R. 2148, the Veteran Caregiver Re-education, Re-employment, and Retirement Act.

Prepared Statement of United Services Automobile Association

On behalf of the United Services Automobile Association (USAA) and our nearly 14 million members of the U.S. military, veterans who have honorably served, and their families, thank you for convening today's hearing on legislative proposals to care for our Nation's veterans and their families. We appreciate the opportunity to provide this statement of support for H.R. 2148, *the Veteran Caregiver Reeducation, Reemployment, and Retirement Act*.

USAA is a membership association that serves members of the military community, including active duty, Guard, Reserve, veterans, and their families. Since our founding in 1922 by 25 U.S. Army officers, USAA has facilitated the financial security of our members, associates, and their families by providing a full range of highly competitive financial products and services. In our second century of service, we remain focused on meeting our members' needs through every stage of life—from joining the military to buying a home to retiring.

H.R. 2148, the Veteran Caregiver Reeducation, Reemployment, and Retirement Act

In September 2024, RAND published a report commissioned by the Elizabeth Dole Foundation titled, "America's Military and Veteran Caregivers: Hidden Heroes Emerging from the Shadows." There are approximately 14.3 million military and veteran caregivers today, representing 5.5 percent of the U.S. adult population. According to RAND, these caregivers on average incur over $8,500 in annual out of pocket costs, while forgoing over $4,500 in annual household income. More than one-third of these caregivers live below 130 percent of the Federal poverty level. Serving as a caregiver can also compound future financial challenges. Military and veteran caregivers often have employment gaps in their resume, which can impact their future employment and earnings prospects, and many lack retirement savings vehicles to invest in their own financial security.

This bipartisan bill will expand support available to veteran caregivers enrolled in the Department of Veterans Affairs (VA) Program of Comprehensive Assistance for Family Caregivers (PCAFC). It would provide employment assistance to eligible caregivers, including fee reimbursement associated with professional certifications or licenses. Caregivers would also be granted access to existing employment assistance programs through the VA, the Department of Defense, and the Department of Labor. In recognition of the fact that caregivers are at higher risk of depression and suicidality, the bill expands caregiver access to bereavement counseling and support. The bill also directs the VA to study the feasibility of establishing a retirement plan or alternate pathway to retirement savings for veteran caregivers.

USAA thanks Representatives Joseph Morelle (D-NY) and Juan Ciscomani (R-AZ) for their leadership on this important proposal to better support the caregivers who selflessly serve our Nation. We urge the Committee to support the bill when considered during a future markup.

Prepared Statement of The Veterans of Foreign Wars of the United States

Chairwoman Miller-Meeks, Ranking Member Brownley, and members of the subcommittee, on behalf of the men and women of the Veterans of Foreign Wars of the United States (VFW) and its Auxiliary, thank you for the opportunity to provide our remarks on this pending legislation.

H.R. 785, Representing our Seniors at VA Act of 2025

The VFW supports this legislation to include a representative from the National Association of State Veterans Homes on the Department of Veterans Affairs (VA) Geriatrics and Gerontology Advisory Committee. This inclusion would give state-run veterans homes a voice in Federal VA policymaking on elder care, and facilitate collaboration between VA and State Veterans Homes (SVHs) as the veteran population continues to age.

SVHs originated in the pre-Civil War era and were initially established to care for injured and aging soldiers. These homes are operated by State governments and provide nursing, assisted living, or domiciliary care specifically for veterans. They offer long-term care services tailored to meet their unique needs.

Living in SVHs offers several benefits, including subsidized care, VA per diem grants that help reduce out-of-pocket expenses, and a supportive environment where veterans can connect with one another and build camaraderie. VA provides general oversight for all 153 SVHs, which care for approximately 14,500 veterans.

H.R. 2068, Veterans Patient Advocacy Act

The VFW supports this legislation to provide veterans living in highly rural areas with better access to patient advocate services. For the past 11 years, the VFW has partnered with Student Veterans of America (SVA) to select student veterans from across the country to research and advocate for improvements on issues that matter to veterans. Past VFW-SVA Fellow and Grand Valley State University graduate Cameron Zbikowski focused his semester-long research proposal on enhancing the patient advocate program at VA. He proposed improvements to ensure that each facility had an adequate number of patient advocates. In that spirit, the VFW continues to support this legislation.

H.R. 2605, Service Dogs Assisting Veterans (SAVES) Act

The VFW strongly supports this legislation to create a 5-year pilot program in which VA would provide up to $2 million in grants to nonprofit organizations to provide service dogs to eligible veterans. It would also provide commercially available veterinary insurance for them. Service dogs assist with various physical, auditory, and trauma-related disabilities. They help empower veterans to regain their independence, pride, and hope. While they are typically provided free of charge, the medical care involved can be costly. This legislation would enable more veterans to receive support animals with less of a financial burden.

The VFW thanks Representative Luttrell for introducing this legislation and for inviting VFW Post 4709 Commander Marcy Phillips from his Post in Conroe, Texas, to speak at the Congressman's press conference for this legislation. The VFW was honored to have her talk about her service dog and how it has had a positive impact on her life.

H.R. 3400, Territorial Response and Access to Veterans' Essential Lifecare (TRAVEL) Act of 2025

The VFW supports this legislation to authorize VA physicians to temporarily serve as traveling physicians for up to 1 year in American Samoa, Northern Mariana Islands, Guam, Puerto Rico, the Virgin Islands, and other U.S. territories. It would improve support for veterans living in these areas or medically underserved regions by offering providers incentives like relocation or retention bonuses. This would allow VA to address gaps in health care in U.S. territories and provide a continuity of care through coordinated integration with local providers.

H.R. 3643, VA Data Transparency and Trust Act

The VFW supports the intent of this legislation, but we have questions about the scope of the information to be collected. This proposal would establish certain VA annual reports to Congress from the Veterans Benefits Administration and the Veterans Health Administration. The reports would span 5 years, focusing on areas such as hospital care, medical services, nursing home care, and the management of these services. It includes a set of metrics designed to provide insights into veterans' demographic profiles, health conditions, service utilization, and benefits usage over time. While the VFW has advocated for improved data reporting by VA, we also want the intent of these reports to be made clear. The VFW also cautions against collecting income and other financial information of veterans that could be used to reduce benefits or prevent veterans from accessing their earned benefits.

Discussion Draft: To direct the Secretary of Veterans Affairs to conduct a study to determine whether RNA sequencing can be used to effectively diagnose PTSD in veterans

As a resolutions-based organization, the VFW does not have a position on this proposal at this time, however, we do have some concerns. This legislation would direct the Secretary of Veterans Affairs to conduct a study on whether ribonucleic acid (RNA) sequencing can effectively diagnose post-traumatic stress disorder (PTSD) in veterans. Although this idea is innovative, focusing solely on biological markers may oversimplify the complexity of the disorder. Trauma, environment, genetics, and psychology are all factors in PTSD. While a biomarker-based diagnostic tool could aid in the early detection of PTSD, it also raises several scientific, practical, and ethical concerns.

Discussion Draft: Health Professionals Scholarship Program Improvement Act of 2025

The VFW supports this legislation to improve the hiring of participants in the VA Health Professional Scholarship Program that provides scholarships to students pursuing health care degrees in exchange for service at VA facilities. It enables VA to provide incentives to qualified health care professionals to work at VA medical centers, particularly in areas where recruitment and retention are difficult.

This legislation would create a more efficient process of placing scholarship recipients into clinical roles, which is particularly important given VA's critical medical staff shortages. It would do this by requiring VA to provide employment contracts within 90 days of students completing their coursework. It would also assign providers to VA facilities with the highest need, and offer competitive salaries and benefits aligned with VA standards.

H.R. 3726, Fisher House Availability Act of 2025

The VFW supports this legislation to allow veterans, service members, and their families to stay at temporary lodging facilities, such as Fisher Houses, when having to travel significant distances for medical care. For more than 30 years, Fisher Houses have been available free of charge. The Fisher House Foundation provided 57 homes to VA and 42 to the Department of Defense. A VA policy change in 2023 restricted these homes to only those receiving VA-directed care, greatly restricting service members with TRICARE from using this option. In 2024, Fisher Houses were operating at only 53 percent capacity, mainly housing the families of hospitalized veterans. This proposal would codify the previous practice of allowing service members who receive non-VA care and their families to stay at temporary lodging facilities on a space-available basis. The priority access would continue to be for veterans and their families. The VFW sees this as a reasonable expansion for TRICARE beneficiaries and their families. Broadening eligibility would help alleviate financial and logistical burdens when a loved one needs to be hospitalized or receive medical care far from home.

H.R. 1404, CHAMPVA Children's Care Protection Act of 2025

The VFW supports this legislation that extends the age limit for children eligible for medical coverage under the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA). This legislation aims to enhance health care access for young adult children of veterans, ensuring they receive continuous care during a critical phase of life and minimizing coverage gaps for military families. This initiative is a key legislative priority for the VFW, and it aligns with other Federal health care programs such as the Affordable Care Act that allows dependent coverage until age 26.

H.R. 2148, Veteran Caregiver Reeducation, Reemployment, and Retirement Act

The VFW supports this legislation to expand medical coverage, counseling, and employment services to individuals who have participated in VA's caregiver programs. These dedicated individuals spend a significant amount of time providing in-home care. When someone leaves the program, typically because the veteran loved one has passed away, the caregiver often faces challenges when attempting to reenter the workforce. Proper training, counseling, and support for reintegration are essential for those who have left their careers to become full-time caregivers.

This proposal would provide employment assistance to former caregivers through reimbursement of certification fees, access to VA training modules, and support through Military OneSource and the Veterans' Employment and Training Service. It would also expand available retirement planning and workforce transition assistance for these individuals; extend CHAMPVA medical coverage to former caregivers for 180 days after their designation ends as long as they were not dismissed for fraud, abuse, or mistreatment; and provide bereavement counseling following the death of the veteran. The VFW sees all of these initiatives as beneficial to the dedicated caregivers who provide long-term care for veterans who need it.

Discussion Draft: VA Mental Health Outreach and Engagement Act

The VFW appreciates the intent of this legislation, but we have certain recommendations for improvement. Currently, VA is required to offer a mental health consultation to veterans within 30 days after submitting a claim for disability compensation for mental health conditions. Offering veterans mental health consultations every year may be a deterrent that creates concerns that their benefits could be reduced, or cause retraumatization when asked to discuss their mental health needs.

The VFW recommends instead that VA conduct regular outreach to veterans who have filed VA claims (regardless of the outcome of these claims) and who do not utilize VA health care services, so they can receive information about services they may need now or in the future. Effective outreach to those within the VA health care system and to those who have not yet enrolled would encourage veterans to consider these services and utilize them when needed.

Chairwoman Miller-Meeks, Ranking Member Brownley, this concludes my statement. Again, thank you for the opportunity to offer our comments on these issues.

Information Required by Rule XI2(g)(4) of the House of Representatives

Pursuant to Rule XI2(g)(4) of the House of Representatives, the VFW has not received any Federal grants in Fiscal Year 2025, nor has it received any Federal grants in the two previous Fiscal Years.

The VFW has not received payments or contracts from any foreign governments in the current year or preceding two calendar years.

Prepared Statement of American Academy of Physician Associates

Subcommittee Chairman Miller-Meeks, Subcommittee Ranking Member Brownley, and Members of the Committee on Veterans' Affairs:

On behalf of the approximately 190,000 physician associates/physician assistants (PAs) throughout the United States, including more than 2,500 PAs employed by the Veterans' Health Administration to serve veterans, the American Academy of Physician Associates (AAPA) thanks the Subcommittee on Health for its continued leadership on veterans' health issues. We appreciate the opportunity to comment on H.R. 3767, the Health Professionals Scholarship Program Improvement Act of 2025 (HPSP Improvement Act of 2025), which was introduced by Reps. Abraham Hamadeh (R-AZ) and Nikki Budzinski (D-IL).

The PA profession proudly maintains a close connection to the VA, as the founding class of PA students in 1965 were veterans. These first PA students were former Navy hospital corpsmen and Army combat medics with considerable medical training from their military service. The VA was the first employer of PAs in 1967 and today is the largest single employer of PAs in the Nation. Eleven percent of all prac-

ticing PAs and 24 percent of PAs employed by the VA are veterans, active-duty military, or serve in the National Guard and Reserves. PAs maintain a strong, personal desire and dedication to serve veterans and AAPA fully supports efforts, such as the law enacted in 2018 that provided funding for HPSP scholarships for PAs, to strengthen the workforce at the VA and expand access to care for veterans.

Last year, AAPA commented on a proposed rule to implement requirements in the Consolidated Appropriations Act of 2023 for the VA to "specifically award scholarships to applicants pursuing degrees or training in mental health disciplines, including advanced practice nursing (with a focus on mental health or substance use disorder), psychology, and social work," and to provide no fewer than 50 additional awards to such applicants beginning in academic year 2022. In its comments, AAPA noted that while it appreciated the VA specifying that PAs should be eligible for the additional HPSP scholarships, it also formally requested that the VA specifically list PAs in the Code of Federal Regulations as well to minimize any future confusion.[1] In its final rule, the VA responded that "PAs are eligible to apply for and receive HPSP scholarships for mental health disciplines under proposed § 17.603(b)(2)," but that it would not be making changes based on AAPA's comments because, "the list of mental health disciplines in proposed § 17.603(b)(2) is not an exhaustive list" and "VA determined that it should maintain a non-exhaustive list in the regulation to permit flexibility so that new mental health professions can be included without the need to amend the regulations."[2] AAPA continues to support efforts that encourage and support PAs to practice in mental or behavioral health and psychiatry to help address national provider shortages.

AAPA has heard from some PAs working for the VA that even after completing the HPSP, there are many problems with communication and administrative delays that have prevented HPSP beneficiary PAs from being able to treat veterans. Some PAs have faced delays as long as 6 months from the time of their interview until they began work at a VA facility. These unnecessary delays impose the burden of an income gap on PAs and other health care providers who would like to care for veterans, while also compounding the problem of student debt. The HPSP Improvement Act of 2025 would address this problem by requiring the Secretary of the VA to ensure that HPSP participants receive a contract for full-time employment withing 90 days of the completion of their training.

The HPSP Improvement Act of 2025 is an important step toward ensuring that the VA is able to hire qualified health care professionals for which recruitment or retention is difficult. However, as the VA and Congress work to strengthen the Veterans Health Administration workforce, it is essential that PAs are included in these efforts. Despite previous inclusion in VA's HPSP, and despite the most recent OIG Determination of Veterans Health Administration's Severe Occupational Staffing Shortages listing numerous severe shortages of PAs, mental health care providers, and primary care providers,[3] the VA has not made PAs eligible for the current round of HPSP.[4] It is important for VA recruitment and retention efforts and for veterans' access to care that PAs be eligible for HPSP, and we believe it is critical to ensure that PAs and other health care providers for which there are severe shortages at VA facilities are included in HPSP.

With clinical expertise, medical training, the initiative to help, and unique connection to our veteran population, PAs are on the ground in local communities and especially positioned to increase access to care in areas of health care in which VA has acute shortages.

AAPA thanks the Subcommittee for this opportunity to provide comments on H.R. 3767, the HPSP Improvement Act of 2025, and welcome any comments or questions you may have for us. Please contact AAPA Vice President of Federal Advocacy Tate Heuer at theuer@aapa.org.

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[1] American Academy of Physician Associates. Comments on Proposed Rule-VA Health Professional Scholarship Program. October, 2023.

[2] Federal Register. 38 CFR Part 17, RIN 2900-AR98, VA Health Professional Scholarship Program. June, 2024.

[3] Veterans Health Administration. OIG Determination of Veterans Health Administration's Severe Occupational Staffing Shortages Fiscal Year 2024. August, 2024.

[4] Department of Veterans Affairs. HPSP. Retrieved June 17, 2025.

Prepared Statement of Concerned Veterans of America

Statement for the Record

of

John Vick

Executive Director, Concerned Veterans for America

on

H.R. 3643, the VA Data Transparency and Trust Act

before the

Subcommittee on Health, House Veterans Affairs Committee

June 12, 2025

Thank you to Chairwoman Miller-Meeks, Ranking Member Brownley, and Members of the Subcommittee for the opportunity to submit this statement on behalf of Concerned Veterans for America (CVA). CVA is a grassroots network of thousands of veterans and military families dedicated to a freer and more secure America where every person is empowered to live their American dream. Our organization elevates veterans' unique perspectives in order to deliver people-empowering policy solutions, rooted in liberty-based principles, to the issues Americans face.

CVA is submitting this statement for the record in support of a common-sense piece of legislation being discussed before the committee today, **H.R. 3643, the VA Data Transparency and Trust Act**.

CVA's History in Veterans' Health Care Reform

Concerned Veterans for America has a thirteen-year track record as a leading advocacy organization for empowering veterans to seek the care that best meets their needs. CVA helped elevate the voices of VA whistleblowers who revealed that veterans had died while waiting for care on secret wait lists during the Phoenix VA scandal of 2014. In the aftermath of Phoenix, CVA also supported early reform efforts like the Veterans Access, Choice, and Accountability Act of 2014, which created the first options for veterans to seek care outside the VA. CVA also helped secure passage of the 2017 VA Accountability and Whistleblower Protection Act to change the personnel incentives that created the Phoenix scandal to begin with.

These early efforts culminated in the VA MISSION Act of 2018, which CVA helped shape and support in Congress. The legislation, which passed with overwhelming bipartisan support, incorporated many of the recommendations of CVA's 2015 Fixing Veterans' Health Care Task Force—namely by creating the Veterans Community Care Program (VCCP).[1] By consolidating existing choice programs into an easier-to-use VCCP and simplifying access standards, the MISSION Act has been a game-changer for millions of veterans' ability to access timely and quality care.

During the Biden Administration, CVA fought for additional congressional oversight as the Department of Veterans Affairs prioritized its bureaucratic interests over the well-being of the veterans it exists to serve. Veterans have suffered because the VA has not properly followed the requirements of the MISSION Act, particularly when it comes to ensuring veterans have access to community care when eligible. Fortunately, the 119th Congress has an opportunity to recommit to empowering veterans by putting them back at the center of their care.

VA data transparency for both Veterans Health Administration (VHA), along with similar measures for the Veterans Benefits Administration (VBA) is a prerequisite to resolving the issues outlined above. Regular reporting on both VHA and VBA operations will give Congress and the public the tools it needs to exercise oversight and identify what does and does not work in current VA policies.

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[1] "Fixing Veterans Health Care: A Bipartisan Policy Task Force," Concerned Veterans for America, 2015. https://cv4a.org/wp-content/uploads/2016/01/Fixing-Veterans-Healthcare.pdf

H.R. 3643, the VA Data Transparency and Trust Act

The VA Data Transparency and Trust Act, introduced by Rep. John McGuire and co-sponsored by Chairman Mike Bost, would institute common-sense new reporting requirements for the VHA and VBA to aid oversight and improve operations. For years, CVA has called for much of the data specified in this bill to be tracked and reported for public review.

The bill would require an annual VHA report to Congress on the furnishing of medical care, including hospital and nursing home services, collecting basic information on major chronic conditions, veteran demographic information, and service-connected disability priority group status. The VHA would also report on enrollment, health insurance status, patient visit types and frequency, and length by category, as well as associated cost data. The reports would also include satisfaction survey data about treatment at the VHA and at community care providers. CVA has long called for the House Veterans Affairs Committee to require this data to be public

This information is valuable on several fronts. Average per-patient cost data has been historically dependent on the level of detail the VA provides in its annual budget requests, which can vary year-by-year and complicate Congress and the public's ability to compare VHA cost data to alternative public and community providers in a rigorous, disaggregated format. Additionally, VHA and community care satisfaction surveys are a valuable source of insight, but one which the VA stopped providing in its FY 2025 budget submission.

The bill would also require reporting on the age, annual maintenance costs, and annual visitors to different VHA facilities, [2] When necessary, Congress should be considering VA construction or consolidation on this kind of data-driven basis

The legislation would create similar reporting requirements for the VBA as well, ensuring Congress is aware of the number of veterans receiving benefits by age, income, length and type of military service, disability priority group level, and other demographic data. The current disability benefits system was put in place in the 1940s, and as Congress considers whether changes are warranted in light of medical advances and new rehabilitation treatment options, data on the number of beneficiaries and their benefits status changes over time between 1997 and 2024 would be an invaluable aid for future commissions assessing how to make the system both more responsive and effective in improving veterans' health outcomes.

Conclusion

Concerned Veterans for America urges Members of the Subcommittee on Health to **support H.R. 3643, the VA Data Transparency and Trust Act**, to promote good governance and help the VA better accomplish its mission. The VA is requesting a $441 billion budget in FY 2026.[3] The agency's solemn obligation to care for "him who shall have borne the battle" can only be

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[2] "VA Recommendations to the Asset and Infrastructure Review Commission," Department of Veterans Affairs, March 2022. https://www.va.gov/AIRCOMMISSIONREPORT/docs/VA-Report-to-AIR-Commission-Volume-I.pdf

[3] U.S. Department of Veterans Affairs FY 2026 Budget Submission, May 2026. https://department.va.gov/administrations-and-offices/management/budget/

fulfilled when Congress and the public have access to key data on the degree to which the VA is succeeding.

Sincerely,



John Vick

Executive Director

Concerned Veterans for America

Prepared Statement of Military Officers Association of America

STATEMENT FOR THE RECORD

of the

MILITARY OFFICERS ASSOCIATION OF AMERICA

for a

LEGISLATIVE HEARING

1st SESSION of the 119th CONGRESS

Before the

SUBCOMMITTEE ON HEALTH
HOUSE COMMITTEE ON VETERANS' AFFAIRS

June 12, 2025

EXECUTIVE SUMMARY

The Military Officers Association of America (MOAA) appreciates the opportunity to submit this statement for the record in strong support of two key pieces of legislation under consideration by the subcommittee. Collectively, these bills represent meaningful progress toward improving quality of life and long-term support for those in the veteran and military community.

- ***H.R. 2148, the Veteran Caregiver Reeducation, Reemployment, and Retirement Act*[1],** empowers caregivers to achieve financial security by providing support services to help them transition into the workforce and retirement.
- ***H.R.1404, the CHAMPVA Children's Care Protection Act*[2],** extends health care eligibility under the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) for dependents up to age 26, aligning with commercial plans and military (TRICARE) standards. This change would close a long-standing gap and offer greater continuity of care for children of severely disabled veterans and survivors.

MOAA urges swift passage of these measures and stands ready to work with Congress to ensure veterans and servicemembers receive the health care and benefits they have earned through service and sacrifice.

CHAIRWOMAN MILLER-MEEKS AND RANKING BROWNLEY MEMBER, and members of the subcommittee, on behalf of the Military Officers Association of America (MOAA) and our more than 350,000 members, we sincerely appreciate the opportunity to provide our views and endorsement of the bills before you today. MOAA looks forward to working with the full committee and the Department of Veterans Affairs (VA) to advance this important legislation in the 119th Congress.

MOAA does not receive any grants or contracts from the federal government.

LEGISLATION

H.R. 2148, VETERAN CAREGIVER REEDUCATION, REEMPLOYMENT, AND RETIREMENT ACT

MOAA, in collaboration with the Quality of Life Foundation, the Elizabeth Dole Foundation, and other veteran advocacy groups, strongly supports the bipartisan *Veteran Caregiver Reeducation, Reemployment, and Retirement Act*. This legislation addresses urgent gaps in support for caregivers of veterans — individuals who provide critical, often lifelong care to our

[1] **H.R. 2148**: https://www.congress.gov/bill/119th-congress/house-bill/2148/text?s=3&r=2&q=%7B%22search%22%3A%22hr+2148%22%7D.
[2] **H.R. 1404**: https://www.congress.gov/bill/119th-congress/house-bill/1404/text?s=1&r=1&q=%7B%22search%22%3A%22hr+1404%22%7D.

nation's heroes. Refer to MOAA's written statement before the House and Senate Committees on Veterans' Affairs on Feb. 26, 2025, for more information[3].

The Need for Action

With veterans aged 65 and older comprising a growing share of VA patients, the demand for long-term care is surging. The RAND Corporation's 2024 report, *America's Military and Veteran Caregivers: Hidden Heroes Emerging from the Shadows*[4], estimates there are 14.3 million military and veteran caregivers nationwide — 5.5% of the adult population. Of these, 74% care for veterans over age 60, and 55,000 are enrolled in the VA's Program of Comprehensive Assistance for Family Caregivers (PCAFC).

Despite their vital role, caregivers face significant financial, professional, and emotional burdens. Many forgo careers, retirement savings, and personal well-being to provide care. The current system classifies caregiver stipends as "unearned income," excluding them from Social Security and retirement contributions — and leaving caregivers financially vulnerable.

Legislative Solutions

The act proposes targeted reforms to improve PCAFC caregivers' long-term stability and quality of life:

- **Reeducation**
  - Reimburse up to $1,000 for licensure fees.
  - Grant access to VA training modules for continuing education.
  - Study a "returnship" program to help caregivers reenter the workforce.
- **Reemployment**
  - Provide employment assistance and job placement support.
  - Examine barriers and incentives to hiring former caregivers, especially within the VA.
- **Retirement**
  - Offer retirement planning services.
  - Study the feasibility of a dedicated caregiver retirement plan.

MOAA Recommends: Congress passes the *Veteran Caregiver Reeducation, Reemployment, and Retirement Act* without delay. This legislation acknowledges caregivers' invaluable contributions by offering a path to restore their financial security, professional dignity, and long-term well-being. By offering education, employment, and retirement opportunities, the act would empower caregivers to achieve financial security while potentially reducing the federal government's long-term economic burden by decreasing their future reliance on government assistance programs.

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[3] **MOAA's written statement before the House and Senate Committees on Veterans' Affairs, February 26, 2025**: https://www.moaa.org/contentassets/cd1fa065732d4f428f70911a7ac311f9/2025-testimony-hvac-svac-final.pdf.

[4] **September 2024 RAND Report, *America's Military and Veteran Caregivers: Hidden Heroes Emerging from the Shadows***, https://www.rand.org/pubs/research_reports/RRA3212-1.html.

H.R.1404, CHAMPVA CHILDREN'S CARE PROTECTION ACT

The Need for Action

Employer-sponsored health plans have been required to cover adult children up to age 26 since the 2010 passage of the Affordable Care Act (ACA). Congress created the Department of Defense (DoD) TRICARE Young Adult program for military families in 2011, but similar coverage has not been extended to those under the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) — children of veterans who are permanently and totally disabled due to service-connected conditions or who died from such conditions.

Under current CHAMPVA rules, coverage ends at age 18 (or 23 if the child is a full-time student). This outdated policy places an undue burden on families already coping with the challenges of disability or loss. It also creates an inequity between CHAMPVA and other federal and private health care programs. Many young adults struggle to find employment with benefits, and the lack of CHAMPVA parity leaves these beneficiaries, and their families, vulnerable.

Legislative Solutions

The *CHAMPVA Children's Care Protection Act* would increase the maximum age for children eligible for medical care under the CHAMPVA program. Doing so will assist these beneficiaries and their families by:

- Aligning the program with the ACA and DoD's TRICARE Young Adult program.
- Providing peace of mind and financial relief.
- Ensuring continuity of care for young adults during a critical period of transition.

MOAA Recommends: Congress enacts the CHAMPVA Children's Care Protection Act without further delay. This critical legislation will correct a long-standing inequity and bring CHAMPVA in line with other federal health programs, honoring the full sacrifice made by these families.

Prepared Statement of Student Veterans of America

STATEMENT OF

STUDENT VETERANS OF AMERICA

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON VETERANS' AFFAIRS

U.S. HOUSE OF REPRESENTATIVES

HEARING ON THE TOPIC OF:

PENDING LEGISLATION

June 12, 2025

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studentveterans.org

SVA

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SVA

Chairwoman Miller-Meeks, Ranking Member Brownley, and Members of the Subcommittee: Thank you for inviting Student Veterans of America (SVA) to submit a statement for the record on the legislation pending before you today.

With a mission focused on empowering student veterans, SVA is committed to providing an educational experience that goes beyond the classroom. Through a dedicated and expansive network of on-campus chapters across the country, SVA aims to inspire yesterday's warriors by connecting student veterans with a community of like-minded chapter leaders. Every day, these passionate leaders work to provide the necessary resources, network support, and advocacy to ensure student veterans, military-connected students, their families and survivors can effectively connect, expand their skills, and ultimately achieve their greatest potential.

SVA thanks the Subcommittee for considering several pieces of legislation that would impact student veterans, military-connected students, their families, caregivers, and survivors in higher education.

H.R. 1404, the CHAMPVA Children's Care Protection Act of 2025

SVA supports H.R. 1404, *the CHAMPVA Children's Care Protection Act of 2025*, which would extend the age of eligibility for the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) to the age of 26 for young adult children of veterans who are permanently and totally disabled, have died of a service-connected disability, or lost their life on active duty and did not qualify for the Department of Defense's TRICARE program.

SVA has always been committed to advancing policies that support student veterans, military-connected students, their families, survivors, and caregivers. No parent or child should have to face the burden of having to worry about their health care coverage, especially an adult child whose parents are veterans and disabled or who have died from a service-connected disability. Currently, CHAMPVA coverage for a beneficiary end at age 18, unless they are enrolled as a full-time student, in which case eligibility is extended until age 23 unless they marry. This legislation would ensure that the health coverage of CHAMPVA beneficiaries is more aligned with most employer-sponsored health care plans and have parity with those in TRICARE[1] and make sure military families get continuous care when it matters most, without losing coverage.

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The continued success of veterans in higher education in the Post-9/11 era is no mistake or coincidence. In our Nation's history, educated veterans have always been the best of a generation and the key to solving our most complex challenges. Today's student veterans carry this legacy forward.

We thank the Chairwoman, Ranking Member, and the Subcommittee Members for your time, attention, and devotion to the cause of veterans, military-connected students, their families, caregivers and survivors.

[1] TRICARE, TRICARE Young Adult Plans, https://tricare.mil/Plans/HealthPlans/TYA (last visited June 3, 2025).

Prepared Statement of K9s For Warriors

Statement for the Record
Daniel Bean, CEO, K9s For Warriors

Prepared for the
U.S. House Committee on Veterans Affairs
Subcommittee on Health

June 12, 2025

Chairwoman Miller-Meeks, Ranking Member Brownley, and distinguished Members of the House Committee on Veterans Affairs' Subcommittee on Health,

On behalf of K9s For Warriors, we thank you for inviting us to submit a statement for the record for today's legislative hearing. As the nation's leading provider of highly trained Service Dogs to military Veterans suffering from post-traumatic stress disorder (PTSD), traumatic brain injury (TBI), and military sexual trauma (MST), we are honored to submit this statement in strong support of H.R. 2605, *The Service Dogs Assisting Veterans Act* (SAVES).

Since our founding in 2011, K9s For Warriors has witnessed firsthand the life-changing impact that expertly trained Service Dogs have on the mental health and overall well-being of Veterans returning from service with invisible wounds. Our three-week, evidence-based program pairs Veterans with highly trained Service Dogs in a fully immersive, residential training environment designed to restore independence, confidence, and quality of life. With graduates of our program located in all 50 States, Puerto Rico, the Philippines, and Guam, we understand the needs of Veterans from all eras who seek to regain their dignity and independence.

The outcomes are profound: reduced suicide risk, depression, and anxiety, decreased reliance on medications, and stronger community reintegration. In fact, it's scientifically proven. Last year, the first National Institutes of Health-funded clinical trial of its kind, led by Dr. Maggie O'Haire of the University of Arizona College of Veterinary Medicine, linked the pairing of Service Dogs with military Veterans to lowered PTSD severity, odds of PTSD diagnosis, and other negative mental health symptoms, and to increased levels of life satisfaction and overall psychological well-being[i].

H.R. 2605, the SAVES Act, represents a critical step forward in recognizing and expanding the reach of these lifesaving interventions. By authorizing a competitive grant program within the U.S. Department of Veterans Affairs to support eligible nonprofit organizations that provide Service Dogs to Veterans, the SAVES Act would help ensure that more Veterans — particularly those coping with PTSD and related conditions — have access to these proven resources.

The funding is critical, as it costs upwards of $50,000 to train a single Service Dog. Exacerbating the situation, the demand for Service Dogs isn't slowing down, it's greater now than ever before. Thousands of Veterans are on the wait lists of these organizations – at K9s, we have almost 400 Veterans waiting to be paired with their battle buddies and nearly the same number of applications currently being processed.

Also importantly, the bill's framework upholds high standards for dog training in compliance with the Americans with Disabilities Act (ADA) and evidenced-based practices for Veteran care, while ensuring diversity and flexibility among nonprofit providers. This inclusive approach recognizes that no single model fits all Veterans, and it ensures that organizations with demonstrated success, like K9s For Warriors, can continue to serve Veterans in need. We are also encouraged that the SAVES Act promotes robust program evaluation and reporting requirements, which will help build on existing research and ensure accountability and quality in service delivery.

Veteran suicide prevention remains one of our nation's most pressing challenges. Expanding access to Service Dogs through public-private partnerships like those envisioned in the SAVES Act provides an innovative and complementary solution. K9s For Warriors is proud to lend its full support to this bipartisan, bicameral legislation and stands ready to assist the Committee and the U.S. Department of Veterans Affairs in its implementation.

We are thankful to Congressman Morgan Luttrell, Congressman Morgan McGarvey, Congresswoman Miller-Meeks, and many other Members of Congress for leading this important, bipartisan effort. We appreciate each distinguished Member of the Committee's steadfast leadership on behalf of our nation's Veterans, caregivers, and their families.

Respectfully submitted,

Daniel Bean
Chief Executive Officer
K9s For Warriors

About K9s For Warriors

Determined to end Veteran suicide, K9s For Warriors is the nation's leading provider of highly trained Service Dogs to military Veterans suffering from post-traumatic stress disorder, traumatic brain injury, and/or military sexual trauma. With most dogs being rescues, this innovative program allows the Warrior and Service Dog team to build an unwavering bond that facilitates their collective healing and recovery. Founded in 2011 as a 501 (c)(3) nonprofit organization, K9s For Warriors remains committed to bringing widespread awareness to Veterans' mental health and contributing to policy-level reform.

The organization's operation facilities include: K9s For Warriors National Headquarters (Ponte Vedra, FL), Davis Family Mega Kennel (Ponte Vedra, FL), Petco Love K9 Center (San Antonio, TX) and Warrior Ranch (Helotes, TX). To learn more, visit www.k9sforwarriors.org.

[i] Rodriguez, K. E., Laurinec, A. N., & O'Haire, M. E. (2024). Association of service dog ownership with veterans' mental health and suicide risk. *JAMA Network Open*, *7*(4), e2410083. https://doi.org/10.1001/jamanetworkopen.2024.10083

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