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HEARING TO CONSIDER PENDING LEGISLATION

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

ONE HUNDRED NINETEENTH CONGRESS

FIRST SESSION

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HEARING TO CONSIDER PENDING LEGISLATION

WEDNESDAY, MAY 21, 2025

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 4 p.m., in Room SR–418, Russell Senate Office Building, Hon. Jerry Moran, Chairman of the Committee, presiding.

Present: Senators Moran, Sheehy, Blumenthal, Murray, Hassan, and King.

OPENING STATEMENT OF HON. JERRY MORAN, CHAIRMAN, U.S. SENATOR FROM KANSAS

Chairman MORAN. Nice to see that works. We have significant time constraints in our hearing today, and we are going to move it as expeditiously but as effectively as we can to go through our agenda. I have not checked with Senator Blumenthal's staff but I assume he is on his way. I am going to make my opening statement, and we have cut it in half, maybe the witnesses have done the same, and we will proceed with our hearing as members join us.

I call the meeting to order. Welcome. Welcome to our witnesses and to those in the audience. We are going to hear from witnesses from the VA, from the Paralyzed Veterans of America, the Wounded Warrior Project, and Disabled American Veterans about 20 pieces of legislation on today's agenda. These bills reflect a wide range of issues facing military and veteran communities as well as the Department tasked with serving them. I am grateful for the sponsors of these bills and will work with them to make certain that they improve services for veterans, and I look forward to hearing from our witnesses today about these proposals.

So recognizing that schedules for many of us, myself included, are particularly constrained this afternoon, in the interest of time I will withhold further comment. I will recognize the Ranking Member when he arrives, and I will now introduce our first panel.

Testifying today from the Department of Veterans Affairs is Dr. Thomas O'Toole, not an unfamiliar face to us, the VA's Acting Assistant Under Secretary for Health for Clinical Services. He is accompanied by Kenneth Smith, the VA's Assistant Deputy Under Secretary for Operations Management, and Acting Executive Director of Education Services, and Phillip Christy, VA's Acting Principal Executive Director and Chief Acquisition Officer.

Again, thank you all for being here, and Dr. O'Toole, I recognize you for your statement.

PANEL I

STATEMENT OF THOMAS O'TOOLE, MD, ACTING ASSISTANT UNDER SECRETARY FOR HEALTH FOR CLINICAL SERVICES, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS ACCOMPANIED BY KENNETH SMITH, ASSISTANT DEPUTY UNDER SECRETARY, OPERATIONS MANAGEMENT, OFFICE OF FIELD OPERATIONS, ACTING EXECUTIVE DIRECTOR OF EDUCATION SERVICES, VETERANS BENEFITS ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; AND PHILLIP W. CHRISTY, ACTING PRINCIPAL EXECUTIVE DIRECTOR AND CHIEF ACQUISITION OFFICER, U.S. DEPARTMENT OF VETERANS AFFAIRS

Dr. O'TOOLE. Thank you, Senator, and before I begin I want to apologize for the delay in getting the testimony before the Committee.

Chairman MORAN. Dr. O'Toole, that was part of my opening statement, critiquing that fact, which I left out.

Dr. O'TOOLE. Well, now we are covered.

Chairman MORAN. Yes, sir.

Dr. O'TOOLE. While the Department has provided detailed views in my written statement, I would like to highlight several of the bills we will be discussing today.

VA supports the intent of S. 1591, Acquisition Reform and Cost Assessment Act of 2025, but recommends amendments to ensure effective implementation. VA does not support Section 6 of the bill, which would require VA to establish a cost assessment and program evaluation office.

VA supports S. 214, the MEDAL Act of 2025, subject to amendments and the availability of appropriations.

VA strongly supports the goal of S. 1533. We do recommend amendments to certain provisions and are happy to work with the Committee.

Regarding S. 649, Guard and Reserve GI Bill Parity Act of 2025, the Department is still examining the bill and is unable to provide comprehensive views at this time.

The Department supports the principles behind expanding access and simplifying eligibility for community care as it appears to be the intent in S. 219, the Veterans Health Care Freedom Act. However, VA believes enacting the Veterans' ACCESS Act of 2025 would be a better way of ensuring veterans can receive care from community providers.

We support the intent of S. 506, to improve care coordination for veterans dual eligible for Medicare and VA health care. However, VA has concerns with certain provisions.

Similarly, VA supports the intent of S. 800, which aims to advance critical research in brain health, blast exposure, and a potential treatment for veterans adversely impacted by their military service. We would appreciate the opportunity to work with the

Committee to discuss any concerns we have with this, and also to discuss our research efforts.

VA supports S. 585, S. 635, S. 778, and S. 1441. Regarding S. 605, the CHAMPVA Children's Care Protection Act of 2025, VA does not support extending CHAMPVA benefits to children up to age 26.

We support the intent of certain provisions in both S. 784 and S. 827, which would expand grant programs aiding transportation to rural veterans. And we are happy to work with the Committee on technical assistance toward those bills.

We do not support S. 599, the DRIVE Act.

This concludes my testimony. Thank you, and we are prepared to answer and respond to any questions you or other members of the Committee may have.

[The prepared statement of Dr. O'Toole appears on page 33 of the Appendix.]

Chairman MORAN. Dr. O'Toole, thank you very much for your testimony. I appreciate the VA's support for one of the bills on the agenda that I introduced, the Coordinating Care for Senior Veterans and Wounded Warriors Act, and your willingness to work with me to make certain we are facilitating timely and efficient information sharing between the VA and CMS and avoiding duplication.

In the interim, between now and potential enactment of this legislation, what is the VA doing to accomplish these outcomes?

Dr. O'TOOLE. Thank you, Senator. The concerns we have with this bill are primarily related to the fact that it addresses many of the things that we are already doing. One of the primary concerns is related to—we currently provide care coordination, and care coordination through the primary care group at the VA. The added provision of having additional care coordination runs the risk, in our view, that we could have redundancy in that care and redundancy in those services.

A significant provision to the bill is the information sharing between CMS and between the Medicare providers to CMS and VA care. This is a long-standing challenge and issue, one that we have currently in the community care effort. We are in the process, particularly through our EHRM efforts and expansion in Oracle Health, developing a health exchange that does provide a more timely way for sharing medical records, and we expect with more rapid transition of implementation of that EHR, we will have a better system in place for the record sharing we are discussing.

Chairman MORAN. Thank you. Let me ask Mr. Smith this question. As VBA continues to tackle the claims backlog as well as remands from the Board of Veterans' Appeals, timely and high-quality medical disability exams are important. My bill, the VA License Portability Act, would permanently authorize the VA License Portability Pilot Program for contract medical disability examiners.

Would you speak to why this is important and what the current hindrance is for veterans receiving medical disability exams in a timely manner, absent expanded license portability for contract examiners?

Mr. SMITH. Thank you for the question, Senator. We strongly support this. Of course, we are operating under a pilot program that has been in existence since 1996, and we are eager to move to a more permanent structure.

We do have a couple of concerns, just with the designation of physicians in the bill. We would prefer to use health care providers because 86 percent of our exams are currently conducted by non-physician health care providers. And last, I would say we have concerns with the submission of evidence to the contract examiners. We would prefer that those records come directly to VA, because we do not have contractual privity with the actual providers. They are all subcontractors to the four main contract vendors.

Chairman MORAN. Thank you. I am going to cut my questions short. Senator King and Senator Hassan, there has not been a coup. I expect Senator Blumenthal to arrive. And there is almost no member of this Committee who could remain here past 5, so we are trying to be very timely.

And I now recognize Senator King for his questions.

HON. ANGUS S. KING, JR.,
U.S. SENATOR FROM MAINE

Senator KING. I have no questions because I believe that the testimony is that this witness supports all of the bills that I have introduced. So I commend you for your insight and the deep intelligence.

[Laughter.]

Chairman MORAN. I think I am going to make sure you are a cosponsor of every bill that I introduce.

[Laughter.]

Senator KING. But I do note that there are reservations about some amendments that you want to discuss. I am happy to work with you on those, because there are some very important provisions here. So thank you.

Thank you, Mr. Chairman.

Chairman MORAN. You're welcome. While Senator Blumenthal gets settled, I will recognize Senator Hassan.

HON. MARGARET WOOD HASSAN,
U.S. SENATOR FROM NEW HAMPSHIRE

Senator HASSAN. Thanks very much, Mr. Chair. Dr. O'Toole, it is good to see you again. A few weeks ago we discussed VA's plan to fire 80,000 workers. You testified then that despite being the Acting Chief Medical Officer at the VA, you had not been consulted about how this plan would affect care for veterans.

Two weeks ago, I asked Secretary Collins about this, and I alerted him to the fact that the top doctor at the VA had not been consulted about how this plan might help or harm veterans' health care.

Since we last spoke Dr. O'Toole, has anyone at VA asked for your input or analysis or asked you to oversee any analysis done by the VA's Clinical Services Department regarding how firing 80,000 VA employees would affect veterans' care?

Dr. O'TOOLE. Thank you, Senator, and I appreciate the opportunity to respond. I will note two things. One is that there is a

larger process. I appreciate the title of "Top Doc," but there are several clinicians, physicians senior to me who are actively involved in this. It is very much pre-decisional. The specifics to the questions you have asked, I do not know. I am not aware of. But that does not mean that these analyses are not ongoing. I would have to take it for the record and respond to you on that. But I am happy to speak to the legislation we have.

Senator HASSAN. Well, that would be excellent. Can you tell me who the doctors senior to you, or the clinicians senior to you are, who are involved in this analysis?

Dr. O'TOOLE. I would like to get back to you on the specific names on that if I can, ma'am.

Senator HASSAN. Okay. You know, part of our job is oversight, and there have been bipartisan concerns, obviously, about what Secretary Collins says is a plan or a goal to fire this many workers. And it is really important that we understand what kind of analysis is being done before they go forward with the decision. I expect them to do analysis. I expect them to measure. I expect them to consult with you and other clinicians to understand what the interplay between the clinician is and, let's say, somebody who orders supplies at the VA. And I think we are running out of time here, and I keep kind of getting these answers, either they have not consulted you or you cannot tell me who they are consulting.

So we will certainly submit a question for the record, but I hope you will take back to the Secretary and his whole team our expectation that they really lay out who is doing this analysis.

Now, the President recently signed an Executive order that requires the Secretary of the VA to commission a feasibility study and an action plan to expand services to support a full-service medical service in New Hampshire. This is a really good first step. We have needed that full-service medical center in New Hampshire for a long time. We are the only state in the contiguous United States that does not have its own full-service medical center.

But I want to make sure that this problem gets the attention it deserves and that Granite Staters get the best possible care. It is critically important that the VA and the Administration engage with New Hampshire veterans, VSOs, and other Granite Staters on the ground to get their input and feedback. As you know, my colleagues and I have been advocating for this full-service VA for a long time, but we want to make sure that as plans are going forward, veteran care is not disrupted at our current facility, and I want to make sure that the Administration is reaching out to get input from folks on the ground in New Hampshire.

So Dr. O'Toole, how will the VA decide what new clinical services to provide to veterans in New Hampshire at the hospital, and how will the VA engage with Granite Staters to make sure the new facility meets the unmet clinical needs of our veterans, and what will the timeline be for this kind of decision?

Dr. O'TOOLE. Thank you, Senator, and first, fully acknowledge and agree with all the points you are making, and that would be the process I would expect would be underway. I do not know, and I am not prepared to be able to speak to the specifics to that. I would have to take it for the record, in terms of where we are with that planning and what the process will be.

Senator HASSAN. Well, I appreciate that. From what I am hearing on the ground, nobody has heard anything from the VA, from the White House since the President's Executive order, which makes us wonder how much of this is window dressing and how much of this is real, right. So we really would appreciate outreach, and again, if you all will take that back to the Secretary's office that would be very helpful.

I have more questions. I will submit them for the record. Thank you, Mr. Chair.

Chairman MORAN. I now recognize the Ranking Member, Senator Blumenthal.

HON. RICHARD BLUMENTHAL,[1]
RANKING MEMBER, U.S. SENATOR FROM CONNECTICUT

Senator BLUMENTHAL. Thank you, Mr. Chairman, and I apologize. I have another subcommittee, the Subcommittee on Permanent Investigations, which is ongoing, as Senator Hassan knows, because she is also a member of that subcommittee, and it is still ongoing. So I do apologize.

Before I begin, I want to ask consent to enter into the record a recent *New York Times* article entitled "Trump's Push to Defund Harvard Prompts Clash Over Veteran Suicide Research."

Chairman MORAN. Without objection.

[The article referred to appears on page 113 of the Appendix.]

Senator BLUMENTHAL. Thank you. This article, I do not know whether you are familiar with it, Dr. O'Toole, shows that there are multiple contracts between the VA and Harvard University that are planned to be canceled, including contracts involving VA suicide prevention efforts and contracts ensuring veterans have adequate access to clinical trials.

VA officials are quoted in the article saying that canceling these contracts would result in, quote, "more veteran suicides that could have been prevented," end quote. They are raising the alarm and pleading with VA leadership not to cancel these highly critical contracts.

Dr. O'Toole, are you aware of this situation?

Dr. O'TOOLE. I have seen the article, sir, and I have heard, obviously I have heard it as you have as well, and the concerns. I would have to take for the record any specifics on the status of those deliberations.

Senator BLUMENTHAL. Well those research contracts are important to prevent veteran suicide, are they not?

Dr. O'TOOLE. Absolutely, sir. I am not, by any means, disputing the nature of the research nor the importance of it.

Senator BLUMENTHAL. Do you agree with their cancellation?

Dr. O'TOOLE. Sir, I am not here to discuss the specifics of that. I am not prepared to be able to discuss that from a departmental perspective, but happy to take for the record what the status of those considerations are.

Senator BLUMENTHAL. Well, I do not mean to be disrespectful, but veterans may be dying as a result of these contracts being can-

[1] The opening statement for Senator Blumenthal appears on page 29 of the Appendix.

celed. You have been involved in the VA for some time. I am disappointed that you will not express perhaps a more critical view of what is happening here.

Dr. O'TOOLE. Well, thank you, sir, and as somebody who has done research in the VA, I can fully appreciate that. I just do not want to get ahead of my skis here in speaking for the Department on this, so I do need to take it for the record.

Senator BLUMENTHAL. Well you are here on behalf of the VA. And I am just going to be really direct. We have been asking the VA about these contracts, including the Harvard contracts, for more than a month, and we have received no response. So that when people come to me and say, "Why are you holding these nominations?" and I say, "It is because the VA is denying us essential information that is necessary for our oversight and we want accountability. Here is Exhibit A, saving lives."

The VA has no more foundational and essential purpose than stopping veteran suicide, and it has denied us and refused to provide information, purposefully. It cannot be an accident, but purposefully. And I know you are on the receiving line of this complaint, and make no mistake, I know you are not the one responsible.

So, when you take this message back, and you get back to us, and I am not going to berate you further, you should make clear that here is the reason why we are putting a hold on these nominees and why we are extremely disappointed, I will put it euphemistically, with the response so far.

And just so we also understand why we are here today, a lot of great legislation. The Children's Care Protection Act, other measures that are important to advance the authority of the VA.

We still do not know the number of fired VA employees, as well as the canceled VA contracts. We have no idea when, if ever, we will have the VA lift its freeze on rulemaking. Remember, rulemaking is important to legislation. Legislation cannot be implemented until the rules are in place. And we have no idea when that freeze will be lifted so laws can be implemented.

Here we are talking about new laws. Laws are dead letter if there are no rules and regulation. Laws are also dead letter if there is no workforce to implement them. If people cannot enforce them and carry them out, they have no meaning. And the VA is planning, it's the stated goal of the VA Secretary, to cut 83,000 employees who are important to carry out those laws.

So, the laws we have passed already, the PACT Act and the Elizabeth Dole Act, great bipartisan measures. They are going to be dead letter if we do not provide the resources for them to be implemented and if the slash-and-trash approach is carried forward.

My time has expired. Mr. Chairman, thank you.

Chairman MORAN. You are welcome. Thank you, Senator Blumenthal. Senator Sheehy.

HON. TIM SHEEHY,
U.S. SENATOR FROM MONTANA

Senator SHEEHY. No questions at this time.

Chairman MORAN. Thank you, Senator. Senator Murray.

HON. PATTY MURRAY,
U.S. SENATOR FROM WASHINGTON

Senator MURRAY. Thank you, Mr. Chairman. Dr. O'Toole, thank you for being here. You know, women veterans, particularly those who have suffered from PTSD or sexual assault, tend to experience menopause much earlier than women who did not serve in the military. One VA study found that 15 percent of women veterans experience menopause before the age of 40. That is 10 years earlier than most women. It is really important that we strengthen menopause research at the VA and DoD so we can provide better care for women servicemembers and our veterans.

That is why I was very proud to join Representative Houlahan and Senator Ernst in introducing the Servicewomen and Veterans Menopause Research Act last month to do that. Can you tell me today what resources are available right now, at the VA, for women veterans who are experiencing menopause? Are there any plans to expand that, and what do you have right now?

Dr. O'TOOLE. Thank you, Senator, and first I acknowledge and fully appreciate and agree with what you are saying there. I do not have that information readily available in terms of what resources are currently being dedicated. I would have to get it for the record.

Senator MURRAY. Okay. How long will that take you to get to me?

Dr. O'TOOLE. We will get it as quickly as we can.

Senator MURRAY. Okay.

Senator KING. But do you support the bill?

Dr. O'TOOLE. Yes. Yes, we strongly support the bill.

Senator MURRAY. Thank you. During a hearing earlier this month I actually asked Secretary Collins about the Trump administration's 90-day pause on VA clinical trials, which is right now delaying planned trials and putting a halt to ongoing clinical trials at VA, everything from predicting stroke risks to addressing substance abuse. Now, Secretary Collins said at the time, there was no decision regarding what would happen to VA researchers and trials when that pause ended.

Do you have an answer to that question I asked a few weeks ago? What will happen after this 90-day pause ends? Where will you direct these patients whose clinical trials were canceled or delayed?

Dr. O'TOOLE. Thank you, Senator. Unfortunately, as noted earlier, I do not have that information available to me. I have to take it for the record.

Senator MURRAY. You do not have any idea?

Dr. O'TOOLE. I do not. No, ma'am.

Senator MURRAY. Can you provide my office with a list of clinical trials that were canceled?

Dr. O'TOOLE. Again, I do not have that available but we can get that information to you. Yes, ma'am.

Senator MURRAY. Well, the VA has to have this information. Certainly if you care about transparency, which we keep hearing, I see no reason why this information would be secret. When can you get that information to us? These are people who are in trials. These are researchers. Just for the next 10 years they are not supposed to know? When are you going to get that to us?

Dr. O'TOOLE. We will get it to you as soon as we can, ma'am.

Senator MURRAY. What does that mean? I have heard that from so many people in the last couple of weeks.

Dr. O'TOOLE. I would obviously defer to our legislative team and our research office on those specifics, but I would imagine we would be able to get——

Senator MURRAY. It is a disappointing response, I have to tell you.

Dr. O'TOOLE. Okay. I would imagine we would be able to get it to you within the next few weeks, 1 to 2 weeks hopefully.

Senator MURRAY. Okay. Well, let me try one more. Women are the fastest-growing demographic within the veteran population. You know that. VA was not initially built for women. It is our collective responsibility to honor women who have bravely served our country by taking action to remove barriers that for too long have restricted their access to the benefits that they earned and the health care that they earned. And I really believe the goal should be a VA system that offers women comprehensive at every stage of life post-service.

Actually, in my home State of Washington, Puget Sound VA saw a 7 percent increase in women veterans utilizing their service over the past few years.

I am appreciative of the mobile mammography centers that were made available for our Puget Sound veterans, but it is a temporary fix. Can you provide me any update today on the progress in establishing a permanent in-house mammography service for veterans in VISN 20, or a timeline?

Dr. O'TOOLE. I do not have the specifics, but I am happy to track those down, and we can get back to you on it.

Senator MURRAY. Okay. I would appreciate answers to those questions as soon as you can. This is critical information that we need. Thank you.

Chairman MORAN. Thank you, Senator Murray. Senator Blumenthal.

Senator BLUMENTHAL. Thank you, Mr. Chairman. I have one more question. And by the way, I strongly support Senator Murray's Servicewomen and Veterans Menopause Research Act. It is a great piece of legislation, another example of how a hiring freeze and firings are chipping away at VA research, and we should have the answers to the questions that she asked.

Let me turn to the Elizabeth Dole Act. Earlier this week, the VA announced it will be implementing Section 101 of the Elizabeth Dole Act, which would definitively give a veteran and their referring VA clinician the final decision regarding eligibility for community care. Our Committee is still waiting to learn or hear how or when the VA will implement dozens of other critical sections of the bill. This is what I am talking about—implementation, rulemaking, time-sensitive provisions such as raising the grant and per diem rate for homeless veterans and expanding home and community-based care for veterans with ALS or spinal cord injuries, provisions that directly impact the most vulnerable veterans we serve. They were top of mind when, in a bipartisan way, our Committee and our Senate passed this measure, overwhelmingly.

If the VA is stalling implementation of the Dole Act and planning to fire tens of thousands of staff, how can the Department adequately implement this additional legislation that we are considering today?

Dr. O'TOOLE. Well, Senator, thank you, and I would first acknowledge that the provisions in the Dole Act are ones that we fully endorse and are actively working to implement, and being personally involved in several of the sections, it is something that we are working on, and I am hoping that we will have results shortly. And I am happy to be reporting back to your staff on those updates.

Senator BLUMENTHAL. Thank you. Mr. Chairman, in the interest of time, I am going to submit my other questions for the record, and we can go on to our next panel.

Chairman MORAN. Thank you, sir. Senator King, in quick summary of the bills I have introduced that are being considered today, at least half of the bills that I have introduced, you are the primary co-sponsor. So I look forward to seeing great success in my efforts [laughter.] The other ones are with Senator Blumenthal. We will see how you compare.

[Laughter.]

Chairman MORAN. They loved every one of his bills.

Thank you all very much for your presence here today. As you can see, the Committee has lots of questions that are broader than the scope of this hearing, and we would continue to encourage the Department of Veterans Affairs to provide the information requested by any member of this Committee, any side of this Committee, and to forthrightly provide us with the information our staffs have asked for.

Thank you, Dr. O'Toole, and your team.

I welcome our second panel, and I will go ahead and introduce you, even though you cannot quite get there yet. Testifying with us today is Morgan Brown, the National Legislative Director for the Paralyzed Veterans of America; Brian Dempsey, the Director of Government Affairs for Wounded Warrior Project; and Jon Retzer, the Deputy National Legislative Director for the Disabled American Veterans.

I thank all three of you for being here. Thank you for the work that you do for veterans, and thank you for your organizations that you represent who take such care and concern for those who served our country.

Mr. Brown, we will recognize you first.

PANEL II

STATEMENT OF MORGAN BROWN, NATIONAL LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA

Mr. BROWN. All right. Thank you, Mr. Chairman and Ranking Member Blumenthal, Members of the Committee. PVA certainly appreciates the opportunity to appear before you today to discuss some of the bills that you are looking at.

First, though, I would like to just take a moment and recognize the fellows that are here from the Elizabeth Dole Foundation. We

have had the privilege of spending some time with them the past couple of days, and I know that they have been out visiting some of the congressional offices, and hopefully you had an opportunity to speak with some of them.

PVA supports the overwhelming majority of the bills that are on the agenda today. I would be remiss if I did not publicly acknowledge our support of the Rural Transportation bills, the 3R Caregiver bill, the SAVES Act, and the Fourth Administration bill. So I am just going to limit real brief comments on three of the others.

The first is the Veterans Accessibility Advisory Committee Act. Over the last five decades, Congress has spent a considerable amount of time passing legislation to improve disability access to both Federal facilities, especially the VA, and, in some cases, into the private sector. These laws provide critical protections to people with disabilities when they interact with all levels of the government and many everyday accommodations like medical offices, grocery stores, and hotels.

Despite all of this effort and these legal requirements, our members routinely face disability access barriers when it comes to accessing VA care within VA facilities and within the community. We have appeared before the Committee before. We have discussed some of the problems that we have encountered. Senator Murray mentioned the fact that a lot of VA facilities were not originally fitted for women veteran health care.

I recall one instance where a woman veteran clinic was established for VA but it did not have like the outdoor controls, the handicapped controls, so that one of our members could enter that facility. And unfortunately, the office staff were positioned within the facility in such a manner that they were not able to see anybody at the door, and our member was stuck outside of the door until somebody came to the door and was able to let them in. Those are the types of barriers that we are talking about.

Because of the complex nature of injuries and illnesses that our members face, we tend to access VA care much more so than the average veteran, and we believe that VA should lead the way in accessibility for disabled veterans, so we are strongly supporting this bill, which directs VA to create an advisory committee on issues relating to the accessibility of VA benefits, services, and facilities, but not just within VA, granted the push toward the private sector. We need to make sure that there is greater emphasis on the accessibility of the primary care facilities, as well.

Next, you are familiar that VA pays eligible veterans and caregivers mileage and other travel expenses to and from approved health care appointments, but the current reimbursement rate is too low. Fifteen years ago, Congress set the rate at 41 cents per mile. That was based on the Federal rate at the time. Since then, the Federal rate has increased significantly, but VA has remained stagnant, even though the cost of gas and vehicle maintenance and car insurance has increased dramatically. We support this bill, which ties the veteran's mileage rate to the GSA rate, and we believe that this will help improve veterans' access to their health care services and reduce their financial burden.

Senator KING. Which bill is that, please?

Mr. BROWN. That is S. 599.

Finally, we support the CHAMPVA Children's Care Protection Act. This is the bill that would allow the surviving spouses, family members using the CHAMPVA program to remain in the program until age 26. Back in 2011, after the ACA extended this health care to all of the other Federal programs and health insurance programs, DoD made the change. VA did not. And so these family members of veterans are forced out of the program, the latest at age 23, and we believe that this program should allow them to remain in until age 26. Thank you.

[The prepared statement of Mr. Brown appears on page 74 of the Appendix.]

Chairman MORAN. Thank you very much, Mr. Brown.

Senator BLUMENTHAL. Mr. Chairman, if I could just——

Chairman MORAN. Senator Blumenthal.

Senator BLUMENTHAL [continuing]. Apologize to the panel. I am obligated to go to the floor of the Senate. I would have asked you a question about how the cutbacks in staff might affect your view of how the Department is functioning. I will submit that question for the record. I appreciate the Chairman giving me this opportunity to apologize and explain the reasons for my absence. It is not out of lack of interest. And I know Senator King will be here. I yield to him my time. And since the Chairman seems to regard him as a favorite anyway——

[Laughter.]

Senator BLUMENTHAL [continuing]. I know I will not be missed.

Chairman MORAN. Just because you are associating with Senator King does not mean you can get your way on everything.

[Laughter.]

Senator BLUMENTHAL. Thank you.

Chairman MORAN. Senator Blumenthal, thank you. Senator Blumenthal and I both had nothing on our schedules whenever the point in time is we chose this date and time for this hearing, and it just has not worked to remain that clear today. We are still trying to figure out—I am still trying to figure out what time of the day and what day of the week is our best opportunity to be most available to most members so that we can hear the most amount of testimony and interact with those who come before us.

Mr. Dempsey, you are recognized.

STATEMENT OF BRIAN DEMPSEY, DIRECTOR OF GOVERNMENT AFFAIRS, WOUNDED WARRIOR PROJECT

Mr. DEMPSEY. Chairman Moran, Ranking Member Blumenthal, and distinguished Committee members, thank you for inviting Wounded Warrior Project to testify on legislation intended to improve access to care and benefits for our Nation's veterans.

Today's agenda includes many bills that are aligned with our mission to honor and empower wounded warriors, and I am pleased to speak on several that would have a heightened impact on the post-9/11 wounded, ill, and injured veterans we serve.

To help those struggling with invisible wounds we strongly support the Precision Brain Health Research Act as the next step in Federal action to address the service injuries caused by blast exposure. Low-level blast injuries have received increased attention

thanks to recent reporting from *The New York Times* and *60 Minutes*, but they have also been the subject of congressional action on the prevention side. The Precision Brain Health Research Act would bring focus to veterans' health care.

The bill would leverage VA's biomarker research capabilities and precision medicine initiative to learn more about the long-term health effects of blast injuries and translate those findings into better and more personalized treatment plans. Over time, the bill will help transform the way we care for those affected by brain injury and ultimately help many veterans lead longer, healthier, and more productive lives.

On a similar note, we support the Coordinating Care for Senior Veterans and Wounded Warriors Act. With clear acknowledgement in its title, this bill speaks to the fact that many veterans are relying on Medicare and VA's geriatrics and extended care programs earlier in life after being catastrophically wounded in service.

Five percent of VHA-enrolled veterans under the age of 45 have Medicare coverage, along with another 15 percent of those between the ages of 45 and 60. For many in these categories, the bill would help address their priorities like better care coordination and patient advocacy through a 3-year pilot program aimed at improving care, lowering costs and eliminating gaps in care and duplication of services. There is clearly much that can be learned from this pilot, so we strongly advocate for the bill's passage as a key for systemic improvements.

To help care for women veterans, we are proud to endorse the Servicewomen and Women Veteran Menopause Research Act, which would require VA and DoD to evaluate and conduct research on menopause, perimenopause, and midlife women's health. This legislation represents a long-overdue recognition of the unique and evolving health care needs of servicewomen and women veterans as they age.

To help the hidden heroes who have supported the most severely injured warriors in our community, we are pleased to endorse the Veteran Caregiver Reeducation, Reemployment, and Retirement Act. By passing this legislation, Congress can invest in the well-being of caregivers, ensuring they have the resources needed to reclaim their careers, stabilize their financial futures, and transition out of their caregiving roles with dignity.

Finally, I want to highlight our support for the Veterans Accessibility Advisory Committee Act of 2025, which has companion legislation that was passed by the House yesterday. Establishing an advisory committee on equal access will help ensure that accessibility is built into every aspect of VA's operations, from facilities and medical equipment to digital platforms and communication tools, all of which are critical parts of a system that should provide accessibility groups with a seat at the table.

Thank you again for the opportunity to testify at today's hearing. Like I said, we support many of the bills on today's agenda. But this concludes my testimony, and I look forward to your questions. Thank you.

[The prepared statement of Mr. Dempsey appears on page 84 of the Appendix.]

Chairman MORAN. Thank you, Mr. Dempsey. Mr. Retzer, you are now recognized.

STATEMENT OF JON RETZER, DEPUTY NATIONAL LEGISLATIVE DIRECTOR FOR HEALTH, DISABLED AMERICAN VETERANS

Mr. RETZER. Thank you, Chairman Moran, Ranking Member Blumenthal, and Members of the Committee. Thank you for the opportunity to testify today, and in respect of your time, that you are all busy, I just want to highlight that DAV, out of all the 20 bills, we support 20 of them with some recommendations, and 5 we have no concerns. However, we urge the Committee to carefully review the following legislation.

S. 506 aims to enhance the care coordination for veterans enrolled in both VA and Medicare, but it lacks clarity on case management and oversight and training standards. Without strong VA oversight, veterans face fragmented care and inadequate coordination between providers, especially since many private sector providers lack specialized expertise in service-connected conditions. DAV urges the Committee to prioritize VA-led case management and provide necessary training to ensure seamless, high-quality care for the dual-enrolled veterans.

S. 635 expands homecare access through nurse registries within the Veterans Community Care Network. While increasing homecare options is critical, the inclusion of non-medical roles, such as companions and homemakers, raises oversight concerns and liability issues tied to the nurse registry. Regulatory changes vary across states, potentially limiting veterans' access to reliable home-based care. DAV recommends refining the bill's language to clearly define the nurse registry's functions within existing VA homecare initiatives, ensuring consistency and quality of services.

Finally, S. 219, the Veterans Health Care Freedom Act, proposes expanding private sector options, but DAV strongly opposes this measure. While community care is vital for veterans facing excessive wait times or travel burdens, a balanced approach is necessary. Diverting resources from VA without additional funding would weaken specialized care designed for service-disabled veterans. Private sector providers often lack the expertise adequate to address conditions related to military service, leading to fragmented and inconsistent care. DAV urges Congress to increase in the VA staffing infrastructure and research to strengthen the VA system and maintain VA as the primary provider while integrating an effective Community Care Network.

DAV members who rely heavily on the VA health care system believe it remains the best choice because it provides the comprehensive, whole-health model of care tailored to veterans' unique needs. Our nation's veterans deserve nothing less.

This concludes my testimony, and I am pleased to answer any questions you or the Committee may have.

[The prepared statement of Mr. Retzer appears on page 99 of the Appendix.]

Chairman MORAN. Thank you for your testimony. Senator King?

Senator KING. I am comfortable with the testimony. I look forward to working with all of you as we refine these bills. I appreciate the comments today, and we will continue to be in touch as we move forward with these bills. But thank you. Very helpful testimony. Thank you, Mr. Chairman.

Chairman MORAN. Thank you, Senator King. Mr. Brown, your testimony was very compelling or catching to me about the VA and its incapacity, its lack of capability of meeting the needs of veterans with disabilities. It seems like one of the last places we would expect to find that to be a problem, and it is legislation that I am introducing that you are talking about. But until you gave your testimony it was not that evident to me that there would be such a significant challenge at the Department of Veterans Affairs in meeting the needs of all veterans.

What impediments does the VA have in fixing this problem, and what efforts are they undertaking to, I don't want to say whittle away, but to solve this problem even over a period of time?

Mr. BROWN. Well, in truth, I mean, VA has made great strides in trying to improve accessibility.

You know, one area I did not have a chance, because we were attempting to try to shorten things up here, but is probably a good example of an area maybe for the Committee to look at is the accessibility of diagnostic equipment. We are talking about mammograms, the x-ray machines, dental chairs, weight scales, even x-ray machines themselves.

In 2017, the U.S. Access Board published new accessibility standards for medical diagnostic equipment, and shortly after that VA jumped on board, very proactively, so that they would adopt those standards to ensure the needs of disabled veterans were met. But since that time we have no updates. We do hear from our members who have been unable to receive dental care at VA facilities because the chairs cannot accommodate them, they cannot get their x-rays or their mammograms because the equipment could not access them.

So clearly there is a problem there, and I would encourage the Committee, maybe, this should be an area to do some additional oversight on, and not only see how far VA has come toward adopting these standards but what else needs to be done.

Chairman MORAN. Mr. Brown, thank you. What you are doing is again causing me to recognize it is not necessarily the automatic door or the curb cut, things that I might think of as being an impediment, but it is the actual equipment and the access to that equipment.

Mr. BROWN. You know, sometimes I think—if I may, sir—it may be because some of these changes are being made, or they are not being made with the view of the veteran in mind. And case in point, we had a veteran that went into the chapel between appointments, and was stuck in the chapel because the door did not have the push bar or the automatic door opener for them to get out, so they were stuck in the chapel until somebody came along to let them out.

Had you had an advisory committee like this legislation is proposing, you would have veterans on that committee that would serve as advisors to the Department and then offer suggestions

coming specifically from the perspective of a veteran with a complex illness or injury.

Chairman MORAN. Senator King?

Senator KING. I want to follow up on exactly that point. It strikes me that you have members all over the country, as all of you do. Perhaps you could have a project of examining the accessibility of various VA facilities and letting the VA know. In other words, give them an inventory—the back door at the Veterans Hospital in Knoxville is not accessible. Do you see what I mean, to use your membership and other veterans and VSOs to kind of survey the veterans facilities and advise the VA and us about where accessibility needs to be. Because often individuals who are not wheelchair-bound do not really appreciate the height of the button, for example. I think you could be very helpful in that.

Mr. BROWN. So I thank you for the recommendation. I know in many cases once a problem is identified, working through our service officers we do notify the facility, and then we work with the Department to get those corrected. But sometimes—and I am just putting on my old IG hat from my time in military service—a problem may be identified in one facility and actually exists in other facilities. So there needs to be a system internally to where a problem has been identified, look throughout the Department, does this problem exist elsewhere, and here is how to correct it.

But I will take that back to my leadership and we will see what we can do.

Senator KING. I am thinking of a nationwide audit.

Mr. BROWN. Okay.

Chairman MORAN. Thank you, Senator King. My thoughts are just, personally, I visit lots of VA facilities. I ought to ask the question and be observant myself. So thank you for highlighting that.

Mr. Dempsey, the Veterans Caregiver Reeducation, Reemployment, and Retirement Act, tell me, and tell the Committee, why it is important to assist family caregivers transitioning back into the workforce or into retirement once they are no longer needed as full-time caregivers.

Mr. DEMPSEY. Thank you for the question, Chairman. A recent report that RAND had published, and again, Wounded Warrior Project is often focused on the post-9/11 wounded, ill, and injured community, that RAND report had found that about 36 percent of post-9/11 caregivers had reported income below 130 percent of Federal poverty levels, and that many were lacking basic health insurance or emergency savings. And particularly for those who are leaving the program of Comprehensive Assistance for Family Caregivers there can be additional challenges when those caregiving responsibilities conclude, as many of the benefits are not portable or inclusive of retirement benefits.

So what the Veteran Caregiver Reeducation, Reemployment, and Retirement Act would do essentially is bundle all of those, I think, elements that are essential to whether it be reclaiming your career, entering retirement on a comfortable level, and making sure that your financial security is future and that you can enter the world post-caregiving responsibilities with more confidence and security.

Chairman MORAN. Thank you. Mr. Retzer, you mentioned dual enrollees, and this is perhaps a question for any and all. Would you

put into the record and educate me and perhaps others on what challenges dual-enrollees face, and how do you think this pilot program could establish the ways to address those challenges?

Mr. RETZER. Thank you for that question, and if VA had a system of interoperability, an EHRM that was in place, so let's put that up front, saying it is there for us, and to have the providers, between VA and Medicare, to be able to understand the priority of the veterans. The veteran's complexity is they are at the VA medical center under eight priorities. We know that Priority Group 8 is a grandfathered-in priority, but when we look at the various priorities, they have service connections, Medal of Honor, Purple Heart requirements that fill in broad spectrum, plus their income.

So then we look at the aging population, which we know right now that 49 percent of the veteran population that are enrolled in the VA health care system is 65 or older, so they are meeting the requirements of Medicare. They have to enroll into at least Medicare B.

We would have to have training on the VA side, where the care coordinator has the expertise and the knowledge of both hemispheres, and to be able to understand what the priority groups are within the VA system to identify first their service connections that can be dealt with within the VA system, identifying also their demographics on where they live, because that is where the challenge comes. Like for your constituents in Kansas, they are mostly rural. So aging population in a rural community, they have to also be trained in the cultural competency, the understanding of the social dynamics of their own state, so that they can best facilitate when it is best to leverage Medicare when the costs can actually be saved on the veteran by providing care directly from VA, or in the veteran community program.

So there is going to have to be a very robust training program and oversight ensuring continuity of that care is not broken. It is really a big component of training and rule bases established.

Chairman MORAN. Senator King.

Senator KING. Mr. Retzer, I wanted to follow up on your testimony and just thank you for your strong testimony about community care not encroaching on the underlying mission of VA-provided care. I think that is something that we just have to keep our eyes on. There are those, I think, who would like to move further and further in that direction, but I believe that preserving the fundamental veterans' health care system is critically important. I take it you agree.

Mr. RETZER. Yes, Senator King, thank you for that. I think it is very important to look at what the veterans' needs are right now. We have heard concerns surrounding the veteran population of enrollment has stayed plateaued and the access to health care that veterans are enrolled in has also plateaued.

One thing that we have noticed in the VA dashboard reports and the annual budget is this trend that is not being spoken about, but it is reported, and that is the episodes of care. In 2019 to 2023, what we saw was that there was an estimate of 120 million veteran episodes of care annually that was provided in 2019, and then in 2023, it was roughly about 130 million estimated episodes of care. That is a very important number because, like Senator Mur-

ray, one of the things that she is really sponsoring is our women veterans. There are now nearly 1 million enrolled in the VA health care system. We have an upward trajectory. And just like I said previously to Senator Moran's question is our veteran population of 49 percent at 65 and older, so they are needing more care.

Let alone, statistics also show us that 70 percent and higher ratings are being given more, so that means younger veterans have more catastrophic ratings from VA that is going to require medical assistance and services, to include long-term care.

So I think it is really important that we look at the needs of our veterans, and to even address the rural complications, remote areas, but also look at the specialized care that is really challenging our women veterans, our minority, LGBTQ+. So it is so important that we do some good research, and that is why DAV also says research is important.

Senator KING. Do those episodes of care, does that data break out community care versus Veterans Administration health care?

Mr. RETZER. I would have to go back and look. I do know that there are——

Senator KING. See if you could look to see if there are any trends in that data.

Mr. RETZER. Yes, there are some trends that indicate where community care is and how many they are having and also with rural veterans care. So we know that out of the 2.7 rural veterans, how much of their care is in what direction.

Senator KING. Thank you, Mr. Chairman.

Chairman MORAN. I am sorry you caused me to think of another question that you may or may not have an answer to, any of you. The veterans who are not enrolled in the VA, or not receiving health benefits, some may be just utilizing Medicare. Do we know the characteristics of the population that the VA does not serve? You started down a path of statistics about who, you mentioned women, Senator Murray's issue. What is the typical veteran who is not utilizing the VA? Do we know that? This may not be the panel.

Mr. RETZER. That is an interesting question, Senator, and with the data that we——

Chairman MORAN. That is what I say when I do not know the answer.

[Laughter.]

Mr. RETZER. And actually, the interesting thing is this may spell out for you where we are at. We know that we have talked about 9 million enrolled veterans. And we know currently that as we look at the trajectory and the reports estimating that the numbers are coming down in the veteran population, and we are sitting at about 18 million. So that is kind of indicating to us that in the general population, half of them are enrolled in the VA health care system. Where are the rest going then? So they must be in the private sector, is what we look at, and we would anticipate that, if they are not enrolled in the VA health care system.

But we are looking further into that to see where the implications are.

Chairman MORAN. I would be interested. This is a question for the VA, as well, and they may know these numbers. But is it young

veterans who are not taking advantage of services from the Department of Veterans Affairs? People in rural America? People with disabilities? Women? Maybe there is no pattern to this, but I am going to try to find out in my own capacity who is not being served, and then look for ways that we can meet that particular segment of our veteran population. Make sense? I guess I am not supposed to be asking you to confirm that what I am asking is a good question.

I have one more thing. Senator King, do you have anything?

Senator KING. I am all set. Thank you.

Chairman MORAN. Okay. And that is—just one moment. I have a bill not with Senator King but with Senator Rosen, Fallen Servicemembers Religious Heritage Restoration Act, that is included in today's hearing. It would make certain that veterans buried overseas in cemeteries under the care of the American Battle Monuments Commission have grave markers that are accurately representing their religious faith.

I saw an episode on television about this topic, and it was compelling, and I am grateful for the support of today's witnesses. I want to just ask for unanimous consent that we put into the record comments on this legislation from the Jewish Community Relations Bureau of Kansas City, the American Gold Star Mothers, Inc., the Republican Jewish Coalition, Veterans of Foreign Wars, Gold Star Spouses of America, the American Legion, Vietnam Veterans of America, Non Commissioned Officers Association, and TAPS, the Tragedy Assistance Program for Survivors.

With no objection, it is so ordered.

[The information referred to appears on pages 117–126 of the Appendix.]

Chairman MORAN. Would any of the three of you like to conclude? I always try to give my witnesses, our witnesses, the chance to add anything to the record or correct anything that you feel needs to be corrected. Any additional comments?

[No response.]

Chairman MORAN. Thank you very much for your testimony.

[Pause.]

Chairman MORAN. I look forward to working with all of you and your organizations, as this Committee does, to improve the circumstances and honor of those who serve.

The hearing record will remain open for five legislative days, and should any Committee member wish to submit additional statements or questions for the record, you may use that time to do so. I ask that today's witnesses respond to any questions for the record that you may receive following today's hearing, Doctor, in a timely manner.

And with that the hearing is adjourned.

[Whereupon, at 4:55 p.m., the hearing was adjourned.]

A P P E N D I X

Hearing Agenda

UNITED STATES SENATE
COMMITTEE ON VETERANS' AFFAIRS

Pending Legislation

Wednesday, May 21, 2025
4:00 p.m.
Russell Senate Office Building, Room 418

1. S. 214, the MEDAL Act of 2025 (Cruz/Cotton)
2. S. 219, the Veterans Health Care Freedom Act (Blackburn/Tuberville/Cramer/Sheehy)
3. S. 506, the Coordinating Care for Senior Veterans and Wounded Warriors Act (Moran/King)
4. S. 585, the Servicemember to Veteran Health Care Connection Act (King/Cramer)
5. S. 599, the DRIVE Act of 2025 (Welch)
6. S. 605, the CHAMPVA Children's Care Protection Act (Blumenthal)
7. S. 635, the Veterans Homecare Choice Act of 2025 (Tuberville)
8. S. 649, the Guard and Reserve GI Bill Parity Act (Moran/Blumenthal)
9. S. 778, the Lactation Spaces for Veteran Moms Act (Rosen/Murkowski)
10. S. 784, the Rural Veterans Transportation to Care Act (Ossoff/Collins)
11. S. 800, the Precision Brain Health Research Act of 2025 (Moran/King)
12. S. 827, Supporting Rural Veterans Access to Healthcare Services Act (Cramer/King/Sullivan)
13. S. 879, the Veteran Caregiver Reeducation, Reemployment, and Retirement Act (Moran/Hirono)
14. S. 1318, a bill to direct ABMC to establish a program to identify American-Jewish servicemembers buried in United States military cemeteries overseas under markers that incorrectly represent their religion and heritage. (Moran/Rosen)
15. S. 1320, the Servicewomen and Veterans Menopause Research Act (Murray)
16. S. 1383, the Veterans Accessibility Act (R. Scott/Moran/Blumenthal/Gillibrand)
17. S. 1441, the Service Dogs Assisting Veterans (SAVES) Act (Tillis/Blumenthal)
18. S. 1533, the VA License Portability Act (Moran/King)
19. S. 1543, the Veterans' Education, Transition and Opportunity Prioritization Plan Act (Banks/Hassan)
20. S. 1591, the Acquisition Reform and Cost Assessment Act of 2025 (ARCA Act of 2025) (Moran)

Opening Statement

Opening Statement of Ranking Member Richard Blumenthal
Senate Veterans' Affairs Committee
Hearing to Consider Pending Legislation
May 21, 2025

- Thank you to our witnesses for being here today.

- Much of the legislation on today's agenda is good policy – some of the bills are even my own, including the *CHAMPVA Children's Care Protection Act.*

- But, as with our last legislative hearing, it is difficult to operate "business-as-usual" when we can't get clear answers or accurate data from this Administration.

- We still don't know the number or nature of fired VA employees or canceled VA contacts. And we have no idea when – if ever – VA will lift its freeze on rulemaking.

- So, we have no idea of VA's capacity to carry out its current duties – much less any additional duties required by new legislation.

- We do know the Secretary has a *goal* to cut 83,000 employees – though we have been completely shut out of that process.

- And we know VA is either incapable or unwilling to implement laws we've *already* passed.

- That includes the *Elizabeth Dole Act*, which was the product of a year-long bipartisan negotiation and provides critical benefits to many vulnerable veteran populations desperately in need.

- How can we consider creating an entirely new Administration, as Senator Banks' *Veterans' Education, Transition and Opportunity Prioritization Plan Act* would do - when Congress has received no information about VA's current reorganization?

- How can we expect Secretary Collins to implement Senator Murray's *Servicewomen and Veterans Menopause Research Act* when his hiring freeze and firings are already chipping away at the VA research apparatus?

- What is the point of expanding VA's Highly Rural Transportation Grant program when the Secretary has made it clear he plans to fire existing administrative and care coordination staff who arrange for rural veterans' transportation needs?

- VA has already indefinitely delayed the bipartisan and long overdue increase to Grant and Per Diem program rates for homeless veterans, as required under the *Dole Act*.

- There are a number of common-sense bills before us today that could make an immediate and positive impact on the lives of veterans.

- But the best laws in the world are dead letter if they're not implemented appropriately. This is done through rules that are promulgated promptly, contracts that are executed effectively, and dedicated employees on the job serving veterans.

- Until we see action – not just words - from VA that demonstrates their support for the existing VA workforce and adherence to the laws passed by Congress, I will not be convinced any new legislation will be carried out expediently or consistent with Congressional intent.

- In the past, this Committee spoke very forcefully in a bipartisan manner to challenge previous Administrations of both parties on this very point. I am hopeful that can be the case again.

- Thank you, Mr. Chairman.

Prepared Statements

STATEMENT OF
THOMAS O'TOOLE, M.D.
ACTING ASSISTANT UNDER SECRETARY FOR HEALTH FOR CLINICAL SERVICES
VETERANS HEALTH ADMINISTRATION (VHA)
DEPARTMENT OF VETERANS AFFAIRS (VA)
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE
ON
PENDING LEGISLATION

May 21, 2025

Chairman Moran, Ranking Member Blumenthal, and other Members of the Committee, 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 Mr. Kenneth Smith, Acting Executive Director of Education Services, Veterans Benefits Administration (VBA), and Mr. Phillip Christy, Acting Principal Executive Director and Chief Acquisition Officer, Office of Acquisition, Logistics, and Construction.

S. 214 Monetary Enhancement for Distinguished Active Legends Act of 2025 (MEDAL Act of 2025)

Section 2 of this bill would state Congress' findings regarding the Medal of Honor.

Section 3(a) of the bill would amend 38 U.S.C. § 1562(a) to increase the codified monthly special pension rate payable to Medal of Honor recipients from $1,406.73 to $8,333.33, subject to periodic cost-of-living adjustments.

Section 3(b) of the bill would amend the same section of law to codify the monthly special pension rate payable to surviving spouses of Medal of Honor recipients—currently identical to the Veteran rate—at $1,406.73, subject to periodic cost-of-living adjustments.

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

VA concurs with the findings of Congress in section 2 that Medal of Honor recipients have earned a substantial increase to monthly special pension rates in recognition of their gallantry and intrepidity at the risk of life above and beyond the call of duty. Additionally, VA notes that the Department of Defense has raised concerns that need to be addressed. VA welcomes the opportunity to meet with the Department of Defense and the committee to provide technical assistance and edits to the bill.

Under current law, the monthly pension rate payable to a surviving spouse is unquantified but identical to the codified monthly pension rate payable to a Veteran. Under both current law and the proposed bill, these rates will be increased by the same percentage as any annual cost-of-living adjustments made to benefit amounts payable under title II of the Social Security Act.

At present, because of prior cost-of-living adjustments to the codified amount, the monthly pension rate payable to both Veterans and surviving spouses is $1,712.94. VA notes, however, that section 3(b) would codify a specific monthly pension rate of $1,406.73 for surviving spouses that is lower than that which they currently receive. Thus, the current bill would effectuate a reduction in special pension payable to surviving spouses.

Additionally, the proposed codified monthly rate for Medal of Honor special pension payable to surviving spouses ($1,406.73) is below the current monthly rate for Dependency and Indemnity Compensation (DIC) of $1,653.07, effective as of December 1, 2024. VA highlights this because 38 U.S.C. § 1562(a)(2)(C) does not allow a surviving spouse to receive both Medal of Honor special pension and DIC simultaneously. As a result of the proposed bill, DIC would become the greater monetary benefit. Surviving spouses would therefore be forced to choose between more monetarily valuable but less prestigious DIC benefits and more prestigious but less monetarily valuable Medal of Honor special pension benefits.

VA suggests amending the Medal of Honor monthly pension rate in section 3(b)(2) of the proposed bill from $1,406.73 to $1,712.94 to ensure Medal of Honor special pension would reflect current payment rates and be the greater benefit for a surviving spouse entitled to both DIC and Medal of Honor special pension. Furthermore, VA notes that this recommendation would be accurate only if the bill is enacted by November 30, 2025, because current Medal of Honor monthly special pension rates will be subject to any cost-of-living increase put into effect on December 1, 2025, pursuant to 42 U.S.C. § 401.

VA does not have a cost estimate for this bill.

S. 219 Veterans Health Care Freedom Act

Section 2(a) of this bill would require VA, acting through the Center for Innovation for Care and Payment (CICP), to carry out a pilot program in a minimum of four Veterans Integrated Service Networks (VISN) to improve the ability of eligible Veterans to access hospital care, medical services, and extended care services through the "covered care system." Section 2(b) would provide that VA would have to furnish such care and services at VA medical facilities, as well as at health care providers under the Veterans Community Care Program (VCCP) and eligible entities or providers that have entered into a Veterans Care Agreement (VCA, under 38 U.S.C. § 1703A). Section 2(c) would provide that eligible Veterans participating in the pilot program could elect to receive care or services at any provider in the covered care system. Section 2(d) would

require each eligible Veteran participating in the pilot program to select a primary care provider in the covered care system; this provider would be responsible for coordinating with VA and other health care providers with respect to care and services furnished to the participating Veteran and referring the Veteran to specialty care providers in the covered care system. VA would have to establish systems as appropriate to ensure a primary care provider can effectively coordinate the care and services furnished to a Veteran under the pilot program. Section 2(e) would allow eligible Veterans participating in the pilot program to select any specialty care provider in the covered care system from which to receive specialty care. VA could designate a specialty care provider as the Veteran's primary care provider if VA determined such a designation was in the health interests of the Veteran. Section 2(f) would allow participating Veterans to select a mental health care provider in the covered care system from which to receive mental health care. Section 2(g) would require VA to furnish to participating Veterans' information on eligibility, cost sharing, treatments, and providers to allow Veterans to make informed decisions.

Section 2(h)(1) would require VA to carry out the pilot program during a 3-year period beginning on the date that is 1 year after the date of enactment. Section 2(h)(2) would amend 38 U.S.C. § 1703(d) to add a new paragraph that would provide that, beginning on the date that is 4 years after the date of enactment, Veteran eligibility for VCCP would no longer be based on the existing five statutory eligibility criteria; instead, VA would have to furnish care and services to covered Veterans under the same conditions as articulated in section 2 of this bill (meaning Veterans could choose any provider from whom to receive care). The bill would also amend 38 U.S.C. § 1703A(a)(1) to add a new subparagraph (E) that would state that the requirements in law that care or services can only be furnished under this section when such care or services are not feasibly available from a VA facility or through a contract or sharing agreement would not apply with respect to furnishing care and services under this section beginning on the date that is 4 years after the date of enactment. Finally, section 2(h)(2)(C) would require VA, beginning on the date that is 4 years after the date of enactment, to furnish care and services to Veterans under chapter 17 of title 38, U.S.C., at VA medical facilities, regardless of whether the facility is in the same VISN as the VISN in which the Veteran resides.

Section 2(i) of the bill would require VA, on a quarterly basis for the first 2 years following enactment, to submit to Congress a report on the implementation of the pilot program; one of the reports would have to include a description of the final design of the pilot program. On an annual basis, beginning 1 year after the final quarterly report described above and ending on the date of the conclusion of the pilot program, VA would have to submit to Congress a report on the results of the pilot program.

Section 2(j) would authorize VA, in consultation with Congress, to prescribe regulations to carry out this section. Section 2(k) would state that no additional funds would be authorized to be appropriated to carry out this section, and the amendments made by this section. Section 2(l) would define various terms. The term "covered care system" would mean each VA medical facility, health care provider specified under

38 U.S.C. § 1703(c), and an eligible entity or provider that has entered into a VCA. The term "eligible veteran" would mean a Veteran who is enrolled in VA health care under 38 U.S.C. § 1705. The terms "hospital care," "medical services," and non-Department facilities" would have the meanings given those terms in 38 U.S.C. § 1701.

VA supports many of the principles in the bill but has significant concerns with specific provisions.

We support many of the principles in this bill. We appreciate that the bill's eligibility criteria would be simple to administer by making every enrolled Veteran in the pilot program eligible to participate. We also appreciate the bill would proceed in a phased approach, which could allow VA to incorporate lessons learned before national deployment. Further, we appreciate the bill's recognition of the importance of care coordination for Veterans receiving community care.

However, we have some concerns with many of the specific provisions in this bill. We note that the general model of eligibility proposed in this bill would depart significantly from the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018 (VA MISSION Act; P.L. 115-182), which VA and the Committee worked hard to enact, implement, and improve. We are aware of the Committee's interest in advancing the Veterans' Assuring Critical Care Expansions to Support Servicemembers (ACCESS) Act of 2025 (S. 275). As VA previously stated to this Committee, VA strongly supports the intent of the Veterans' ACCESS Act of 2025, and we appreciate the Committee's willingness to work together on this bill to improve it. The Veterans' ACCESS Act of 2025 is an important step in reaffirming VA's commitment to providing timely access to care and prioritizing Veterans. VA believes enacting the Veterans' ACCESS Act of 2025 would be a better way of ensuring Veterans can receive care from community providers as it builds upon and improves the VCCP established by the MISSION Act instead of replacing it altogether. Some amendments proposed by S. 219 would be difficult to enact in conjunction with the amendments proposed in S. 275.

In terms of our specific concerns with this bill, we offer the following.

Section 1703A authorizes VA to enter into VCAs and use VCAs in limited circumstances. These limitations were established because VCAs are not subject to general contracting requirements under the Federal Acquisition Regulations and the VA Acquisition Regulations. Section 1703A is an authority for how VA purchases care. The principal statute through which Veterans are authorized to receive community care is 38 U.S.C. § 1703, which established the VCCP. The proposed amendments to § 1703A would undo the limitations Congress established to ensure that VCAs are used on a limited basis when conventional procurement options are not available. Further, this bill would expand the scope of § 1703A to control both the authorization of care and the purchasing of care as well, duplicating the VCCP authority under section 1703. VA may use VCAs for individuals other than Veterans, and this bill would seemingly expand their

eligibility to elect to receive non-VA care in ways that are not contemplated by current statute and regulation. We recommend against changes to § 1703A.

The bill's efforts at modifying 38 U.S.C. § 1703, the VCCP authority, could create ambiguity that could have unintended effects on Veteran eligibility for community care. Specifically, the bill would reverse all existing criteria for community care eligibility except for permissive eligibility upon the determination by VA that a medical service line is not providing care that complies with VA's standards for quality (under 38 U.S.C. § 1703(e)). Further, prohibiting additional appropriations to carry out the amendments made by this bill would create the risk of a shortfall of funding if demand for community care increased. In such a situation, VA would be forced to delay care for Veterans when funds cease to be available.

The bill would amend § 1703(d) to require VA to furnish care and services to covered Veterans "with the same conditions on the ability of the veteran to choose health care providers" as provided for in this bill. However, those "conditions on the ability of the veteran to choose health care providers" are not well-defined. For example, section 2(c) would provide that eligible Veterans participating in the pilot program could elect to receive care "at any provider in the covered care system;" however, section 2(d)(2) would require the primary care provider of the eligible Veteran to coordinate with VA and other providers in the covered care system and refer Veterans to specialty care providers as clinically necessary. In this context, it is unclear whether the primary care provider issuing the referral determines which provider sees the patient or whether the patient determines which provider sees the patient. It seems likely that designated primary care providers, particularly those who are not VA employees, are unlikely to know how to make referrals within the "covered care system," and our contracts are not structured in a way to permit them to do so (except in limited circumstances where a bundled set of services has been authorized). If a non-VA provider were selected as the primary care provider, this could make care coordination by VA difficult, which could jeopardize patient care and limit VA's ability to ensure proper care is being authorized and furnished. Moreover, § 1703(a) would remain unchanged, and paragraph (2) of that subsection requires VA to coordinate the furnishing of care, while paragraph (3) of that subsection states that care and services can only be provided upon VA's authorization. It is not clear that VA could structure the pilot program consistent with these requirements.

There are several elements of VA care that are subject to additional restrictions or eligibility criteria such as dental or domiciliary care. Therefore, allowing Veterans to select their own provider could produce significant complications in verifying that such care is statutorily authorized. If enacted, Veterans could choose certain providers for certain care, and receive a referral for that care, before VA could determine whether or not the Veteran was eligible for such care. This could produce confusion and frustration for Veterans and providers.

We also note that the language allowing Veterans to elect to receive care outside their home VISN is unnecessary. This currently happens today in many situations,

particularly when Veterans are located along the border of two VISNs. Further, in the pilot program phase of this authority, it is unclear how this would affect a Veteran's ability to elect to receive care from a VISN that is not participating. Similarly, it is unclear whether this is intended to authorize additional beneficiary travel payments when Veterans elect to receive care at a different location. We note the bill would not alter VA's authority to furnish beneficiary travel payments, which are generally limited only to the nearest VA facility.

VA believes certain provisions would raise particular risks to VA and has some concerns regarding the contracting that would be required to implement this bill, and VA would appreciate the opportunity to discuss these further with the Committee.

The bill also refers to carrying out a pilot program through CICP, but it is not clear if this is intended to mean that the pilot program would involve a waiver request submitted to Congress for approval and otherwise subject to the limitations set forth in 38 U.S.C. § 1703E. Section 1703E(g)(2) generally prohibits VA from expending more than $50 million in any fiscal year (FY) in carrying out pilot programs. This proposal would almost certainly exceed that amount. It also is not clear that this proposal would meet the requirements of § 1703E(a)(3)(B), which requires VA to test payment and service delivery models to determine whether such models create cost savings for the Department. The pilot program proposed in this bill seems unlikely to do so.

The bill's reporting and briefing requirements under section 2(i) would represent additional administrative expense for the Department. Section 2(j), which would authorize VA, in consultation with Congress, to prescribe regulations, is ambiguous as to its intended effect. VA would need regulations to implement the pilot program, and it would need to promulgate regulations to reflect the changes that would be made to § 1703. However, this provision of the bill seems to condition VA's prescribing of regulations to only what is done in consultation with Congress. During the drafting and development phase of the rulemaking process, much of the work is considered pre-decisional and deliberative in nature. Section 2(g) would require VA to furnish to eligible Veterans' information on cost sharing, but other than VA copayments, there are no cost shares associated with care for VA enrollees. It is unclear if this reference is meant to authorize VA to impose additional cost shares or not.

Regarding extended care services, VA generally requires Veterans receiving nursing home care (whether in a VA community living center, a state nursing home, or a community residential center) to receive their primary care from the institutional providers to ensure there is no duplication of services and to avoid fragmentation of care. By including extended care services within the scope of this bill, the language could create situations where such care cannot be coordinated effectively, increasing the risk of adverse outcomes for Veterans.

VA also notes for the Committee's awareness that DoD providers would be among those participating Veterans could select under the bill language. If a sufficient

number of Veterans selected DoD providers for their source of care, this could put an unsustainable added workload on them.

VA notes that the MISSION Act was enacted almost 7 years ago and has been in effect for almost 6 years. VA supports the underlying intent of this bill but believes amending and expanding the MISSION Act through the Veterans' ACCESS Act of 2025 is a better path forward.

VA does not have a cost estimate for this bill but is concerned that this could have a significant effect on demand, which could also disrupt access to community care in participating markets. When combined with the prohibition on the authorization of additional appropriations, this puts VA's ability to carry out the VCCP and furnish Veterans community care in a difficult position.

S. 506 Coordinating Care for Senior Veterans and Wounded Warriors Act

Section 2(a) of this bill would require VA, in consultation with the Secretary of Health and Human Services (HHS), to carry out a pilot program to coordinate, navigate, and manage care and benefits to covered Veterans. Section 2(b) would state that the purposes of the pilot program would be to improve access to health care services for covered Veterans at VA medical facilities, from providers under the VCCP, from providers who have entered into a VCA, and from Medicare providers. Additional purposes would include improving outcomes and the quality of care received by covered Veterans, lowering the costs of care received by covered Veterans, eliminating gaps in care and duplication of services and expenses for covered Veterans, and improving care coordination for covered Veterans (including coordination of patient information and medical records between providers). Section 2(c) would require VA to carry out the pilot program through the CICP and in not less than four VISNs with a large number of covered Veterans and varying degrees of urbanization. Section 2(d) would require VA to assign each covered Veteran participating in the pilot program a case manager responsible for developing an individualized needs assessment for such Veteran and a care coordination plan with defined treatment goals. Case managers would be responsible for assisting such Veterans in accessing needed services and navigating the VA health care system and the Medicare program. Section 2(e) would require VA, in designing the pilot program and to the extent practicable, to use existing models (including value-based care models) used by commercial health care programs to improve access, health outcomes, quality, and customer experience while reducing per capita costs. Section 2(f) would require VA, to the greatest extent practicable, to contract with private sector entities carrying out commercial health care programs for assistance in designing, implementing, and managing care and benefits under the pilot program, including care coordination. If VA determined that such contracts were not practicable, it would have to provide notice and other information to Congress. Section 2(g) would require VA to track a number of metrics under the pilot program. Section 2(h) would provide that the pilot program would last for 3 years from its commencement. Section 2(i) would require VA submit quarterly reports (for 2 years, beginning from the date of enactment) to Congress on the development, implementation, results, and design of the pilot program, including information on the

tracked metrics under subsection (g). Not later than 1 year after the last quarterly report, and annually thereafter for the duration of the pilot program, VA would have to submit to Congress a report on the results of the pilot program; not later than 180 days before the termination of the pilot program, VA would have to submit to Congress a final report that includes VA's recommendation for whether the pilot program should be extended or made permanent. Section 2(j) would define the term "covered veteran" to mean a Veteran who is enrolled in both the Medicare program and the system of annual patient enrollment under 38 U.S.C. § 1705.

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

VA supports the intent of this bill to improve care coordination and benefit alignment for Veterans who are enrolled in both VA health care and Medicare. Veterans dually eligible for these programs often experience fragmented care, duplicative billing, and confusion navigating their benefits. We share the Committee's goal of improving access, reducing administrative burden, and ensuring that Veterans receive timely, coordinated care—whether through VA or Medicare. However, while we support the bill's objectives, VA has several concerns that we believe must be addressed to ensure effective implementation. First, the bill does not provide sufficient detail regarding how the pilot program would operate in practice. VA is already required to coordinate care under its statutory authorities—either when delivering care directly through VA facilities under 38 U.S.C. § 1710 or when furnishing care through community providers under 38 U.S.C. § 1703(a)(2). The bill's interaction with those authorities remains unclear. In addition, VA is currently required to administer an education program under section 7331 that informs Veterans about their health care options and how their VA benefits interact with other public and private insurance. This program would need to be amended for pilot participants to the extent the pilot affects coordination between VA and Medicare.

Second, while the bill outlines commendable goals, such as improving access to Medicare providers and lowering costs of care for Veterans, some of these outcomes may already be addressed under current law or may not be fully achievable without broader statutory changes. For example, most Medicare providers already meet eligibility requirements to participate in the VCCP under section 1703(c)(1). Moreover, the bill seeks to reduce costs to Veterans, but some cost-sharing is required by statute under both Medicare and VA programs. Veterans may be responsible for a copayment under one program or the other, and the bill does not alter these statutory requirements. The bill also references eliminating gaps and duplication in care, but it is unclear what specific gaps are being referenced or how the pilot would eliminate duplicative services without limiting Veterans' access to benefits under either program. VA also has concerns with the bill's approach to case management. The assignment of a dedicated case manager may duplicate existing efforts by VA's integrated care teams, including the work already performed by VA primary care providers and care coordinators. Veterans often already have individual care plans and needs assessments; requiring a separate case manager to create new ones may introduce redundancy rather than

added value. We also note that while the bill in subsection (b)(1) discusses coordination between various VA providers and facilities and "health care providers participating in the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.)". "Health care providers" is not a defined term in the Social Security Act, and "participating in Medicare" may have a different meaning than intended. It may be more appropriate to use more inclusive language like "providers, physicians or other practitioners, or suppliers that are enrolled or participating in the Medicare program" to capture a broader group of individuals, facilities, and entities that provide care to Medicare beneficiaries.

Finally, while we appreciate the bill's intent to use established models for measuring access, quality, outcomes, and Veteran experience, VA may determine that a new or tailored model would better serve the goals of the pilot. The bill requires use of existing models "to the extent practicable," but this could inadvertently limit VA's flexibility to adopt more appropriate evaluation frameworks. In addition, the reporting requirements, while important for transparency and accountability, would require significant resources—particularly in staffing, IT infrastructure, and data analytics—which may divert capacity from direct care unless additional funding is provided. VA also notes that concerns raised in our testimony on S.219 regarding community-integrated care pilots apply here as well.

VA has other technical edits on this bill, including amending section 2(i)(3) to only require VA to submit recommendations, if any, for whether the pilot program should be extended or made permanent.

VA does not have a cost estimate for this bill.

S. 585 Servicemember to Veteran Health Care Connection Act of 2025

Section 2(a) of this bill would create a new section 1705B in title 38, U.S.C., regarding registration in a pre-transition system and facilitation of enrollment in VA health care. This new section would require VA, not later than 180 days before the anticipated separation from the Armed Forces of a member of the Armed Forces, to automatically register the member in the pre-transition health care registration system. Such registration would have to consist of the entry of relevant information of such member into such system so as to facilitate and permit, at a future date, a final determination with respect to the enrollment of such member in VA health care if the member elects to enroll and is eligible to do so. Proposed section 1705B(b) would require VA, not later than 30 days after separation of a covered individual from the Armed Forces, or as soon as feasibly possible following such separation, to engage the individual to assist and facilitate the completion of the process for enrolling in VA health care and scheduling an initial primary care or other health appointment for the individual with VA if the individual is interested in such an appointment. VA would have to communicate through a combination of effective mechanisms, including by electronic means (through email and text message), paper mail, and by phone. In this subsection, the term "covered individual" would mean an individual who is eligible for or expected to

be eligible for enrollment in the patient enrollment system but who is not yet enrolled. Proposed section 1705B(c) would require VA, to the greatest extent feasible, to conduct timely outreach to members of the Armed Forces registered in the pre-transition health care registration system (in advance of their separation from the Armed Forces) and to explain what such registration means, what steps each member must take after separation to enroll (if eligible) in VA health care. VA would also have to explain what health care services are available through VA upon enrollment (including the general rules of eligibility) and services that may be available without enrolling (such as counseling for military sexual trauma, readjustment counseling, and others). VA would also need to explain the steps required to access services limited to enrollees and those available without regard to enrollment. Outreach would have to be conducted through a combination of effective mechanisms as described above. If an individual enrolls in VA health care, VA would have to contact the individual at least once during the first 180 days following such enrollment if the individual had not scheduled a primary care or other appointment with VA and offer to schedule an appointment if the individual was interested. VA could conduct this outreach as part of the Solid Start program or other processes. Proposed section 1705B(d) would define the term "pre-transition health care registration system" to mean an information technology or other system or systems in which VA enters or stores the relevant information of a transitioning member of the Armed Forces to facilitate and permit, at a future date, a final enrollment determination with respect to the enrollment of such member in VA health care. Section 2(a)(3) of the bill would make this subsection and its amendments take effect on the date of the enactment of the Act; it would further state the amendments would apply to any member of the Armed Forces who is anticipated to separate from the Armed Forces on and after the date that is 1 year after the date of enactment.

Section 2(b) would require VA, not later than 1 year from enactment, in consultation with the Department of Defense (DoD), to establish and implement an automated process to implement the pre-transition health care registration system required under the proposed section 1705B. VA would have to provide a briefing to Congress not later than 180 days, 1 year, and 2 years after enactment on the implementation of this process.

Section 2(c) would allow VA, in implementing these requirements and amendments, to integrate and coordinate such implementation with the Solid Start program or other processes as VA determined appropriate to ensure collaboration and coordination with relevant DoD programs. On and after the date that is 1 year after enactment, DoD would have to include an explanation of the pre-transition health care registration system required by the proposed section 1705B as part of the Transition Assistance Program.

Section 2(d) would require VA to make enrollment in VA health care, including pre-transition health care registration under the proposed section 1705B, a simple and streamlined process for all transitioning members of the Armed Forces and Veterans. This process would need to facilitate access to and utilization of VA services to which the individuals are entitled, ensure such individuals have a healthy and smooth

transition out of the Armed Forces and into civilian life, to support their mental and physical health, and to reduce, to the greatest extent possible, Veteran suicide. VA would need to continuously monitor, improve, and modernize this process.

Section 2(e) would require VA to proactively conduct outreach to transitioning and recently transitioned members of the Armed Forces to assist them in enrolling in VA health care; proactively and regularly engage with enrolled Veterans to offer assistance in accessing VA health care; proactively and regularly engage with Veterans who may not be eligible to enroll in VA health care but may be eligible to access certain VA health services; proactively engage with Veterans from traditionally under-represented groups; and engage with Veterans who are eligible but not enrolled in VA health care and offer information and assistance regarding the steps to facilitate enrollment.

Section 2(f) would amend 38 U.S.C. § 8111(f), which requires VA and DoD to submit to Congress a joint report on health care coordination and sharing activities under such section, to require VA and DoD to report on information about the registration of members of the Armed Forces in the pre-transition health care registration system under proposed section 1705B.

Section 2(g) would require VA, in consultation with DoD and not later than 1 year after enactment, to submit to Congress a report on the feasibility and advisability of permitting transitioning members of the Armed Forces (including those on separation leave), while still on active duty, to receive at least one no-cost health care appointment at a VA facility. Not later than 1 year after the date of enactment, VA, in consultation with DoD, would also have to submit to Congress a report assessing VA's efforts regarding the pre-transition health care registration system; assessing any challenges experienced by VA in receiving timely and reliable information from DoD and other Federal or non-Federal entities regarding the separation of members from the Armed Forces; identifying an individual in the Senior Executive Service within VA that is coordinating (or will coordinate) all VA programs relating to improving the registration and enrollment of transitioning or transitioned members of the Armed Forces in VA health care; and describing how such individual manages or will manage various programs across VA.

Section 2(h) would establish a rule of construction that nothing in this section could be construed to require any member of the Armed Forces, former member of the Armed Forces, or Veteran to use any VA service or to enroll in VA health care.

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

VA supports the overall intent of the proposed legislation as it would simplify the enrollment process for transitioning Service members and increase the number of Veterans who have access to health care. Veterans are most at risk for suicide and other adverse events in the year following discharge from the military. Those who are connected to VA for health care fare better than those who are not connected to VA.

This is especially true for those most at risk for poor outcomes, who might not be inclined to seek out help on their own but would attend appointments if they were scheduled. While the bill would not automatically enroll Veterans, it would put Veterans first and facilitate easier access to their earned benefits.

VA has some concerns with the specific language in the bill. For example, the bill would require VA to automatically pre-register all members of the Armed Forces at least 180 days before their anticipated separation. The term "Armed Forces" is defined in 38 U.S.C. § 101 to include the National Guard and members of the Reserve components. However, if such individuals have not satisfied the minimum active-duty requirements set forth in 38 U.S.C. § 5303A, they would not generally be eligible to enroll in VA health care (or access most VA benefits). Additionally, some individuals may have an anticipated separation date based on a disqualifying discharge from service; such individuals would generally be barred from eligibility under 38 U.S.C. § 5303. The bill would still require VA to collect and pre-register these individuals.

Additionally, the pre-transition health care registration system would have to consist of the entry of "relevant information…so as to facilitate and permit, at a future date, a final determination with respect to the enrollment of such member". See proposed § 1705B(a)(2). However, VA cannot make a final enrollment determination absent the individual's DD-Form 214. VA would have to interpret the phrase "relevant information" to mean "available information" at the time of such registration. Similarly, VA may require income information to determine eligibility, which VA could obtain from other Federal databases (such as maintained by the Internal Revenue Service (IRS) or Medicare); however, the IRS and VA would require additional authority to connect to those resource to verify eligibility without placing additional burdens on the transitioning Service member. Moreover, some information (such as preferred facility) could only be gathered with the input of the applicant. VA would also need to know at which facility to register the new Veteran, and this would require the input of the separating Service member. Further updates to TAP and other DoD data sharing may also be required.

VA also notes the effective date provision in section 2(a)(3) is unclear. The bill states that the amendments and the subsection would take effect on the date of enactment and apply to any member of the Armed Forces who is anticipated to separate on and after the date that is 1 year after the date of enactment. However, section 2(b)(1) provides VA up to 1 year from enactment, in consultation with DoD, to establish and implement an automated process to implement the pre-transition health care registration system. Read together, presumably VA would be required to manually implement the pre-transition health care registration system, but this could be labor- and resource-intensive. VA recommends providing sufficient time to establish an automated process and having the requirements in the proposed section 1705B apply from that date forward. We do note that the automated process would require significant updates to IT systems, which would require additional resources. Given these concerns, the timeline for implementation is insufficient.

Finally, because the pre-registration would occur automatically, there is a high risk that records will remain open, potentially for years, with no clear resolution. Generally speaking, individuals must apply for benefits, and if they do not complete an application with a certain period of time, VA can consider such claims as abandoned. The bill, however, would provide no such mechanism, so VA would presumably need to retain these records for at least the lifetime of the transitioning Service member. This could create additional (perhaps unnecessary) privacy risks, increase VA's administrative costs, and increase the potential for errors regarding information records. We recommend the bill clearly set forth a timeline for VA's record retention period.

VA has a few technical comments on the bill and would appreciate the opportunity to share these with the Committee. Similar to our discussion of S. 506, VA recommends amending section 2(g) to only require VA to submit recommendations, if any, for changes in law and legislative action.

VA does not believe the bill would result in a significant change in enrollment or utilization rates given current efforts to enroll transitioning Service members. However, VA would require additional staff and resources to facilitate this type of engagement for all separating Service members and to provide the reports required by this bill. Mandatory and discretionary costing have not been evaluated at this time.

S. 599 Driver Reimbursement Increase for Veteran Equity Act of 2025 (DRIVE Act of 2025)

This bill would amend 38 U.S.C. § 111, which authorizes VA to provide beneficiary travel benefits, in two principal ways. First, it would amend subsection (g), which currently permits VA to adjust the mileage reimbursement rate for eligible individuals to be equal to the mileage reimbursement rate for the use of a privately owned vehicle by Government employees on official business when a Government vehicle is available. The amended text would require VA ensure the mileage rate is equal to or greater than the mileage reimbursement rate for the use of a privately owned vehicle by Government employees on official business when no Government vehicle is available; it would also make a conforming amendment to 38 U.S.C. § 111(a). Second, it would require VA, when VA exercises the authority under 38 U.S.C. § 111 to make any payments, to take such actions as may be necessary to ensure an allowance based on mileage paid under § 111(a) is paid not later than 90 days after the date on which a request for such allowance is properly submitted to VA in accordance with such regulations as VA may prescribe.

VA does not support this bill.

VA is committed to delivering Veterans the health care and benefits they have earned. Recognizing that transportation can be a barrier for many Veterans in accessing timely and necessary medical care, VA has developed a range of robust programs to facilitate transportation for Veterans. These initiatives are designed to meet the diverse needs of Veterans and ensuring that no Veteran is left without options. VA

operates a number of programs designed to meet the transportation needs of Veterans, including:

- Veterans Transportation Service (VTS): The Veterans Transportation Service (VTS), operated under the authority of 38 U.S.C. § 111A(a) and 38 C.F.R. part 70, subpart B) offers a network of safe and reliable transportation options for Veterans. VTS provides door-to-door service through a fleet of vehicles at many VA medical centers. This service is particularly valuable for Veterans with disabilities or those who need additional assistance.
- Highly Rural Transportation Grants (HRTG): The Highly Rural Transportation Grant program (which would be amended by S. 784 and S. 827, discussed below) awards funds to eligible organizations to provide transportation services to Veterans in highly rural areas. These grants support efforts to bring Veterans from underserved, remote regions to VA medical facilities, enhancing their ability to receive care.
- Volunteer Transportation Network (VTN): The Volunteer Transportation Network, supported by the Disabled American Veterans (DAV) organization, and operated under the authority of 38 U.S.C. § 111A(b), mobilizes volunteers to provide free transportation to Veterans. These dedicated volunteers use their personal vehicles or VA-provided vehicles to ensure Veterans can attend their appointments without worrying about travel logistics or costs.
- Shuttle Services and Interfacility Transfers: Many VA medical centers provide limited transportation between VA facilities, including community-based outpatient clinics, or between different locations within a single VA campus. These shuttles help expand access by assisting Veterans and other eligible individuals who may require assistance in accessing VA facilities.

VA's beneficiary travel program (authorized by 38 U.S.C. § 111 and 38 C.F.R. part 70, subpart A) provides mileage reimbursement to eligible individuals traveling to and from locations for compensation and pension examinations, vocational rehabilitation and counseling, and health care. This program is essential in mitigating travel costs, particularly for eligible individuals residing in rural or remote areas. Currently VA reimburses mileage at the amount of $0.415 per mile. This bill would raise that amount to a minimum of $0.70 per mile, as that is the rate currently established by the General Services Administration (GSA) as of January 1, 2025.

According to the Government Accountability Office (GAO) report, "VA Health Care: Additional Assessments of Mileage Reimbursement Data and Veterans' Travel Costs Needed" (GAO-24-106816; May 2024), the current mileage reimbursement rate of 41.5 cents per mile, set by Congress in 2010, covers the cost of fuel for Veterans traveling 25 miles or more round-trip. Additionally, VA's beneficiary mileage rate is almost double the standard mileage rate set by the IRS for tax-deductible expenses. As of December 19, 2024, the IRS standard mileage rate for medical travel was 21 cents per mile (IR-2024-312). Maintaining the current rate allows VA to allocate resources more effectively across a range of transportation initiatives that benefit a broader segment of the population of eligible individuals, including Veterans.

VA does not have a cost estimate for this bill, but by increasing the mileage reimbursement rate for all Veterans and eligible individuals, this bill would significantly increase costs for health care and the Medical Disability Examination Office program; it also would increase mandatory costs for the Veterans Benefits Administration (VBA).

S. 605 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 DoD's 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. 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, but by providing coverage to dependents up to the age of 26 under CHAMPVA, this bill would significantly increase costs for VHA.

S. 635 Veterans Homecare Choice Act of 2025

Section 2 of this bill would amend 38 U.S.C. § 1703 in two ways. First, it would amend subsection (c), which defines eligible entities and providers for purposes of the VCCP, to include any nurse registry, including any registered nurse, licensed practical nurse, certified nursing assistant, home health aide, companion, or homemaker furnishing services through a nurse registry. Second, it would define the term "nurse registry" in a new subsection (q)(3) to mean a person that satisfies any applicable state licensure requirement and that procures, or attempts to procure, contracts or other agreements on behalf of registered nurses, licensed practical nurses, certified nursing assistants, home health aides, companions, or homemakers under which such individuals can provide health care-related or assistive services and receive compensation for such services.

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

VA supports efforts to increase the number of qualified providers under the VCCP; however, this bill's addition of nurse registries under § 1703(c) would likely have no significant effect on the VCCP because nurse registries already can be an eligible entity or provider. Any entity or provider that wants to participate in the VCCP must enter into an agreement with VA (or a third-party administrator) to furnish covered health care services and comply with the terms of that agreement and any applicable laws and regulations. Being an eligible entity or provider does not mean that such entity or provider is participating under the VCCP.

VA understands that some state laws (such as Florida) require providers in a nurse registry to be independent contractors that have agreements directly with the patient. It is unclear how VA would contract with the registry instead of the provider and still provide protections to Veterans with billing issues from independent contractors. This could present complications that would make the attempted inclusion of nurse registries, at least as described in this bill, more difficult.

The requirement that a nurse registry be a person that "satisfies any applicable state licensure requirement" could raise concerns that such persons would not meet the same standards required by other providers. Licensure requirements can vary greatly by state, and a state's requirement for nurse registry license alone may not provide enough oversight of these providers. Florida law, for example, appears to preclude any such oversight, where it states that "A nurse registry may not monitor, supervise,

manage, or train a registered nurse, licensed practical nurse, certified nursing assistant, companion or homemaker, or home health aide referred for contract under this chapter." *See* 2024 Florida Statutes, § 400.506(19). In this case, VA contracts would need to provide additional requirements to ensure patient safety that may be uniquely applicable to these registries.

We also have several technical concerns with the bill. The term "companion", for example, is undefined, and the intended effect of its inclusion is unclear. Additionally, the term "nurse registry" is defined to mean a person, while we believe in most situations the registry would be an entity. Further, a person or entity that "procures, or attempts to procure, contracts or other agreements on behalf" of nurses or other providers could potentially include a much broader category of organizations than is intended—labor unions or employment companies, for example, would seem to fit this description. Finally, the term "health care-related or assistive services" is undefined, and these may include services that are not hospital care, medical services, or extended care services (which is all that can be provided under the VCCP pursuant to § 1703).

VA does not have a cost estimate for this bill.

S. 649 Guard and Reserve GI Bill Parity Act of 2025

This bill would amend 38 U.S.C. § 3301(1)(B) to expand eligibility criteria for those who are on active duty to include active-duty service as defined in 10 U.S.C. § 101(d), inactive-duty training as defined in 10 U.S.C. § 101(d), or annual training duty. Under 10 U.S.C. § 101(d), the term "active duty" is defined as those individuals who are on full-time duty in the active military service of the United States including full-time training duty, annual training duty, and attendance, while in the active military service, at a school designated as a service school by law or by the Secretary of the military department concerned.

The bill would also amend 38 U.S.C. § 3301(1)(C) by expanding the eligibility criteria for those with active-duty service as a member of the Army National Guard or Air National Guard. Currently, such individuals are limited to those with service described in § 3301(1)(C) with full-time service: (i) in the National Guard of a State for the purpose of organizing, administering, recruiting, instructing, or training the National Guard, or (ii) in the National Guard under 32 U.S.C. § 502(f) when authorized by the President or the Secretary of Defense for the purpose of responding to a national emergency. The amendment would now define "active duty" to include: (i) full-time service in the National Guard of a State for the purpose of organizing, administering, recruiting, instructing, or training the National Guard, (ii) full-time service in the National Guard when performing full-time National Guard duty as defined in 32 U.S.C. § 101, which includes the Army National Guard and the Air National Guard, and (iii) full-time service in the National Guard when performing active duty, as defined in 32 U.S.C. § 101.

Currently, Guard and Reserve service is only creditable for the Post-9/11 GI Bill benefit if it's service in very limited circumstances: on active duty under a call or order to

active duty under §§ 688, 12301(a), 12301(d), 12301(g), 12301(h), 12302, 12304, 12304a, or 12304b of title 10 or section 712 of title 14; or in the case of a member of the Army National Guard of the United States or Air National Guard of the United States full-time service in the National Guard of a State for the purpose of organizing, administering, recruiting, instructing, or training the National Guard; or in the National Guard under section 502(f) of title 32 when authorized by the President or the Secretary of Defense for the purpose of responding to a national emergency declared by the President and supported by Federal funds.

The proposed legislation would be effective 1 year after the date of enactment. The amendments would apply to service performed on or after September 11, 2001.

Finally, the time limitation under 38 U.S.C. § 3321(a) for using VA education benefits acquired from the expansion of eligibility for Reserve and National Guard members by this bill would apply as if the amendments had been enacted immediately after the enactment of the Post-9/11 Veterans Educational Assistance Act of 2008 (P.L. 110-252).

VA will provide views on S. 649 to the Committee at a later date.

A cost estimate is not available at this time.

S 778 Lactation Spaces for Veteran Moms Act

This bill would add a new 38 U.S.C. § 1720M to require, not later than 2 years after enactment, that each VA medical center (VAMC) contain a lactation space. It would clarify that nothing in this section would authorize an individual to enter a VAMC or portion thereof if that individual is not otherwise authorized to enter. It would define the term "lactation space" to mean a hygienic place, other than a bathroom, that is shielded from view, free from intrusion, accessible to disabled individuals, contains a chair and a working surface, is easy to locate, is clearly identified with signage and is available for use by women Veterans and members of the public otherwise authorized to enter a VAMC to express breast milk.

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

Since 2010, Federal agencies have been required to provide employees with a private space, permanent or temporary, that is shielded from view and free from intrusion from coworkers and the public, to allow employees to express breast milk for up to 1 year after the birth of the employee's child. We have supported the acquisition and installation of breastfeeding pods in our facilities, and we have encouraged facilities to develop and dedicate lactation spaces for Veterans and members of the public. Access to dedicated lactation spaces supports Veteran health and well-being and fosters trust in VA.

While we support the goal of this bill, we have some concerns with the legislative text as written. As noted before, we fully support ensuring lactation spaces are available in our facilities. The need to retrofit and renovate facilities would require a longer time period for compliance. Our biggest impediment is simply the lack of space in existing facilities. In this context, we fully support the intent of this legislation, and we would like to work with the Committee to determine how VA can meet the intent of this bill.

VA does not have a cost estimate for this bill.

S. 784 Rural Veterans Transportation to Care Act

This bill would amend section 307 of the Caregivers and Veterans Omnibus Health Services Act of 2010 (P.L. 111-163; 38 U.S.C. § 1710, note), as amended, which requires VA to establish a grant program to provide innovative transportation options to Veterans in highly rural areas. The bill would amend this authority to include rural areas as well. It would also make county Veterans Service Organizations and Tribal organizations eligible to be awarded a grant. It would amend the maximum amount of a grant under this section from $50,000 to $60,000 and would provide an exception to this threshold if the recipient is required to purchase a vehicle to comply with the requirements of the Americans with Disabilities Act of 1990 (ADA), 42 U.S.C. § 12101 et seq.) in carrying out this section; in these cases, the maximum grant amount would be $80,000. The bill would replace the current definition of highly rural in section 307 with definitions for the terms rural and highly rural, which would have the meanings given those terms under the Department of Agriculture Rural-Urban Commuting Areas coding system. Finally, the bill would authorize to be appropriated such sums as may be necessary to carry out section 307 and remove the current language authorizing the appropriation of $3,000,000 each for FY 2010 through 2022.

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

Lack of transportation in rural and highly rural areas is a well-known barrier to access to care. VA wants to ensure that Veterans living in rural and highly rural areas have access to transportation for their VA-authorized medical care and supports use of this grant program. We do have some recommendations to improve the bill and further improve access to care for rural Veterans. The current definition of highly rural in section 307 makes grants under this authority available only to applicants in 25 states. Expanding the scope of this grant to include rural, in addition to highly rural, areas and additional eligible recipients who serve Veterans in these areas would increase the impact of this program and would allow more eligible Veterans the opportunity to receive medical care that they may not otherwise receive.

VA recommends several changes to the bill. First, the bill would authorize a total award amount of $80,000 if a grantee needed to purchase a vehicle to comply with the ADA. Instead, VA recommends allowing such grantees to receive up to $60,000 (the same as other grantees) to operate the program, and an additional $80,000 for the

purchase of a vehicle. This would allow interested parties who need to purchase a vehicle compliant with the ADA to do so to implement or continue a grant-funded program. Without this additional support, the high-cost of purchasing an ADA-compliant vehicle may dissuade eligible applicants from applying for a grant or from continuing their grant program. Second, we recommend including specific authority for VA to establish limitations regarding the purchase of new vehicles, including the frequency of vehicle purchasing and the number of vehicles that can be purchased by each grantee. This would provide VA clear authority to establish reasonable limitations to ensure proper use of taxpayer funds.

VA would be pleased to provide additional technical assistance to this bill to address these recommendations.

VA does not have a cost estimate for this bill.

S. 800 Precision Brain Health Research Act

Section 2 of this bill would amend section 305 of the Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019 (P.L. 116-171; 38 U.S.C. § 1712A, note), which generally requires, in subsection (a), VA to develop and implement an initiative (the Precision Medicine for Veterans Initiative) to identify and validate brain and mental health biomarkers among Veterans with specific consideration for certain conditions. Specifically, the bill would include among the list of conditions repetitive low-level blast exposure, dementia, and other brain conditions as VA considers appropriate. The bill would further amend this section of law to require VA to work with DoD to establish a data-sharing partnership between the two Departments. The partnership would have to be stored in the open platform already required by law. The data supplied by DoD would have to include all relevant data, Department-wide, collected through the U.S. Armed Forces, the U.S. Special Operations Command, and the Long-Term Impact of Military-Relevant Brain Injury Consortium Chronic Effects of Neurotrauma Consortium maintained by the Defense Health Agency. It would also add five new subsections at the end.

Proposed subsection (f) would require VA, in carrying out the Precision Medicine for Veterans Initiative to conduct specific types of research. First, VA would have to conduct a big-data assessment of the clinical and non-clinical interventions that are illustrating positive outcomes for patients within VA with likely low-level repetitive blast injuries, including a categorization of military occupational specialties, and units, known to experience higher levels of low-level repetitive blast injuries. Second, VA would have to conduct not fewer than two large-scale implementation studies of research-proven interventions within VA for patients with likely low-level repetitive blast injuries, including a categorization of military occupational specialties, and units, known to experience higher levels of low-level repetitive blast injuries. Third, VA would have to conduct a translational research study on the use of growth hormone replacement therapy on the improvement of cognitive function, quality of life, brain structure, and other negative symptoms on patients within such health system with likely low-level repetitive blast

injuries. Finally, VA would have to conduct not fewer than four large-scale quality improvement studies on improving the diagnosis and care of Veteran patients with likely low-level repetitive blast injuries.

Proposed subsection (g) would require VA, not later than 60 days after enactment, to seek to enter into a contract with the National Academies of Sciences, Engineering, and Medicine (NASEM) under which NASEM would work in tandem with the Precision Medicine for Veterans Initiative on validation of brain and mental health biomarkers among Veterans and report to Congress, not less frequently than once every 2 years, on such work.

Proposed subsection (h) would require VA to conduct an assessment of all translational research studies in progress and planned under the Precision Medicine for Veterans Initiative, including the research that would be required under the proposed subsection (f). VA would have to submit a report to Congress on this assessment not later than 60 days after completing the assessment.

Proposed subsection (i) would require VA, not less frequently than once every 2 years, to submit to Congress a report on the Precision Medicine for Veterans Initiative; each report would have to include recommendations for immediate administrative and legislative action to improve the Initiative.

Proposed subsection (j) would authorize to be appropriated to VA $5 million for each of FY 2025 through 2034 to carry out the Initiative.

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

VA supports efforts to expand work in this critical research area involving sharing of research data, advancing brain health, blast exposure, and a potential treatment for specific Veterans adversely affected by their military service. However, we have concerns with codifying research approaches or methodologies, as this bill would do, and we note many of the research requirements of this bill could be conducted with current authority but would require additional resources. We would appreciate the opportunity to discuss current research efforts in this area and how legislation might support these. We also would appreciate the opportunity to discuss how this bill might affect eligibility for benefits more broadly under the Honoring our PACT Act of 2022 (P.L. 117-168). Some elements of this bill may be better suited to DoD being the responsible agency. Other elements, such as studying the use of growth hormone replacement therapy, may not be clinically appropriate.

Similar to prior discussions, VA recommends amending the reporting requirement to only require VA to make recommendations for legislation, if any, VA determines appropriate. VA has other technical edits as well; for example, the Long-

Term Impact of Military-Relevant Brain Injury Consortium Chronic Effects of Neurotrauma Consortium is not maintained by the Defense Health Agency

VA does not have a cost estimate for this bill.

S. 827 Supporting Rural Veterans Access to Healthcare Services Act

This bill, similar to S. 784, would amend section 307 of the Caregivers and Veterans Omnibus Health Services Act of 2010 (P.L. 111--163; 38 U.S.C. § 1710, note), as amended, which requires VA to establish a grant program to provide innovative transportation options to Veterans in highly rural areas. S. 827 would amend this authority to make Tribal organizations and Native Hawaiian organizations eligible to be awarded a grant. It would permit VA to award up to an additional $25,000 in grant funds in the case of a county that has more than five communities that are off the road system. The bill would add a definition of "Native Hawaiian organization," which would have the meaning given that term in section 6207 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. § 7517), and a definition of "Tribal organization," which would have the meaning given that term in section 4 of the Indian Self-Determination and Education Assistance Act (ISDEAA) (25 U.S.C. § 5304). Finally, the bill would authorize to be appropriated such sums as may be necessary for FY 2025 through 2029 to carry out section 307 and remove the current language authorizing the appropriation of $3,000,000 each for FY 2010 through 2022.

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

VA supports the intent of the bill but notes that the Department of Justice has raised serious concerns that need to be addressed. VA welcomes the opportunity to meet with the Department of Justice and the committee to provide technical assistance and edits to the bill. As noted earlier, S. 827 is similar to S. 784. VA's preferred revisions to section 307 of the Caregivers and Veterans Omnibus Health Services Act of 2010 are described in VA's testimony on S. 784. We understand the intent of S. 827, but we have some concerns with the additional grant amount language. We would welcome the opportunity to speak with the Committee to better understand the intended effect and then to propose changes to reflect that intent. Additionally, the draft bill defines Tribal organizations (TO) using the ISDEAA definition (25 U.S.C. 5304). While the definition of TO in the ISDEAA technically captures an Indian Tribe, to the extent that it includes the Tribe's governing body, there is some concern that it can cause potential confusion and/or pushback because the bill does not explicitly include/define Indian Tribe, which is defined separately in the ISDEAA. At minimum, the drafters may want to clarify the intent of the bill. If it is intended to also include Indian Tribes, the drafters may want to consider explicitly adding and separately defining Indian Tribe as defined in the ISDEAA.

VA does not have a cost estimate for this bill.

S. 879 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 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 the PCAFC and during the 180-day period following the date on which the individual is no longer participating in the 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 the 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 the 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 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.

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 here to determine if legislation is needed.

VA does not have a cost estimate for this section.

S. 1318 Fallen Servicemembers Religious Heritage Restoration Act

This bill would require the American Battle Monuments Commission (ABMC) to establish a program, known as the Fallen Servicemembers Religious Heritage Restoration Program, to identify covered members and to contact survivors and descendants of covered members. ABMC would carry out this Program during the first 10 FYs beginning after the date of enactment. During each of these FYs, ABMC would have to seek to enter into a contract with a non-profit organization under which such organization would have to carry out the purpose of the Program. Each contract would be for a period of 1 year and in the amount of $500,000 to the non-profit organization. ABMC would have to give priority in awarding these contracts to non-profit organizations that have demonstrated capability and expertise in carrying out such a program. There would be authorized to be appropriated $500,000 for each FY to ABMC. The term “covered member” would mean a deceased member of the Armed Forces who was Jewish and buried in a U.S. military cemetery located outside the U.S. and under a marker that indicates such member was not Jewish. The term “non-profit organization” would mean an organization described in section 501(c)(3) of the Internal Revenue Code of 1986 and exempt from taxation under section 501(a) of such Code.

VA defers to ABMC on this bill.

VA does not have a cost estimate for this bill.

S. 1320 Servicewomen and Veterans Menopause Research Act

Section 2 of the bill would define certain terms for purposes of this Act. Specifically, it would define the term "covered provider" to mean a provider employed by VA or DoD. The term "menopause" would mean the stage of a woman's life when menstrual periods stop permanently and she can no longer get pregnant and that is not a disease state but a normal part of aging for women. The term "mid-life" would mean a life stage that coincides with the menopausal transition in women, which may be physical or emotional, encompasses the late reproductive age, which can begin at approximately 35 years of age, to the late post-menopausal stages of reproductive aging, which can extend to approximately 65 years of age, and often marks the onset of many chronic diseases. The term "perimenopause" would mean the time during a woman's life when levels of estrogen fall un-evenly in a woman's body and is also called the menopausal transition. The term "post-menopausal" would mean the stage of a woman's life after a woman has been without a menstrual period for 12 months that lasts for the rest of a woman's life and reflects a time when women are at an increased risk for osteoporosis and heart disease.

VA has no objection to this section.

This section would only define terms, and VA has no objection to these definitions. Bill sponsors should consider changing the term "Armed Forces" each place it occurs in the bill to "uniformed services (as such term is defined in section 101 of title 10, United States Code)". Officers of the United States Public Health Service (USPHS) Commissioned Corps and NOAA Commissioned Corps do not fall under the term "Armed Forces"; however, USPHS officers and NOAA officers receive their care from Military Treatment Facilities and, once separated from Service, are considered veterans on the Federal level and are eligible to receive VA care in Veteran spaces. Therefore, it is appropriate to ensure all Servicewomen in each of the uniformed services benefit from the research described in this bill.

Regarding the bill overall, VA supports its efforts to advance research and care related to menopause, perimenopause, and mid-life women's health among women who serve or have served in the Armed Forces.

VA does not have a cost estimate for this section.

Section 3(a) would require DoD, in coordination with VA, to evaluate: (1) the results of completed research related to menopause, perimenopause, or mid-life women's health among women who are members of the Armed Forces or Veterans; (2) the status of such research that is ongoing; (3) any gaps in knowledge and research

on treatments, safety and effectiveness of such treatments, the relation of service in the Armed Forces to perimenopause and menopause, the effect of combat roles on symptoms relating to perimenopause and menopause (including exposure to burn pits, toxic chemicals, and perfluoroalkyl and polyfluoroalkyl substances (commonly known as PFAS)), and the impact of perimenopause and menopause on the mental health of women who are members of the Armed Forces or Veterans; (4) the availability of and uptake of professional training resources for covered providers relating to mid-life women's health with respect to the care, treatment, and management of perimenopause and menopausal symptoms, and related support services; and (5) the availability of and update of treatments for women who are members of the Armed Forces or Veterans who are experiencing perimenopause or menopause.

Section 3(b) would require DoD and VA to each submit a report to Congress, not later than 180 days after enactment, on the findings of the evaluation required by subsection (a), recommendations for improving professional training resources for covered providers, and a strategic plan that resolves the gaps in knowledge and research identified in the report and identifies topics in need of further research relating to potential treatments for menopause-related symptoms of women who are members of the Armed Forces or Veterans.

Section 3(c) would provide that, in carrying out activities under this section, DoD and VA would have to ensure that such activities minimize duplication and supplement, not supplant, existing information sharing efforts of HHS.

VA defers to DoD regarding section 3(a) and has no objection to sections 3(b) and 3(c).

VA does not have a cost estimate for this section.

Section 4 would express the sense of Congress that DoD and VA should each conduct research related to menopause, perimenopause, or mid-life health regarding women who are members of the Armed Forces or Veterans.

VA defers to Congress on this section.

VA does not have a cost estimate for this section.

S. 1383 Veterans Accessibility Advisory Committee Act of 2025

Section 2 of this bill would require VA, within 180 days of enactment, to establish an advisory committee (the Veterans Advisory Committee on Equal Access) to provide advice on matters related to accessibility of VA for individuals with disabilities. The bill sets forth conditions regarding membership, terms and vacancies, meetings, selection of a chairperson, duties (including providing advice and preparing reports), and

personnel and resource matters relevant to the committee. The committee would terminate on the date that is 10 years after enactment.

This committee would be subject to the provisions of the Federal Advisory Committee Act, 5 U.S.C., Ch. 10.

Section 3 of the bill would require VA, not later than 180 days from enactment (and before establishing the Veterans Advisory Committee on Equal Access) to either: (1) abolish a VA advisory committee that was not established by an Act of Congress and that is inactive; (2) consolidate two such advisory committees; or (3) submit to Congress a recommendation to abolish a VA advisory committee that was established by an Act of Congress and that is inactive.

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

While there are several existing advisory committees that focus on disability accessibility to VA services, benefits, and facilities, this new committee would be fully focused on the issue of providing accessibility to individuals with disabilities. It is also important to stand up this committee as its own entity. Combining committees or merging committees would create serious efficiency concerns. It also may dilute the important work that the already established committee is doing. By creating and standing up this Veterans Advisory Committee on Equal Access, the members can be focused and committed on the sole issue of accessibility that they have been tasked with.

However, the proposed committee could be tasked with responsibilities that may duplicate existing efforts. For example, the committee would evaluate compliance with the ADA, which is not generally applicable to Executive Branch agencies. It also would evaluate compliance with sections 504 and 508 of the Rehabilitation Act of 1973, which are applicable to Executive Branch agencies, but this could create greater obligation on the Department in terms of compliance and could be redundant. The Department would welcome the opportunity to work with the committee on technical amendments to the bill.

Regarding section 3, VA is already required to evaluate all existing discretionary committees to determine an existing need for continuation and engages in this process biennially. Discretionary committees are terminated when no longer valid. The nine active discretionary committees have all been determined to provide necessary insight and advice to VA operations. There are no discretionary committees that would currently meet the requirements for abolishment. The VA is concerned that section 3 may be duplicative to other requirements that the Department already has in place. As stated above, VA thanks the Committee for the opportunity to provide views on this proposed bill and would be happy to work with the Committee on technical assistance.

The estimated cost of establishing the committee is approximately $750,000 per year and $7.5 million over the initial proposed 10-year period of existence, unless extended by Congress.

S. 1441 Service Dogs Assisting Veterans Act of 2025 (SAVES Act of 2025)

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 demonstrated experience in training service dogs in compliance with the requirements of the ADA).

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 and ensures only eligible Veterans are allowed to participate in the program. 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 under 38 U.S.C. § 101 who, as determined by a physician, have one more of the following disabilities, conditions, or diagnoses: 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); or 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 five 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 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.

S. 1591 Acquisition Reform and Cost Assessment Act of 2025 (ARCA Act of 2025)

This bill includes nine total sections, with section 1 providing a short title and table of contents.

Section 2(a) would add new subchapter VII, "Acquisition Organization, Cost Assessment, and Program Evaluation," to chapter 81 of title 38, U.S.C. The new subchapter would include section 8181, "Definitions," which would add definitions for the terms "major acquisition program" and "non-major acquisition program" that would apply

throughout the subchapter. Section 2(b) would amend 38 U.S.C. § 308 to increase the number of Assistant Secretaries from seven to eight, including the addition of an Assistant Secretary for “Acquisition and innovation”.

Section 2(c) would add a new section 8182, “Acquisition organization,” to title 38, U.S.C., which would direct the Secretary to designate an Assistant Secretary for Acquisition and Innovation, who would also be the Chief Acquisition Officer (CAO). The Assistant Secretary would be the head of the Office of Acquisition and Innovation, and major program offices would align under the Office. The budget for the Office would be established in VA’s budget justification materials submitted to Congress. The Secretary would appoint three Deputy Assistant Secretaries (DAS), who would report to the Assistant Secretary for Acquisition and Innovation—a DAS for Logistics, a DAS for Innovation, and a DAS for Procurement. The DAS for Logistics would be responsible for the administration of logistics and supply chain operations. The DAS for Innovation would be responsible for all research development, testing, and innovation development organizations, including the VHA Innovation Ecosystem. The DAS for Procurement would be responsible for all VA procurement and contracting organizations.

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

VA supports the intent of this section, subject to amendments, because it enhances the focus on and coordination of acquisition and innovation activities, ensuring they align with Presidential priorities to streamline processes, improve efficiency, and foster a more innovative approach to acquiring and developing capabilities. This new role and organization better support and reflect the CAO's responsibilities and the increasing complexity of VA's acquisition needs. The CAO serves as the primary advisor to the Secretary for all major acquisitions, manages 17,000 acquisition professionals, and is responsible for providing oversight of approximately $100 billion in VA's major acquisition programs. VA believes additional amendments are needed to give effect to the intent of this section, particularly with revising the dollar value for major/non-major acquisition programs to align with the definition of “Major Information Technology Project” in 38 U.S.C. § 8171(5) (as added by the Department of Veterans Affairs Information Technology Reform Act of 2022 (section 403 of the Joseph Maxwell Cleland and Robert Joseph Dole Memorial Veterans Benefits and Health Care Improvement Act of 2022; P.L. 117-328, Div. U)). VA also recommends adding a DAS for Acquisition, Program Management, and Performance, who would report to the Assistant Secretary for Acquisition and Innovation. This additional DAS role would focus on the critical aspects of VA's "Big A" acquisitions. This role would transcend mere procurement, placing a strong emphasis on lifecycle management that is intricately structured around vital elements: requirements planning, programming and budgeting, policy innovation, performance standards, governance, and enhancing the capabilities of the acquisition workforce. This comprehensive approach would ensure that our major acquisitions are both effective and forward-thinking, paving the way for successful outcomes.

VA does not have a cost estimate for this section.

Section 3 would add a new section 8183, "Major acquisition program managers." The new section would direct the Deputy Secretary to appoint a manager to administer a major acquisition program not later than 30 days after the Secretary approves commencement of the program. Each appointed manager would report to the Assistant Secretary for Acquisition and Innovation and be responsible for developing a "program baseline." The program baseline would include a description of each acquisition phase; requirements for advancing the program; and estimates for cost, schedule, and performance for the lifecycle of the program. The manager would be responsible for ensuring that the program is in compliance with such requirements, securing funding, adopting standardized processes, and ensuring personnel responsible for estimating the budget for the program are able to raise concerns prior to the establishment of the program baseline. The manager would be responsible for ensuring that: the program complies with cost accounting standards as applicable; the program has a qualified workforce; and the program has adequate technology and production capacity prior to commencing if the program is related to manufacturing.

The manager would be required to submit a certification, within 90 days of establishing the program baseline, stating that alternative requirements were considered prior to establishing the program baseline. The certification would be submitted to the program decision authority (the Assistant Secretary for Acquisition and Innovation). The Secretary would ensure that the program management offices for the major acquisition programs are independent of VBA, VHA, and the National Cemetery Administration (NCA), and other staff offices by reporting directly to the Assistant Secretary for Acquisition and Innovation. The manager would be required to notify the program decision authority within 30 days of the conclusion of an acquisition phase of a major acquisition program. The manager would not be allowed to proceed to a subsequent acquisition phase without the authorization of the program decision authority.

VA supports the intent of this section, subject to amendments.

VA supports the intent of this section, subject to minor amendments, as VA has taken action to establish a policy that major acquisition programs require certified program managers and teams appointed by the Deputy Secretary to ensure efficient planning, execution, and oversight of VA's most complex and high-stakes programs. VA also seeks to ensure that Assistant Secretary for Acquisition and Innovation would align and seek input from other senior functional areas regarding statutory requirements for program oversight.

VA does not have a cost estimate for this section.

Section 4 would transfer all contracting officers and acquisition centers to the Office of Acquisition and Innovation. All activities related to the administration of logistics and supply chain operation would be consolidated under the DAS for Logistics.

VA supports the intent of this section.

VA does not have a cost estimate for this section.

Section 5 would require the Secretary to enter into one or more contracts for the independent verification and validation (IV&V) of a major acquisition program or major information technology project. To be awarded a contract, the CAO would have to determine that the entity performs or has performed, within a 3-year period as prime contractor, IV&V or systems engineering and technical advisory support of major acquisition programs or defense systems. The entity, including its subsidiaries, subcontractors, and investments, would be precluded from receiving an award if it was performing or had performed within a 3-year period a covered contract for the project or system involved or for VA. If requested by Congress, contracting officers would be required to submit an organizational conflict of interest mitigation plan submitted by the entity within 30 days from the request. VA would send a copy of the IV&V to Congress not later than 30 days after it was performed. The Chief Financial Officer would need to ensure, to the extent practicable, that each organizational subdivision that enters into a contract for IV&V proportionally contributes to the funding of each contract.

VA supports the intent of this section, subject to amendments.

VA supports the intent of this section, subject to amendments. With the exclusive mandate for IV&V by external contractors, the Department would need to carefully review existing IV&V and testing-related contracts for compliance while ensuring continuity. This shift may unintentionally exclude experienced VA contractors who lack the required DoD-related contract experience; therefore, VA believes refining the proposed legislative language for clarity and proactively addressing these exclusions would be crucial to mitigating operational disruptions. To preserve operational integrity and effectiveness, leveraging both governmental expertise and external contractor support in IV&V processes is vital, and adhering to industry standards such as IEEE Std. 1012 while maintaining flexibility in IV&V implementation will ensure comprehensive oversight without compromising quality.

VA does not have a cost estimate for this section.

Section 6 would add a new section 8184, "Cost assessment and program evaluation." This new section would establish a Director of Cost Assessment and Program Evaluation (CAPE) who would report directly to the Secretary. The CAPE Director would provide independent analysis and advice to the Secretary and other senior VA officials on matters assigned to the Director pursuant to this section and to 38 U.S.C. § 303. Proposed section 8184(c) would establish two Deputy Directors within the CAPE Office, one for Cost Assessment and one for Program Evaluation. Proposed section 8184(d) would define the responsibilities of the CAPE Director. The Secretary would have to ensure that the Director promptly received the results of all cost estimates and cost analyses conducted by VBA, VHA, NCA, or staff offices and all studies conducted by the Administration, in connection with such cost estimates and cost analyses for major acquisition programs and major automated information system programs of the Administrations. The Director also would have to have timely access to any records and data in the Department. Proposed section 8184(h) and section 6(b) of the bill would define VA's annual reporting requirements. Finally, section 6(b) would define reporting requirements on the monitoring of operating and support costs for major acquisition programs.

VA does not support this section

While VA agrees with the intent behind establishing a CAPE Director function to enhance oversight, VA does not support this section. VA does not believe that establishing the function and roles in law is necessary. VA seeks the flexibility to develop and expand existing capabilities within the Office of Management without the additional constraints prescribed in this section.

VA does not have a cost estimate for this section.

Section 7 would add two new sections, 8185 and 8186, titled "Other transaction authority" and "Advance market commitments for technologies or services for provision of health care," respectively. Proposed section 8185 would establish another transaction authority (OTA) that would permit VA to enter into transactions with non-traditional contractors to perform certain types of research or innovation development activities. The authority could also be exercised by the Deputy Assistant Secretary for Innovation for activities that align with the mission of the VHA Innovation Ecosystem, provided certain requirements are met. The criteria include research that is not duplicative, a determination by the senior procurement executive that the research is appropriate, that the transaction will not exceed $5 million to include all options (unless a determination is made to exceed such limits), and other details and limitations. It also would specify notice and reporting requirements to Congress, require VA prescribe regulations to carry out the section, and limit authority under this section to a term of 3 years after the date of enactment. Finally, it would define various terms.

Proposed section 8186 would grant VA authority to enter into advance market commitments by guaranteeing VA purchase, at a predetermined price, a technology or service provided by an entity that addresses an unmet need in the provision of health care to Veterans. It further would specify criteria that must be met prior to entering into an advanced market commitment, to include clearly defined and transparent rules, clear definitions, defined dispute settlement mechanisms, and the ability to modify under certain conditions. The section also would outline a reporting requirement to notify Congress within 120 days of execution of an advanced market commitment.

VA supports the intent of this section.

VA supports the intent of this section because it would provide VA with the tools to drive rapid innovation. OTA would minimize barriers, facilitate more streamlined bidirectional collaborations with industry, and help VA attract new, private sector entities that do not traditionally engage with VA. Having OTA, including for research, prototyping, and follow-on production, as a flexible acquisition tool would enable VA to address its immediate challenges today and prepare us to tackle future challenges to modernize VA rapidly in the years to come.

VA does not have a cost estimate for this section.

Section 8 would require VA to monitor the training and experience gap of professionals and establish or expand any existing internship or development pipelines for 1102 contracting officers at VA.

VA supports the intent of this section.

VA supports the intent of this section because it underscores VA's need to expand internship and development pipelines for 1102 contracting officers to address training and experience gaps. VA has initiatives underway and will continue to prioritize improving the skills and competencies of its acquisition workforce, thereby enhancing the Department's long-term operational efficiency and effectiveness in managing acquisitions.

VA does not have a cost estimate for this section.

Section 9 is a clerical amendment to amend the table of sections to add subchapter VII and sections 8181-8186 to 38 U.S.C.

VA supports the intent of this section.

VA welcomes the opportunity to work with the Committee on technical assistance, including necessary conforming amendments.

There is no cost associated with this section.

S. 1543 Veterans Opportunity Act of 2025

This bill includes four total sections, with section 1 including a short title.

Section 2(a) of this bill would create a new chapter 80 in title 38, U.S.C. This new chapter 80 would include three new sections: 8001, 8002, and 8003. The new section 8001 would establish and outline the functions of the Veterans Economic Opportunity and Transition Administration (VEOTA) and make clear that it is headed by an Under Secretary for Economic Opportunity and Transition.

Under new Section 8002, VEOTA would be responsible for administering the following:

(1) Vocational rehabilitation and employment programs.
(2) Educational assistance programs.
(3) Veterans' housing loan and related programs.
(4) The Secretary's responsibilities with respect to the Transition Assistance Program under 10 U.S.C. § 1144.
(5) Any other VA program that the Secretary determines appropriate.

New Section 8003 would require an annual report to Congress regarding program-related data from the fiscal year covered by the report.

Section 2(b) specifies that the effective date for the establishment of chapter 80 would be October 1 of the first fiscal year commencing after the enactment of the Act. Section 2(c) addresses labor rights, and specifies that any labor rights, inclusion in bargaining units, and collective bargaining agreements affecting VA employees transferred to VEOTA would remain the same post-transfer.

Section 3 would establish the position of Under Secretary for Veterans Economic Opportunity and Transition, outline the Under Secretary's responsibilities, and establish the procedures under which the position would be filled. These procedures would be codified in a new section 306A of title 38, U.S.C.

Section 4 of the bill would require VA to report to Congress, within 180 days of the date of enactment, on the progress toward establishing VEOTA and would prevent the transfer of functions to VEOTA until VA certifies to Congress that the transition of services to VEOTA will not negatively affect the provision of services to veterans and that services are ready to be transferred. This certification must be submitted no earlier than April 1 and no later than September 1 of the first fiscal year commencing after the

enactment date. If the certification is not made by the specified date, the Secretary must provide Congress with a report explaining the delay and estimating when certification will be made.

VA does not support this bill.

While VA appreciates the Committee's focus on improving services and resources offered, the Education, Loan Guaranty, Veteran Readiness and Employment (VR&E), and Outreach, Transition, and Economic Development (OTED) programs are part of an integrated suite of interdependent services and benefits that also includes compensation, pension, and insurance programs. Together, they form a suite of benefit-related resources that Veterans can rely on.

In FY 2024, VA processed over 4.3 million education claims in an average of 5.7 days. Over 2.1 million claims were automated, delivering real-time benefit decisions to Veterans and their dependents. VA paid over $12 billion in education benefits for 901,463 Veterans and their beneficiaries. VA guaranteed 416,376 loans worth $155.4 billion in FY 2024. Loan Guaranty also assisted 158,290 borrowers retain homeownership and/or avoid foreclosure, resulting in a $3.33 billion savings in estimated foreclosure costs to the Government. VR&E helps Service members and Veterans with service-connected disabilities and a barrier to employment prepare for, find, and maintain suitable jobs through counseling and case management. There were over 140,000 VR&E participants in FY 2024, with more than 44,000 new plans developed to assist Veterans, and over 12,000 Veteran Rehabilitations. Since the launch in December 2019 through April 2025, VA Solid Start has successfully connected with 586,029 recently separated Service members, representing a 74.7% successful contact rate. This includes a total of 140,123 successful contacts in FY 2025 through April 2025.

To support such robust and complex operations, numerous enabling staff offices are necessary, such as finance, human resources, facilities, production optimization, outreach and engagement, field operations, business process integration, strategic program management, performance analyses, communications, and executive review. These enabling organizations would have to be recreated within the new administration in order to effectively operate, requiring additional executive leadership and replicated structures. The addition of another administration would increase the leadership oversight for programs that are currently in place, contrary to the modernization efforts that are underway.

Additionally, if the VEOTA was enacted, VA would require ample time to plan for this considerable transition to ensure services are not negatively affected. Therefore, while VA remains committed to communicating closely with the Committees, it does not support a specified timeframe for reporting or certification.

VA does not have a cost estimate for this bill. We note that General Operating Expense costs would result from the enactment of this bill for Management Direction

and Support for enabling staff offices, which would include payroll and non-payroll costs (travel, contract support, centralized payments, etc.). No mandatory costs would be associated with the proposed legislation. We also note that the creation of a new administration could require additional information technology resources to support an increase in staff and any new information technology solutions that may be needed.

S. 1533 Making Permanent and Codifying Pilot Program for use of Contract Physicians for Disability Examinations

Subsection (a) of the bill would add a new section 5103B to title 38, U.S.C., regarding the use of contract physicians for disability examinations.

Subsection (a)(1) of proposed § 5103B would allow disability examinations carried out through the Under Secretary for Benefits be made by qualified persons other than VA employees.

Subsection (a)(2) of proposed § 5103B would allow disability examinations conducted by a qualified person under paragraph (1) be performed under a contract entered into by the Under Secretary for Benefits.

Subsection (b)(1) of proposed § 5103B pertains to the licensure of contracted health care professionals and would allow contracted disability examiners to conduct examinations at any location in any State as long as the examination is within the scope of their authorized duties under the contract.

Subsection (b)(2) of proposed § 5103B would define a health care professional as "a person who is eligible for appointment to a position in the Veterans Health Administration [(VHA)] covered by [38 U.S.C. § 7402(b)] who—(A) has a current unrestricted license to practice the health care profession of the health care professional; (B) is not barred from practicing such health care profession in any State; and (C) is performing authorized duties for the Department pursuant to a contract entered into under subsection (a)."

Subsection (c) of proposed § 5103B would direct that the expenses associated with contracted disability examinations, including payments for examination travel and incidental expenses, "be reimbursed to the accounts available for VBA general operating expenses of the Veterans Benefits Administration and information technology systems from amounts available to the Secretary for payment of compensation and pensions."

Subsection (d) of proposed § 5103B would require establishment of a mechanism whereby medical evidence introduced by applicants for benefits during examinations "that the health care professional considers new and material to the application" can be transmitted to the Secretary.

Subsection (b) of the bill would provide a clerical amendment to the table of

sections based on the proposed § 5103B.

Subsection (c) of the bill would require VA, no later than 3 years after enactment, to report to Congress on the effect of the contract examination authority on the cost, timeliness, and thoroughness of medical disability examinations.

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

VA appreciates the Committee's intent to make permanent and codify the pilot program for use of contract physicians for disability examinations and strongly supports that goal. However, VA provides the following comments.

In the proposed title, *§ 5103B. Use of contract physicians for disability examinations*, VA recommends replacing "physicians" with "health care providers," as VA utilizes a wide range of qualified medical professionals to conduct disability examinations. Additionally, this would ensure consistency with the language used in proposed § 5103B.

VA recommends adding the terms "registration, or certification" after the phrase "…has a current unrestricted license," in subsection (b)(2) of proposed § 5103B since not all providers require a license (see, for instance, 38 U.S.C. § 7402(b)(3), (b)(8), (b)(11)). Of note, the requirement set forth in subsection (b)(2)(B) may be redundant to the requirements set forth in 38 U.S.C. § 7402(f) which requires that health care providers not have had a state license, registration, or certification terminated for cause or have voluntarily relinquished such license, registration, or certification after being notified of potential termination for cause.

VA also recommends that proposed § 5103B(d) be removed. This provision has the potential to create problems with custody of official government records, which may impact date of claim and timely receipt of evidence. VA does not have contractual privity with the contract examiners. Instead, the examiners are subcontracted with VA's contract vendors. Proposed § 5103B(d) would allow a non-VA employee or non-VA-contracted party to establish constructive custody of records on behalf of VA. While VA may create policies regarding the timing of delivery of such records with contract vendors, VA cannot enforce those policies directly with the subcontracted examiners. Any delay on the part of a subcontracted examiner in submitting evidence to VA on behalf of a Veteran might result in a later date of claim than if the Veteran submitted the evidence directly to VA and raises the risk of litigation over the matter.

Additionally, the proposed § 5103B(d) would create an evidentiary burden on contract examiners that is not applied to VHA examiners. If an applicant for benefits provides evidence during an examination, the VHA examiner is directed to review the evidence, document it in the examination report, and then return it to the applicant with the instruction that the applicant immediately submit it to VBA.

Of particular concern, the proposed § 5103B(d) would condition the transmission of evidence to the Secretary on the health care professional's determination that the evidence is "new and material." Initially, VA notes that the phrase "new and material" is no longer in use and has been replaced with the phrase "new and relevant" evidence (*see* 38 U.S.C. §§ 5103A, 5108, 5110). More problematically, health care professionals are responsible for providing examinations to aid in the adjudication of claims for VA benefits; they are not qualified or authorized to determine what constitutes evidence that is new or relevant (or material) to those claims. These are adjudicative (rather than medical) standards that must be addressed by trained claims adjudicators.

VA thanks the Committee for the opportunity to provide views on this proposed bill and would be happy to work with the Committee on technical assistance.

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 Committee may have.

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STATEMENT OF MORGAN BROWN

NATIONAL LEGISLATIVE DIRECTOR

PARALYZED VETERANS OF AMERICA

BEFORE THE

SENATE COMMITTEE ON VETERANS' AFFAIRS

ON

PENDING LEGISLATION

MAY 21, 2025

Chairman Moran, Ranking Member Blumenthal, and members of the committee, Paralyzed Veterans of America (PVA) would like to thank you for the opportunity to testify on some of the pending legislation impacting the Department of Veterans Affairs (VA) that is before the committee. No group of veterans understand the full scope of benefits and care provided by the VA better than PVA members—veterans who have acquired a spinal cord injury or disorder (SCI/D). PVA provides comments on the following bills included in today's hearing.

S. 214, the MEDAL Act of 2025

PVA supports the MEDAL Act, which recognizes the exceptional bravery and commitment of the nation's living Medal of Honor recipients. Specifically, this legislation raises the monthly special pension provided to them from $1,406.73 to $8,333.33. It also establishes $1,406.73 as the rate of the monthly pension provided to the surviving spouses of Medal of Honor recipients and requires that both rates be adjusted annually for inflation. This change is a fitting way to honor those who have given so much in service to our nation.

S. 219, the Veterans Health Care Freedom Act

This bill directs the VA to establish a three-year pilot program in four Veterans Integrated Service Networks (VISN) that would eliminate the VA MISSION Act's (P.L. 115-182) rules for access to non-VA care. Eventually, the program would become permanent for all VISNs. Uncoordinated care like this would most certainly lead to rapidly rising costs and drain off resources needed for VA direct care.

Therefore, we have grave concerns about the impact this legislation would have on catastrophically disabled veterans who rely on VA's specialty care for their ongoing health and independence.

S. 506, the Coordinating Care for Senior Veterans and Wounded Warriors Act

Many veterans who are over the age of 65 and those who are disabled are often enrolled in both Medicare and the VA. The lack of coordination between these two agencies can lead to duplication of care, poor coordination of services, higher costs, and in the worst cases, it endangers the health and wellbeing of the veteran. PVA supports the Coordinating Care for Senior Veterans and Wounded Warriors Act, which seeks to create a three-year pilot program within the VA to better coordinate, navigate, and manage the delivery of health care for veterans enrolled in both Medicare and VA health care. This would test VA's ability to coordinate and manage care and benefits between these two systems for covered veterans.

S. 585, the Servicemember to Veteran Health Care Connection Act

PVA supports this legislation, which would codify and expand the existing VA pre-transition healthcare registration process for all servicemembers transitioning to civilian life. This would ensure that the VA, in partnership with the Department of Defense (DOD), will pre-register all servicemembers leaving active duty and contact them within 30 days after their discharge to complete registration if they wish to enroll in VA healthcare services. It also requires the department to be more proactive in its outreach efforts to transitioning servicemembers, so they are better informed about the VA healthcare services available to them, before and after enrollment. This improvement to the existing process will help greater numbers of veterans overcome challenges, particularly in accessing health care as they transition to civilian life.

S. 605, 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. Surviving children of military veterans 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.

S. 635, the Veterans Homecare Choice Act of 2025

The VA currently excludes nurse registries from the VA's Community Care Network, which prevents them from qualifying for reimbursement. Meanwhile, aging and disabled veterans want to live independently in their own homes but sometimes they need extra assistance to do so. For many of our members, they require extra assistance throughout their lives. Across the country, there is an increasing shortage of direct care workers, and a national effort is needed to expand and strengthen this workforce. Until then, we should leverage as much of the existing workforce as possible to help ensure veterans' needs are being met. Prior to the passage of the VA MISSION Act, the VA would reimburse veterans who employed a home care professional via a nurse registry, making it a great option for many veterans. Since that time, only services provided by a home care agency have been covered. PVA supports this bill, which seeks to correct an obvious error, giving veterans more options for their home care needs.

S. 649, the Guard and Reserve GI Bill Parity Act

PVA supports the Guard and Reserve GI Bill Parity Act. Today, serving in the military looks a lot different than it did 20 or 30 years ago. Our guard and reserve uniformed services are being called up to serve more frequently; however, they are often locked out of the GI Bill due to limited time on Title 10 orders. This legislation would allow those serving in the Reserve Components to count their drill time, annual training, military training schools, and state-level orders towards their Post-9/11 GI Bill eligibility.

S. 784, the Rural Veterans Transportation to Care Act

Veterans living in rural areas regularly face barriers to receiving care as they are more likely to be over the age of 65[1] and may have financial challenges that make travel costs for healthcare appointments burdensome. Others, especially those with catastrophic illnesses or injuries, cannot drive and some don't own a car. Longer distances to healthcare facilities in rural areas also mean veterans may not have immediate access to all types of healthcare providers, including specialists.

PVA supports the Rural Veterans Transportation to Care Act, which seeks to expand eligibility for the department's Highly Rural Transportation Grants (HRTG) Program to both rural and highly rural counties. The "highly rural" definition of seven persons per square mile is unique to this VA program, and is quite restrictive, applying to very few areas in the country (e.g., North Dakota has some counties that meet the definition). Other VA rural programs use rural-urban commuting area codes to assess rurality. Including "rural" and "highly rural" areas would allow grantees to serve more veterans. The bill would also increase the maximum amount of funding grant recipients are eligible for from $50,000 to $60,000, or up to $80,000 for grantees to purchase an ADA-compliant vehicle. We strongly support efforts to increase transportation options, particularly for veterans who use wheelchairs and have limited mobility resources.

S. 800, the Precision Brain Health Research Act of 2025

There is growing concern with potential subconcussive neurological injuries following repetitive low-level military occupational blast exposure, such as heavy weapons training and breaching activities.[2][3] Precision medicine is an innovative approach for traumatic brain injury (TBI) treatment that customizes medical treatment to the individual characteristics of each patient. Instead of using a one-size-fits-all approach, providers consider aspects of a patient's genetics, environment, and lifestyle to select targeted therapies that may be more effective. PVA supports the Precision Brain Health Research Act, which adds repetitive, low-level blast exposure to a list that includes TBI, depression, anxiety, and posttraumatic stress disorder (PTSD) as targets for validating brain and mental health biomarkers as part of VA's Precision Medicine for Veterans Initiative. It also requires the VA to work with the National Academies of Science, Engineering, and Medicine to create a ten-year research plan to establish the effects of repetitive low-level blast injuries. Both changes will help make certain veterans have the evidence-based care and benefits they deserve.

S. 827, the Supporting Rural Veterans Access to Healthcare Services Act

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[1] RURAL VETERANS - Office of Rural Health

[2] Repetitive Low-level Blast Exposure and Neurocognitive Effects in Army Ranger Mortarmen | Military Medicine | Oxford Academic.

[3] The Neurological Effects of Repeated Exposure to Military Occupational Blast: Implications for Prevention and Health: Proceedings, Findings, and Expert Recommendations from the Seventh Department of Defense State-of-the-Science Meeting.

As previously stated, VA's HRTG program helps veterans in highly rural areas travel to VA or VA-authorized healthcare facilities. The program provides funding to veterans service organizations (VSO) and state veterans service agencies to provide transportation services in eligible counties. Currently, the HRTG provides transportation programs in counties with fewer than seven people per square mile and there is no cost to participate in the program for veterans who live in areas where the program is available. This bill seeks to improve the existing program by extending grant eligibility to tribal and Native Hawaiian organizations. It also addresses the financial limitations of the current program by allowing for an increase in the maximum grant amount for counties with more than five communities that are off the road system. This provision acknowledges the additional logistical challenges faced by veterans in these remote areas and aims to provide more substantial support to overcome transportation barriers. Also, it eliminates the existing funding cap of $3 million per year, replacing it with such "sums as may be necessary for each of fiscal years 2025 through 2029." This would ensure the program is truly funded based on veterans' actual needs in that area, not some arbitrary amount.

S. 879, the Veteran Caregiver Reeducation, Reemployment, and Retirement (RRR) 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. 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 address these issues. Also, those who were relying 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.

The Veteran Caregiver RRR Act 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 (DOL VETS). 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. Lastly, 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.

S. 1383, the Veterans Accessibility Advisory Committee Act of 2025

PVA strongly supports this legislation, which directs the VA to create an advisory committee on issues relating to the accessibility of VA benefits, services, and facilities for veterans and employees with mobility, hearing, visual, cognitive, or other disabilities. Few veterans have a greater reliance on VA benefits and services than veterans with SCI/D. Because of the complex nature of catastrophic disabilities, PVA members utilize healthcare services at a much higher rate than other groups of veterans. For most, it is a lifetime partnership, beginning immediately after injury or diagnosis and continuing through rehabilitation and periods of sustaining care. So, anytime there is a problem accessing VA benefits or services, it tends to severely affect our members.

Over the last five decades, Congress has passed several bills to improve disability access both in the VA and in the community. These include the Architectural Barriers Act (ABA), the Rehabilitation Act of 1973, and the Americans with Disabilities Act (ADA). The ABA requires buildings and facilities that are built, altered, or designed after August 12, 1968, using federal funds or that federal agencies lease be accessible. The Rehabilitation Act includes protections against disability discrimination in federal agency programs. The prohibition also extends to entities that receive federal funds, federal employment, and federal electronic and information technology. The ADA provides protections from discrimination at the state and local government levels, as well as by private entities that provide public accommodations. Taken together, these laws provide critical protections to people with disabilities when they interact with all levels of government and many everyday accommodations, like medical offices, grocery stores, and hotels.

Despite these comprehensive legal requirements, PVA members routinely face disability-access barriers when it comes to accessing care at the VA and within the community. In one VA facility, PVA members have relayed that they must wait and check in and out in hallways because spaces designated for those tasks are too small to accommodate their wheelchairs, meaning privacy isn't possible. We've also heard of VA women's clinics that have examination rooms that are too small for veterans who use wheelchairs or lack overhead patient ceiling lifts.

PVA members also report issues with automatic doors that need servicing and are inoperable, making them far too heavy for a veteran with SCI/D to open. Several members have also complained of

doorways being too narrow and causing significant damage and scrapes to their equipment and wheelchairs, which might not sound like a big deal until that veteran needs to battle with their prosthetics office to get repairs. And at several locations, veterans have encountered out of order elevators that often take days to repair. For SCI/D veterans who use wheelchairs, scooters, or other assistive devices, elevators are critical in getting to their appointments, particularly those within the VA that are in other departments and clinics outside the SCI/D system of care.

Veterans also encounter inaccessible medical diagnostic equipment (MDE). MDE includes equipment like medical examination tables, weight scales, dental chairs, x-ray machines, mammography equipment, and other imaging equipment. In 2017, the U.S. Access Board, published new accessibility standards for MDE. As soon as the new standards were issued, the VA proactively said they would adopt the new standards to ensure that the needs of disabled veterans were met. Since that time, we have received no updates from the VA on the status of implementing the MDE accessibility standards, and we have been unable to determine the extent of the department's progress.

Although VA has worked to address access barriers for disabled veterans, there is more work to do. Establishing a Veterans Accessibility Advisory Committee would help ensure the VA is meeting the needs of veterans, by allowing disabled veterans, experts, employees, and VSOs to identify problems and offer solutions via a formal committee whenever the VA is "missing the mark." We believe that the ongoing existence of access barriers points to the need for more focused, collaborative efforts with the VA.

Passing this legislation would help ensure VA's facilities and programs are better prepared to welcome, accept, and care for disabled veterans and employees by placing disability access at the forefront. The time is now for action, and we call on Congress to pass this legislation as soon as possible.

S. 1441, 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.

S. 1533, the VA License Portability Act
The Johnny Isakson and David P. Roe, M.D. Veterans Health Care and Benefits Improvement Act of 2020 (P.L. 116-315) created a pilot program that allowed VA's contracted healthcare professionals to provide medical disability examinations across state lines. PVA supports this effort to permanently extend this authority.

S. 1543, the Veterans' Education, Transition and Opportunity Prioritization Plan Act
PVA strongly supports this legislation, which would create a new administration within VA to oversee the agency's education, training, employment, and other programs focused on helping veterans as they transition to civilian life. The new Veterans Economic Opportunity and Transition Administration would be headed by an Under Secretary for Veterans Economic Opportunity and Transition.

Two of the programs that would transition to the new administration include VA's Veteran Readiness and Employment (VR&E) program and the Specially Adapted Housing (SAH) program. These programs are relatively small in terms of budget and numbers of veterans served. However, they are vital to veterans who have catastrophic disabilities as a result of their military service. Without them, these veterans would not be able to access independent living services or adapt their homes to meet their disability-related access needs.

Unfortunately, these programs, along with other VA economic opportunity programs, simply are not able to receive the staffing, IT, and other support needed due to their position within the Veterans Benefits Administration (VBA). This administration plays the crucial role of providing needed disability compensation and pension benefits to veterans. Removing programs like VR&E from VBA's list of responsibilities will not only allow for more attention to be placed on those programs but it will also allow them to better focus on processing claims for compensation and pension benefits.

Under the Economic Opportunity and Transition Administration, programs like VR&E and SAH will receive a higher level of visibility. This increased visibility will foster stronger oversight and accountability for the delivery of services and benefits. We believe that such oversight and accountability will help to foster the innovation needed to ensure that the delivery of these benefits and services is modernized. It will also allow for focused collaboration with other agencies and programs, including DOL VETS, that also serve veterans, increasing program efficiencies.

S. 1591, the Acquisition Reform and Cost Assessment Act of 2025
The Acquisition Reform and Cost Assessment Act establishes an Office of Acquisition and Innovation to better define major acquisition programs at the VA, streamlines its oversight and contracting processes, enhances accountability through independent evaluations and reporting, and improves training for department staff. PVA recognizes that effective supply chain management plays a pivotal

role in ensuring that the VA can deliver timely, high-quality care to veterans. The VA has faced numerous challenges with its supply and logistics programs in recent years, so we support efforts like this to ensure the department receives the right materials on time, in the right condition, and of course, at the right price.

S. 599, the DRIVE Act of 2025

The Drive Act increases the mileage reimbursement rate available to beneficiaries for travel to or from VA facilities in connection with vocational rehabilitation; required counseling; or for the purpose of examination, treatment, or care. Specifically, the bill makes the reimbursement rate for such travel equal to or greater than the mileage reimbursement rate for government employees using private vehicles when no government vehicle is available. Government employees' travel rates are adjusted annually but reimbursement rates for veterans are not. Under current regulations, VA reimburses veterans when traveling for a VA healthcare appointment at a rate of 41.5 cents per mile, which is far less than what government employees receive. PVA endorses this bill, because veterans should not be subject to a lower reimbursement rate than federal employees.

S. 778, the Lactation Spaces for Veteran Moms Act

PVA supports passage of the Lactation Spaces for Veteran Moms Act, which would help many veteran mothers feel more welcome at VA facilities. There is abundant scientific evidence showing that breastfeeding benefits both babies and mothers and a recent study found a high percentage of women veterans nurse their infants until at least four weeks postpartum.[4] For their health and the health of their babies, veteran mothers and the VA employees that serve them need a safe, private place other than a lavatory to feed or pump breast milk. A few VA facilities have or are thinking about creating dedicated lactation rooms, but they should be required system wide. We recommend adding language to the bill stating that lactation rooms should provide square footage in accordance with national accessibility standards and have a wall mounted sink and fixed bench seating to ensure that maneuvering clearances are met for women veterans who use wheelchairs.

S. 1320, the Servicewomen and Veterans Menopause Research Act

The percentage of women actively serving in all military branches rose from 14.6 percent in 2005 to 17.7 percent in 2023.[5] As increasing numbers of women choose to serve in uniform, more of them will turn to VA for their healthcare needs. More than two million women veterans live in the U.S. today and by 2040, the VA estimates that 18 percent of all veterans will be women. These ever-increasing numbers spotlight the need for both VA and DOD to evaluate health-related programs and services for women who are serving or have served the nation in uniform. Currently, 50 percent of the women

[4] Disparities in Breastfeeding Among Military Veterans - PubMed (nih.gov).
[5] DOD's 2023 Demographics Report Indicates More Women, Fewer Separations - Defense Department News.

enrolled at VA for primary care are between the ages of 45-64, the age range for perimenopause and menopause.[6]

PVA supports this bill which directs the DOD and the VA to investigate how military service influences menopause. Per the legislation, their research must explore the impact that combat roles, hazardous exposures, and overall mental health has on menopause, perimenopause, and mid-life women's health in general. Also, it requires the two departments to look at the availability of and uptake of professional training resources for covered providers relating to mid-life women's health with respect to the care, treatment, and management of these conditions. If done properly, this bill could be a significant step towards providing better health care for women servicemembers and veterans while improving military readiness.

PVA would once again like to thank the committee for the opportunity to testify on some of the bills being considered today. We look forward to working with you on this legislation and would be happy to answer any questions.

[6] Women Veterans' Healthcare Needs, Utilization, and Preferences in Veterans Affairs Primary Care Settings.

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WOUNDED WARRIOR PROJECT

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Statement of:
Brian Dempsey
Director of Government Affairs

Submitted for the Hearing to Consider Pending Legislation:

S. 214, Monetary Enhancement for Distinguished Active Legends Act of 2025; S. 219, Veterans Health Care Freedom Act; S. 506, Coordinating Care for Senior Veterans and Wounded Warriors Act; S. 585, Servicemember to Veteran Health Care Connection Act; S. 599, Driver Reimbursement Increase for Veteran Equity Act of 2025; S. 605, CHAMPVA Children's Care Protection Act; S. 635, Veterans Homecare Choice Act of 2025; S. 649, Guard and Reserve GI Bill Parity Act; S. 778, Lactation Spaces for Veteran Moms Act; S. 784, Rural Veterans Transportation to Care Act; S. 800, Precision Brain Health Research Act of 2025; S. 827, Supporting Rural Veterans Access to Healthcare Services Act; S. 879, Veteran Caregiver Reeducation, Reemployment, and Retirement Act; S. 1318, Fallen Servicemembers Religious Heritage Restoration Act; S. 1320, Servicewomen and Veterans Menopause Research Act; S. 1383, Veterans Accessibility Act; S. 1441, Service Dogs Assisting Veterans (SAVES) Act; S. 1533, VA License Portability Act; S. 1543, Veterans' Education, Transition and Opportunity Prioritization Plan Act; S. 1591, Acquisition Reform and Cost Assessment Act of 2025

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

May 21, 2025

Chairman Moran, Ranking Member Blumenthal, and distinguished members of the Senate Committee on Veterans' Affairs – thank you for the opportunity to submit Wounded Warrior Project's views on pending legislation.

Wounded Warrior Project (WWP) was founded to connect, serve, and empower our nation's wounded, ill, and injured veterans, Service members, and their families and caregivers. We are fulfilling this mission by providing life-changing programs and services to more than 231,000 registered post-9/11 warriors and 57,000 of their family support members, continually engaging with those we serve, and capturing an informed assessment of the challenges this community faces. We are pleased to share that perspective for this hearing on pending legislation that would likely have a direct impact on many we serve.

S. 219: *Veterans Health Care Freedom Act*

Since the passage of the *VA MISSION Act* (P.L. 115-182), community-based health care has endured as a necessary complement to direct VA health care. Extending VA's ability to provide veterans with timely access to quality care, the community care network has had a heightened impact for groups like rural veterans, women veterans, and veterans live in communities where certain specialty care is not in high enough demand for VA to employ its own providers. While VA authorizes eligible veterans to receive health care from community providers, this is only an option once VA has determined that the veteran meets certain conditions and eligibility requirements and has received approval from a VA provider for the specific care needed. This process can take final decision-making authority out of the hands of the veteran and their trusted care team, and places it in the hands of VA administrators.

The *Veterans Health Care Freedom Act* would establish a three-year pilot program through the VA Center for Innovation for Care and Payment in no less than four Veterans Integrated Service Networks (VISNs) during which participating veterans may elect to receive hospital care, medical services, and extended care services at any provider in the covered care system without consideration for current eligibility requirements or the VISN that they reside in. Notably, this would include mental health care, and the veteran may also choose to move their care coordination to a primary care provider outside of VA.

Wounded Warrior Project supports VA's role as coordinator of care in a dynamic health system that requires coordination with community-based providers; however, veterans and their family support members should be at the center of the decision-making process. This legislation would create a truly open marketplace that allows veterans to "vote with their feet" regarding when and where they receive their care – a departure from the current VA healthcare system model, but one which could generate data and the first real metrics concerning veteran choice given current limits on access to community care. This data could be used to better inform future policy decisions for both community and VA direct care moving forward. As an important caveat, this legislation would require VA to provide veterans with all relevant information prior to making decisions about when and where to receive their care.

While WWP supports the overall intent of piloting a program to give veterans more health care decision-making power, we are concerned about the provision that would amend 38 U.S.C. §1703(d) and §1703A(a)(1) to make these changes permanent and VA-wide following the conclusion of the pilot program. We believe proper consideration and review should be given to the data and outcomes from the pilot program prior to any system-wide implementation to ensure that the program can be successfully scaled up and more importantly, can efficiently and effectively meet the needs of all veterans enrolled in VA healthcare. While the included reporting requirements will provide oversight opportunities, we believe any nationwide implementation should not take place until Congress, VA, and veteran stakeholders are given the opportunity to fully understand the impact these changes will have on VA staffing, budget requirements, and direct care abilities. WWP recommends removal of Section 2 (h)(2)(A) and (h)(2)(B) to allow for this review prior to implementation. Additionally, we are concerned by the size and scope of the pilot and the impact it can have on the overall VA healthcare ecosystem. By requiring that no less than four (of 18 total) VISNs participate in the pilot, it

stands to reason that no less than 20 to 25 percent of VA patients would become eligible to participate. Change at such scale could significantly challenge VA's ability to project cost and medical personnel needs.

S. 506: ***Coordinating Care for Senior Veterans and Wounded Warriors Act***

The Veterans Health Administration (VHA) and Medicare are independent systems that each provide separate and distinct health care benefits to enrollees. Certain veterans, including those over the age of 65 and younger veterans with certain disabilities, including catastrophic injuries, may qualify for coverage under both VHA and Medicare.[1] According to a 2024 survey of VA enrollees, half (50 percent) reported also having Medicare coverage.[2] Eligible veterans may benefit from participating in both healthcare systems for including expanded coverage, more options, and convenience.

While enrollment in both healthcare systems can help veterans take advantage of the best options for care, dual enrollment may also lead to confusion about which to use for specific health needs and challenges coordinating information and medical records between the two providers. Moreover, VA and Medicare providers may not be aware of the care received through the other system and may require duplicative tests or procedures, leading to unnecessary costs, additional time committed to appointments (for both patients and providers), and reduced quality of care for veteran patients.

Warriors participating in WWP's most recent Warrior Survey identified cost and care coordination as priorities in accessing healthcare; with approximately 20 percent of warriors reporting care coordination or patient advocacy as one of the top five factors most important in selecting healthcare.[3] Additionally, care coordination is particularly vital for warriors with catastrophic injuries, such as those served by WWP's Independence Program. This program provides long-term support for wounded warriors living with injuries that impact their independence, such as moderate to severe brain injury, spinal cord injuries, and neurological conditions. Many of these warriors use Medicare earlier in life because of catastrophic injuries from military service. In fact, five percent of VA enrollees under the age of 45 have Medicare coverage, and 15 percent of VA enrollees between the ages of 45-64 have Medicare coverage.[4]

The *Coordinating Care for Senior Veterans and Wounded Warriors Act* would require VA to establish a three-year pilot program to coordinate, navigate, and manage care and benefits for veterans who are enrolled in both VHA and Medicare. The pilot program, which would be administered through VA's Center for Innovation for Care and Payment, would be conducted at three to five Veterans Integrated Service Networks (VISNs), including ones in rural and medically underserved areas. Each veteran participating in the pilot program would be assigned a case manager to develop a personalized care coordination plan and provide the veteran assistance with navigating and accessing care.

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[1] CTRS. MEDICARE & MEDICAID SVCS, *Original Medicare (Part A and B) Eligibility and Enrollment* (last modified Jan. 8, 2025), https://www.cms.gov/medicare/enrollment-renewal/original-part-a-b.
[2] U.S. DEP'T OF VET. AFF., 2024 SURVEY OF VETERAN ENROLLEES' HEALTH AND USE OF HEALTH CARE (Jan. 2024), *available at* https://www.va.gov/VHASTRATEGY/SOE2024/SOE24.pdf.
[3] To review WWP's Warrior Survey in more detail, please visit https://www.woundedwarriorproject.org/mission/warrior-survey.
[4] U.S. DEP'T OF VET. AFF., *2024 Survey of Veteran Enrollees' Health and Use of Health Care.*

Under this legislation, VA would track metrics for the pilot program, including the number of participating veterans; veterans' reliance on VHA and Medicare services, respectively; cost of care; access to and quality of care; patient outcomes; patient and provider satisfaction; and care coordination, including timely information sharing and medical documentation return. VA would also track the type of services provided and the care which is related to a service-connected disability. VA would be required to submit quarterly reports to Congress on implementation and results, and a final report recommending whether the pilot should be made permanent.

The proposed pilot program would offer an innovative way to help these warriors navigate and manage care received through both systems and improve access to and quality of healthcare services, enhance care outcomes, reduce costs, eliminate service gaps and duplications, and improve care coordination. For these reasons, WWP strongly supports the *Coordinating Care for Senior Veterans and Wounded Warriors Act*.

S. 585: *Servicemember to Veteran Health Care Connection Act of 2025*

The process of transitioning from military service back to civilian life, a change that roughly 200,000 Service members undergo each year,[5] is a challenging time for every individual who goes through it regardless of their rank, branch of service, or time spent in uniform. The challenges they face are not limited to simply finding a new source of income or a new place to live – many transitioning Service members are also leaving behind years of career advancement, established social support networks, and the care made available to them through the Department of Defense (DoD) healthcare system. These changes often provide the biggest stressors and disruptions during the transition period and serve as a list of areas that can be addressed with enhanced programs and services to help transitioning Service members.

In its 2024 National Veteran Suicide Prevention Annual Report[6], VA's Office of Suicide Prevention found that veterans who have recently transitioned are at a higher risk for suicide than the general veteran population, particularly those who have dealt with mental health or substance use issues prior to separation. This, combined with the fact that only 7 of the 17.6 veterans who commit suicide every day were receiving VA care, underscores the critical need to ensure those transitioning back to civilian life are provided a simple and efficient path to the VA benefits that they have earned, and may very well help to save their lives.

The *Servicemember to Veteran Health Care Connection Act of 2025* would require VA to pre-register all transitioning Service members into the VA health care system during their final year in uniform ensuring that if they choose to enroll after separation, the process will be more efficient and less burdensome. It also requires that Service members participating in the DoD Transition Assistance Program (TAP) be informed about this pre-registration process and how to complete enrollment after separation. Additionally, this legislation would improve efforts to connect veterans to VA services after discharge, requiring VA to conduct proactive outreach as

[5] U.S. DEP'T OF VET. AFF., TRANSITION PROGRAMS, Transition Assistance Program (last updated Feb. 18, 2025), https://discover.va.gov/transition-programs/transition-assistance-program/.
[6] U.S. DEP'T OF VET. AFF., 2024 NATIONAL VETERAN SUICIDE PREVENTION ANNUAL REPORT: PART 1 OF 2: IN-DEPTH REVIEWS (2024), *available at* https://www.mentalhealth.va.gov/docs/data-sheets/2024/2024-Annual-Report-Part-1-of-2_508.pdf.

part of the VA Solid Start program and beyond, both encouraging and assisting veterans to complete the enrollment process. Notably, Service members would only be pre-registered for VA care, which would not represent a commitment to enroll or entitlement to benefits without completing the process – final determinations would come at a later date after the individual is provided with additional relevant information.

Wounded Warrior Project believes a healthy transition is an essential part of creating a healthy warrior. We also believe that this process requires collaboration between VA, DoD, and the community to ensure that all the unique needs of each transitioning Service members are met. WWP supports the *Servicemember to Veteran Health Care Connection Act of 2025* and its intent to better foster collaboration between DoD and VA during the transition process, simplify VA health care enrollment, and increase proactive outreach to those veterans who have yet to engage with VA services.

S. 599: *Driver Reimbursement Increase for Veteran Equity (DRIVE) Act*

Access to healthcare is a critical issue for veterans, particularly those who reside in rural or underserved areas where traveling to VA medical facilities can be a significant burden. For many, the cost of long-distance travel for care is compounded by the rising expenses associated with operating a personal vehicle – costs such as gas, maintenance, and insurance premiums. Unfortunately, the current mileage reimbursement rate provided by VA has not kept pace with these increasing costs, leaving veterans to shoulder a greater financial burden.

VA's current mileage reimbursement rate, set at $0.41 per mile, has remained unchanged since 2010, despite significant increases in the cost of vehicle operation, including rising gas prices, maintenance costs, and insurance premiums. In contrast, the GSA reimbursement rate for federal employees has increased to $0.70 per mile. This discrepancy disproportionately affects veterans in rural and underserved communities where long-distance travel is often the only option to receive VA healthcare services. The *DRIVE Act* would correct this disparity by ensuring that the VA's reimbursement rate aligns with the GSA rate, helping to ease the financial strain on veterans.

In addition to aligning the reimbursement rate with federal standards, the *DRIVE Act* includes provisions to ensure that reimbursements are processed in a timely manner. Veterans currently experience delays in receiving their travel reimbursements, which can create additional financial strain and uncertainty. By mandating that reimbursements be processed within 90 days of submission, this effort would provide much-needed relief to veterans, ensuring they are not left waiting for reimbursement while they continue to bear the financial burden of travel for care.

Wounded Warrior Project supports the *DRIVE Act*. Passing this legislation would demonstrate a strong commitment to ensuring that veterans are treated with fairness and respect by addressing a longstanding issue that can affect veterans' health care decisions. Aligning VA's reimbursement rate with the GSA standard would help ensure that veterans receive fair compensation for the travel required to access their health care.

S. 605: *CHAMPVA Children's Care Protection Act of 2025*

VA's Civilian Health and Medical Program (CHAMPVA) provides comprehensive health care benefits for dependents of permanently and totally disabled veterans, survivors of veterans who died as a result of a service-connected disability, and, in some cases, survivors of Service members who died in the line of duty. Under current law, a child of a veteran loses their eligibility for CHAMPVA at age 18. Children who are students remain eligible until age 23, unless they marry.

After the *Affordable Care Act* (P.L. 111-148) was signed into law in 2010, private-sector health insurance plans were required to allow children to remain on their parents' insurance until the age of 26. This provision was later added to TRICARE in 2011 but was never extended to families using VA health care. The *CHAMPVA Children's Care Protection Act* would extend the maximum age for children eligible under the CHAMPVA program to the age of 26, regardless of their marital status.

According to a 2024 RAND report, approximately 2.3 million children under the age of 18 live with a veteran who is wounded, ill, or injured. These children frequently need to assist with the care of their veteran parent from a young age, which can result in stress that heightens their risk of developing physical and mental health conditions themselves. The report also found that nearly a quarter of military and veteran child caregivers experienced the need for mental health treatment within the past year.[7] As the needs of disabled veterans tend to increase with age, children often assume more caregiver responsibilities over time. This can lead to exhaustion and other conditions that negatively impact their health as they enter adulthood and take on additional commitments, such as higher education, careers, and family life. Extending the eligibility for CHAMPVA would help ensure their continued access to quality care during what is often a difficult transition period.

This bill seeks to bring health care benefits for eligible children of disabled veterans in line with what other families on private sector plans are already receiving. WWP recognizes the challenges faced by this population and the importance of ensuring their physical and mental health needs are also met. We support this legislation and appreciate the associated vision of improving the quality of life for the children of our nation's veterans by extending their access to the care and support they need.

S. 635: *Veterans Homecare Choice Act of 2025*

In March 2023, the Home Care Association of America (HCAOA) released a report, which found that the "workforce shortage in home-based care has reached crisis proportions."[8] An October 2024 *Harvard Public Health* article similarly identified that demand for home care

[7] Rajeev Ramchand et al., *America's Military And Veteran Caregivers: Hidden Heroes Emerging From The Shadows*, RAND (2024), *available at* https://www.rand.org/content/dam/rand/pubs/research_reports/RRA3200/RRA3212-1/RAND_RRA3212-1.pdf.

[8] *The Home Care Workforce Crisis: An Industry Report and Call to Action*, HOME CARE ASSOC. OF AMERICA (Mar. 2023), https://www.hcaoa.org/workforceaction.html.

workers is far exceeding supply, with a 4.6 million job deficit predicted by 2032.[9] This labor shortage, driven by a growing number of older adults and increased longevity, is also impacting veterans' ability to find at-home health care providers and has created challenges as VA continues to expand access to long-term care in noninstitutional settings.[10]

One way that veterans may connect with homecare professionals is through nurse registries, which serve as referral services to connect patients with independent contractors. Prior to 2018, VA provided reimbursements to veterans who employed a homecare professional through a nurse registry. However, following establishment of the Veterans Community Care Program (VCCP) through the 2018 *VA MISSION Act* (P.L. 115-182), nurse registries are no longer recognized as eligible service providers, making any caregivers hired through nurse registries ineligible for reimbursement. VA currently uses the Community Care Network (CCN) of licensed providers to purchase care for veterans, and only home care companies in the CCN are eligible to provide covered services.

The *Veterans Homecare Choice Act* seeks to amend 38 U.S.C. § 1730 to make nurse registries eligible for the CCN, reinstating nurse registries as eligible providers and restoring veterans' access to homecare professionals operating as independent contractors. The bill defines a nurse registry as an entity that procures contracts or other agreements on behalf of registered nurses, licensed practical nurses, certified nursing assistants, home health aides, companions, or homemakers, and receives compensation for such services. The bill also requires that nurse registries comply with any relevant state licensure requirements.

The *Veterans Homecare Choice Act* would improve access to care for veterans struggling to find at-home health care providers as labor shortages limit the capacity for long-term care. It would also expand options for aging veterans and younger veterans with long-term care needs seeking to live independently in their own homes. Younger veterans with long-term care needs are often overlooked. Many younger veterans prefer not to live at nursing home facilities that may not feel age appropriate. Noninstitutional care can prevent or delay the need for nursing home care, allowing younger veterans to remain in their homes while also representing significant cost savings for VA. WWP supports the *Veterans Homecare Choice Act of 2025*, particularly for the impact it will have on younger veterans with heighted health challenges, who are bringing care into their homes earlier in their lives.

S. 778: *Lactation Spaces for Veteran Moms Act*

Veterans – particularly women – encounter unique challenges when transitioning from military service to civilian life, including the ongoing struggle to access adequate lactation spaces, even in VA facilities. Currently, many VA facilities lack these necessary accommodations, discouraging mothers from breastfeeding, which is one of the most beneficial and cost-effective forms of infant nutrition. With 1,380 facilities across the nation, including 170 medical centers and over 1,100 outpatient clinics, VA is the largest integrated healthcare

[9] Liz Seegert, *Could Worker Cooperatives be a Fix for the Home Care Worker Shortage*, HARVARD PUBLIC HEALTH (Oct. 16, 2024), https://harvardpublichealth.org/policy-practice/us-direct-care-worker-demand-outstrips-supply-can-co-ops-help/.
[10] U.S. GOV'T ACCOUNTABILITY OFF., GAO-20-284, VA HEALTH CARE: VETERANS' USE OF LONG-TERM CARE IS INCREASING, AND VA FACES CHALLENGES IN MEETING THE DEMAND (2020), *available at* https://www.gao.gov/assets/gao-20-284.pdf.

system in the country. Despite this extensive infrastructure, many facilities still lack lactation spaces even though safe, private, and designated lactation spaces are essential for supporting veterans and their children.

The *Lactation Spaces for Veteran Moms Act* seeks to address this gap by mandating the establishment of private, clean, and accessible lactation spaces within VA facilities. These spaces will ensure that veterans who are breastfeeding or pumping can do so in a safe and dignified manner, reducing barriers to breastfeeding and supporting better health outcomes for both mothers and their children. The bill implicitly recognizes that many new veterans are balancing family life while transitioning back to civilian life, making access to these spaces even more critical for a smoother and healthier transition.

This legislation also encourages VA facilities to design lactation spaces based on the specific needs and experiences of women veterans, especially those who may face additional challenges like PTSD or other service-connected disabilities that complicate the postpartum experience. Access to lactation rooms is not just a convenience but a basic healthcare issue, as it significantly impacts mental and physical health outcomes for both mothers and infants. Studies show that access to proper lactation support is linked to increased breastfeeding rates and improved infant health, ultimately reducing long-term healthcare costs.[11][12]

Wounded Warrior Project supports the *Lactation Spaces for Veteran Moms Act* and urges its swift passage. This bill would help ensure that VA facilities are equipped to meet the unique needs of women veterans – particularly new mothers. By supporting breastfeeding veterans, we not only help improve their health outcomes but also foster a more inclusive and supportive VA healthcare system for all veterans.

S. 800: ***Precision Brain Health Research Act***

Veterans returning from combat or living with service-connected injuries often face invisible wounds that persist long after their time in uniform. Since 2000, U.S. forces in various locations worldwide have experienced more than 515,885 traumatic brain injuries (TBIs).[13] Individuals diagnosed with a TBI may continue to suffer from lasting effects that overlap with mental health conditions, substance use disorders, and chronic physical symptoms. These complex and interconnected challenges demand a more precise, data-driven approach to care.

While TBI can result from various causes, Service members experience blast injury as a complex but less understood form of trauma. Direct or indirect exposure to an explosion may cause blast injuries, but those injuries do not always produce immediate symptoms. However, when injury occurs, it often leads to TBI, commonly known as a "signature wound" of post-9/11 service. Many of these injuries stem from repeated low-level blast exposures that may not result in a diagnosable concussion but can still have long-term neurological effects. Those at highest

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[11] Keyaria D. Gray et al., *Influence of Early Lactation Assistance on Inpatient Exclusive Breastfeeding Rates,* J. HUMAN LACTATION (Sep. 2020), *available at* https://journals.sagepub.com/doi/10.1177/0890334420957967.
[12] U.S. DEP'T OF HEALTH & HUMAN SERV., BREASTFEEDING: SURGEON GENERAL'S CALL TO ACTION FACT SHEET (Jan. 19, 2011), https://www.hhs.gov/surgeongeneral/reports-and-publications/breastfeeding/factsheet/index.html.
[13] U.S. DEP'T OF DEF., DOD NUMBERS FOR TRAUMATIC BRAIN INJURY WORLDWIDE (Apr. 18, 2025), https://health.mil/Reference-Center/Reports/2025/04/18/2000-2024-Q4-DOD-Worldwide-Numbers-for-TBI.

risk include armorers, artillery and gunnery personnel, combat engineers, explosive ordnance disposal specialists, special operations forces, and medical personnel assigned to expeditionary units – as well as individuals working with shoulder-mounted weapons, .50 caliber systems, and indirect fire platforms.

Precision medicine tailors healthcare treatments and interventions to each patient's unique characteristics, including their genetic makeup, lifestyle, and environment. Instead of a one-size-fits-all model, precision medicine uses advanced diagnostic tools – such as genetic testing, biomarker analysis, and imaging techniques – to identify the most effective therapies for individuals. In brain health, this approach takes a specialized form, focusing on neurological and psychiatric conditions. Clinicians analyze a patient's brain structure, function, genetic profile, and cognitive patterns to create targeted treatment plans for conditions like Alzheimer's disease, Parkinson's disease, depression, and TBI. This personalized strategy enhances therapeutic outcomes, reduces side effects, and ensures lasting benefits. Specifically for veterans, this approach can help identify those at higher risk for long-term neurological or psychological effects, such as chronic traumatic encephalopathy (CTE), post-traumatic stress disorder (PTSD), and cognitive decline.

The *Precision Brain Health Research Act* represents a critical step forward in transforming how we understand and address brain health across the lifespan. As emerging science increasingly links brain health to long-term cognitive resilience, our national response must be both comprehensive and forward-thinking. This effort would establish a national strategy to close that gap, ensuring that brain health research reflects the diverse experiences of high-risk populations, including aging veterans and those with complex service histories. This bill builds on existing efforts to understand brain and mental health by authorizing funding for 10 years for VA and its research partners to focus on the cognitive impacts of repetitive, low-level blast exposure. It also strengthens collaboration with the National Academies of Sciences to advance biomarker research, continuing the momentum from the *Commander John Scott Hannon Act* (P.L. 116-171).

Wounded Warrior Project supports the *Precision Brain Health Research Act* and urges swift action to advance this legislation. This forward-looking investment prioritizes evidence-based approaches, promotes equity in research participation, and addresses one of the most pressing issues facing our veteran population today. By establishing a national framework for precision brain health research, this bill will help transform the way we care for those affected by neurological conditions and ultimately help more veterans lead longer, healthier, and more productive lives.

S. 827: *Supporting Rural Veterans Access to Healthcare Services Act* and S. 784: *Rural Veterans Transportation to Care Act*

Veterans living in rural and highly rural areas face persistent and often overlooked barriers to accessing timely, quality healthcare. Long distances to VA care facilities or authorized providers, lack of reliable public transportation, and limited broadband connectivity create compounding obstacles that threaten the well-being of rural veterans – 44% of whom earn less than $35,000 annually, and over half of whom are over age 65. These challenges are even

more pressing as increasing numbers of post-9/11 veterans settle in rural communities, with VA estimating that roughly 21% of rural veterans (approximately 880,000) served during the post-9/11 era. To help address these barriers, two critical pieces of legislation – S. 827, the *Supporting Rural Veterans Access to Healthcare Services Act* and S. 784, the *Rural Veterans Transportation to Care Act* – seek to strengthen and modernize the VA's Highly Rural Transportation Grant (HRTG) program.

The *Supporting Rural Veterans Access to Healthcare Services Act* would formally reauthorize the HRTG program for five years, ensuring continued support for transportation services that connect rural veterans to essential care. It removes the $3 million funding cap, offering flexible funding to better support the unique challenges of highly rural areas. Additionally, the bill expands eligibility to include Tribal and Native Hawaiian organizations, directly addressing the healthcare access needs of these communities.

The *Rural Veterans Transportation to Care Act* focuses on modernizing the HRTG program's eligibility criteria by replacing the restrictive county-based standard (counties with fewer than seven people per square mile) with Rural-Urban Commuting Area (RUCA) designations. This shift aligns eligibility with how VA defines rurality in other contexts and would significantly expand access to transportation services for rural veterans. The bill also increases the maximum grant award from $50,000 to $60,000 and allows up to $80,000 for ADA-compliant vehicles – ensuring veterans with mobility challenges are not excluded.

Together, these bills provide complementary solutions – one ensuring sustained funding and expanded access, and the other updating outdated eligibility standards to better serve veterans. By passing both measures, Congress can ensure that veterans in rural and highly rural areas are not left behind in their access to healthcare services. WWP is pleased to support of these important initiatives.

S. 879: *Veteran Caregiver Reeducation, Reemployment, and Retirement Act*

According to findings published by RAND in 2024, more than 1.4 million Americans provide daily care to wounded, ill, or injured military service members or veterans, with many of them managing these responsibilities while balancing careers, finances, and personal health.[14] Within this population, a significant percentage of post-9/11 caregivers struggle financially, with 36% reporting incomes below 130% of the federal poverty level and many lacking basic health insurance or emergency savings. These caregivers, particularly those who have participated in VA's Program of Comprehensive Assistance for Family Caregivers (PCAFC), face additional challenges when their caregiving responsibilities conclude, as many benefits are not portable or inclusive of retirement benefits.

The *Veteran Caregiver Reeducation, Reemployment, and Retirement Act* would offer crucial support to caregivers as they transition back into the workforce or plan for their retirement after their caregiving duties end. This legislation would ease the financial strain and

[14] Michael Robbins et al., *America's Post-9/11 Military and Veteran Caregivers,* RAND (Sep. 2024), *available at* https://www.rand.org/pubs/research_reports/RRA3212-4.html.

provide long-term stability for veterans' caregivers through key provisions that focus on reeducation, reemployment, retirement planning, and bereavement counseling.

The bill offers reeducation support by providing reimbursement of up to $1,000 for fees associated with renewing professional licenses or certifications, as well as access to VA training modules for continuing education credits. It also calls for a study on the feasibility of establishing a "returnship" program to assist caregivers in reentering the workforce. The bill would provide reemployment assistance by offering eligibility for existing VA employment assistance programs and calls for a study on barriers to employment and incentives for hiring former caregivers within the VA system. To support caregivers in planning for their futures, the bill would provide retirement planning services and calls for a study on the feasibility of establishing retirement savings plans specifically for caregivers, addressing challenges posed by their caregiving roles. Finally, the bill would offer bereavement counseling services for caregivers following the death of the veteran they cared for.

Wounded Warrior Project supports the *Veteran Caregiver Reeducation, Reemployment, and Retirement Act* and urges Congress to pass this bill swiftly. This legislation recognizes the essential yet often overlooked contributions of caregivers to the well-being of veterans. While caregivers provide critical support to their loved ones, many face personal, professional, and financial challenges that hinder their ability to thrive. The bill offers a vital pathway to help caregivers reenter the workforce, plan for their futures, and recover from the toll caregiving takes on their financial and emotional health. By passing this legislation, Congress can invest in the well-being of caregivers, ensuring they have the resources needed to reclaim their careers, stabilize their financial futures, and transition out of their caregiving roles with dignity.

S. 1320: *Servicewomen and Women Veteran Menopause Research Act*

Women veterans represent one of the fastest-growing segments of the veteran population, with many now entering midlife and facing menopause-related health challenges. Unlike their civilian counterparts, women veterans often carry the added burden of military-specific exposures, higher rates of trauma –including military sexual trauma – and complex chronic health conditions that can intensify menopause symptoms. Despite this, menopause care remains under-researched and under-prioritized in both VA and DoD systems. Many women veterans report feeling dismissed or underserved when seeking care for menopause-related issues, and studies have shown significant gaps in provider training, access to appropriate therapies, and culturally competent care. Addressing menopause is not just about comfort – it is a readiness, quality of life, and equity issue.

The *Servicewomen and Veterans Menopause Research Act* would require VA and DoD to evaluate and conduct research on menopause, perimenopause, and mid-life women's health. This legislation represents a long-overdue recognition of the unique and evolving health care needs of Servicewomen and women veterans as they age. Research has demonstrated that women veterans experiencing menopause are more likely to suffer from chronic pain, insomnia, and sexual dysfunction.

Wounded Warrior Project supports this legislation and urges swift passage. By mandating coordinated research across VA and DoD, this bill would fill critical knowledge gaps and drive better clinical practices – ensuring our systems are equipped to deliver responsive, informed, and respectful care for this growing population.

S. 1383: *Veterans Accessibility Advisory Committee Act of 2025*

Many veterans with physical and sensory disabilities continue to face avoidable barriers when trying to access care and services through VA. From navigating a facility in a wheelchair, reading essential documents with vision loss, to using VA's online tools with assistive technology, too many aspects of the system remain inaccessible. Despite these longstanding challenges, VA still lacks a dedicated advisory body focused specifically on identifying and eliminating accessibility barriers for veterans with disabilities.

The *Veterans Accessibility Advisory Committee Act of 2025* would address this critical gap by establishing the Veterans Advisory Committee on Equal Access. This committee would advise the Secretary of Veterans Affairs on how to improve equitable access to VA health care and benefits. It would be tasked with evaluating access barriers, analyzing disparities among subpopulations of veterans, and providing specific, data-informed policy recommendations to reduce those gaps. The legislation also requires the advisory committee to submit annual reports to Congress to promote accountability and transparency, an oversight mechanism recommended by the Government Accountability Office (GAO) in its reviews of VA operations.

Without this kind of dedicated structure, VA may continue to overlook or under-address the persistent inequities experienced by many veterans. While the agency has made progress through efforts like the Office of Health Equity, there is still no formal mechanism to provide consistent, system-wide oversight or external advisory input. Establishing this advisory committee would enhance VA's responsiveness, enabling it to identify problems proactively and shape solutions that meet the needs of all veterans, not just the majority.

Wounded Warrior Project supports this legislation as a necessary step toward improving how VA serves veterans with physical and sensory disabilities. Establishing the Veterans Advisory Committee on Equal Access would help ensure that accessibility is built into every aspect of VA's operations from facilities and medical equipment to digital platforms and communication tools. Veterans who rely on these accommodations should not have to navigate a system that was not designed with them in mind.

S. 1441: *Service Dogs Assisting Veterans Act*

Veterans with physical and psychological injuries often face persistent challenges in their recovery and reintegration, including limited access to non-traditional therapies that address daily functional needs. While service dogs have shown demonstrable benefits for veterans with PTSD, TBI, and mobility impairments, access remains scarce due to cost and limited program availability. The *SAVES Act* would help address this need by creating a five-year pilot grant program through VA to support nonprofit organizations that provide service dogs to veterans to fill a critical gap in care and support.

In addition to authorizing VA to provide grant funding to nonprofits who provide service dogs to eligible veterans, this bill would streamline access to VA's Veterinary Health Insurance Benefit (VHIB) by automatically enrolling in the program any veteran who receives a service dog through the pilot. This would remove the cumbersome VHIB application process and would ensure that more veterans can receive support without bureaucratic hurdles. The bill's inclusion of data collection and program standards also offers a path to greater accountability and long-term policy improvements by measuring outcomes and setting clear expectations for participating organizations.

Despite the bill's positive intent, veteran and service dog advocates remain concerned that the updated 119th Congress version of this legislation weakens oversight mechanisms. The current VHIB program policy (38 CFR § 17.148) requires accreditation through Assistance Dogs International (ADI) and/or the International Guide Dog Federation (IGDF), a safeguard that ensured service dogs were properly trained to perform specific tasks and behave safely in public. The anticipated shift to relying solely on *Americans with Disabilities Act* (P.L. 101-336) and *Air Carrier Access Act* (49 U.S.C. § 41705) compliance, while well-intentioned, lowers the threshold for quality assurance and opens the door to inconsistencies in training standards, which could compromise veteran safety and public trust.

To ensure the success of this program, Congress must insist on maintaining strong, enforceable standards for participating organizations. This includes either retaining accreditation requirements or clearly defining equivalent evidence-based training benchmarks to confirm it upholds rigorous quality standards while still expanding access. An ongoing dialogue with stakeholders – including service dog organizations, accrediting bodies, and veteran advocates – is essential to strike this balance.

Additionally, the *SAVES Act* would only address providing the VHIB to those veterans who receive their service dogs through the Act's grant program. WWP encourages Congress to consider modifying language that would be inclusive of service dogs that fall under the ongoing *PAWS for Veterans Therapy Act* (P.L. 117-37) pilot program to ensure VA is not creating a streamlined process for only one set of service dogs.

S. 1533: *VA License Portability Act*

During the COVID-19 pandemic, VA temporarily suspended in-person medical exams related to claims for disability benefits. In response, the *Johnny Isakson and David P. Roe, M.D. Veterans Health Care and Benefits Improvement Act of 2020* (P.L. 116-135) included a provision authorizing a three-year pilot program in which certain health care professionals contracted with the Veterans Benefits Administration (VBA) were permitted to conduct medical exams across state lines and in states where they did not hold a medical license (known as license portability) for VA. Although physicians have had the flexibility to perform exams across state lines since 2016, this new program extended license portability authorization to physicians' assistants, nurse practitioners, audiologists, and psychologists. Initially set to expire in 2024, Congress extended the pilot for an additional two years (see P.L. 118-19) until January 5, 2026.

The expansion of license portability has helped to increase the number of exams administered to veterans across the country and extend VA's reach to more rural and underserved communities. Veterans in these regions often experience long commutes, lack of public transportation, and scarcity of providers or specialty care, challenges which further complicate and add time to an already lengthy claims process; in September 2024, VA averaged nearly 145 days to complete a disability-related claim.[15]

In addition to long wait times for processing, VA has experienced an influx in claims; during Fiscal Year (FY) 2025, claims for disability have increased nearly 16 percent so far.[16] VA continues to face pressure to process veteran claims in a timely fashion; however, if license portability authorization is allowed to expire, the ability of contracted medical professionals to provide exams will be significantly reduced and likely lead to compromised efficiency and even longer wait times for veterans.

This bill would codify the 2020 pilot program to permanently expand license portability requirements for VA-contracted medical professionals, thereby increasing access to timely medical examinations – or at least lowering wait times – for veterans filing claims for a service-connected disability. It would also impose a reporting requirement on VA to ensure accountability and monitor the cost, promptness, and comprehensiveness of exams being performed by contract physicians.

This permanent expansion of license portability would broaden VBA's ability to reach high-need areas, help veterans by increasing their access to timely exams and medical specialists, and support VA with additional medical staff to address the exam backlog. As more veterans file claims following their service and seek VA care, this legislation will address the need for more licensed health care professionals to provide medical disability exams when and where they are needed. WWP supports this legislation and its goal to help meet veterans where they are and ensure their timely access to critical exams and the high-quality care they have earned.

Agenda items not addressed in this Statement for the Record

- S. 214: *Monetary Enhancement for Distinguished Active Legends (MEDAL) Act of 2025*
- S. 649: *Guard and Reserve GI Bill Parity Act*
- S. 1318: *Fallen Servicemembers Religious Heritage Restoration Act*
- S. 1543: *Veterans' Education, Transition and Opportunity Prioritization Plan Act*
- S. 1591: *Acquisition Reform and Cost Assessment Act of 2025*

Concluding Remarks

Wounded Warrior Project once again extends our thanks to the Committee for its continued dedication to our nation's veterans. Our commitment to keeping the promise by rebuilding the lives of warriors impacted by war and military service remains as strong as ever,

[15] LYNN SEARS, CONG. RSCH. SERV., IF12799, VETERAN DISABILITY COMPENSATION AND PENSION EXAMS (2024), *available at* https://www.congress.gov/crs-product/IF12799.
[16] Press Release, U.S. Dep't of Vet. Aff., VA Processes One Million Disability Claims Faster Than Ever Before (Feb. 2025), https://news.va.gov/press-room/va-processes-one-million-disability-claims-faster-than-ever-before/.

and we are honored to contribute our voice to your discussion about pending legislation. As your partner in advocating for these and other critical issues, we stand ready to assist and look forward to our continued collaboration.

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STATEMENT OF
JON RETZER
DEPUTY NATIONAL LEGISLATIVE DIRECTOR FOR HEALTH
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE
May 21, 2025

Chairman Moran, Ranking Member Blumenthal, and Members of the Committee:

Thank you for inviting DAV (Disabled American Veterans) to testify at today's legislative hearing of the Senate Veterans' Affairs Committee. DAV is a Congressionally chartered non-profit veterans service organization composed of nearly one million wartime service-disabled veterans. Our single purpose is to empower veterans to lead high-quality lives with respect and dignity.

S. 214, the Monetary Enhancement for Distinguished Active Legends Act of 2025 or the MEDAL Act of 2025

S. 214, the MEDAL Act of 2025, increases the monthly special pension of $1,406.73 to $8,333.33 for living Medal of Honor recipients. This bill will also allow surviving spouses of these heroes to continue receiving the monthly special pension at the current rate, subject to periodic adjustments, for the remainder of their lives. This act serves as a recognition of gratitude for the unwavering commitment and extraordinary sacrifices made by our nation's Medal of Honor recipients and their families.

While DAV does not have a specific resolution addressing the proposed pension increase for living Medal of Honor recipients, we have no objection to the Committee's approval of this legislation.

S. 219, the Veterans Health Care Freedom Act

S. 219 establishes a three-year pilot program allowing veterans to choose their health care providers within the VA system or in the private sector. The bill aims to expand access to care by removing certain restrictions on non-VA providers and enabling veterans to seek treatment outside the VA network without meeting existing eligibility criteria.

While ensuring timely access to care is critical, DAV opposes S. 219 because it risks weakening the VA health care system, which is uniquely designed to meet the specialized needs of service-disabled veterans. Expanding private sector care without additional funding could strain VA resources, making it harder for veterans to access

integrated, high-quality services such as mental health care, prosthetics, and rehabilitation programs.

DAV supports community care when the VA cannot directly provide necessary services, but we believe the VA must remain the primary provider and coordinate care to ensure continuity, quality and oversight. Private sector providers may lack expertise in treating service-connected conditions, leading to fragmented care and inconsistent treatment standards.

Instead of diverting resources away from the VA, Congress should invest in VA infrastructure, staffing, veteran-focused research, and IT modernization to strengthen the system. DAV urges lawmakers to prioritize policies that reinforce the VA's ability to serve veterans effectively, ensuring timely access to care without compromising quality.

S. 506, the Coordinating Care for Senior Veterans and Wounded Warriors Act

S. 506, the Coordinating Care for Senior Veterans and Wounded Warriors Act, proposes a pilot program to improve health care coordination for veterans enrolled in both VA and Medicare. While the bill presents an opportunity to expand health care options, close service gaps, and improve access, several concerns must be addressed to ensure that veteran health care remains fully accountable to those it serves.

First, the VA must remain the primary entity responsible for care coordination. DAV Resolution No. 403 reinforces concerns regarding outsourcing veteran health care services, cautioning against reliance on private-sector entities to provide essential care management functions. If the VA determines contracting with private organizations is necessary, stringent oversight and performance evaluations should be implemented to ensure that care remains veteran-centric and not profit-driven.

The assignment of case managers is a crucial element of this bill. Veterans often struggle to navigate complex health care systems, and placing trained, VA-led case managers to support dual-enrolled veterans will help to improve access, efficiency, and quality of care. While the bill outlines care coordination goals, it lacks specificity on who will oversee case managers and ensure they are adequately trained to handle questions about both VA and Medicare services. We strongly suggest that VA takes direct ownership of training and supervising these case managers, ensuring they remain deeply integrated within veteran health care networks rather than functioning as third-party contractors with limited experience in VA programs and veterans' needs.

For rural and medically underserved veterans, health care expansion remains a critical issue. While S. 506 mandates implementation of the pilot in three to five Veterans Integrated Service Networks (VISNs), this limited rollout may not reach veterans who experience the greatest barriers to care. The VA must expand telehealth programs, incentivize providers to serve rural communities, and integrate community-based outreach strategies to bridge this gap. Medicare resources must be leveraged

efficiently to ensure health care access aligns with existing VA programs, rather than introducing additional bureaucratic hurdles for veterans seeking care.

Privacy concerns surrounding medical record sharing between VA and Medicare providers must also be addressed. Veterans deserve strong HIPAA protections, secure technological safeguards, and autonomy over their health data. The bill requires tracking metrics to evaluate patient satisfaction, quality of care, provider engagement, and cost efficiency.

The three-year pilot program is required to include early assessments within the first year to ensure data-driven adjustments are applied before challenges escalate. The bill also requires that if the pilot program shows clear benefits in care coordination, reduced health care costs, and improved patient outcomes, scaling the initiative into a permanent program should be considered.

S. 506 presents an opportunity to enhance care coordination for VA and Medicare dual-enrolled veterans. We urge revisions to the bill that reinforce the VA as the primary provider of veteran health care services. VA-led case management and oversight are essential to ensuring continuity of care. Veterans must also be fully informed of all options and guided toward the best choice for their individual needs, including access to specialized, veteran-centric services.

S. 585, the Servicemember to Veteran Health Care Connection Act

DAV supports S. 585, the Servicemember to Veteran Health Care Connection Act, which advances the goals of DAV Resolution No. 68 by making it easier for all separating service members to access VA health care. This bill establishes universal pre-transition registration by automatically enrolling service members in VA 180 days before discharge. It requires proactive outreach and follow-up to assist veterans in VA enrollment and health care access.

The Servicemember to Veteran Health Care Connection Act reduces barriers to care and ensures transitioning service members receive information on critical resources, including Vet Centers and military sexual trauma counseling. DAV supports efforts to provide continuity of care through streamlined support for these vital services.

S. 599, the Driver Reimbursement for Veteran Equity (DRIVE) Act of 2025

The VA Beneficiary Travel Program seeks to ensure veterans can access needed medical care. However, the current mileage reimbursement rate of 42 cents per mile fails to cover actual travel costs, which inflation and rising fuel prices continue to increase.

S. 599, the Driver Reimbursement Increase for Veteran Equity or DRIVE Act of 2025 would align the VA mileage reimbursement rate for veterans traveling to and from VA health care facilities with the rate provided to government employees using personal

vehicles for official business, currently set at 70 cents per mile. The bill mandates the VA to process and pay mileage allowance claims within 90 days, preventing undue financial hardship from reimbursement delays. By matching veterans' reimbursement rates with federal standards, this legislation reduces financial strain on veterans and helps to eliminate potential barriers to care.

We support this legislation as it aligns with DAV Resolution No. 233, which urges the VA to adopt the General Services Administration (GSA) mileage reimbursement rate to safeguard against the depreciation of the benefit's value due to inflation. DAV urges the VA to request sufficient resources to ensure that adjustments to veterans' beneficiary travel reimbursement rates are fully supported within the program, without compromising funding for direct medical care.

S. 605, the CHAMPVA Children's Care Protection Act

Families of eligible veterans receive health insurance through Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA). S. 605, the CHAMPVA Children's Care Protection Act of 2025, extends coverage for children of veterans until their 26th birthday, regardless of marital status, aligning eligibility with the Affordable Care Act (ACA) and ensuring equitable treatment for eligible children.

We support S. 605, as it aligns with DAV Resolution No. 356, which advocates for extending coverage for children of veterans under the same conditions as private health plans.

S. 635, the Veterans Homecare Choice Act of 2025

The Veterans Homecare Choice Act of 2025 (S. 635) aims to broaden access to home-care services for veterans by formally incorporating nurse registries into the Veterans Community Care Program. This legislative effort would provide veterans who live in states that require nurse registries with more flexibility in selecting qualified caregivers, ensuring they receive the personalized support they need within their own homes.

Veterans often struggle to find appropriate home-care providers, facing unnecessary delays and bureaucratic hurdles. This bill seeks to improve their access by allowing the VA to procure contracts with nurse registries, ensuring veterans can receive services from registered nurses, licensed practical nurses, certified nursing assistants, home health aides, companions, and homemakers—particularly in states where existing regulations create barriers for nurse registries. These professionals provide essential health care-related and assistive services directly to veteran patients or to support health care facilities, while complying with state licensure requirements.

However, certain provisions of this bill require further clarification. The expanded definition of "nurse registry" includes roles beyond skilled nursing, such as companions and homemakers, raising questions about appropriate oversight. It is essential to

distinguish medical care from non-medical services to ensure quality and proper regulation. The bill lacks clarity on whether nurse registries should operate solely within the Veterans Community Care Program or whether some roles, particularly non-medical ones, would be better suited under existing VA home care programs. Without clear distinctions, implementation challenges may arise, potentially affecting funding, oversight, and efficiency.

To address these concerns, the Committee should refine the language in the bill to clearly define the scope and regulation of nurse registries, ensuring alignment with existing VA home care initiatives. Establishing a structured oversight mechanism will help maintain consistency in service quality. The VA must implement accountability measures to track provider performance and safeguard veterans' access to reliable care.

Veterans need seamless, high-quality home care options that respect their individual needs while maintaining strong oversight and efficiency. By refining this legislation, we can ensure that nurse registries serve their intended purpose without creating administrative confusion or unintended gaps in care. We urge the Committee to work closely with the bill's sponsors to refine these provisions and ensure clarity in implementation.

S. 649, the Guard and Reserve GI Bill Parity Act

Since the establishment of the GI Bill in 1944, these programs have played a role in assisting service members with their transition to civilian life. Active duty members receive full GI Bill benefits for their service, while National Guard and Reserve members—who train, deploy, and respond to emergencies—have different eligibility criteria.

S. 649, the Guard and Reserve GI Bill Parity Act of 2025, would adjust Post-9/11 GI Bill eligibility for National Guard and Reservists to account for every day spent in uniform under Titles 10 or 32. This includes operations, training, military schooling, weekend drills, annual training, and responses to national disasters or emergencies. The bill identifies full-time National Guard duty and certain federal duty statuses for Reservists in determining eligibility for GI Bill benefits.

DAV does not have a resolution on this issue and takes no position on the bill.

S. 778, the Lactation Spaces for Veteran Moms Act

As more women veterans utilize VA health care, the VA must ensure its facilities remain safe, welcoming, and accessible to all veterans. This effort includes providing private, convenient, and hygienic lactation stations that women can easily and safely access while receiving the health care they need and have earned.

S. 778, the Lactation Spaces for Veteran Moms Act, requires each VA Medical Center to establish a dedicated lactation space for nursing veterans. These spaces should remain hygienic, shielded from view, free from intrusion, and be easily accessible, ensuring veteran mothers have a comfortable and dignified environment to nurse.

We support this bill as it aligns with DAV Resolution No. 39, which urges the VA to enhance medical services and benefits for women veterans and address their unique health care needs.

S. 784, the Rural Veterans Transportation to Care Act

Currently, 2.7 million veterans live in rural areas and many face barriers to accessing VA health care. Limited transportation options are a key factor and often prevent veterans from receiving timely medical treatment.

S. 784, the Rural Veterans Transportation to Care Act, would expand eligibility for the VA's Highly Rural Transportation Grant (HRTG) Program to include county veterans service organizations and tribal organizations, broadening the scope of entities that could receive funding to support veteran transportation services. The bill would increase the maximum grant funding available for the purchase of Americans with Disabilities Act (ADA)-compliant vehicles, ensuring veterans with mobility challenges access safe and reliable transportation.

DAV supports the Rural Veterans Transportation to Care Act as it aligns with DAV Resolution No. 177, which urges the VA to expand transportation systems through affiliates and local community partnerships to include ADA-compliant modes of transportation.

S. 800, the Precision Brain Health Research Act of 2025

S. 800, the Precision Brain Health Research Act of 2025, seeks to amend the Precision Medicine for Veterans Initiative of the VA to identify and research critical brain health and mental wellness concerns among veterans affected by repetitive low-level blast exposures, dementia, and other brain and mental health conditions sustained during service. Research indicates that even mild traumatic brain injury (TBI) can have long-term mental health and medical consequences, including an increased risk of dementia. Symptoms are often comorbid with post-traumatic stress disorder (PTSD), depression, and post-traumatic visual syndrome, further complicating diagnosis and treatment.

The bill would require a collaborative data-sharing platform between the VA and the Department of Defense (DOD). This platform would serve as a central repository for research data, ensuring secure storage and accessibility for future studies aimed at advancing veterans' brain and mental health programs.

While we support S. 800 in accordance with DAV Resolution No. 278, which advocates for a robust VA rehabilitative and research program for veterans with TBI, we also recognize the importance of providing researchers with the flexibility needed to innovate and adapt. To address concerns about potential overreach, we recommend broadening the research scope to allow exploration of additional related areas and innovative treatment methods. Implementing flexible funding allocation for exploratory studies and pilot projects is also crucial. Establishing a mechanism for periodic review and adjustment of research directives based on new findings and technological advancements will ensure the initiative remains relevant and effective.

By incorporating these recommendations, S. 800 can maintain its focus on improving veteran care while empowering researchers to adapt and innovate in response to emerging challenges and opportunities.

S. 827, the Supporting Rural Veterans Access to Healthcare Services Act

S. 827, the Supporting Rural Veterans Access to Healthcare Services Act, seeks to enhance the VA transportation grant program to better serve veterans in rural communities, where limited access to health care often presents a significant challenge. The bill expands eligibility to tribal and Native Hawaiian organizations and increases grant funding to improve transportation services in underserved areas.

Reliable transportation enables rural veterans to access timely medical care, ensuring they receive the treatment they need, have earned, and deserve. By strengthening the VA transportation system through affiliates and local community partnerships, this legislation would help to remove barriers to care and advance health equity for veterans in remote locations.

Aligned with DAV Resolution No. 177, we support this bill to expand transportation resources, recognizing that improved access leads to better health outcomes and overall well-being for rural veterans.

S. 879, the Veteran Caregiver Reeducation, Reemployment and Retirement Act

Family caregivers make significant personal and financial sacrifices to provide essential care for veterans with service-connected injuries and illnesses. Many lose income, face financial strain, endure emotional and physical stress, and struggle with reduced retirement savings as they dedicate themselves to supporting their loved ones.

S. 879, the Veteran Caregiver Reeducation, Reemployment, and Retirement Act, seeks to expand support for veterans' family caregivers by extending medical care coverage; providing employment assistance; enhancing caregiver services; offering bereavement counseling; mandating studies on caregiver support; and exploring retirement options for caregivers. By recognizing the critical role of family caregivers, this bill directly addresses their challenges and ensures they receive the resources and support to facilitate a smoother transition as they move out of their caregiving roles.

Aligned with DAV Resolution No. 343, we support this legislation as it would strengthen and expand comprehensive services for caregivers of severely wounded, injured and ill veterans from all eras.

S. 1318, the Fallen Servicemembers Religious Heritage Restoration Act

S. 1318, the Fallen Servicemembers Religious Heritage Restoration Act, requires the American Battle Monuments Commission to identify and research graves incorrectly marked. The commission partners along with non-profit organizations would locate affected graves, notify descendants, and ensure corrections are made to accurately reflect religious heritage.

This legislation takes a meaningful step toward accurately honoring these fallen service members, allowing families to find comfort in seeing their heritage properly memorialized. While we have no specific resolution, DAV has no concerns about this legislation to remark these grave sites.

S. 1320, the Servicewomen and Veterans Menopause Research Act

Perimenopause and menopause represent a major health transition that can have profound effects on physical and mental well-being, yet its impact on service women and veterans remains understudied and often overlooked in military and veteran health care planning. Service-related exposures—such as burn pits, toxic chemicals, and prolonged high-stress environments—can exacerbate menopause-related symptoms, leading to increased risks of cardiovascular disease, osteoporosis, and psychological distress. Despite these concerns, women veterans frequently struggle to find specialized care that adequately addresses their unique medical needs.

S. 1320, the Servicewomen and Veterans Menopause Research Act, takes necessary steps to bridge this gap by directing the VA and DoD to evaluate existing research, identify key areas requiring further study, and assess the quality of health care provider training related to menopause treatment. The bill establishes a framework for developing targeted research initiatives aimed at improving health care outcomes and providing evidence-based care for women veterans.

Women in the military often experience premature menopause due to service-related stress, which doubles the risk of depression and suicide among veterans. DAV's report, *Women Veterans: The Journey to Mental Wellness*, highlights significant gaps in research on menopause's impact and urges improved care for veterans. DAV supports S. 1320, as it aligns with DAV Resolution No. 32, which calls for research into menopause and its impact on the mental health and overall well-being of women veterans.

S. 1383, the Veterans Accessibility Act

S. 1383, the Veterans Accessibility Advisory Committee Act, would establish the Veterans Advisory Committee on Equal Access within the VA to enhance accessibility for individuals with disabilities. Comprising veterans, experts, and service organization representatives, the committee will advise the VA Secretary, ensure compliance with accessibility laws, and submit regular recommendations to improve access to VA facilities, services, and benefits. The committee would be required to meet at least twice a year and dissolve after 10 years. The bill mandates the consolidation or elimination of inactive advisory committees within the VA to improve efficiency.

While DAV has no specific resolution calling for the establishment of a Veterans Accessibility Advisory Committee, we have numerous resolutions that call for ensuring that veterans have access to VA services and benefits and therefore are pleased to support the bill.

S. 1441, the Service Dogs Assisting Veterans (SAVES) Act

S. 1441, the Service Dogs Assisting Veterans (SAVES) Act, establishes a five-year pilot program directing the VA to award grants to nonprofit organizations that provide trained service dogs to veterans at no cost. The bill ensures proper care for these service animals through veterinary insurance coverage.

Service dogs play a vital role in enhancing veterans' quality of life, independence, and overall well-being. These highly trained animals provide essential support for veterans facing physical and mental health challenges, helping them regain confidence and stability in daily life.

DAV supports S. 1441, the SAVES Act. This bill is aligned with DAV Resolution No. 590, which recognizes the rehabilitation support service dogs provide service-disabled veterans and calls for consistent benefits for prescribed service dogs.

S. 1533, the VA License Portability Act

The VA conducts over one million disability examinations annually through VHA employees and Veterans Benefits Administration (VBA)-contracted examiners. License portability enables examiners to work across state lines, expanding codifying access through telehealth and mobile clinics. In 2020, Public Law 116–315 temporarily granted portability to non-physician contractors, while VBA physicians have had permanent portability since 2016, and VHA examiners since 2018 for telehealth.

S. 1533, the License Portability Act, would permanently authorize contract physicians to conduct disability examinations nationwide, streamline medical evidence submission, and ensure that VA covers related expenses. The bill requires a three-year congressional report evaluating the program's cost and effectiveness.

DAV supports S. 1533 as it would expand access to disability examinations, help simplify claims processing, and strengthen license portability to improve efficiency in alignment with DAV Resolution No. 306, which advocates for the efficiency and accuracy of disability examinations, and emphasizes the importance of modernizing the system to ensure timely and fair adjudications for veterans.

To strengthen S. 1533, the mechanism for submitting new and material medical evidence must be clearly defined to ensure timely and accurate consideration in veterans' claims. Currently, the bill requires the VA to establish a process for contract examiners to transmit evidence introduced during examinations. However, without a well-structured and efficient system, delays in processing claims and inconsistent assessments could occur.

Implementing this mechanism requires significant investment in technology and training. Contract examiners must have a streamlined, standardized method to submit medical evidence so it can be properly integrated into VA records without causing disruptions or administrative bottlenecks. The VA must ensure that examiners understand the criteria for new and material evidence, preventing unnecessary submissions and optimizing the claims process.

S. 1543, the Veterans Opportunity Act of 2025

S. 1543 would establish the Veterans Economic Opportunity and Transition Administration within the VA to consolidate vocational rehabilitation, education, housing and transition programs for better oversight and efficiency.

These programs currently compete for resources within VBA and are often overshadowed by compensation and pension services. The bill would require a Senate-confirmed Under Secretary to provide leadership and accountability. The legislation requires annual reports to Congress tracking claims, outcomes, staffing, and expenditures to ensure transparency. It would also protect labor rights, guaranteeing VA employees retain their bargaining agreements during the transition. Before services are transferred, the VA Secretary must certify that the transition will not negatively affect veterans. If delayed, the Secretary must submit a report to Congress explaining the reasons and the estimated date when the certification will be made.

DAV supports S. 1543, the Veterans Opportunity Act, in accordance with DAV Resolution No. 382, which directs Congress to establish an Economic Opportunity Administration within the VA. This bill would strengthen oversight, streamline assistance, and help ensure veterans receive the support they need for a successful transition to civilian life. DAV Resolution No. 372, also supports these reforms, advocating for stronger oversight and veteran service organization involvement in TAP to improve transition success.

S. 1591, the Acquisition Reform and Cost Assessment (ARCA) Act of 2025

S. 1591, the Acquisition Reform and Cost Assessment (ARCA) Act of 2025, aims to restructure the acquisition process within the VA and establish a Director of Cost Assessment and Program Evaluation within the department. The focus of the bill is to help streamline procurement operations, hold major acquisition programs accountable, and facilitate the rapid adoption of medical technologies through advance market commitments.

We recognize the importance of effective oversight and responsible resource management. However, DAV has no resolution specific to this proposed acquisition restructuring effort and takes no position on the bill.

Mr. Chairman, this concludes my testimony. I would be pleased to answer questions you or members of the Committee may have.

Submissions for the Record

Trump's Push to Defund Harvard Prompts Clash Over Veteran Suicide Research

The proposed termination of medical research funded by the V.A. is part of the Trump administration's broader pressure campaign against the university.

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By Nicholas Nehamas
Reporting from Washington

May 16, 2025

The Trump administration's move to cancel an array of federal contracts at Harvard University has set off an internal clash over the impact on medical research intended to help veterans, including projects involving suicide prevention, toxic particle exposure and prostate cancer screening, according to emails reviewed by The New York Times.

The dispute among officials at the Department of Veterans Affairs has focused in part on a collaboration with Harvard Medical School to develop a predictive model to help V.A. emergency room physicians decide whether suicidal veterans should be hospitalized, according to the records.

Canceling that contract would result in "more veteran suicides that could have been prevented," Seth J. Custer, an official in the V.A.'s Office of Research and Development, wrote in a May 8 email asking leaders at the agency to reverse their decision. But John Figueroa, a longtime private industry health care executive and a senior adviser to Doug Collins, the veterans affairs secretary, said that researchers at other institutions could do the work instead.

Peter Kasperowicz, a V.A. spokesman, said that the department's research contracts with Harvard were "under review." He said the goal of the review was to ensure that "the projects best support the Trump administration's veterans-first agenda."

Mr. Custer declined to comment. In a brief telephone interview, Mr. Figueroa said the V.A. was examining "every contract" it had issued. A White House spokeswoman declined to comment. So did a spokeswoman for Harvard.

The tensions inside the V.A. over the Harvard contracts demonstrate how President Trump's use of research funds as leverage in his broader pressure campaign on universities carries political risks. Mr. Trump and other Republicans have courted veterans as a key political constituency, and Mr. Collins has repeatedly promised that veteran care would not be affected, even as he enacts major cost-cutting measures and other changes.

The Trump administration has increasingly targeted Harvard, demanding it overhaul its admissions, curriculum and hiring practices to comply with the president's political agenda. The government has canceled roughly $2.7 billion in grants, frozen nearly $1 billion in funding for Harvard's research partners and told the university it would not receive future research grants.

Are Freed **Unexpected Places**

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Scores of termination notices began arriving for Harvard researchers on Thursday and Friday. In a letter to the university community, Alan M. Garber, Harvard's president, described the terminations as "part of a broader campaign to revoke scientific research funding," and said their impact on scientific research "could be severe and lasting." The university has sued the government to stop the cuts.

Pushed by Elon Musk and the Department of Government Efficiency, the V.A. has pledged to cut costs by canceling contracts and slashing more than 80,000 jobs — roughly a sixth of its total work force. The department has also instituted a broad return-to-office mandate, forcing clinicians to work in crowded offices where some have said they cannot guarantee their patients' confidentiality.

The emails and other records reviewed by The Times show that the V.A. has begun the process of ending half a dozen contracts on a range of research projects at Harvard.

On May 7, a V.A. employee told colleagues that "if you are not already aware, contracts associated with Harvard are under termination" or being narrowed. She then listed the six contracts to be canceled, warning that requests to maintain the contracts would be met with "hard scrutiny."

"Please start the termination process ASAP," she wrote.

One of those agreements was to evaluate the quality of cancer care at non-V.A. health facilities that contract with the department to treat veterans. Republicans have pushed for veterans to be able to access more care outside the V.A. "This high-priority contract aligns with both congressional and V.A. secretary priorities," Mr. Custer wrote.

Another contract assisted the V.A. in analyzing its vast reams of clinical data. The contract, Mr. Custer wrote, helped ensure that "veterans have access to clinical trials, with notable efforts directed toward advancing precision prostate cancer screening."

"This is HIGHLY critical to fulfill the V.A. mission," he wrote in bold, adding: "There is NOT an internal V.A. solution."

Dr. Walter Willett, a professor of epidemiology and nutrition at the Harvard T.H. Chan School of Public Health, said he had worked with the V.A. for roughly five years on one of the projects being canceled, helping to analyze nutrition data for a large study on the diet and health of 500,000 veterans. One of the study's goals is to illuminate the links between diet and chronic disease.

"This science benefits everybody," Dr. Willett said. "It's not political. But we are being caught up in politics."

Andrea Fuller, Ellen Barry, Michael C. Bender, Alan Blinder and Steven Moity contributed reporting. Susan C. Beachy contributed research.

Nicholas Nehamas is a Washington correspondent for The Times, focusing on the Trump administration and its efforts to transform the federal government.

A version of this article appears in print on , Section A, Page 12 of the New York edition with the headline: Trump's Push to Defund Harvard Threatens Medical Research Geared to Veterans

American Gold Star Mothers, Inc.

National Headquarters
2128 Leroy Place NW
Washington, DC 20008
202-265-0991

Organized 4 June 1928
Incorporated 5 January 1929
Chartered by Congress 12 June 1984
Founded by Grace Darling Seibold

April 13, 2025

The Honorable Jerry Moran
Chairman, U.S. Senate Committee on Veterans' Affairs
Washington, DC 20510

The Honorable Jacky Rosen
United States Senator
Washington, DC 20510

Re: Fallen Servicemembers Religious Heritage Restoration Act

Dear Chairman Moran and Senator Rosen:

American Gold Star Mothers, Inc., (AGSM) is a 97-year-old Congressionally Chartered 501(c)(3) Veterans Service Organization. Our members are Mothers who lost a child who was serving in the United States Armed Forces. Each year, these Mothers volunteer thousands of hours to support Veterans, current Military Service Members, Gold Star Mothers, and the families connected to these communities.

On behalf of AGSM, I am writing to express our strong support for the **Fallen Servicemembers Religious Heritage Restoration Act**. This legislation honors the memory and beliefs of our fallen heroes by ensuring that religious symbols may be respectfully included. The establishment of the **Fallen Service Members Religious Heritage Restoration Program** under the American Battle Monuments Commission will provide the necessary support for correcting a wrong following WWII.

As mothers who have lost sons and daughters in service to our nation and those of our allies, we know deeply how meaningful it is to honor their sacrifice in a way that reflects who they were, including their faith. This bill affirms a grieving family's right to commemorate their loved one's values and convictions without unnecessary restriction.

AGSM believes that this legislation upholds the principles of religious freedom and personal dignity, while allowing survivors and descendants to participate in the grave marker change and to grieve and remember in a manner most meaningful to them. We thank you for your leadership and urge swift passage of this important measure.

Warmly,

Patti Elliott
2024-2025 National President

THE AMERICAN LEGION
Veterans Strengthening America
OFFICE OF THE NATIONAL COMMANDER
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May 15, 2025

The Honorable Jerry Moran
United States Senate
Washington, D.C. 20510

The Honorable Jacky Rosen
United States Senate
Washington, D.C. 20510

The Honorable Debbie Wasserman Schultz
United States House of Representatives
Washington, D.C. 20515

The Honorable Max Miller
United States House of Representatives
Washington, D.C. 20515

Dear Chairman Moran, Senator Rosen, Congresswoman Wasserman Schultz, and Congressman Miller:

On behalf of the more than 1.5 million dues-paying members of The American Legion, I write to express our strong support for the *Fallen Servicemembers Religious Heritage Restoration Act*.

This legislation reflects a long-overdue commitment to correct a historic accident affecting hundreds of Jewish American servicemembers who made the ultimate sacrifice during World War I and World War II. Due to the overwhelming scale of wartime operations and clerical inconsistencies—many of which were unavoidable given the era—an estimated 600 to 900 Jewish servicemembers were mistakenly buried under Latin crosses in overseas American military cemeteries, rather than the Star of David that reflects their faith and heritage.

The American Legion believes, as a matter of both principle and national honor, that every fallen American warrior must be remembered in accordance with their beliefs and identity. Faith was an integral part of the lives of many who served. Failing to honor that in death does a disservice not only to those individuals but also to their families, their communities, and the country for which they gave their lives.

Your bill's creation of the Fallen Servicemembers Religious Heritage Restoration Program—to empower the American Battle Monuments Commission to research and facilitate marker corrections—provides the necessary framework and funding to begin this solemn and sacred task. We particularly commend the legislation's attention to the real-world challenges that descendants face in navigating the marker correction process, and the provision of dedicated funding to support that work over the next decade.

The American Legion applauds your bipartisan leadership on this issue, and we urge swift passage of this important legislation so that we may, at long last, properly honor these heroes.

For God and Country,

James A. LaCoursiere
National Commander

RESILIENCE THROUGH
REMEMBRANCE

GOLD STAR SPOUSES OF AMERICA, INC.
16192 Coastal Highway, Lewes, DE 19958
302-200-9715 www.goldstarspouses.org
501(c)3 Non-Profit EIN: 99-3755224

May 6, 2025

Chairman Jerry Moran
412 Russell Senate Office Building
Washington, DC 20510

Dear Chairman Moran,

On behalf of Gold Star Spouses of America, I write to express our strong support for the Fallen Servicemembers Religious Heritage Restoration Act. As an organization dedicated to honoring the legacy and dignity of our nation's fallen heroes and supporting the spouses they leave behind, we commend your leadership in introducing this meaningful and long-overdue legislation.

This bipartisan bill represents a profound commitment to preserving the individual identity and faith of servicemembers who gave their lives in defense of our nation. By creating a dedicated 10-year program within the American Battle Monuments Commission, your legislation will help identify and correct grave markers that inaccurately represent the religious heritage of Jewish-American servicemembers buried overseas.

Honoring our fallen is not simply a matter of ritual—it is a moral responsibility. Ensuring that every servicemember is remembered in accordance with their faith and heritage reflects the deepest values of dignity, respect, and truth. For surviving spouses and families, seeing their loved one's final resting place properly marked is a critical element of healing and remembrance. This legislation empowers families to initiate change and provides essential support for historical research and verification, bridging the gap between past sacrifice and present honor.

Gold Star Spouses of America applauds the care and intentionality behind this legislation, and we stand proudly among the many voices calling for its swift passage. We remain committed to supporting all efforts that uphold the memory of our fallen servicemembers and bring comfort, clarity, and recognition to those they leave behind.

Thank you again for your leadership on this important issue.

Respectfully,

Tamra Sipes, President

JCRB | AJC Kansas City
COMBATING ANTISEMITISM & PURSUING JUSTICE

Dear Chairman Moran,

On behalf of the Jewish Community Relations Bureau | American Jewish Committee, representing the Jewish communities of Kansas and Western Missouri in matters of public policy, **I'm writing to you in support of the Fallen Servicemembers Religious Heritage Restoration Act (S. 1318),** which would identify and research Jewish-American servicemembers interred in American cemeteries overseas who are buried beneath grave markers that do not accurately reflect their religion and heritage.

This is a challenging time for the Jewish community. AJC's State of Antisemitism in America 2024 Report included several very alarming data points, including one in particular that stands out in the context of this legislation. Nearly six in 10 (56%) American Jews surveyed said they had altered their behavior out of fear of antisemitism in 2024—a sharp increase from previous years. This means avoiding wearing religious symbols that would identify them as Jews, opting not to attend an event or religious service at a synagogue or Jewish institution, or deciding not to post content on social media that might identify them as Jewish, all in the hopes of avoiding antisemitic backlash.

And the fear isn't imagined. The Anti-Defamation League's 2024 Audit of Antisemitic Incidents recorded 9,354 antisemitic incidents across the United States, the highest number on record since ADL began tracking antisemitic incidents 46 years ago. Incidents were recorded in all 50 states and the District of Columbia, and included harassment, vandalism, and assault.

It is a moment unlike any other in recent memory, yet the Jewish community must never forget to celebrate who we are. One of the ways we can do that is by being proudly and publicly Jewish. JCRB|AJC is proud to support legislation that recognizes, honors, and affirms the religious heritage of American-Jewish servicemembers who served this country proudly.

Neta Meltzer
Executive Director
Bert Berkley Chair for Community Relations

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Non Commissioned Officers Association of the United States of America
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The Honorable Jerry Moran
Chairman
Senate Committee on Veterans' Affairs
412 Russell Senate Office Building
Washington, D.C. 20510

The Honorable Richard Blumenthal
Ranking Member
Senate Committee on Veterans' Affairs
706 Hart Senate Office Building
Washington, D.C. 20510

Subject: Support for the Moran-Rosen Fallen Servicemembers Religious Heritage Restoration Act (S.1318)

Dear Chairman Moran and Ranking Member Blumenthal,

On behalf of the Non Commissioned Officers Association (NCOA), which proudly represents enlisted service members, veterans, and their families across all branches of the uniformed services, I write to express our strong support for the **Moran-Rosen Fallen Servicemembers Religious Heritage Restoration Act (S.1318)**.

This legislation restores and protects the ability of families to honor their fallen service member's religious beliefs through appropriate inscriptions and symbols on memorial markers. It ensures that expressions of personal faith—when requested by the next of kin—remain a respected and dignified part of memorializing those who gave the ultimate sacrifice for our country.

For decades, spiritual expression has been central to the identity and service of many military members. This bill strikes an important balance between preserving individual freedoms and respecting the deeply personal wishes of surviving families.

NCOA strongly supports S.1318 and believes its passage will reaffirm our national commitment to honoring both the service and the faith of America's fallen heroes.

We respectfully request that this letter be included in the official record of the Senate Committee on Veterans' Affairs legislative hearing scheduled for **May 21, 2025**. Thank you for your continued leadership and support of our military community.

Respectfully,

Levi H. Sadr
Director of Government Affairs

Republican Jewish Coalition

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May 13, 2025

The Honorable Jerry Moran
Chairman, Senate Committee on Veterans' Affairs
Washington, D.C. 20510

Dear Chairman Moran:

On behalf of the Republican Jewish Coalition, we are pleased to share our support for your Fallen Services Members Religious Heritage Restoration Act (S. 1318).

Jewish tradition teaches that a selfless act of kindness is the highest form of charity. The epitome of selfless kindness is to act on behalf of the deceased, who are unable to repay us.

S. 1318 will establish a program to identify Jewish U.S. servicemembers buried in military cemeteries overseas under markers that incorrectly represent their religion and help their families replace the grave markers of our nation's fallen heroes to properly reflect their religious heritage.

Preserving the memory of Jewish servicemen who made the ultimate sacrifice will express the greatest form of kindness. It will reflect the vibrant tapestry of our nation by providing an appropriate memorial to every American who fought, and was buried with his fellow servicemembers, side by side, in defense of liberty. While we can never fully repay the debt owed to our heroes, it is fitting to honor them as they honored our Country.

Thank you for your leadership on this important matter and your friendship to Jewish Americans.

Sincerely,

Norm Coleman
National Chairman

Matthew Brooks
Chief Executive Officer

TRAGEDY ASSISTANCE PROGRAM FOR SURVIVORS
★ NATIONAL HEADQUARTERS ★
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May 9, 2025

The Honorable Jerry Moran
Chairman
Senate Committee on Veterans' Affairs
Washington, DC 20510

The Honorable Richard Blumenthal
Ranking Member
Senate Committee on Veterans' Affairs
Washington, DC 20510

Dear Chairman Moran and Ranking Member Blumenthal,

On behalf of the Tragedy Assistance Program for Survivors (TAPS), I write to express our strong support for the **Fallen Servicemembers Religious Heritage Restoration Act (S.1318).** This important legislation would establish a 10-year program within the American Battle Monuments Commission (ABMC) to identify and conduct research on service members who are incorrectly memorialized. It would also empower the ABMC to locate and engage surviving families to facilitate the correction of grave markers to properly reflect the service member's religious heritage.

TAPS greatly appreciates Chairman Moran, Senator Rosen, and Representatives Wasserman Schultz and Miller for their commitment to recognizing and honoring the personal faith of those who gave their lives in service to our nation. It is a sacred obligation to ensure that every American service member who fought and died for our country has their beliefs and heritage properly honored—wherever they are laid to rest.

As the national organization that provides comfort, care, and resources to over 120,000 surviving families of military loss, TAPS urges the Senate Committee on Veterans' Affairs to advance the **Fallen Servicemembers Religious Heritage Restoration Act** and calls on the full Senate to pass this important legislation without delay.

Thank you for your continued leadership and your commitment to honoring our veterans and their families with dignity and respect.

Respectfully,

Bonnie Carroll

Bonnie Carroll
President and Founder
Tragedy Assistance Program for Survivors (TAPS)

May 14, 2025

The Honorable Jerry Moran
United States Senate
521 Dirksen Senate Office Building
Washington, D.C. 20510

The Honorable Jacky Rosen
United States Senate
713 Hart Senate Office Building
Washington, D.C. 20510

Dear Senators Moran and Rosen:

On behalf of the more than 1.4 million members of the Veterans of Foreign Wars of the United States (VFW) and its Auxiliary, we offer our support of S.1318, *Fallen Servicemembers Religious Heritage Restoration Act.* American-Jewish service members who fought and died for our country deserve to have their religious heritage properly recognized and honored. We advocate rectifying this long-standing error to properly commemorate our war dead.

The large number of casualties and the chaos of war directly contributed to burials with inappropriate headstones. During World War I, more than 100,000 Americans fell abroad during the country's first large scale overseas combat deployment, and administrative errors were not uncommon. Complicating the situation during World War II, some American-Jewish service members who served in the European Theater deliberately concealed their religious affiliation to avoid torture or death if captured by the Nazis.

This legislation would facilitate identifying the several hundred improperly marked graves of American-Jewish service members and then confirming the decedent's religious affiliation. This information would enable descendants to apply for a replacement headstone, which is a difficult task for an extended family member without assistance. An attractive feature of this bill is contracting with experienced nonprofit organizations rather than assigning the responsibility to the relatively small staff of the American Battle Monuments Commission—the organization that administers, operates, and maintains these overseas cemeteries.

The VFW commends your leadership on this issue and your commitment to our nation's veterans. We look forward to the swift passage of this legislation.

Sincerely,

Kristina Keenan, Director
VFW National Legislative Service

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VIETNAM VETERANS OF AMERICA
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NEVER AGAIN WILL ONE GENERATION OF VETERANS ABANDON ANOTHER.

May 16, 2025

Senator Jerry Moran
Dirksen Senate Office Building
Room 521
Washington, DC 20510

Dear Senator Moran,

I hope this letter finds you in good spirits. I am writing to express my unwavering support for Senate Bill 1318, the Fallen Service Members Religious Heritage Restoration Act. This important legislation is a vital step toward honoring the sacrifices made by our service members and ensuring that their religious beliefs and heritage are respected and preserved.

The men and women who serve in our Armed Forces make tremendous sacrifices to protect our freedoms. In recognizing their commitment to support and defend the treasured concepts embodied in our Constitution, it is essential that we respect and honor their diverse religious backgrounds. Senate Bill 1318 seeks to ensure that the religious heritage of fallen service members is acknowledged and that their beliefs are reflected in memorials and commemorations.

This legislation resonates our Nation's commitment to religious freedom and serves as a gesture of compassion and respect to the families of those who have made the ultimate sacrifice. By supporting this bill, we affirm our dedication to honoring the legacy of our fallen heroes in a manner that reflects their individual values.

I urge you to continue advocating for this important legislation and to encourage your colleagues to lend their support as well. Together, we can ensure that the sacrifices of our service members are honored in a way that reflects the rich tapestry of beliefs that make our Nation strong.

Thank you for your attention to this matter and for your continued service to our country.

Sincerely,

Jack McManus
National President

Questions for the Record

Department of Veterans Affairs (VA)
Questions for the Record
Committee on Veterans' Affairs
United States Senate
Legislative Hearing

May 21, 2025

Questions for the Record from Senator Maggie Hassan:

Question 1: Dr. O'Toole - since you testified before the Senate Veterans Affairs Committee in April of this year, has anyone at VA asked for your input or analysis, or asked you to oversee any analysis done by the VA's Clinical Services Department, regarding how firing 80,000 VA employees would affect veterans' care?

VA Response: Since the hearing in April, I have provided input related specifically to programmatic efficiencies within the Office of Clinical Services. That said, on July 7, 2025, VA announced that it has achieved desired efficiencies for fiscal year 2025. VA will continue to review how we do business to ensure that we effectively provide services and benefits to Veterans and their families while efficiently using taxpayer dollars.

Question 2: Dr. O'Toole – during your appearance before the Senate Veterans Affairs Committee on May 21, 2025, you stated, in effect, that there are several clinicians and physicians senior to you that are actively involved in the process of evaluating the VA's plan to fire roughly 80,000 employees. For the record, who are the doctors or clinicians senior to you who are involved in this analysis? Please list their names, titles, and departments.

VA Response: Some of the roles more senior to my role as the Deputy Assistant Under Secretary for Health for Clinical Services include the Assistant Under Secretary for Health for Clinical Services, the Chief Operating Officer, Deputy Under Secretary for Health, and the Under Secretary for Health. While VA initially considered a Department-wide reduction in force (RIF) to reduce staff levels by up to 15%, employee reductions through the Federal hiring freeze, deferred resignation program, retirements, and normal attrition have eliminated the need for the RIF at this time. VA continues to review staffing levels to ensure there will be no impact to Veterans' care or benefits.

Question 3: Dr. O'Toole – Only recently, after months of delay, the VA finally provided to this Committee a list of more than 400 contracts it has closed and terminated. Did anyone at VA ask for your input or analysis, or ask you to oversee any analysis done by the VA's Clinical Services Department, regarding how cutting these contracts would affect veterans' care?

VA Response: VA undertook a deliberative, multi-level review that involved the career subject-matter expert employees responsible for the contracts as well as VA senior leaders and contracting officials. I provided input and recommendations for contracts under my office's purview. My office also has a number of mechanisms in place to escalate any potential issues and ensure that contract actions do not impact our ability to provide health care or benefits to Veterans.

Question 4: Dr. O'Toole – Are any doctors or clinicians senior to you involved in any analysis regarding how cutting the contracts referenced in Question 3 would affect veterans' care? If so, please list their names, titles, and departments.

VA Response: Yes, VA undertook a deliberative, multi-level review that involves the career subject matter experts responsible for the contracts as well as VA senior leaders and contracting officials. I provided input and recommendations for contracts under my office's purview.

Questions for the Record from Senator Dan Sullivan:

Question 1: Thank you for your testimony regarding the *Supporting Rural Veterans Access to Healthcare Services Act.* This is an incredibly important bill for Alaska as it is for North Dakota and Senator Cramer, King, and I appreciate you taking the time to review it. The legislation would reauthorize the existing program as well as increase the cap for communities that have five or more off-the-road system communities by 50%. This would be huge for my state.

While I respect that many of my colleagues in the Senate are advocating to expand this program to include rural communities, I must express my strong concern with that approach. The grant was created for "highly rural" communities as the name "highly rural transportation grants" suggests. As the Senator from Alaska, I represent some of the most remote and underserved frontier communities in the nation—areas where access to basic services is already severely limited.

In Alaska, the current funding allocated to this program is exhausted in just six months, even though it is intended to support us for a full year. This stark reality highlights how under-resourced truly rural and frontier regions already are, and the Congressional intent of this program originally was to target these types of communities. Proposals to broaden eligibility to more populated or less isolated communities, while well-intentioned, would further dilute the limited resources available and disproportionately disadvantage the communities that need them the most.

Expanding this program risks undermining its core mission. It shifts scarce support away from the areas that it was originally designed to help—places like the ones I represent—where the need is greatest and alternatives are few.

I wanted to follow up on a point you raised. In your testimony, you expressed concern about increasing the cap for counties with five or more off-the-road-system communities. At the same time, I noted your support for expanding the definition of "highly rural" under S.784 to reach more veterans.

While I appreciate the intention to broaden access, I'm concerned that without a corresponding increase in appropriations — which is not guaranteed as we are not an appropriating committee — this approach could unintentionally reduce the funding available to Alaska's highly rural communities, which are the original focus of this grant.

Given the uncertainty around increased appropriations, how can we responsibly expand eligibility without jeopardizing existing services in highly rural areas like those in Alaska? What solutions would you recommend ensuring that expanding access doesn't come at the expense of the veterans currently being served in Alaska?

VA Response: VA appreciates your strong advocacy and support to increase the cap for communities that have five or more off-the-road system communities. While the prospect of increased appropriations may be a concern, VA believes all Veterans residing in highly rural areas, and to the extent that definitional expansion to rural areas occurs, deserve equal footing in the availability of assistance that these transportation grants provide. Specific to Alaska, in the fiscal year (FY) 2023 grant cycle, the grantee (Alaska Department of Military and Veterans Affairs—a state agency serving military personnel and Veterans in the state), received $250,000 to serve the boroughs of Southwest Fairbanks, Kodiak Island, Matanuska-Susitna, Kenai Peninsula, and Prince of Wales-Hyder. Based on the FY 2023 funding grant cycle, Alaska was able to assist 2,589 Alaskan Veterans by providing 5,825 trips.

VA takes note of your specific concerns of the adequacy of funding availability within the highly rural areas of Alaska and remains committed to ensuring grants are equitably reviewed and awarded based on the merit and justifications of the qualified applicant.

Question 2: I also want to comment on the remarks made around the definition of Indian Tribe. I believe what your testimony is saying is that in addition to using ISDEAA to define Tribal Organization, we also need to use the ISDEAA definition to define what a tribe is. That is an easy fix as ISDEAA does have that definition in statute we can reference. However, I want to go on record saying that ISDEAA is the only appropriate definition for a tribal organization because it includes Alaska Native Corporations. Any other definition is discriminatory against Alaska Natives. ANCSA makes clear that the Alaska Native people are the heart and soul of the ANCs, and for whom the ANCs were formed to benefit. Alaska Native people are not to be considered "less than" other Indian people just because they fall into one designation rather than another. With its passage in 1975, ISDEAA also explicitly recognized and imported ANCs into concepts of self-determination by including them in the definition of 'Indian tribe.

VA Response: VA acknowledges that the definition of "Indian tribe" under the Indian Self-Determination and Education Assistance Act (ISDEAA; 25 U.S.C. § 5304) includes any "Alaska Native village[s] or regional or village corporation[s]." However, the bill refers to the definition of "Tribal organization" under the ISDEAA. While the definition of "Tribal organization" under the ISDEAA technically captures an Indian Tribe, to the extent that it includes the Tribe's governing body, there is some concern that it can cause potential confusion because the bill does not explicitly include or define Indian Tribe, which is defined separately in the ISDEAA. At minimum, the drafters may want to clarify the intent of the bill. If it is intended to also include Indian Tribes, the drafters may want to consider explicitly adding and separately defining Indian Tribe as defined in the ISDEAA. VA stands ready to provide additional technical assistance to this bill to address this recommendation.

Questions for the Record from Senator Tommy Tuberville:

Question 1: Mr. O'Toole, in your testimony you raise concerns with the VA's ability to contract with the nurse registry instead of the provider. Prior to 2018, the VA did in fact reimburse veterans for homecare services from independent contractors through nurse registries. If that's the case, couldn't the VA just return to the same reimbursement model used prior to 2018? Why or why not? If the VA can't return to that exact reimbursement approach used before 2018, couldn't implementation of my legislation still be based off that? This isn't a new concept.

VA Response: VA's current contracting environment prioritizes standardization, accountability, and integration across all community care channels. This ensures Veterans receive high-quality, timely care while maintaining compliance with Federal procurement laws and the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018 (VA MISSION Act of 2018) intent.

Nurse registries typically operate under local, often informal arrangements that do not meet the credentialing, quality assurance, and oversight standards required by Community Care Network (CCN) contracts. Both the VA MISSION Act of 2018 and the Cleland-Dole Act of 2022 require individual credentialing review of all health care professionals providing care to Veterans.

The passage of the VA MISSION Act of 2018 fundamentally restructured how VA delivers care through community providers. VA contracts with Third Party Administrators (TPA) like Optum and TriWest to manage provider networks, credentialing, claims processing, and scheduling. VA is required to ensure that all non-VA providers meet relevant Federal credentialing standards, including licensure verification and exclusion checks.

The Cleland-Dole Act of 2022 introduced continuous credentialing verification through mandatory enrollment in the National Practitioner Data Bank Continuous Query, monthly and annual audits aligned with National Committee for Quality Assurance and Utilization Review Accreditation Commission standards, and formal oversight by

credentialing committees with VA participation. These enhancements ensure real-time monitoring of provider eligibility and swift removal of those who no longer meet standards. Generally, these requirements cannot be met by decentralized and informally governed mechanisms like nurse registries, which cannot meet the documentation, monitoring, and compliance requirements now embedded in VA's credentialing system. These requirements, however, significantly strengthen the quality, safety, and accountability of care delivered to Veterans in the community.

Question 2: Mr. O'Toole, you also mention concern with the requirement that a nurse registry be a person that "satisfies any applicable state licensure requirement." Shouldn't the requirement of having a state license be sufficient to provide care? And if that's not sufficient what additional requirements does the VA think are needed for independent contractors to provide care?

VA Response: VA's current contracting environment prioritizes standardization, accountability, and integration across all community care channels. This ensures Veterans receive high-quality, timely care while maintaining compliance with Federal procurement laws and the VA MISSION Act of 2018 intent.

Nurse registries typically operate under local, often informal arrangements that do not meet the credentialing, quality assurance, and oversight standards required by CCN contracts. Both the VA MISSION Act of 2018 and the Cleland-Dole Act of 2022 require individual credentialing review of all health care professionals providing care to Veterans.

The passage of the VA MISSION Act of 2018 fundamentally restructured how VA delivers care through community providers. This legislation consolidated and replaced previous programs, including the Veterans Choice Program, and established the requirement that VA establish regional contract networks, like CCN as a vehicle for delivering care in the community. VA contracts with TPAs like Optum and TriWest to manage provider networks, credentialing, claims processing, and scheduling. VA is required to ensure that all non-VA providers meet relevant Federal credentialing standards, including licensure verification, exclusion checks, and documentation in the Provider Profile Management System.

The Cleland-Dole Act of 2022 introduced continuous credentialing verification through mandatory enrollment in the National Practitioner Data Bank Continuous Query, monthly and annual audits aligned with National Committee for Quality Assurance and Utilization Review Accreditation Commission standards, and formal oversight by credentialing committees with VA participation. These enhancements ensure real-time monitoring of provider eligibility and swift removal of those who no longer meet standards. Generally, these requirements cannot be met by decentralized and informally governed mechanisms like nurse registries, which cannot meet the documentation, monitoring, and compliance requirements now embedded in VA's credentialing system. These requirements, however, significantly strengthen the quality, safety, and accountability of care delivered to Veterans in the community.

Statements for the Record

AMERICAN BATTLE
MONUMENTS COMMISSION

Senate Committee on Veterans' Affairs Legislative Hearing
May 21, 2025

Statement for the Record

S. 1318—*Fallen Servicemembers Religious Heritage Restoration Act*; Chairman Moran (R-KS), RM Blumenthal (D-CT), Sen. Rosen (D-NV), Sen. Cornyn (R-TX)

Summary of Bill: To direct the American Battle Monuments Commission (ABMC) to establish a program to identify American-Jewish servicemembers buried in a US military cemetery overseas under markers that incorrectly represent their religion and heritage, and for other purposes.

Official Position: ABMC supports the proposed bill.

Statement for the Record:

Chairman Moran, Ranking Member Blumenthal, and distinguished members of the Senate Committee on Veterans' Affairs, thank you for your support of the American Battle Monuments Commission (ABMC) and the opportunity share ABMC's views on the proposed legislation and how it benefits our mission.

Since ABMC was founded in 1923, the success of our mission has depended on the engagement of our stakeholders. Over time, our approach to accomplishing our mission has evolved to meet the changing needs of these various individuals. We have traditionally served:

- Veterans, Family, and Friends Honored for Their Service or Their Loss – We honor the veterans, family members, and friends of United States (U.S.) military who have served our country or endured the loss of a loved one who served. This group has the closest ties to our sites, and we strive to provide them with the most positive experience possible. For immediate family members who want to visit a family member's burial or memorialization site, we provide letters authorizing fee-free passports for traveling overseas to visit the memorial site. In addition, we offer a variety of other services, including information on an individual buried or honored, and escort services for family members visiting grave and memorial sites within the cemetery.

- Military and Public Officials – We host a variety of special events and commemorations throughout the year, including Memorial Day and Veterans Day holidays, to honor the freedom preserved and restored and the lives lost. Host country and U.S. government officials, diplomats, and military representatives attend these events with the public. In addition, military

units hold ceremonies to honor their fallen comrades, and foreign organizations pay tribute to those who died liberating their regions.

- Guests and Visitors – We receive millions of American and foreign visitors of all generations at ABMC cemeteries and memorials. They learn and are inspired by the stewardship of the sites themselves, and the stories of our armed forces shared within our visitor centers and contact stations. We provide a variety of services to these visitors, including direction, advice on modes of transportation, and information on local accommodations.

- ABMC Partners – We support and provide information to our partners that help us further our mission, including other government agencies, historians and educators, the travel and tourism industry, and the media. Through these partnerships, we promote our mission, encourage visits to our commemorative sites, and help educate and inspire the public.

Recognizing the need for a federal agency to be responsible for honoring the fallen members of American armed forces where they had served abroad and for controlling the construction of military monuments and markers on foreign soil, Congress enacted legislation creating the ABMC.

As an independent agency of the Executive Branch, ABMC is responsible for commemorating the service, achievements, and sacrifice of American armed forces in the U.S. and where they have served overseas since April 6, 1917 (the date of U.S. entry into World War I), through the erection of suitable memorial shrines; for designing, constructing, operating, and maintaining permanent American military burial grounds in foreign countries; for controlling the design and construction of U.S. military monuments and markers in foreign countries by other U.S. citizens and organizations, both public and private; and for encouraging the maintenance of such monuments and markers by their sponsors. In performing these functions, ABMC administers, operates and maintains 26 permanent American military burial grounds and 31 separate memorials, monuments and markers, of which three are located in the U.S.

Nearly 208,000 U.S. war dead from World War I and World War II are buried or memorialized on Walls of the Missing at ABMC sites. Additionally, more than 8,200 war dead listed as missing from the Korean War and 2,500 from the Vietnam War are memorialized at ABMC's Honolulu Memorial. ABMC also administers three cemeteries not associated with the world wars: Mexico City National Cemetery, Corozal American Cemetery in Panama, and Clark Veterans Cemetery in the Philippines. More than 15,000 members of the armed forces, veterans, and others are interred in these sites.

Each grave site in the permanent American World War I and World War II cemeteries on foreign soil is marked by a headstone of white marble. Annotated on the headstones of the World War I war dead who could not be identified is the phrase, "HERE RESTS IN HONORED GLORY AN AMERICAN SOLDIER KNOWN BUT TO GOD." In the World War II cemeteries, the words "AMERICAN SOLDIER" were replaced with "COMRADE IN ARMS."

ABMC's World War I, World War II, and Mexico City cemeteries are closed to future burials except for the remains of U.S. war dead found from time to time in the World War I and World

War II battle areas. Corozal American Cemetery outside Panama City, Panama, and Clark Veterans Cemetery in the Philippines are the only active cemeteries that ABMC maintains.

The ***Fallen Servicemembers Religious Heritage Restoration Act*** serves our stakeholders and as such, ABMC has no objections to the purpose or language of S. 1318. However, ABMC requests clarification regarding when the proposed funds will be appropriated. In support of this legislation and to advance the program and its merits, ABMC would prefer funds be appropriated for this purpose in fiscal year (FY) 2026. If not appropriated in FY 2026, ABMC will request funding in its (FY) 2027 budget and the next ten budget cycles in support of this program.

ABMC's appropriations are used to maintain and operate the 26 overseas American cemeteries and 31 federal memorials, monuments and markers that ABMC maintains on behalf of the American people. Without the legislative authority and accompanying funding, ABMC will remain focused on using its appropriations for existing statutory authorities to achieve its sacred duty of telling the story of service and sacrifice of American men and women who fought to preserve our freedom and now rest in American cemeteries overseas.

For nearly a decade, ABMC has partnered with Operation Benjamin—a nonprofit organization of the type that is described in the proposed bill—to identify American-Jewish servicemembers who were mistakenly buried under Latin crosses and replace those crosses with headstones bearing the Star of David. ABMC is proud to bear witness to Operation Benjamin's many successes and looks forward to embracing many new endeavors of properly honoring the religion and heritage of servicemember sacrifice in the causes of democracy and freedom as outlined in S.1318 - ***Fallen Servicemembers Religious Heritage Restoration Act***.

Thank you for the opportunity to expand on ABMC's promise to honor those entrusted to our care by preserving their legacy of service and sacrifice for generations to come. Through this proposed bill and appropriated funding, ABMC will ensure that "time will not dim the glory of their deeds."

AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES, AFL-CIO

Eric Bunn Sr.
National Secretary-Treasurer

Dr. Everett B. Kelley
National President

Dr. Kendrick B. Roberson
NVP for Women & Fair Practices

May 21, 2025

The Honorable Jerry Moran
Chairman
Senate Veterans' Affairs Committee
United States Senate
Washington, DC 20510

The Honorable Richard Blumenthal
Ranking Member
Senate Veterans' Affairs Committee
United States Senate
Washington, DC 20510

Dear Chairman Moran, Ranking Member Blumenthal, and Members of the Committee:

On behalf of the American Federation of Government Employees, AFL-CIO (AFGE) and its National Veterans Affairs Council (NVAC), I write regarding today's Senate Veterans' Affairs Committee hearing on pending legislation. AFGE represents more than 800,000 federal and District of Columbia government employees, 304,000 of whom are Department of Veterans Affairs (VA) employees.

AFGE strongly opposes S. 219, the "Veterans Health Care Freedom Act," which would create a pilot program allowing eligible veterans to choose providers—without VA referral or authorization—among medical facilities, private providers participating in the Veterans Community Care Program (VCCP), and private providers with Veterans Care Agreements.

After four years, the bill permanently phases out the requirements for accessing care under the VCCP and Veterans Care Agreements and requires the VA to provide such care under the same conditions as the pilot program. Additionally, after four years, veterans may receive care at a VA medical facility regardless of whether the facility is in the same Veterans Integrated Service Network as the veteran.

S. 219 would greatly accelerate privatization, ultimately leading veterans to lose the choice of the high-quality, integrated care delivery model that VA offers. No health care system is sustainable if it is forced to pay for whatever out-of-network provider a member wishes to see and still provide services on demand to its enrollees. VA has cited rapid privatization as one of the primary causes of the VHA budget shortfall. Referrals to private care have been rising at between 15-20 percent a year, a clearly unsustainable trend for the direct care system.[1]

[1] [1] Kizer KW, Perlin JB, Guice K, Granger E, Friesen D, Safran DG. The Urgent Need to Address VHA Community Care Spending and Access Strategies – Red Team Executive Roundtable Report. March 30, 2024.

Simply put, money that is directed to private care reduces the available budget for direct care inevitably leading to service closures and creating more limited options for veterans who wish to have their care at the VA. AFGE therefore opposes this proposal to transform VA from a comprehensive integrated delivery system into an insurance company. Our members already feel the effects of rapid privatization in the form of unpredictable staffing and service closures related to widespread VA facility budget problems that make it difficult to provide veterans with the care they deserve.

Proponents of privatization say they are doing this in the name of veteran choice. However, approximately 92 percent of veterans already have other options for health insurance; the majority have employer-sponsored coverage or access to private health care plans through Medicare.[2] The unique benefit of the VA is the direct-care system that specializes in the unique health needs of veterans.

A large body of research indicates that VA provides care that is as good and often better than private care. In a systematic review of quality and efficacy studies, VA dramatically outperformed private care - including VA Community Care, private care provided to the general population, and private care veterans received outside VA through other insurance. VA did better than private care on all or most outcomes in most of the reviewed studies on the quality/safety of non-surgical care.[3]

If we want VA to continue to provide veterans with high-quality care, we must reverse privatization rather than accelerate it. For these reasons, AFGE urges you to oppose S. 219 and looks forward to working with the committee on more productive ways of improving VA for veterans and workers.

Additionally, as the committee considers S. 1533, the "VA License Portability Act," introduced by Senators Tillis and King, AFGE urges the committee to link its consideration of this legislation with the yet to be re-introduced "Medical Disability Exam Improvement Act." This bill from 118th congress (S. 2718), co-sponsored by Senators Tillis and King, contained a provision (Section 4) that would require VA to pay for all in-house disability exams from the VBA account, instead of the VHA account. Doing this would encourage VBA to reduce waste and control costs, which would in turn encourage bringing these exams in house, improving the quality of exams and reducing the cost to the VA. Veterans would be better served by bringing as many exams as possible, especially specialty exams, in-house, and this committee should not consider further expanding contract exams without also making this commonsense change.

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[2] Wagner TH, Schmidt A, Belli F, et al. Health Insurance Enrollment Among US Veterans, 2010-2021. JAMA Netw Open. 2024;7(8):e2430205. doi:10.1001/jamanetworkopen.2024.30205.

[3] Shekelle P, Maggard-Gibbons M, Blegen M, et al. VA versus Non-VA Quality of Care: A Living Systematic Review. Washington, DC: Evidence Synthesis Program, Health Systems Research Office of Research and Development, Department of Veterans Affairs. VA ESP Project #05-226; 2024.

Thank you for considering AFGE's views on these important pieces of legislation. For additional information or questions, please contact Lisa Swirsky at Lisa.Swirsky@afge.org or Elliot Friedman at Elliot.Friedman@afge.org.

Sincerely,

Daniel M. Horowitz
Director of Legislation

TESTIMONY
OF
MATTHEW CARDENAS
POLICY ANALYST
VETERANS' AFFAIRS AND REHABILITATION DIVISION
THE AMERICAN LEGION
BEFORE THE
SENATE COMMITTEE ON VETERANS' AFFAIRS
LEGISLATIVE HEARING
ON
"PENDING LEGISLATION"

MAY 21, 2025

EXECUTIVE SUMMARY

LEGISLATION	POSITION
S. 214: the MEDAL Act of 2025 (Cruz/Cotton) *Pg. 3*	Support
S. 219: the Veterans Health Care Freedom Act (Blackburn/Tuberville/Cramer/Sheehy) *Pg. 4*	Oppose
S.506: the Coordinating Care for Senior Veterans and Wounded Warriors Act (Moran/King) *Pg. 5*	Support
S. 585: the Servicemember to Veteran Health Care Connection Act (King/Cramer) *Pg. 6*	Support
S. 599: the DRIVE Act of 2025 (Welch) *Pg. 7*	Support
S. 605: the CHAMPVA Children's Care Protection Act (Blumenthal) *Pg. 8*	Support
S.635, the Veterans Homecare Choice Act of 2025 (Tuberville) *Pg. 8*	Oppose
S. 649, the Guard and Reserve GI Bill Parity Act (Moran/Blumenthal) *Pg. 9*	Support
S. 778, the Lactation Spaces for Veteran Moms Act (Rosen/Murkowski) *Pg. 10*	Support
S. 784, the Rural Veterans Transportation to Care Act (Ossoff/Collins) *Pg. 11*	Support
S.800, the Precision Brain Health Research Act of 2025 (Moran/King) *Pg. 12*	Support
S.827, Supporting Rural Veterans Access to Healthcare Services Act (Cramer/King/Sullivan) *Pg. 13*	Support
S.879, the Veteran Caregiver Reeducation, Reemployment, and Retirement Act (Moran/Hirono) *Pg. 13*	Support
S. 1318, a bill to direct ABMC to establish a program to identify American-Jewish servicemembers buried in United States military cemeteries overseas under markers that incorrectly represent their religion and heritage. (Moran/Rosen) *Pg. 15*	Support
S. 1320, the Servicewomen and Veterans Menopause Research Act (Murray) *Pg. 16*	Support
S. 1383, the Veterans Accessibility Advisory Committee Act (R. Scott/Moran/Blumenthal/Gillibrand) *Pg. 17*	Support
S. 1441, the Service Dogs Assisting Veterans (SAVES) Act (Tillis/Blumenthal) *Pg. 18*	Support
S. 1533, the VA License Portability Act (Moran/King) *Pg. 19*	Support
S. 1543, the Veterans' Education, Transition and Opportunity Prioritization Plan Act (Banks/Hassan) *Pg. 20*	No Position

TESTIMONY
OF
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MAY 21, 2025

Chairman Moran, Ranking Member Blumenthal and distinguished members of the Committee, on behalf of National Commander Jim 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.

S. 214: the MEDAL Act

To amend title 38, United States Code, to increase the rate of the special pension payable to Medal of Honor recipients, and for other purposes.

Created in 1861 and 1862, respectively, the Navy and Army versions of the "Medal of Valor" or "Medal of Honor" were established to provide recognition to servicemembers who distinguished themselves "conspicuously by gallantry and intrepidity" in combat with an enemy of the United States.[1] In 1916, this nation authorized an additional, lifetime monthly "special pension" of $10/month for any Medal of Honor (MoH) recipient. It increased to $100/month in 1961 and was last raised to $1000/month in 2002. Adjusting for cost-of-living for the year 2025, this comes out to $1,712.94/month.[2]

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[1] The American Legion. "Pending Veterans Affairs Legislation." *The American Legion*, April 2016. HYPERLINK "https://www.legion.org/information-center/news/legislative/2016/april/pending-veterans-affairs-legislation"https://www.legion.org/information-center/news/legislative/2016/april/pending-veterans-affairs-legislation.

[2] Troy E. Nehls. "House Passes Nehls' Bill to Increase Pension for Medal of Honor Recipients." *Rep. Troy E. Nehls*, February 26, 2025. HYPERLINK "https://nehls.house.gov/media/press-releases/house-passes-nehls-bill-increase-pension-medal-honor-recipients"https://nehls.house.gov/media/press-releases/house-passes-nehls-bill-increase-pension-medal-honor-recipients.

For our nation's brave heroes, this is not enough. Although not required, many MoH recipients volunteer their time through the Congressional Medal of Honor Society's education and outreach initiatives. In doing so, they absorb personal travel and logistical costs to share their experiences or providing support and encouragement to veterans, or when instilling the virtues of courage, sacrifice, integrity, commitment, patriotism in the daily lives of students.[3]

This legislation proposes increasing the special pension provided to living Medal of Honor recipients from $1,406.73 to $8,333.33/month. The American Legion has long supported this issue and on May 22, 2019, submitted a Statement for Record (SFR) which included support for S. 857, the 116th Congress' version of this legislation. These heroes deserve our nation's gratitude and unwavering support. By ensuring the financial means necessary to sustain their continued public service and outreach efforts, this legislation honors their enduring contributions. The American Legion supports this legislation through Resolution No. 366: Honoring those who have Earned the Medal of Honor, which supports legislation that would expand the benefits to Medal of Honor recipients.

The American Legion supports S. 214 as currently written.

S. 219: the Veterans Health Care Freedom Act

To direct the Secretary of Veterans Affairs to carry out a pilot program to improve the ability of veterans to access medical care in medical facilities of the Department of Veterans Affairs and in the community by providing veterans the ability to choose health care providers.

The Veterans Health Care Freedom Act would offer veterans a choice between receiving their care through the VA or through the community. For a period of 4 years, inside four designated Veterans Integrated Service Network (VISN) areas, this bill would allow an enrollee to elect whether to receive care through the traditional VA, or through the Veterans Community Care Program (VCCP). Once the trial program has ended, barring no further action, this policy would become effective for all veterans under Subsection (h)(2).

Community care has been an important relief valve for VA and has a large role to play in getting veterans the care they need when they need it. However, this legislation would be a major deviation from how the Legion has typically viewed and supported the provision of veteran health care. The American Legion strongly believes that VA should remain the center of care for veterans. The overuse of VA community care providers would not only be extremely costly to the VA, but it would also be very difficult to ensure that veterans receive the same standard of care provided internally at VA facilities. According to the Congressional Budget Office, the total amount that VA has spent on community care has steadily increased, from $7.9 billion in 2014 to $18.5 billion in 2021.[4] This trend of increasing the use of community care has continued, accounting for 40

[3] "Medal of Honor: Answering Frequently Asked Questions." Congressional Medal of Honor Society, December 14, 2020. HYPERLINK "https://www.cmohs.org/news-events/blog/medal-of-honor-answering-frequently-asked-questions/"https://www.cmohs.org/news-events/blog/medal-of-honor-answering-frequently-asked-questions/.

[4] Rasmussen, Petra, and Carrie M. Farmer. "The promise and challenges of VA community care: veterans' issues in focus." *Rand Health Quarterly* 10, no. 3 (2023): 9.

percent of the VA's total contract obligations in fiscal year 2023. [5] This is concerning as the GAO found that program staff lack clearly defined procedures on how to track and communicate problems such as contractor performance and operational issues. This limits the VA's ability to respond to issues quickly and address them. [6]

In 2016, The American Legion National Commander Dale Barnett spoke to the congressionally appointed Commission on Care, saying "Veterans believe VA's problems can be fixed and trust can be restored. The quality of VA health care continues to outperform the private sector in study after study. Veterans do not want a reduction in quality. They just want reasonable access to Care." Further, The American Legion opposes this legislation via Resolution No. 7: Ensuring VA Remains the Center of Care, and Resolution No. 14: Access to Care.

The American Legion opposes S. 219 as currently written.

S. 506: the Coordinating Care for Senior Veterans and Wounded Warriors Act

To require the Secretary of Veterans Affairs to carry out a pilot program to coordinate, navigate, and manage care and benefits for veterans enrolled in both the Medicare program and the system of annual patient enrollment of the Department of Veterans Affairs.

The Coordinating Care for Senior Veterans and Wounded Warriors Act establishes a three-year pilot program to assist veterans enrolled in Medicare with navigating VA healthcare services, including community care. This program aims to ensure seamless coordination of health records via a third-party contractor. Many veterans in rural communities lack access to VA facilities and are assigned to Patient Aligned Care Teams. However, these teams often fall short in facilitating communication between VA providers and community providers, leading to gaps in care coordination. This legislation would improve the coordination of medical care across the two healthcare systems.

The American Legion supported this legislation in a previous Congress. Continued support is grounded in Resolution No. 14: Access to Care, which urges VA to implement a streamlined community care referral process for veterans. This bill is further supported through Resolution No. 7: Ensuring VA Remains the Center of Care. This resolution urges the VA to maintain the community care cost and maintain the VA as the center of care for veterans.

The American Legion supports S. 506 as currently written.

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[5] U.S. Government Accountability Office. *Veterans Community Care Program: VA Needs to Strengthen Contract Oversight*. Report to the Ranking Member, Committee on Veterans' Affairs, House of Representatives, August 2024. https://www.gao.gov/assets/gao-24-106390.pdf.

[6] U.S. Government Accountability Office. "A Veterans' Program Meant to Help Increase Access to Health Care May Struggle to Do So." *GAO WatchBlog*, August 29, 2024. https://www.gao.gov/blog/veterans-program-meant-help-increase-access-health-care-may-struggle-do-so.

S. 585: the Servicemember to Veteran Health Care Connection Act

To amend title 38, United States Code, to establish a pre-transition health care registration process to facilitate enrollment in the patient enrollment system of the Department of Veterans Affairs by members of the Armed Forces who are separating from the Armed Forces, and for other purposes.

A 2020 study conducted on two million recently separated servicemembers found that individuals, particularly young males with shorter lengths of service in the Marine Corps or Army, faced a significantly higher risk of suicide following separation.[7] A recent July 2024 Government Accountability Office (GAO) report cited deficiencies in the Department of Defense (DOD) *inTransition* program, a mental health initiative designed to assist servicemembers during transition to civilian life. Notably, the GAO found that DOD was unable to successfully connect with over 70% of servicemembers who were automatically enrolled in the program.[8] DOD's failure to connect is concerning as many transitioning servicemembers may be unaware of existing medical benefits, such as the five years of cost-free VA health care available to "combat-exposed" veterans;[9] a benefit recently extended to 10 years through enactment of the *PACT Act*. Strengthening outreach and coordination during this critical transition period is essential to reducing risk and ensuring veterans receive the care and support they have earned.

S. 585 would eliminate DOD's *inTransition* screening and selection process by automatically pre-enrolling all servicemembers within 180-days of separation from military service. This automatic pre-enrollment approach would better inform separating servicemembers of their health care options under the Department of Veterans Affairs (VA), reducing barriers to access at a critical point in transition. The Federal Government has seen measurable success with automatic enrollment with other areas, such as voter registration and organ donation, that have been integrated in the application process for obtaining a driver's license.

Mandating closer collaboration between the Secretary of Veterans Affairs and Secretary of Defense provides a necessary and proactive step in addressing the veteran suicide crisis. Collaboration also ensures that recently separated servicemembers, both combat-exposed and noncombat-exposed, are not left to navigate transition and the healthcare system on their own. The American Legion's current position calls for DOD and VA to accept shared responsibility for patient care and seamless transition with no interruption in services. The American Legion can support S. 585 as currently written through Resolution No. 11: Automatic Enrollment into Veterans Affairs Health Care System which RESOLVED to automatically enroll eligible veterans into VA care, with the option to opt out, upon transition from military service to reduce barriers to care and encourage help-seeking behavior.

The American Legion Supports S. 585 as currently written.

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[7] Ravindran, Chandru, Sybil W. Morley, Brady M. Stephens, Ian H. Stanley, and Mark A. Reger. "Association of suicide risk with transition to civilian life among US military service members." Journal of the American Medical Association network open 3, no. 9 (2020): e2016261-e2016261

[8] U.S. Government Accountability Office. "DOD and VA Health Care: Actions Needed to Better Facilitate Access to Mental Health Services During Military to Civilian Transitions," July 15, 2024. https://www.gao.gov/products/gao-24-106189 .

[9] "Five Years of VA Health Care for Combat Veterans." VA News, February 26, 2008. https://news.va.gov/press-room/five-years-of-va-health-care-for-combat-veterans/ .

S. 599: the DRIVE Act

To amend title 38, United States Code, to increase the mileage rate offered by the Department of Veterans Affairs through their Beneficiary Travel program for health-related travel, and for other purposes.

This legislation would require the Department of Veterans Affairs to ensure the Beneficiary Travel reimbursement rate is at least equal to the General Services Administration (GSA) rates. This would help to ensure the VA's reimbursement rate keeps up with the cost of inflation and properly accounts for fluctuations in gas prices (and inflation) overtime. During The American Legion's System Worth Savings program town halls, many veterans residing in rural and ultra rural areas stated that they "must travel 3-to-4 hours" to attend their scheduled VA appointments.[10]

Moreover, with higher inflation rates and increased energy costs to deliver consumer goods, the Consumer Price Index (CPI) has been significantly higher in the post-COVID era (309.0 for year 2024 vs. 250.5 for year 2019).[11] Despite this, the VA's mileage reimbursement rate has remained unchanged since a minimum rate was established in 2010. Currently, VA reimburses beneficiary travel at $0.41 per mile while GSA reimburses beneficiary travel at a rate of $0.70 per mile.[12]

Deciding whether to put food on the table or put gas in your vehicle should never be a choice veterans have to make. But too often this is the reality some veterans face, as the VA Office of Rural Health (ORH) often cites transportation insecurity as a top five reason for rural veterans missing or cancelling scheduled appointments.[13] While The American Legion appreciates VA launching new strategies "to alleviate *[the]* long travel to VA centers by covering Uber rides for veterans through its VHA-UBER Health Connect initiative," [14] this pilot is still in its infancy, leaving many rural veterans with very expensive transportation options to make it to their VA appointments.

The American Legion supports this legislation through Resolution No. 46: Department of Veterans Affairs non-VA care programs, which RESOLVED...the Department of Veterans Affairs develop a well-defined and consistent non-VA care coordination program, policy and procedure that includes a patient-centered care strategy which takes veterans' unique medical injuries and illnesses as well as their travel and distance into account. Further support for this legislation can be found in Resolution No. 62: Veterans Transportation System and Benefits Travel which RESOLVED, That The American Legion urge the Secretary of Veterans Affairs to periodically

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[10] The American Legion (2024). *System Worth Saving Team Engages with Rural Veterans and VA Staff in Montana, Returning to Pre-Pandemic Levels of Visits.* The Legion. Veterans' Healthcare News, Sep 24, 2024. https://www.legion.org/information-center/news/veterans-healthcare/2024/september/sws-visit-achieves-milestone

[11] U.S. Department of Social Security. Average CPI by Quarter and Year, last accessed Feb 9, 2025. HYPERLINK "https://www.ssa.gov/oact/STATS/cpiw.html"Consumer Price Index (CPI-W)

[12] U.S. General Services Administration. *Privately owned vehicle (POV) mileage reimbursement rates.* Dec 30, 2024. https://www.gsa.gov/travel/plan-a-trip/transportation-airfare-rates-pov-rates-etc/privately-owned-vehicle-pov-mileage-reimbursement

[13] U.S. Department of Veterans Affairs (Jan 2023), *Fact Sheet: Clinical Resource Hubs*; accessed Feb 7, 2025, HYPERLINK https://www.ruralhealth.va.gov/docs/ORH1458-002_Clinical_Resource_Hubs_508.pdf https://www.ruralhealth.va.gov/docs/ORH1458-002_Clinical_Resource_Hubs_508.pdf.

[14] Henry Howard, "Reframed SWS Visits Make Shining Debut," *The Legion*, Jan 31, 2024. https://www.legion.org/information-center/news/system-worth-saving/2024/january/reframed-sws-visits-make-shining-debut.

adjust the rate to assure that the per mile reimbursement rate is increased at a reasonable and acceptable level.

The American Legion supports S. 599 as currently written.

S. 605: 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% 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 when (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.[15] 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 S.605 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 S. 605 as currently written.

S.635: the Veterans Homecare Choice Act

To amend title 38, United States Code, to direct the Secretary of Veterans Affairs to recognize nurse registries for purposes of the Veterans Community Care Program, and for other purposes.

S. 635, The Veterans Homecare Choice Act, would recognize nurse registries as eligible providers under the Veterans Community Care Program (VCCP), allowing home health aides to furnish services to homebound veterans without requiring the caregiver to enroll with Medicare.

Home health aides are often self-employed or work with a small agency, and the administrative burden of Medicare enrollment may be unnecessary for the level of care they provide, including fall protection, medication management, mobility assistance, and other activities of daily living. The VA is well positioned to credential these care providers through the Office of Community Care and regulatory framework established under the MISSION Act. While Medicare enrollment

[15] 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.

plays a critical role in verifying the quality of many specialty services provided under VCCP, such extensive oversight is not necessary for home health support.

However, S. 635 is not limited to home health aides and does not clearly define which providers would be exempt from Medicare enrollment. If the intent of the bill is to streamline access to in-home caregivers, the current language vastly exceeds the scope by allowing any nurse registry to skip this process. Nurse Registries are not federally regulated, and their oversight varies greatly between states, with some states having robust requirements whereas others have none.

The Department of Veterans Affairs formally opposed this bill citing concerns that relying on state-by-state eligibility would increase administrative burden. The VA also stated that existing regulations do not unnecessarily bar home health aides from providing care to homebound veterans.[16] Moreover, the Secretary of the Veterans Affairs already has the authority, under 38 USC §1703 (c), to waive any provider, or class of provider including home health aides, from the Medicare requirement.

The American Legion unequivocally supports veterans' right to age in place and backs legislation which improves access to home care, whether such care provided by a family caregiver, traveling nurse, or home health aide. However, through Resolution No. 13: Standards and Training for Community Care Providers, whereas The Legion RESOLVED to hold community care providers to the same standards of care that it requires of VA employees, we oppose S.635 as currently written. The bill lacks the clarity needed for effective implementation and could introduce unintended consequences for the veterans it aims to help.

The American Legion opposes S. 635 as currently written.

S. 649: the Guard and Reserve GI Bill Parity Act

To amend title 38, United States Code, to expand eligibility for Post-9/11 Educational Assistance to members of the National Guard who perform certain full-time duty, and for other purposes.

S. 649, the Guard and Reserve GI Bill Parity Act, would expand eligibility for *The Harry W. Colmery Veterans Educational Assistance Act of 2017* (Public Law 115-48), commonly known as the "Forever GI Bill," to servicemembers from the National Guard and Reserves by including most periods of activation. For National Guardsmen, any full time National Guard duty or active duty as defined in section 101 of Title 32 will be considered towards eligibility for the Forever GI Bill. Additionally, for servicemembers in the Reserve Component, any service on active duty, inactive duty training, or annual training defined in section 101 of Title 10 and various active-duty orders under Title 14 will be considered towards eligibility for the Forever GI Bill.

National Guard and Reserve servicemembers play a crucial role in defending our borders, responding to public health crises, and supporting local law enforcement. These servicemembers

[16] U.S. Department of Veterans Affairs. *Statement of Dr. Miguel Lapuz, Assistant Under Secretary for Health for Integrated Veteran Care, Veterans Health Administration, Department of Veterans Affairs, Before the Committee on Veterans' Affairs, U.S. Senate, July 12, 2023*. Washington, DC: U.S. Senate Committee on Veterans' Affairs. https://www.veterans.senate.gov/services/files/9017894E-0BAE-41FF-81B5-CAF50616DA4B.

face unique challenges on the home front, often leaving families and civilian jobs behind for extended periods, sometimes at considerable financial loss. Despite their significant contributions, they are often denied a fundamental benefit of service that the Forever GI Bill remedies.

Under current law, National Guard and Reserve servicemembers accrue GI Bill entitlements only when activated under federal orders. When activated under state orders, Guard and Reserve members do not qualify for GI Bill benefits, creating a disparity in access to these resources. This issue became particularly evident during the COVID-19 pandemic when National Guard units were activated in response to the public health emergency. In 2020, service members in the National Guard served more than 7.6 million duty days directly related to the COVID-19 pandemic, more than three times as many days activated during 2019.[17] Those called under federal orders to assist with pandemic relief were eligible for GI Bill benefits, but those activated under state orders, such as those supporting governors' declarations, were not. Similarly, National Guard members who helped construct the U.S.-Mexico border wall earned GI Bill benefits, but more than 66,000 National Guard members who responded to civil rights protests in 2020 did not.[18] Even more recently, the activation in response to fires in Los Angeles involved nearly 3,000 servicemembers who were activated under Title 32; they will not be recognized for GI Bill benefits.[19] Moreover, in recent weeks, National Guard units have been activated in response to emerging domestic challenges. In New York, Guardsmen were deployed following unrest, including incidents of rioting within the state's correctional system. In New Mexico, National Guard personnel have been called upon to support law enforcement efforts in combating the growing fentanyl crisis.

The distinction between federal and state military activation orders in determining GI Bill eligibility has led to thousands of servicemembers being ineligible for GI Bill benefits. The American Legion strongly believes that "every day in uniform counts" and that National Guard and Reserve servicemembers, who serve alongside their active-duty counterparts, should receive the same benefits. That is why The American Legion supports S. 649 as currently written through Resolution No. 24: GI Bill Fairness for Activated National Guard and Reserve Servicemembers, which RESOLVED that The American Legion seek and support any legislative or administrative proposal providing Post 9/11 GI Bill eligibility for National Guard and reserve service.

The American Legion supports S. 649 as currently written.

S. 778: the Lactation Spaces for Veteran Moms Act

To amend title 38, United States Code, to require a lactation space in each medical center of the Department of Veterans Affairs.

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[17] 2021 National Guard Bureau Posture statement, n.d. https://www.nationalguard.mil/portals/31/Documents/PostureStatements/2021 National Guard Bureau Posture Statement.pdf.

[18] Soucy, Jon. "Guard Members in 23 States, D.C. Called up in Response to Civil Unrest." National Guard, May 31, 2020. https://www.nationalguard.mil/News/Article-View/Article/2202946/guard-members-in-23-states-dc-calledup-in-response-to-civil-unrest/.

[19] Soucy, Jon. "National Guard Members Continue La Wildfire Response." National Guard, January 21, 2025. https://www.nationalguard.mil/News/Article-View/Article/4034416/national-guard-members-continue-la-wildfireresponse/#:~:text=More%20than%202%2C700%20National%20Guard,ground%20and%20in%20the%20air

This bill ensures that all VA medical centers have at least one designated lactation room. The designated rooms must be free from intrusion, hygienic, contain a chair and work surface, shielded from view, and must be a space other than a restroom.

The United States has 170 VA medical centers and 1,193 outpatient medical centers.[20] As of 2022, there are only 90 VA medical centers that provide lactation rooms.[21] In 2022, the Department of Veterans Affairs developed a five-year plan to implement the installation of additional lactation spaces.[22]

Breastfeeding benefits both the mother and the infant. Over the years, research has shown that breastmilk improves overall health and well-being for the child from infancy through adulthood. Breastfeeding decreases the risk of type 1 diabetes, allergies, obesity, and cancers in mothers. Benefits of breastmilk include introducing antibodies to the infant's immune system that fight infection and reducing the risk of sudden infant death syndrome. In early 2022, the US had a national formula shortage, and many mothers were required to breastfeed their infants to provide adequate nutrients in lieu of purchasing formula. The VA should provide adequate space in their facilities for breastfeeding.

The American Legion urges the VA to continue prioritizing the current and future needs of women veteran population, as outlined in Resolution No. 147: Women Veterans. The American Legion also encourages the VA to develop a strategic plan that will continue to foster women veterans' access through Resolution No. 39: Women Veterans Strategic Plan. The American Legion supports the efforts that the VA is making to provide more comprehensive care for women veterans who choose to have children.

The American Legion supports S. 778 as currently written.

S. 784: the Rural Veterans Transportation to Care Act

To expand and modify the grant program of the Department of Veterans Affairs to provide innovative transportation options to veterans in highly rural areas, and for other purposes.

This bill expands the Highly Rural Transportation Grant (HRTG) grant program by eliminating a restriction that made it only available to counties with fewer than seven people per square mile; this opens eligibility to more counties nationwide. Additionally, the bill increases the maximum amount grant recipients can receive to $80,000 from a previous range of $50,000-60,000.

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[20] Veterans Health Administration. *Providing Health Care for Veterans.* Apr 22, 2025. https://www.va.gov/health/#:~:text=The%20Veterans%20Health%20Administration%20is%20America%E2%80%99s%20largest%20integrated,clinics%29%2C%20serving%209.1%20million%20enrolled%20Veterans%20each%20year.

[21] Rosen, Murkowski, Underwood Introduce Bipartisan, Bicameral Legislation to Ensure All VA Medical Centers Have Dedicated Nursing Spaces - Jacky Rosen. https://www.rosen.senate.gov/2025/03/05/rosen-murkowski-underwood-introduce-bipartisan-bicameral-legislation-to-ensure-all-va-medical-centers-have-dedicated-nursing-spaces/#:~:text=The%20bipartisan%2C%20bicameral%20Lactation%20Spaces,the%20country%20with%20such%20rooms. March 5, 2025.

[22] Congressional Budget Office. "H.R. 5738, Lactation Spaces for Veteran Moms Act." Apr 6, 2022. https://www.cbo.gov/publication/58107

With nearly five million veterans living in rural areas and the veteran population increasingly migrating to these communities, The American Legion strongly supports of HRTG grants. The American Legion posts across the country actively use these grants to improve medical transportation for veterans in their areas.

Support for this legislation can be found in Resolution No. 62: Veterans Transportation System and Benefits Travel, which advocates for changes within the VA to accommodate veterans' changing needs, particularly regarding transportation. Additionally, Resolution No. 119: Support More Service Programs Benefitting the Rural Veteran reaffirms The American Legion's strong commitment to expanding programs that directly serve rural veteran populations. This resolution clearly states The American Legion's unequivocal support for initiatives that improve access and services for veterans living in rural communities.

The American Legion supports S. 784 as currently written.

S. 800: the Precision Brain Health Research Act

To modify the Precision Medicine for Veterans Initiative of the Department of Veterans Affairs.

The legislation calls for the *Commander John Scott Hannon Veterans Mental Health Care Improvement Act* (38. U.S.C. Public Law 116-171) to be amended by inserting "repetitive low level blast exposure, dementia, and such other brain and mental health conditions." The American Legion supports increased education and research into this emerging issue, as occupational exposure to repetitive, low-level blasts in military training and combat has been tied to sub-concussive injury and poor health outcomes for service members.[23] A variety of effects have been linked to low-level blast exposure, some more tenuously than others. These include cognitive impairments, sleep disturbances, depression, panic attacks, and posttraumatic stress disorder. However, there is a lack of published, peer-reviewed, scientific evidence linking repeated low-level military occupational blast to injury.[24]

Further, this legislation calls for the Secretary of Defense to establish a data-sharing partnership between VA and DOD. Finally, the legislation includes a big-data assessment of the clinical and non-clinical interventions that are illustrating positive outcomes for veterans. Not later than 60 days after the date of this enactment, the Secretary of Veterans Affairs will seek to enter a contact with the National Academies of Sciences, Engineering, and Medicine under the National Academies to submit a report to Congress at least every two years.

The American Legion supports this bill through Resolution No 165: Traumatic Brain Injury and Post Traumatic Stress Disorder Programs which RESOLVED, The American Legion urge

[23] Woodall, J. L. A., J. A. Sak, K. R. Cowdrick, B. M. Bove Muñoz, J. H. McElrath, G. R. Trimpe, Y. Mei, R. L. Myhre, J. K. Rains, and C. R. Hutchinson. "Repetitive Low-Level Blast Exposure and Neurocognitive Effects in Army Ranger Mortarmen." *Military Medicine* 188, no. 3–4 (March 20, 2023): e771–e779. https://doi.org/10.1093/milmed/usab394.

[24] Samantha McBirney. "Repeated Exposure to Low-Level Military Occupational Blasts: An Overview of the Research, Critical Gaps, and Recommendations." Testimony before the Senate Armed Services Committee, Subcommittee on Military Personnel, U.S. Senate, February 28, 2024. https://www.armed-services.senate.gov/imo/media/doc/mcbirney_statement.pdf.

Congress to increase the budgets for DOD and VA to improve the research, screening, diagnosis and treatment of TBI/PTSD as well as provide oversight over DOD/VA to develop joint offices for collaboration between DOD/VA research.

The American Legion supports S. 800 as currently written.

S. 827: Supporting Rural Veterans Access to Healthcare Services Act

To extend and modify the transportation grant program of the Department of Veterans Affairs, and for other purposes.

The Rural Veterans Transportation to Care Act would reauthorize the Highly Rural Transportation Grant (HRTG) program through FY 2029. The HRTG has provided much support to veterans who struggle to get to their VA medical appointments due to transportation challenges. Many American Legion posts in rural areas have applied for this grant in efforts to transport veterans to their medical appointments. Without this grant, many local veteran service organizations will not have the necessary funds to continue to provide rides for veterans to their appointments.

There are nearly 5 million veterans who live in rural areas across the country. This number makes up 35% of the veterans that are enrolled in the VA healthcare system. Many veterans living in rural areas, some elderly, ill, or disabled, may drive over an hour to get to their VA medical appointments. The time and distance to travel to VA medical facilities can be daunting for some veterans, which leads to missed appointments. HRTG provides much needed peer support for those who need a little extra help to travel to medical care.

The American Legion strongly urges Congress to continue to fund the HRTG grant through FY2029 via this legislation. Support for continued efforts to assist veterans in rural areas can be found in Resolution No. 62: Veterans Transportation System and Benefits Travel. The American Legion further supports programs that benefit rural veterans through Resolution No. 119: Support More Service Programs Benefiting the Rural Veteran. With the expanded number of veterans in rural areas using VA health care since the passage of the *PACT Act*, it is imperative that we ensure all veterans have access to the medical care that they have earned.

The American Legion supports S. 827 as currently written.

S.879: 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 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 of continuing education. PCAFC caregivers often provide 24-hour support for their veterans, often delivering over 80 hours per week of care.[25] This level of responsibility greatly hinders career prospects, with 16% of veteran caregivers reporting reducing their work hours or leaving the workforce entirely.[26] This stipend ensures caregivers seeking gainful employment, many of whom have professional experience and public trust, are able to smoothly transition into this next chapter.

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 caregivers cost approximately $2,700 per year in 2017,[27] or about $1,350 for a six-month extension. If extended to all 57,000 caregivers enrolled in PCAFC, this would represent a meaningful expansion to the program.[28] However, without additional VA data on caregiver turnover and healthcare utilization, a precise cost estimate of this expansion is not possible.

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.[29,30] While this data 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

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[25] 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

[26] Ibid

[27] 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

[28] 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, HYPERLINK "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.

[29] 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

[30] 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

reimbursed State Veterans Homes at a rate of $397 per day for severely disabled veterans,[31] 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.[32]

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 modest cost of re-credentialing will help more veterans remain at home at a fraction of the cost of institutionalization in long-term facilities.

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 S. 879 as currently written.

S. 1318: A bill to direct ABMC to establish a program to identify American-Jewish servicemembers buried in United States military cemeteries overseas under markers that incorrectly represent their religion and heritage

To direct the American Battle Monuments Commission to establish a program to identify American-Jewish servicemembers buried in United States military cemeteries overseas under markers that incorrectly represent their religion and heritage, and for other purposes.

For over a century, The American Legion has stood in unwavering defense of the men and women who served and sacrificed in our nation's armed forces. Our dedication to preserving the memory and integrity of our fallen heroes is enshrined in our founding pillars and remains steadfast today.

S. 1318 exemplifies that same commitment. The bill directs the American Battle Monuments Commission to establish a 10-year initiative—the Fallen Servicemembers Religious Heritage Restoration Program—to identify American-Jewish servicemembers who were killed during World War I and World War II and mistakenly interred under Latin Crosses in overseas U.S. military cemeteries. This program will ensure that these servicemembers are accurately honored under the religious symbol that reflects their faith, the Star of David.

It is estimated that approximately 900 American-Jewish servicemembers are among those whose graves that do not reflect their religious heritage. This is not merely a matter of symbolism. It is a matter of dignity, accuracy, and respect—for the servicemembers themselves, for their families, and for the history we leave to future generations.

These cemeteries are not only sacred ground; they are also places of pilgrimage. With over two million visitors each year, overseas cemeteries continue to serve as solemn reminders of the price

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[31] 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.
[32] 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

of freedom. It is imperative that they reflect the truth of those who lie in repose there—men and women of diverse backgrounds united in the defense of liberty.

The American Legion has long championed the preservation of religious expression in military memorials. Through Resolution No. 11: Support and Defend Veteran and Military Memorials, The Legion affirms its strong support for memorials that include religious symbols—be they Latin Crosses, Stars of David, Crescents, or others—as essential to honoring the personal faith and sacrifice of the individual veteran.

The American Legion supports S. 1318 as currently written.

S. 1320: the Servicewomen and Veterans Menopause Research Act

To direct the Secretary of Defense and the Secretary of Veterans Affairs to take certain steps regarding research related to menopause, perimenopause, or mid-life women's health, and for other purposes.

This bill will require both the DOD and VA to research the many aspects of menopause, including environmental effects, treatment, combat roles, and treatment availability. The VA has taken steps to enhance gender-specific and sensitive services through the Office of Women's Health to effectively care for the unique needs of women veterans. Almost half of women veterans enrolled in VA care are between the ages of 45 and 64 years old, making this middle age group the largest group of women enrolled in VA healthcare.[33] Women who fall into this age group are likely peri-menopausal or experiencing the conditions and symptoms of menopause. Women in the midlife age group are more likely than men to suffer from chronic pain.[34] The symptoms of menopause are often exacerbated in women veterans due to their military experiences that have led to other physical and mental health conditions.

The American Legion supported the Women Veteran Care and Research Improvement Act, which called for research into the care and treatment of women veterans and fully supports age-inclusive research. VA must ensure that women veterans, the fastest growing demographic in the veteran community, have an optimal quality of life.

The American Legion applauds VA's effort on this issue, but there is room for improvement. Support for Servicewomen and Veterans Menopause Research Act can be found in Resolution No. 147: Women Veterans. This resolution urges the VA to conduct long-term studies on the effects of combat on women veterans.

The American Legion supports S. 1320 as currently written.

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[33] Women Veterans Report," n.d., accessed May 19, 2025, https://www.va.gov/vetdata/docs/specialreports/women_veterans_2015_final.pdf.

[34] Mayo Clinic. *Perimenopause.* n.d., accessed May 19, 2025, https://www.mayoclinic.org/diseases-conditions/perimenopause/symptoms-causes/syc-20354666

S. 1383: the Veterans Accessibility Advisory Committee Act

To establish the Veterans Advisory Committee on Equal Access, and for other purposes.

The Department of Veterans Affairs (VA) is the largest integrated medical system in the world, serving over nine million veterans every year.[35] However, veterans face accessibility challenges including physical access to medical centers, transportation barriers such as long drive times, a lack of wheelchair-compatible vehicles, and navigating VA's benefit system.[36] S. 1383 will establish an advisory committee made up of 15 members to include veterans, VA employees and experts which will meet at least twice a year to address multiple accessibility issues.[37]

Many wheelchair-bound veterans continue to face significant challenges in accessing their VA medical appointments due to physical barriers at VA facilities such as narrow doorways, inoperable elevators, or inadequately designed sidewalks and curbs. VA continues to address these issues and has made many improvements in access to care through innovative efforts such as UberHealth. This program partners with Uber to provide rides for veterans to get to their VA medical appointments, but services may fall short for veterans who require specialized wheelchair-accessible transport. Many of these veterans depend on medical transportation companies that offer wheelchair access, or VSOs for transportation to their medical appointments. However, these options are not always available or sufficient, and do not fully resolve the broader accessibility gaps that persist in the system. [38] [39]

As VA eligibility has expanded under the *MISSION, COMPACT*, and *PACT Acts*, Community Care has grown by approximately 20% annually since 2019.[40] While 51% of Community Care consultations result from excessive drive times,[41] all veterans receiving care through community providers deserve the same level of accessibility as they would at official VA facilities. This bill empowers the VA to enforce consistent compliance with existing laws at VA facilities and community partners, ensuring that all veterans have equitable and reasonable access to care as required by law.

The American Legion supports S. 1383 which aims to help veterans overcome barriers within the VA system, including access to electronic information, facility accessibility, service accessibility and benefits navigation. Support is grounded through Resolution No. 14: Access to Care, which outlines congressional actions to strengthen programs that will assist veterans with receiving care that fulfills the Legion's commitment of service to the community, state, and nation. The American Legion believes that the VA Health Care system offers "The Best Care Anywhere" to our nation's

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[35] Vankar, Preeti, 'Veterans health care system in the U.S.-statics and facts". December 18,2023. https://www.statista.com/topics/10813/veteran-health-care-system-in-the-united-states/.

[36] Casey, Bob, and Rick Scott. "Casey, Scott Introduce Bill to Ensure VA Services Are Accessible for Veterans with Disabilities." *Senator Bob Casey*, August 2, 2023. https://www.casey.senate.gov/news/releases/casey-scott-introduce-bill-to-ensure-va-services-are-accessible-for-veterans-with-disabilities.

[37] RAND Corporation. "Veterans' Barriers to Care." Last modified May 1, 2023. https://www.rand.org/health-care/projects/navigating-mental-health-care-for-veterans/barriers-to-care.html.

[38] U.S. Department of Veterans Affairs. "DAV Vans: Transportation for Veterans." Last modified April 4, 2024. https://www.va.gov/washington-dc-health-care/dav-vans-transportation-for-veterans/.

[39] Ibid

[40] "Women Veteran Task Force | House Committee on Veterans Affairs." 2023. House.gov. 2023. https://veterans.house.gov/resources-for-veterans/women-veteran-task-force.htm.

[41] Ibid

veterans and great benefits to those who served. We believe that veterans should be able to receive care in a timely manner and many veterans do not have access to VA facilities and must access their care in their communities.

The American Legion Supports S. 1383 as currently written.

S. 1441: the Service Dogs Assisting Veterans (SAVES) Act

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

The Department of Veterans Affairs (VA) has provided service dogs to veterans since 1958, with the program originally created to support blind veterans. [42] The program has been expanded over time to provide service dogs to veterans with a wide variety of other physical and mental disabilities. The VA has designated organizations to provide service dogs for veterans, and with an average two-year turnaround to train a new service dog, many of these organizations have long wait lists of veterans needing support.[43]

A recent VA study has demonstrated that veterans who receive a service dog have an average 3.7-point drop in PTSD symptoms, less suicidal ideation, and overall improved mental health compared to veterans with emotional support dogs.[44] Further, veterans with service dogs are documented to have lower depression, higher quality of life, and increased social functioning than veterans on the waiting list for service dogs.[45] This is a widely successful treatment and support program.

In 2021, the American Legion testified in support of the PAWS for Veterans Therapy Act.[46] This bill awards grants to nonprofit organizations to provide veterans with puppies and the training for them to become therapeutic service dogs, very similarly to the SAVES Act. The American Legion supports the SAVES Act of through Resolution 134: Service Dogs for Injured Service Personnel and Veterans with Mental Health Conditions, as it provides an alternative treatment for veterans returning home from deployment with a traumatic brain injury and/or PTSD. Many individuals suffering from PTSD and other mental health disorders refuse to seek treatment because of the

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[42] 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.

[43] "How Long Does It Take to Train a Service Dog?" K-9 Culture dog Training, September 27, 2022, https://www.k-9culture.com/post/how-long-does-it-take-to-train-a-service-dog.

[44] 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.

[45] 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/

[46] U.S. Senate Committee on Veterans' Affairs. *Hearing on Pending Legislation,* Jun 23, 2021. https://www.veterans.senate.gov/2021/6/hearing-on-pending-legislation-6-23-2021

stigma surrounding mental health. The American Legion also supports this bill through Resolution No. 262: Department of Veterans Affairs Provide Service Dog Allowance.

The American Legion supports connecting veterans in need of a service or guide dogs. Service animals are just as vital to veterans with physical and mental impairments as prosthetic body parts.

The American Legion Supports S. 1441 as currently written.

S. 1533: the VA License Portability Act

To amend title 38, United States Code, to make permanent and codify the pilot program for use of contract physicians for disability examinations, and for other purposes.

The Government Accountability Office (GAO) noted in July 2023 that VA has migrated its workload from almost a 1:1 ratio of VHA-employed to VBA-contracted medical disability examiners in 2017, to a nearly 3:1 ratio (or 1,100,000-to-335,000) in the year 2021, with the majority of the disability claims exams assigned to VA-contracted examiners.[47]

With the influx of new disability claims from recent passage of *PACT Act* legislation, VA announced back in July 2023 that 401,107 new filed claims concerning toxic exposures are still pending examination review and processing.[48] With contracted VA-vendors playing a significant role in augmenting VHA workforce to help clear VBA claims backlog, now is not the time to allow a statutory sunset clause to go into effect. Contracted vendors have played an integral role allowing VA to improve its various performance metrics.

As noted in its FY23 report, VBA's ability to process compensation claims within a "125-days goal" metric dipped from 75% in FY20 to 65.5% in FY21. Its goal metric for FY23 is 50%, which underscores the new caseload realities when grappling with the influx of PACT Act-related claims.[49] Congress should not restrict VHA/VBA's capacity to authorize VA-contracted vendors to initiate medical exams across state lines.

The American Legion supports this legislation through Resolution No. 14: Quality Assurance for Department of Veterans Affairs (VA) Contracted Compensation and Pension (C&P) Examinations, which urges Congress to pass legislation that will ensure the quality and timeliness of C&P examinations performed by VA contractors, and ensure that they provide veterans with professional, high-quality service. We further support this bill through Resolution No. 118: Environmental Exposures, which RESOLVED that veterans reporting to VA medical care

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[47] U.S. Government Accountability Officer (GAO*), VA Disability Exams: Opportunities Remain to Improve Program Planning and Oversight,* GAO-23-106939 (Washington, DC, 2023), accessed September 13, 2023, https://www.congress.gov/118/meeting/house/116269/witnesses/HHRG-118-VR09-Wstate-CurdaE-20230727.pdf

[48] Martin Caraway, "Q3 PACT Act Offsite slides *Planning for Success"* (presentation, 3rd Quarter *PACT Act* Offsite VSO conference in Boston, MA July 15-16, 2023).

[49] U.S. Department of Veterans Affairs, *FY 2023 Annual Performance Plan/FY 2021 Report* (APP& R), Washington, DC, 2023), accessed September 13, 2023, va-annual-performance-plan-and-report-2021-2023.pdf.

facilities claiming exposure to such environmental hazards be provided examinations and treatment which are thorough and appropriate.[50]

The American Legion supports S. 1533 as currently written.

S. 1543: the Veterans' Education, Transition and Opportunity Prioritization Plan Act

To amend title 38, United States Code, to establish in the Department of Veterans Affairs the Veterans Economic Opportunity and Transition Administration, and for other purposes.

The *Veterans Opportunity Act of 2025* would create the Veterans Economic Opportunity and Transition Administration (alongside the Veterans Benefits Administration, the Veterans Health Administration, and the National Cemetery Administration) to manage these economic opportunity programs more effectively. The new Administration within VA would be headed by an Under Secretary for Veterans Economic Opportunity and Transition, nominated solely on the basis of expertise in economic opportunity programs and information technology, through a commission process similar to what is used to nominate the Under Secretary for Benefits and Under Secretary for Health. In order to establish the new Administration, the Secretary would submit a plan to Congress within 180 days and then certify that VA is ready to create the new Administration and doing so would not negatively affect services to veterans. Congress's intent is that the creation of the new Administration would not increase or decrease overall VA spending or staffing. The legislation would merely transfer functions from VBA to the new Administration.

The provisions of this bill fall outside the scope of established resolutions of The American Legion. As a large member-driven and resolution-based organization, The American Legion takes positions on legislation based on resolutions passed by membership. With no current resolutions addressing the provisions of the legislation, The American Legion is researching the material and working with our membership to determine the course of action which best serves veterans.

The American Legion has no position on S. 1543 as currently written.

CONCLUSION

Chairman Moran, Ranking Member Blumenthal and distinguished members of the Committee, 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 Julia Mathis, Legislative Director, at jmathis@legion.org

[50] The American Legion Resolution No. 14 (2021): "https://archive.legion.org/node/3595"Quality Assurance for Department of Veterans Affairs (VA) Contracted Compensation and Pension (C&P) Examinations; The American Legion Resolution No. 118 (2016): Environmental Exposures.

STATEMENT FOR THE RECORD

ROGER D. WALDRON

PRESIDENT OF THE COALITION FOR COMMON SENSE IN GOVERNMENT PROCUREMENT

BEFORE THE COMMITTEE ON VETERANS' AFFAIRS

UNITED STATES SENATE

MAY 21, 2025

Chairman Moran, Ranking Member Blumenthal, and members of the Committee, I appreciate the opportunity to provide our views on S. 1591, the Acquisition Reform and Cost Assessment Act of 2025. All of us, including this Committee, Department of Veterans Affairs (VA), and industry want to provide our veterans, who have given this country and its citizens so much, the best possible service, including healthcare. We also all share the goal of being good stewards of taxpayer dollars and getting the best value from the goods and services the VA acquires to deliver service to our veterans. The Coalition for Common Sense in Government Procurement (Coalition) is appreciative of the efforts of the Committee, and we are pleased to share our thoughts, on behalf of our members, on the possible positive benefits of the proposed legislation.

By way of background, the Coalition is a non-profit association of firms selling commercial services and products to the Federal Government. Our members collectively account for more than $145 billion of the sales generated through General Services Administration (GSA) and VA contracts, including the Multiple Award Schedule (MAS) and Federal Supply Schedule (FSS) programs. Coalition members include small, medium, and large businesses. Many of our members, including veteran-owned and service-disabled veteran-owned small businesses, provide commercial healthcare goods and services to the VA. The Coalition is proud to have collaborated with Government officials for 45 years in promoting the mutual goal of common-sense acquisition.

Below, please find our analysis of the Acquisition Reform and Cost Assessment Act of 2025.

Assistant Secretary of Veterans Affairs for Acquisition and Innovation

The proposed legislation would create an Assistant Secretary of Veterans Affairs for Acquisition and Innovation, who would serve as the VA's Chief Acquisition Officer and be responsible for managing the VA's logistics, innovation, and procurement offices. The legislation places all VA contracting officers and acquisition centers under the Assistant Secretary. We believe **elevating acquisition management to the Assistant Secretary level corresponds to the importance of the goods and services needed to care for and service our veterans.**

The consolidation of procurement operations will:

- *Lead to the development of standard operating procedures*. This will reduce lead times, inject greater consistency in requirements and interpretation of policies and procedures, make it easier to add products to contracts, and streamline solicitations, modifications, and awards.
- *Improve communication with industry.* This will result in lower costs and better performance, improving the healthcare of veterans. Currently, vendors have duplicative contracts with the VA for the same goods or services. For example, a small business vendor selling medical supplies to the VA may have both a blanket purchase agreement under the Medical/Surgical Program Office within the Veterans Health Administration (VHA) and an FSS contract managed by the VA. The costs on both sides of the relationship are duplicative. The government has two sets of contracting officers administering two different contracts in different ways, using different procedures, for the same goods and services. Vendors have to spend twice as much time bidding on, performing, monitoring and complying with the terms and conditions of each contract, to deliver the exact same product or service to the VA. Consolidating the contract offices for contracts that manage

the same goods and services under the same organization will create efficiencies that will lower administration costs for government and lower administration costs for vendors, which will result in lower prices and best value. This will be a win-win-win for veterans, taxpayers, and industry.

According to the VA Office of Inspector General, the VA spent approximately $5.5 billion through government purchase cards during a one-year period between 2022 and 2023. Open market, one-off purchases of medical supplies via a credit card is not a cost-effective way to do business. The VA should adopt an online ordering system—a standard practice in the commercial market—to maximize purchases under VA contracts with negotiated prices and reduce use of government purchase cards. An online ordering system tied to existing contract pricing will save the government money by maximizing volume buying; give the VA better data on its buying patterns and trends; and protect the healthcare of the veteran from the potential purchase of counterfeit and lower quality goods that can be acquired, often from our adversaries, on the open market via credit card.

- *Leverage resources and workforce.* With one Assistant Secretary responsible for logistics, procurement, and innovation, the VA will be better positioned to manage its resources and workforces to ensure that VA acquisition policies and procedures are being followed and applied consistently across the agency, and to adapt to changing needs and emergency situations. Such flexibility is especially critical in the current environment as the VA goes through a transformation.

Consolidating procurement operations will also provide the Assistant Secretary with an opportunity to examine whether the VA should adopt GSA best practices associated with the MAS for its VA administered FSS contracts. For example, GSA refreshes its contracts periodically through a transparent process that seeks industry input. This ensures that both sides have a better understanding of contract requirements and the terms and conditions. GSA also does not require pre-award audits prior to every contract award, but instead audits after award, as necessary based on risk and resources. Adopting these GSA best practices for the VA FSS program could result in vital cutting-edge healthcare products and services reaching veterans more quickly.

Other Transaction Authority

The Coalition **strongly supports the proposal to extend other transaction authority (OTA) to the VA**, which would enable the VA to acquire cutting-edge technologies and solutions. However, if the VA really wants the best solution, the opportunity should be open to all potential contractors, without limitation. Limiting the parties that participate will limit the benefits achieved. Under the existing procurement system, it is difficult for the government to acquire the goods and services that the government knows are best value without a long solicitation and award process that is subject to protest. This is one of the primary reasons OTAs were created. The definition of a non-traditional contractor in the proposed legislation, "an entity that is not currently performing and has never performed any contract or subcontract for any department or agency of the Federal Government," is extremely limited and we fear will severely hamper the ability of the VA to utilize the OTA authority.

We also recommend increasing the proposed $5 million threshold (including options) above which approval is required. Requiring approvals adds bureaucracy and time to the acquisition process. Setting the threshold to $15 million would better strike the balance between oversight and providing flexibility and authority to the acquisition workforce. With respect to the cost sharing provision, we believe that such a provision adds unnecessary restrictions to OTAs. If the VA needs something that will benefit veterans, the priority should be getting what the VA needs when it needs it, not on having OTAs be conditioned on funding structures. Finally, instead of separate notifications to Congress each time an OTA is executed, we recommend requiring an annual report that includes details on all the participating providers and the associated benefits resulting from each OTA award over the preceding year.

Independent Verification and Validation

We believe **that the independent verification and validation requirements of Section 5 of the proposed legislation is a best practice** that will likely benefit the VA and ensure that taxpayer money is well spent and that the VA, and the veterans it serves, are getting best value.

Independent Cost Estimate

Section 6 of the proposed legislation creates a Director of Cost Assessment and Program Evaluation, who will report directly to the Secretary of the VA. **We also support this as a best practice to help the VA judiciously spend taxpayer dollars** on critical systems that are vital to servicing its veteran constituents. Independence is vital to provide the Secretary the best advice on spending taxpayer dollars on critical systems and procurements.

Clinician Input

Of course, it is imperative that the centralized contracting organization and its personnel respect and honor clinician input when making contracting decisions to ensure that veterans receive the best possible healthcare outcomes.

We stand ready to provide you with any additional information at your request. Thank you.

May 20, 2025

Letter of Support for the Veterans Health Care Freedom Act

Dear Senators,

On behalf of the thousands of veterans and military families around the country we represent, Concerned Veterans for America (CVA) offers its strong support for **S. 219, the Veterans Health Care Freedom Act**. This legislation, sponsored by Sen. Marsha Blackburn, would transform veterans' health care by creating a pilot program to extend full health care choice to enrolled veterans.

While the VA MISSION Act significantly expanded health care choices for veterans by expanding community care eligibility through its access standards, veterans still do not have the same options as most Americans regarding where and when they access care. Longstanding challenges exist within the VA health care system to deliver timely and quality care to our veterans.

Even with expanded choice under the VA MISSION Act, veterans have faced four years of delayed and denied care. Despite its clear intent to offer veterans more control over their own health care, the VA MISSION Act made the mistake of giving the VA bureaucracy too much discretion to gatekeep community care access. Instead of following the law, FOIA-obtained documents have shown that the Biden administration attempted to reduce community care usage as much as possible. The 119th Congress should fix these mistakes and remove opportunities for bureaucratic meddling in veterans' health care choices by implementing S. 219 the Veterans Health Care Freedom Act. This legislation will remove barriers to care to create a fully integrated health care system where veterans can choose the health care provider that best meets their needs.

The Veterans Health Care Freedom Act leverages the Center for Innovation for Care and Payment created by the VA MISSION Act to create a three-year pilot program allowing veterans in four Veteran Integrated Service Networks (VISNs) to choose either treatment at VA facilities or community care providers without preapproval. By using existing authorities in the law, the pilot program removes the set of conditions veterans must currently meet to gain community care referrals under the MISSION Act, instead granting "full choice" to all eligible veterans in select pilot program regions. Four years after enactment, the pilot program would be expanded permanently nationwide.

The Veterans Health Care Freedom Act will honor the sacrifices made by veterans by empowering them with the choice and flexibility to access the health care options that best meet their needs – a right already enjoyed by most Americans. This approach to expanding choice for veterans is a solution to meet their changing healthcare needs and offers a model of empowering individuals in their treatment options that can benefit all Americans. **For these reasons, CVA urges you to support S. 219, the Veterans Health Care Freedom Act.**

Sincerely,

John Vick

John Vick
Executive Director
Concerned Veterans for America

Statement for the Record

of

John Vick
Executive Director, Concerned Veterans for America

on

S. 219, The Veterans Health Care Freedom Act of 2025

before the

Senate Veterans Affairs Committee

Legislative Hearing

May 21, 2025

Thank you to Chairman Moran, Ranking Member Blumenthal, and the Members of the Committee for the opportunity to submit this statement on behalf of Concerned Veterans for America (CVA). CVA is a grassroots network of thousands of veterans, military family members, and patriotic citizens that advocates for and defends policies to preserve freedom and prosperity for all Americans. Our organization builds engaged communities of veterans, elevating their unique experiences and perspectives to help improve American lives.

CVA is commenting in support of **S. 219, The Veterans Health Care Freedom Act of 2025**, sponsored by Senator Marsha Blackburn, which is under consideration today. The legislation would mark a truly transformative shift in veterans' health care. By providing "full choice" the Veterans Health Care Freedom Act would put veterans at the center of their own treatment journey, empowering them to seek care at the provider of their choice, whether at the VA or a community care provider, without navigating the complicated and too-often obstructive process of VA pre-approval.

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 perverse incentives that created the Phoenix VA scandal.

These early efforts culminated in the VA MISSION Act of 2018, which CVA helped shape and support in Congress. The legislation passed with overwhelming bipartisan support, incorporating 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' access to timely and quality care.

Over the past four years, CVA has fought for additional congressional oversight as the Department of Veterans Affairs prioritized its bureaucratic interests over the well-being of 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. This status quo has hurt veterans and must change under the new administration. Fortunately, the Restore VA Accountability Act and the Veterans ACCESS Act offer important opportunities for Congress to course-correct.

Why Full Choice Matters: Prior VA Resistance to Community Care Access

While the VA MISSION Act significantly expanded health care choices for veterans by expanding community care eligibility through its access standards, veterans still do not have the same options as most Americans regarding where and when they access care. Longstanding challenges exist within the VA health care system to deliver timely and quality care to our veterans.

Even with expanded choice under the VA MISSION Act, veterans faced four years of delayed and denied care. Despite its clear intent to offer veterans more control over their own health care, the VA MISSION Act gave the VA bureaucracy too much discretion to gatekeep community care access. Instead of

[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

following the law, FOIA-obtained documents have shown that the Biden administration attempted to reduce community care usage as much as possible.

As directed under the MISSION Act, the VA wrote the implementing regulations determining veterans' eligibility rules, or access standards, for community care. These access standards specify that when wait times at Veterans Health Administration (VHA) facilities exceed 20 days or a 30-minute drive from the veterans' residence for primary or mental health care, and 28 days or a 60-minute drive for specialty care, veterans are eligible for a community care referral.[2] The regulations also allow a veteran's VHA clinician to refer them to community care, regardless of wait or drive time, if he or she determines that doing so is in the veteran's best medical interest.

Over the past four years, the VA repeatedly chose to ignore these rules and even issue contradictory internal guidance. VA training documents recommended that schedulers not inform veterans of their community care eligibility unless veterans directly asked for it.[3] On top of this, VA scheduling scripts instructed employees to actively try to dissuade veterans from choosing community care instead of VHA facilities.[4] Veterans who knew about and wanted community care nevertheless faced a variety of obstacles for access.

FOIA-obtained training documents revealed that officials added an additional approval layer for community care requests. Despite appearing nowhere in the MISSION Act or its implementing regulations, the VA created a new standard for determining whether a veteran's community care request was "clinically appropriate," which in practice functioned as an additional opportunity to improperly deny referrals despite no legal basis for the VA to do so.[5]

Undermining Community Care Through Wait Time Manipulation

One of the VA's more alarming efforts to undermine the MISSION Act was its widespread use of improper wait time measurements in direct violation of its own regulations. The MISSION Act's access standards, listed under CFR § 17.4040, clearly state that wait times for the purposes of community care eligibility determinations are to be calculated from the veteran's "date of request" for an appointment to the date the veteran is able to receive treatment.

FOIA evidence confirmed that the VA violated its own MISSION Act implementing regulations by using obsolete "patient indicated date" (PID) wait time criteria—a measurement dating from the earlier 2014 Choice Act.[6] In practice, PID measurements were usually set by a scheduler sometime after the veterans' initial appointment request and could dramatically reduce the appearance of wait times for reporting and community care eligibility purposes. This broken wait time system—eerily reminiscent of the conditions

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[2] CFR § 17.4040

[3] "Unless the patient requests to review their other eligibility, no additional [community care] eligibility is required to be reviewed other than wait time." See: "Standard MISSION Act Guidance: Patient Eligibility and Scheduling Reference Sheet," *Department of Veterans Affairs*, October 28, 2020, pg. 2. https://americansforprosperity.org/wp-content/uploads/2021/09/03-Mission-Act-Guidance-Oct.-2020.pdf

[4] "Referral Coordination Initiative Implementation Guidebook," Veterans Health Administration, *Department of Veterans Affairs*, March 10, 2021. https://americansforprosperity.org/wp-content/uploads/2021/09/Referral-Coordination-Initiative-Guidebook.pdf#page=62

[5] VA training flowcharts obtained via FOIA: https://americansforprosperity.org/wp-content/uploads/2022/01/21-06268-F_Responsive_Records_1-Part-1.pdf#page=347

[6] See examples of VA training materials using PID wait time measurements in: ""More Evidence the VA is Improperly Delaying or Denying Community Care to Eligible Veterans," January 28, 2022, Americans for Prosperity Foundation, https://americansforprosperity.org/blog/va-denying-delaying-care/

that created the Phoenix VA scandal—was criticized by the Government Accountability Office for being too subjective and prone to manipulation.[7]

An April 2025 report from the VA Office of Inspector General (OIG) revealed that this trend continued at least through last year. OIG investigators found that between March and April 2024, Omaha VA officials were inputting default wait time metrics into internal systems designed to limit community care referral eligibility and drive patients to Veterans Health Administration-run facilities instead.[8] Secretary Collins' stated commitment to MISSION Act implementation is commendable, but veterans' access to care cannot rely on the goodwill of the VA leadership at any given time. Congress must act to protect veterans' health care choices from VA officials like those in Omaha by reducing the agency's ability to subvert care options with a future change in VA leadership.[9]

Any plan Congress has to expand access to care both inside and outside the VA needs to reduce the ability of the agency to deliberately obstruct veterans who seek to choose community providers that the VHA sees as competitors and threats instead of partners. **Offering "full choice," the ability to qualify for community care in addition to VHA options without preapproval, can break the historical pattern of the VA too frequently undermining the will of Congress on veterans' care options.**

The Veterans Health Care Freedom Act

The 119th Congress can advance full choice and remove the VA's opportunities for bureaucratic meddling in veterans' health care choices by **supporting S. 219, The Veterans Health Care Freedom Act, sponsored by Senator Blackburn**. This legislation will remove barriers to care to create a fully integrated health care system where veterans can choose the health care provider that best meets their needs.

The Veterans Health Care Freedom Act leverages the Center for Innovation for Care and Payment created by the VA MISSION Act to create a three-year pilot program allowing veterans in four Veteran Integrated Service Networks (VISNs) to choose either treatment at VA facilities or community care providers without preapproval.

By using existing authorities in the law, the pilot program removes the set of conditions veterans must currently meet to gain community care referrals under the MISSION Act. Eligible veterans in the pilot program regions would instead have full choice to seek care from the community care or VHA provider that best met his or her needs. Four years after enactment, the pilot program would be expanded permanently nationwide.

Conclusion

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[7] Comptroller General Gene Dodaro to Secretary Denis McDonough, *U.S. Government Accountability Office*, May 10, 2021. https://www.gao.gov/assets/720/714332.pdf

[8] "A Prohibited Default in the Clinically Indicated Date Field Limited Some Veterans' Eligibility for Community Care at the Omaha VA Medical Center in Nebraska," Office of Inspector General, *U.S. Department of Veterans Affairs*, April 10, 2025, https://www.vaoig.gov/sites/default/files/reports/2025-04/vaoig-24-02356-58_0.pdf

[9] Kevin Schmidt, "VA Omaha Leaders Rig Consult System to Deny Veterans Access to Community Care," *Americans for Prosperity Foundation*, April 30, 2025. https://americansforprosperityfoundation.org/featured/va-omaha-leaders-rig-consult-system-to-deny-veterans-access-to-community-care/

The Veterans Health Care Freedom Act will honor the sacrifices made by veterans by empowering them with the choice and flexibility to access the health care options that best meet their needs – a right already enjoyed by most Americans. This approach to expanding choice for veterans is a solution to meet their changing health care needs and offers a model of empowering individuals in their treatment options that can benefit all Americans. **For these reasons, I urge you to support S. 219, the Veterans Health Care Freedom Act.**

Sincerely,

John Vick
Executive Director
Concerned Veterans for America

CONGRESSIONAL MEDAL OF HONOR SOCIETY

May 19, 2025

The Honorable Jerry Moran
Chairman
Senate Committee on Veterans Affairs
412 Russell Senate Office Building
Washington, D.C. 20510-6050

Dear Senator Moran,

Thank you for your enduring support of the Congressional Medal of Honor Society and for championing legislation that reflects the immense responsibility that comes with wearing our nation's highest military award.

As you know, the Medal of Honor is awarded for acts of conspicuous gallantry and intrepidity at the risk of life, above and beyond the call of duty. But for those who wear it, the duty does not end on the battlefield. Recipients are seen as lifelong stewards of the values the Medal represents—sacrifice, courage, patriotism, and humility. We are often called to serve not only as living reminders of valor, but as role models, public servants, and civic leaders.

That calling is not ceremonial. It is real, it is relentless, and it is increasingly demanding.

This expectation is also codified in the founding documents of the Congressional Medal of Honor Society, established by Congress in 1958. As directed by our Congressional Charter, Recipients are charged to:

- Protect, uphold, and preserve the dignity and honor of the Medal at all times and on all occasions.
- Protect the name of the Medal and all holders of the Medal from exploitation.
- Serve the country in peace as in war.
- Inspire and stimulate youth to be worthy citizens of our country.
- Foster and perpetuate Americanism.

Meeting this mandate demands constant awareness and availability. Recipients are invited—almost daily—to speak in schools, attend military functions, meet with civic leaders, support veteran causes, and engage with communities across the country. Most of these appearances are unpaid. Many are at personal cost. And yet, we do them gladly, because service does not end with the Medal—it begins anew.

But the financial realities cannot be ignored. Recipients often cover travel, give up income, and take time away from family to meet these expectations. While the Society provides limited philanthropic support for logistics, that support cannot begin to offset the true cost: our time, energy, emotional labor, and the continued demands of public service.

CONGRESSIONAL MEDAL OF HONOR SOCIETY

It's important to recognize the toll that sustained public service takes on a Recipient's overall well-being. The constant travel, public appearances, and emotional weight of representing the Medal can be physically and mentally exhausting—especially over time.

As President of the Congressional Medal of Honor Society, I see firsthand how few shoulders now carry this burden. The civilian workforce presents its own set of challenges. Recipients are often treated differently—used, even unintentionally, as symbols—when all they want is to contribute as teammates. The pressure to live up to a public ideal never fades. The number of living Recipients is declining, yet the demand on those who remain continues to rise. These men did not seek recognition—but they continue to answer the call, over and over again.

Increasing the Medal of Honor pension is not about reward—it is about respect. It acknowledges the extraordinary, lifelong obligation Recipients shoulder and provides the flexibility to manage the demands that come with it. This support allows Recipients to continue fulfilling the responsibilities their role requires—without sacrificing their livelihood. It is a modest but meaningful step to ensure they can continue serving the nation.

On behalf of the Society, I thank you and the Members of this Committee for your leadership, and for considering this important legislation. It honors not just the Recipients, but the enduring ideals the Medal represents for our nation.

Sincerely,

Britt Slabinski
President
Congressional Medal of Honor Society

cc: The Honorable Richard Blumenthal, Ranking Member

Elizabeth Dole Foundation
CARING FOR MILITARY FAMILIES

Elizabeth Dole Foundation
Statement for the Record
United States Senate Committee on Veterans Affairs
Legislative Hearing
May 21, 2025

Chairman Moran, Ranking Member Blumenthal, distinguished Members of the Senate Veterans Affairs Committee, thank you for the opportunity to submit the Elizabeth Dole Foundation's views on pending legislation.

As a national nonprofit, our mission is to empower military and veteran caregivers, their families and their communities through programs, partnerships, and advocacy that drive innovative, impactful, and sustainable solutions. Through our numerous programs, such as our Hidden Helpers initiative for caregiver children, the Bob & Dolores Hope Fund for critical financial assistance, and our network of Dole Caregiver Fellows in every state, we seek to support caregivers so both they and the veterans for whom they care can thrive—reaching optimal physical health, psychological wellbeing, social connectedness, personal growth, and a sense of purpose in life. To achieve our goal of a seamless continuum of care for veterans, caregivers, and survivors, we focus on issues directly impacting family caregivers as well as those of significant interest to them, including the care and services available to their loved ones.

EDF is keenly aware of the challenges, issues, and remarkable strength of the military and veteran caregiving community we are honored to serve. The Foundation recently commissioned RAND to conduct a new landmark study, released 10 years after its initial work, updating us on the current challenges in the military and veteran caregiver community.[1] In response to the new RAND report and considering our own everyday

[1] RAND. *America's Military and Veteran Caregivers: Hidden Heroes Emerging from the Shadows.* Rajeev Ramchand, et. al. Washington, D.C., September 2024.

experiences with military and veteran caregivers, we would like to offer our thoughts on the following pieces of pending legislation:

S.879, *the Veteran Caregiver Reeducation, Reemployment, and Retirement Act*

For many enrolled in the Department of Veterans Affairs' Program of Comprehensive Assistance for Family Caregivers (PCAFC), their caregiving role will come to an end, hopefully due to improvement in the veteran for whom they care, but, sadly, often due to the veteran passing. As spouses, parents, siblings, children, and friends of these vulnerable veterans, the former caregiver is often left unemployed with little to no retirement savings. 2025 Dole Caregiver Fellow Mozella Richardson Kamara from Delaware, for example, 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 neurological and other physical disabilities. Mozella made this choice to ensure the well-being of her husband and family, but, in the process, was also forced to sacrifice her career and her retirement.

This legislation is an important first step in helping caregivers like Mozella prepare for their for financial future, whether it be re-entering the workforce or planning for retirement. Specifically, this legislation would:

- Extend enrollment in the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) for up to 180 days after disenrollment from PCAFC
- Allow the VA to pay caregivers up to $1,000 to maintain and reacquire professional licensure
- Study the feasibility of establishing a retirement plan for family caregivers
- Study the barriers and incentives to hiring former family caregivers to work for the VA to alleviate shortages in related fields

EDF strongly endorses this legislation. We also suggest the Committee consider a related issue to correct a current inequity related to retirement planning for parent caregivers enrolled in PCAFC. The VA offers a program known as Dependency and Indemnity Compensation (DIC), a monthly tax-free monetary benefit offered to eligible survivors. This program is often a financial lifeline for those who are eligible, and spouse survivors are rightfully not subject to an income threshold. Parent caregivers, however, are subject to an annual income threshold, in some cases as low as approximately $18,000.

For example, Christine Cooley of Florida cared for her severely combat-injured Marine

son, Josh, until he passed away just over a year ago. As a single mother, she was his caregiver for 17 years following his severe injuries. Now in her mid-seventies, she is unable to return to work. Because she is a parent, she is subject to the DIC income limit, and her $23,000 annual social security payment exceeds the threshold. With Social Security now her sole source of income, she has lost the home she shared with her son, compounding her grief and sense of loss.

EDF requests that the Committees consider abolishing or greatly increasing the DIC income limits for non-spouse caregivers enrolled in PCAFC, allowing them to plan for retirement and leaving them far less financially vulnerable when their caregiving roles come to an end.

S.506, the *Coordinating Care for Senior Veterans and Wounded Warriors Act*

As part of the Elizabeth Dole Foundation's Resource Navigation Program, we regularly hear from caregivers who spend hours every day trying to access the care and services the veterans for whom they care need and earned, to varying degrees of success. While potentially eligible, veterans and their caregivers must navigate a complex array of benefits and services to find the right "Easter egg" and often are not aware of programs that could benefit them. In addition, there are gaps and outdated restrictions on many programs that limit access to those in need. The near constant effort to identify resources and advocate on behalf of the veteran can weigh heavily on both the caregiver and veteran. Simply connecting veterans with complex needs to programs that already exist, like Veteran Directed Care, PCAFC, Home Maker/Home Health Aide, etc., promotes better outcomes and provides needed support to caregivers without the addition of costly programs.

Imagine being the caregiver of an elderly veteran or a wounded warrior with complex needs. Your veteran is likely eligible for care and services within multiple agencies like the VA, the Centers for Medicare and Medicaid (CMS), the Department of Defense and others, but to access those benefits and service you must overcome an overwhelming myriad of bureaucratic hurdles. In short, eligibility does not ensure access. Caregivers often tell us they have never heard of or are unable to gain access to services for their care recipient and spend hours on the phone or pouring over paperwork to identify the correct path, try to determine eligibility, and collect records to share across agencies.

This legislation seeks to begin to address these issues by establishing a pilot program between the VA and Health and Human Services:

- To improve access to health care services for covered veterans
- To improve outcomes of care received by covered veterans.
- To improve quality of care received by covered veterans.
- To lower costs of care received by covered veterans.
- To eliminate gaps in care and duplication of services and expenses for covered veterans.
- To improve care coordination for covered veterans, including coordination of patient information and medical records between providers.

In recognition of this struggle and the effort to improve the care ecosystem for veterans and caregivers in the home, in the clinical setting, and in the community, the Elizabeth Dole Foundation supports the passage of S.506, *the Coordinating Care for Senior Veterans and Wounded Warriors Act*.

S. 605 the *CHAMPVA Children's Care Protection Act of 2025*

When the Affordable Care Act was signed into law in 2010, it required private-sector health plans to allow children to stay on their parents' insurance until they are 26 years old, but this coverage was not extended to military or veteran health coverage. This legislation corrects that inequity by raising the maximum age of automatic eligibility for dependents in CHAMPVA from 18 to 26, aligning this program with the civilian sector.

If enacted, this legislation would offer real, direct, and immediate relief to those young adults who grew up in caregiving homes, often sharing in the caregiving responsibilities. According to the recently released RAND report, approximately 40% of military and veteran caregivers are also raising a child. While these children often exhibit more prosocial behaviors and an increased level of empathy than their non-caregiving peers, they also are more likely to miss school and experience behavioral issues that can ultimately impact their academic performance. In addition, they may not seek higher education immediately upon graduation due to continuing caregiving duties. Raising the age of eligibility for CHAMPVA allows these young adults the time they need to care for their loved ones as well as set themselves up for their future success.

In addition, the current system causes major disruptions in the health care of those covered. Young adult caregivers who have entered higher education lose coverage at the end of each semester, leaving significant gaps in coverage, and they must also recertify their enrollment at the beginning of each new semester. Because the CHAMPVA system

uses the United States Postal Service for most claims and all certifications, the program is far behind in the process.

For example, a young adult caregiver in Florida, the daughter of a wounded warrior, is enrolled in school but must recertify her enrollment each semester to remain eligible for CHAMPVA. During last year's Christmas break from school, she unfortunately had to go to the emergency room, forcing her to pay out of pocket and landing her in debt. Moreover, because the program is significantly delayed in processing medical claims, she still does not have coverage 5 months into the semester and has been forced to pay for her prescription medicines. Passage of this legislation would alleviate all of these challenges by automatically ensuring coverage for those deemed eligible—alleviating a significant source of stress and financial burden for these young adults who have often sacrificed their childhoods to care for their loved ones.

Conclusion:
The Elizabeth Dole Foundation again thanks the Committee for this opportunity to share our experiences and perspective on the pending legislation. We are proud to support many of the initiatives under consideration and look forward to continuing to work with you to honor the service of veterans and their caregivers.

Statement for the Record
Daniel Bean, CEO, K9s For Warriors

Prepared for the
U.S. Senate Committee on Veterans Affairs

May 21, 2025

Chairman Moran, Ranking Member Blumenthal, and distinguished Members of the Senate Committee on Veterans Affairs,

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 S. 1441, *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].

S. 1441, 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 Senator Thom Tillis and Ranking Member Richard Blumenthal for leading this important effort and 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

STATEMENT FOR THE RECORD

of the

MILITARY OFFICERS ASSOCIATION OF AMERICA

for a

LEGISLATIVE HEARING

1st SESSION of the 119th CONGRESS

Before the

SENATE COMMITTEE ON VETERANS' AFFAIRS

May 21, 2025

EXECUTIVE SUMMARY

The Military Officers Association of America (MOAA) appreciates the opportunity to submit this statement for the record in strong support of several key pieces of legislation under consideration by the committee. Collectively, these bills represent meaningful progress toward improving quality of life and long-term support for those in the veteran and military community.

- ***S. 879, 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.
- ***S. 1383, the Veterans Accessibility Advisory Committee Act[2],*** establishes a formal advisory body to guide and improve accessibility across VA facilities and services for veterans with disabilities, ensuring consistent input from stakeholders and promoting infrastructure and service reforms.
- ***S. 605, the CHAMPVA Children's Care Protection Act[3],*** 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.
- ***S. 649, the Guard and Reserve GI Bill Parity Act[4],*** corrects a structural inequity by ensuring all qualifying service — including certain types of active duty performed by Guard and Reserve members — counts toward Post-9/11 GI Bill eligibility, recognizing the full contributions of all who serve and enhancing access to education benefits.

MOAA urges swift passage of each 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.

CHAIRMAN MORAN AND RANKING MEMBER BLUMENTHAL, and members of the committee, 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 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.

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[1] **S. 879**, https://www.congress.gov/bill/119th-congress/senate-bill/879/.
[2] **S. 1383**, https://www.congress.gov/bill/119th-congress/senate-bill/1383/.
[3] **S. 605**, https://www.congress.gov/bill/119th-congress/senate-bill/605/.
[4] **S. 649**, https://www.congress.gov/bill/119th-congress/senate-bill/649/.

LEGISLATION

S. 879, 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 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[5].

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*[6], 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.

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[5] **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.
[6] **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.

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.

S. 1383, THE VETERANS ACCESSIBILITY ADVISORY COMMITTEE ACT

MOAA supports S.1383, the *Veterans Accessibility Advisory Committee Act*. This important legislation establishes an independent advisory body focused on improving accessibility and disability-related accommodations for veterans within the VA. This legislation reflects a critical step forward in ensuring all veterans can access the benefits, services, and programs they need.

The Need for Action

While the VA has made progress in addressing the needs of veterans with disabilities, significant challenges remain in ensuring consistent, reliable access to VA facilities, medical equipment, communications platforms, and support services. Veterans with physical, sensory, and cognitive impairments continue to encounter barriers limiting their ability to receive timely, equitable care.

For example, in a 2024 report titled *Better Oversight Needed of Accessibility, Safety, and Cleanliness at Contract Facilities Offering VA Disability Exams*[7], the VA Office of Inspector General (OIG) found 114 out of 135 examined medical disability examination facilities had one or more deficiencies related to accessibility, safety, or cleanliness. The report emphasized that the VA's Medical Disability Examination Office relied on vendors to self-certify compliance without adequate oversight, leading to persistent issues with facility conditions.

Legislative Solutions

The Veterans Accessibility Advisory Committee would be charged with:

- Assessing access barriers across VA programs and services.
- Recommending improvements to facilities, medical equipment, information systems, and service delivery.
- Advising on policies that enhance usability and reduce obstacles for veterans with disabilities.
- Reporting annually to the VA secretary and to Congress on findings, priorities, and progress.

The committee would include veterans with disabilities, medical and rehabilitation experts, and other stakeholders with relevant experience. This structure ensures practical, veteran-centered guidance is consistently incorporated into VA planning and operations.

[7] **VA OIG Report:** ***Better Oversight Needed of Accessibility, Safety, and Cleanliness at Contract Facilities Offering VA Disability Exams***: https://www.vaoig.gov/reports/review/better-oversight-needed-accessibility-safety-and-cleanliness-contract-facilities.

MOAA Recommends: Congress passes the *Veterans Accessibility Advisory Committee Act* without further delay. The legislation provides dedicated oversight and recommendations aimed at improving accessibility across the department.

S. 605, 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.

S. 649, THE GUARD AND RESERVE GI BILL PARITY ACT

MOAA, along with other veteran advocacy groups, supports the bipartisan *Guard and Reserve GI Bill Parity Act*. This legislation ensures Guard and Reserve troops, who serve and sacrifice alongside their active-duty counterparts, no longer face undue barriers earning the education benefits warranted by their service.

The Need for Action

MOAA has long supported this parity for Guard and Reserve members. We also support the principle that every day of service should count toward earned education and other benefits. We continue to urge reform that grants fair treatment for reserve-component troops and support bolstering benefits of the reserve component to attract new talent. We believe this will also incentivize those in the active component to join the reserves instead of making a clean break from service.

Legislative Solutions

The act makes key updates to ensure Guard and Reserve members receive the education benefits they've earned by:

- Expanding eligibility for Post-9/11 GI Bill benefits to include certain full-time National Guard duties, retroactive to Sept. 11, 2001.
- Covering all types of federal activation, even without a presidential emergency declaration.
- Including full-time National Guard service for training and other assigned duties.
- Counting drill weekends (inactive duty training) toward benefit eligibility, so Guard members training alongside active-duty troops are treated equally.

MOAA Recommends: Congress passes the *Guard and Reserve GI Bill Parity Act* without delay. This legislation acknowledges the service performed by Guard and Reserve members serving alongside their active-duty counterparts. This acknowledgment of this benefit not only alleviates a burden, but it also encourages reserve-component participation following separation from active-duty service.

MEDAL OF HONOR
FOUNDATION

MEDAL *of* HONOR FOUNDATION
40 Patriots Point Road, Mount Pleasant, SC 29464

May 18, 2025

The Honorable Jerry Moran
Chairman
Senate Committee on Veterans Affairs
412 Russell Senate Office Building
Washington, D.C. 20510-6050

Dear Senator Moran,

I write to you as Chairman of the Board of Directors of the Congressional Medal of Honor Foundation. The Foundation is a nonprofit established in 1999 to advance the mission and provide a path for financial support of the Congressional Medal of Honor Society.

Chartered by Congress in 1958, the Congressional Medal of Honor Society's membership is comprised of those bestowed the Medal of Honor, our nation's highest military award for valor. Its mission is to preserve the legacy of the Medal of Honor, inspiring America to live the values the Medal represents, and supporting Recipients of the Medal as they connect with communities across America.

Medal of Honor Recipients have been selflessly carrying out the Society's mission of outreach, education and preservation programs including the Congressional Medal of Honor Character Development Program, Medal of Honor Museum, Congressional Medal of Honor Outreach Programs, and the annual Congressional Medal of Honor Citizen Honors Awards for Valor and Service.

However, the mission assigned to the Society nearly 70 years ago was, effectively, an unfunded mandate—but not one Recipients could ignore. With no government agency tasked to preserve their stories and project forward the meaning of the Medal, the burden has fallen squarely on the Recipients themselves. Unsurprisingly, Recipients use the Medal of Honor pension to carry out the Society's unfunded Congressional mandate.

Congress created the Army and Navy Medal of Honor Roll in 1916, which granted Recipients a special pension of $10 per month. Since then, the pension has increased and is now $1,712.94 per month—roughly $20,550 annually. Yet, this amount is insufficient to fully defray the cost they incur carrying out the Society's outreach and education program.

The reality is that these Recipients are not compensated for the precious time and energy taken away from family, from work, from their personal lives nor are they paid or reimbursed to cover their own travel expenses. Moreover, when the Society once had hundreds of living members, and there were enough Recipients to rotate through periods of active service to the organization.

Now, with just 61 living Recipients, that load is being carried by fewer shoulders. While the Medal itself is the highest honor our nation can bestow, honor alone does not pay the bills or restore lost time.

Mr. Chairman, no one can replace the influence of a living Recipient. The work of carrying the Medal forward—of standing as its living embodiment—is something only they can do.
They are custodians of American values, history, and patriotism. Their presence educates and inspires not just military audiences, but the American public as a whole. I have been privileged to see it close up for nearly twenty-five years, as I have been humbled to know many of them since. I do hope that the Senate Veterans Affairs Committee, and indeed the whole Senate, will follow the action of the House and act to increase the Medal of Honor special pension and support Medal of Honor recipients as they continue to fulfill the Society's Congressionally mandated mission.

Sincerely,

David J. McIntyre, Jr.
Chairman of the Board of Directors

cc: The Honorable Richard Blumenthal, Ranking Member

STATEMENT FOR RECORD

NATIONAL GUARD ASSOCIATION OF THE UNITED STATES

Senate Committee on Veterans' Affairs

Joint Hearing on Legislative Presentations

May 22, 2025

Chairman Moran, Ranking Member Blumenthal, and distinguished members of the Senate Committee on Veterans' Affairs:

On behalf of nearly 45,000 members of the National Guard Association of the United States (NGAUS) and over 430,000 Soldiers and Airmen of the National Guard, we thank you for the opportunity to submit this statement for the record in strong support of the GI Bill Parity Act. This legislation represents a long-overdue correction to a persistent inequity in how National Guard and Reserve service is recognized under the Post-9/11 GI Bill.

The Current Inequity

The Post-9/11 GI Bill is one of the most transformational veterans' benefits programs in American history, rightly honoring service in uniform with access to higher education and vocational training. Yet, for thousands of members of the National Guard and Reserve — particularly those who served under Title 32 orders or in short-term federal mobilizations — their service has not counted equally toward eligibility for these benefits. This is fundamentally unjust.

National Guard Soldiers and Airmen perform critical missions — at home and abroad — that directly support national defense objectives, disaster response, civil unrest operations, and pandemic relief. However, much of this service falls under duty statuses that are excluded from Post-9/11 GI Bill accrual, such as:

- Title 32 Section 502(f) orders for domestic operations
- Annual training and drill weekends
- Short-term operational support that does not meet the rigid Title 10 90-day threshold

This exclusion creates a system in which two service members standing shoulder to shoulder in the same mission may receive vastly different education benefits. The role of the National Guard has greatly increased since the creation of the GI Bill and it is far time that the policy be updated to reflect those contributions.

Why the GI Bill Parity Act Matters

The GI Bill Parity Act would address this inconsistency by ensuring that every day of uniformed service performed under federal orders counts toward Post-9/11 GI Bill eligibility, regardless of

duty status code. This reform would bring the Guard and Reserve components in line with the intent of the original GI Bill — to recognize service, not bureaucracy.

The bill does not provide any "extra" benefits. It simply recognizes service that is already being performed. This includes:

- Counterdrug interdiction
- COVID-19 response
- Wildfire and hurricane response
- Cybersecurity and infrastructure protection missions

These are not training exercises. They are real-world operations, often requiring service members to leave their families, civilian jobs, and educational pursuits — all while taking on the same responsibilities as their active-duty counterparts.

Real-Life Impacts

NGAUS regularly hears from Guardsmen who are stunned to learn that despite deploying or responding for months at a time under federal orders, their service does not count toward education benefits. For example:

- A Guardsman who served over 100 days during the COVID-19 pandemic under Title 32 orders accrued zero days of GI Bill credit.
- Another member who deployed for two months under a short-term overseas mobilization received no credit due to the lack of a formal Title 10 designation.

These inconsistencies are not just unfair — they undermine morale and decrease retention. Service members expect their sacrifices to be honored equally, regardless of component.

A Strategic and Moral Imperative

Ensuring parity in GI Bill eligibility is not just a matter of fairness — it is a strategic imperative. As the Department of Defense continues to rely more heavily on the National Guard and Reserve to meet global and domestic mission requirements, it is critical that benefits keep pace with that increased reliance.

Furthermore, treating Guard and Reserve members as full partners in the Total Force requires policies that reflect equity in benefits and recognition. This reform would:

- Improve retention of skilled Guardsmen and Reservists
- Enhance recruitment by demonstrating tangible respect for non-active service
- Promote educational attainment across the force, improving readiness and capability

Conclusion

The GI Bill Parity Act represents a common-sense, bipartisan solution to a long-standing injustice. It honors the principle that service is service, regardless of the component or the type of orders. It upholds the promise made to all who wear the uniform: that their sacrifice will be recognized and repaid with opportunity.

We thank this Chairman Moran, Ranking Member Blumenthal, and members of this committee for their continued leadership in supporting America's veterans and urge you to advance the GI Bill Parity Act without delay. Our nation's citizen-soldiers and airmen have earned nothing less.

STATEMENT FOR THE RECORD
QUALITY OF LIFE FOUNDATION
FOR
THE SENATE VETERANS AFFAIRS' COMMITTEE
HEARING ON SENATE BILL S. 879
VETERAN CAREGIVER RE-EDUCATION, RE-EMPLOYMENT, AND RETIREMENT ACT

Thank you Chairman Moran, Ranking Member Blumenthal, and distinguished members of the Committee for allowing us to emphasize and advocate for Senate bill 879, 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 Senator Moran, Senator Hirono, and former Senator Sinema for taking my words in the SVAC hearing in March of 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 D.C. in July 2009, my husband was on his third hospitalization since returning from Iraq in February of 2007. During those years, I had tried to maintain my thirteen 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 of 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 was something only 141,000 teachers nationwide have achieved. The last day of that school year in June of 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 fifteen 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 three months of stipend paid when the caregiver exits PCAFC.

S.879, 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. S.879 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 two 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 leverage 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 twenty 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 twenty 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 caregivers 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.

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 work force 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, 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 Senate bill 879, the Veteran Caregiver Re-education, Re-employment, and Retirement Act.

Reserve Organization of America

OFFICIAL STATEMENT OF
JAKE FALES AND PETER DONLON

FOR THE
U.S. SENATE COMMITTEE ON VETERANS' AFFAIRS

ON
PENDING LEGISLATION

MAY 19, 2025

Serving Citizen Warriors through Advocacy and Education since 1922

ARMY • MARINE CORPS • NAVY • AIR FORCE • SPACE FORCE • COAST GUARD • NOAA • USPHS

1 Constitution Avenue N.E.
Washington, DC 20002-5618

The Reserve Officers Association of the United States, now doing business as the Reserve Organization of America, is a military service organization incorporated under Internal Revenue Service Code section 501(c)(19), and comprising all ranks of servicemembers, veterans, and family members of our nation's eight uniformed services separated under honorable conditions. ROA is the only national military service organization that solely and exclusively supports the reserve components.

ROA was founded in 1922 by General of the Armies John "Black Jack" Pershing, during the drastic reductions of the Army after World War I. It was formed to support a strong national defense and focused on the establishment of a corps of reserve officers who would be the heart of a military expansion in the event of war. Under ROA's 1950 congressional charter, our purpose is unchanged: To promote the development and execution of policies that will provide adequate national defense. We do so by developing and offering expertise on the use and resourcing of America's reserve components.

Executive Director:
Maj. Gen. Jeffrey E. Phillips, U.S. Army (Ret.) 202-646-7701

Director, Legislation and Military Policy:
Matthew L. Schwartzman 202-646-7713

DISCLOSURE OF FEDERAL GRANTS OR CONTRACTS

The Reserve Officers Association of the United States, now doing business as the Reserve Organization of America, has not received any grants, contracts, or subcontracts from the federal government in the past three years.

CURRICULUM VITAE

Jake Fales serves as ROA's Senior Policy Fellow for Veterans' Affairs. Responsible for much of ROA's Veterans' Affairs policy portfolio, Jake has more than three years of experience in government affairs, legislative analysis, customer relations, and communications. While working in the military and veterans' policy sector, Jake has written congressional testimony, led a fly-in day, and crafted engagement plans on ROA's priorities.

Peter Donlon serves as ROA's Senior Policy Fellow for Defense and Acquisitions. With a background in international relations, Peter has played a significant role in crafting ROA's D&A policy portfolio. Peter has been with ROA for over a year, and in that time has written congressional testimony, planned events, and led meetings on Capitol Hill.

INTRODUCTION

Chairman Moran, Ranking Member Blumenthal, and distinguished members of the Senate Committee on Veterans' Affairs:

On behalf of the Reserve Organization of America, the only national military organization solely dedicated to supporting the Reserve and National Guard, *thank you* for the opportunity to submit this statement for the record regarding pending legislation.

This statement addresses legislation directly aligned with ROA's mission and adopted resolutions, specifically S.647, the *Guard and Reserve GI Bill Parity Act.* Additionally, we underscore the urgent need for duty status reform, which remains stalled in the Office of Management and Budget and requires immediate action.

S.647, the Guard and Reserve GI Bill Parity Act

ROA thanks Senator Moran and Senator Blumenthal for sponsoring this legislation and thanks senators Booker, and Baldwin support. ROA in solidarity with the 23 Military and Veterans Service Organizations that supported this legislation last congress, urges the Committee to support the bill unanimously and without amendment.

From their origins as state militias to their current role as a modern operational force constituting 43 percent of the Total Force, the reserve components have undergone continuous evolution.

Foundational legislation such as the *Dick Act of 1903* and the *Armed Forces Reserve Act of 1952* helped define the roles and authorities of the Reserve and National Guard.

Under current law, reserve component members may qualify for Post-9/11 GI Bill benefits if they serve at least 90 cumulative days or 30 continuous days on active duty and are discharged due to a service-connected disability or receive the Purple Heart.

However, regular annual training and many other duty statuses under Titles 10, 14, or 32 *do not* count toward eligibility, even when such service directly supports federally directed missions.

Today's patchwork of approximately 30 different duty statuses under Titles 10, 14, and 32 reflects a legacy of legal complexity. These various authorities were additive in nature and designed to provide convening authorities, including the president and governors, with the flexibility to mobilize forces based on mission requirements.

This federal-state tension is especially apparent in the National Guard. Initiatives like Air Force Legislative Proposal 480, recently codified in the FY 2025 NDAA, present new challenges to longstanding gubernatorial manpower authorities that have been in place for more than a century.

Depending on the specific authority used, a National Guardsman or reservists may or may not earn post 9/11 GI Bill credit. In such cases, it is the legal basis for activation, not the mission's risk or duration, that determines eligibility.

This statutory exclusion creates a fundamental inequity. It penalizes citizen-warriors for the nature of their

orders rather than the merit or importance of their service.

For example, a National Guard soldier activated under Title 32 U.S.C. §502(f) for a federally funded border mission may receive no GI Bill credit unless the Secretary of Defense designates the mission as a response to a national emergency, even though the mission is federally approved and critical to national security.

The *Guard and Reserve GI Bill Parity Act* would address this issue by allowing the significantly more duty statuses to count toward Post-9/11 GI Bill eligibility[1]; better reflecting the operational reality of the modern Total Force.

These developments come at a time when the reserve components are central to ongoing discussions about national security, manpower, and mission scope. Their roles at the Southern Border, in contested homeland defense scenarios, and as a consistently relied-on manpower reserve underscore their growing strategic importance.

At the same time, growing dissatisfaction among reserve component spouses is contributing to a strained support environment. This trend is likely driven by increased time away from home and family due to rising operational demands.

According to the Department of Defense's *2023 Reserve Component Spouse Survey*:

- Satisfaction with the National Guard and Reserve way of life declined in 2023.
- Activations increased since 2019, with 40 percent of spouses reporting that their servicemember deployed to a combat zone.
- A higher percentage of spouses whose servicemember deployed in the past two years reported extended deployments in 2023 compared with 2019.
- Twenty-two percent of Reserve Component spouses experienced some degree of food insecurity.
- More spouses reported financial planning efforts prior to deployment than in 2019.
- Sixty-seven percent of spouses who were dissatisfied with the Reserve Component lifestyle favored leaving military service.
- Dissatisfied spouses were more than 12 times as likely to support separation from the military as satisfied spouses.

Ensuring that citizen-warriors and their families receive the support they need is more important than ever. A critical step is expanding educational benefits by increasing their access to the Post-9/11 GI Bill. This investment is essential to building and sustaining a ready, resilient, and retained reserve force.

Reserve component members frequently perform the same missions as active-duty personnel but often under different authorities that may deny them earned educational benefits.

This is more than a fairness issue. It is a readiness issue. The Reserve and National Guard have become not just a complementary force, but often a primary source of military manpower and operational capacity.

[1] See Addendum One for a full list of duty statuses covered under the bill

Take the Army Reserve for example which is critical to Total Force logistics, providing essential capabilities that underpin global sustainment operations. Containing eight out of the Army's 14 Expeditionary Sustainment Commands, it delivers 95% of the Army's bulk fuel line-haul capacity and approximately 50% of its water distribution and storage, core functions that ensure warfighters remain supplied across extended battlefields.

With a shrinking pool of eligible recruits, strong public resistance to conscription, and growing global instability, the reserve components are a foundational manpower base of today's military.

Yet under the current system, a reserve component servicemember supporting a mission critical to national defense may receive no GI Bill credit simply due to the technical nature of their activation status.

DoD and Congress have both worked to address these gaps on a case-by-case basis. Leaders within the reserve components have also supported broader reforms, including the implementation of comprehensive duty status reform, which currently remains "under review" within the Office of Management and Budget.

ROA urges the Committee to work with its Armed Services counterpart and OMB to expedite implementation of duty status reform.

There are real-world consequences to the continued inequity in benefits. Educational support plays a critical role in retention, leadership development, and promotion, particularly for citizen-warriors who manage dual civilian and military careers.

Reserve component members often rely on dual incomes, and GI Bill access significantly impacts their willingness to continue service. The disparity in Regular Military Compensation, especially for senior enlisted personnel, whose earnings fall below the 70th percentile for civilians with bachelor's degrees, and drop to the 59th percentile after 20 years of service, makes education benefits an indispensable incentive.

Yet under the current system, a reservist with years of credible service across multiple short-term activations may never reach the threshold required for full GI Bill benefits. Meanwhile, an active-duty servicemember accrues those benefits automatically after a single enlistment. This inconsistency damages morale and retention and is inconsistent with the needs of the modern force.

ROA urges again that the Committee, and the 119th Congress, pass the *Guard and Reserve GI Bill Parity Act* without delay or amendment.

CONCLUSION

As global threats intensify and the reserve components are called upon with increasing frequency, ensuring fair and consistent access to earned benefits is essential to sustaining the force of today, and generating the force of tomorrow.

Thank you for your continued attention to this matter and for your steadfast support of our citizen-warriors and their family.

Too often, military and veterans law is developed without sufficient appreciation for the distinctions between active and reserve service. Invariably, members of the Reserve and National Guard—and their families—are left behind.

When that happens, America's military readiness suffers. We cannot afford that loss.

We look forward to working with you to advance the *Guard and Reserve GI Bill Parity Act*, implement duty status reform, and pursue other shared priorities in support of our nation's reserve components.

ADDENDUM ONE

List of all Duty Statuses That Would be Eligible to Receive Points for Benefits Under the Guard and Reserve GI Bill Parity Act of 2025

Title 10, U.S.C

- §101(d): Defines Active Duty, Active Service, Active Status, and Full-Time National Guard Duty.
- §688: Authorizes recall of retired members to active duty.
- §12301(a): Full mobilization during declared war or national emergency.
- §12301(d): Voluntary active duty with consent.
- §12301(g): Activation for members in captive status.
- §12301(h): Medical hold or treatment duty.
- §12302: Partial mobilization in response to national emergencies.
- §12304: Presidential Reserve Call-up for national security missions.

Title 14, U.S.C

- §3713: Coast Guard emergency activation for natural disasters or terrorist threats.

Title 32, U.S.C

- §101(19): Full-Time National Guard Duty performed under federal funding.
- §101(12): Federal Active Duty definition for National Guard and Reserve service.

ADDENDUM TWO

Letter of support from The Military Coalition

THE MILITARY COALITION
PROUDLY SERVING ALL EIGHT UNIFORMED SERVICES

June 25, 2024

The Honorable Mike Bost
Chairman
House Committee on Veterans' Affairs
By e-mail

The Honorable Jon Tester
Chairman
Senate Committee on Veterans' Affairs
By e-mail

The Honorable Mark Takano
Ranking Member
House Committee on Veterans' Affairs
By e-mail

The Honorable Jerry Moran
Ranking Member
Senate Committee on Veterans' Affairs
By e-mail

Dear Chairmen Bost and Tester and Ranking Members Takano and Moran:

The Military Coalition (TMC), representing more than 5.5 million service members, veterans, their families, and survivors, urges your support for swiftly codifying H.R.7543/S.3873, the *Guard and Reserve GI Bill Parity Act of 2024*, in public law.

Under current law, Reserve and National Guard members can accrue "qualifying days" toward receiving the Post-9/11 GI Bill if they have served at least 90 cumulative or 30 continuous days on active duty and are discharged with a service-connected disability or awarded the Purple Heart after September 10, 2001.

These citizen-warriors must perform their duty responsibilities for a minimum of 39 days each Fiscal Year (24 inactive duty training days and 15 days of active duty in annual tour status). Unfortunately, these duty days *do not* count towards Post-9/11 GI Bill eligibility.

Drill weekends and annual tours are increasing in scale and significance as the Reserve Components are more frequently relied on. Recent examples include joint training operations showcasing the capabilities of our reserve force. Unfortunately, the strides in achieving component interoperability (particularly since the beginning of the Global War on Terrorism) have been far greater than the strides in equitably rewarding personnel for the effort and skillset required to achieve such interoperability.

In many instances, for the same training day, it is possible for an Active Component member to receive Post-9/11 Bill credit whereas a Reserve Component member would not. The *Guard and Reserve GI Bill Parity Act of 2024* is *bi-cameral*, *bi-partisan* legislation that resolves this disparity by allowing Reserve Component members to accrue all paid points days toward receiving the Post-9/11 GI Bill.

The GI Bill has been a proven investment with a tangible R.O.I. Facing the most significant recruiting challenge in the history of the All-Volunteer Force, the time to invest in our current and prospective Reserve Component service members and their families is *now*. Thank you for your consideration of this request.

TMC looks forward to working with you on this and other areas of mutual interest.

Respectfully,

Jack Du Teil
President
The Military Coalition
The Military Coalition:

Air and Space Forces Association (AFA)
Air Force Sergeants Association (AFSA)
American Veterans (AMVETS)
Association of the U.S. Navy (AUSN)
Blue Star Families (BSF)
Commissioned Officers Association of the U.S. Public Health Service (COA)
USCG Chief Petty Officers Association (CPOA)
Chief Warrant Officers Association of the U.S. Coast Guard (CWOA)
Fleet Reserve Association (FRA)
Iraq and Afghanistan Veterans of America (IAVA)
Jewish War Veterans of America (JWV)
Military Chaplains Association of the United States of America (MCA)
Marine Corps League (MCL)
Marine Corps Reserve Association (MCRA)
Non-Commissioned Officers Association (NCOA)
Naval Enlisted Reserve Association (NERA)
National Military Family Association (NMFA)
Reserve Organization of America (ROA)
Service Women's Action Network (SWAN)
Tragedy Assistance Program for Survivors (TAPS)
The Retired Enlisted Association (TREA)
United States Army Warrant Officers Association (USAWOA)
Veterans of Foreign Wars (VFW)

STATEMENT OF

STUDENT VETERANS OF AMERICA

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS

U.S. SENATE

HEARING ON THE TOPIC OF:

PENDING LEGISLATION

May 21, 2025

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studentveterans.org

SVA

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SVA

Chairman Moran, Ranking Member Blumenthal, and Members of the Committee: 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 Committee for considering this legislation that would impact student veterans, military-connected students, their families, caregivers, and survivors in higher education.

S. 649, the Guard and Reserve GI Bill Parity Act of 2025

SVA strongly supports S. 649, *the Guard and Reserve GI Bill Parity Act of 2025*, which ensures that every day is uniform counts equally towards receiving their educational benefits.

The National Guard and Reserve members are vital in our nation's defense, often serving alongside active-duty servicemembers and subject to the same risks and sacrifices. Many National Guard and Reserve members are deployed to combat zones or participate in other high-risk missions, like their active-duty counterparts. Denying them equitable education benefits not only undermines the principle of equity for those who serve our country, but also denies the transformative power of higher education to those who have signed up to sacrifice their time, careers, and lives in service to our nation.

Members of the National Guard and Reserve face unique challenges in accessing education benefits that often place them at a disadvantage compared to both their active-duty counterparts and student veterans who have completed their service obligation.[1] Unlike veterans who have transitioned fully into civilian life and can plan their education with relative stability, Guardsmen and Reservists must constantly balance military commitments with civilian responsibilities, including school, employment, and family obligations.[2] One of the primary challenges they face is the unpredictability of their service obligations. Weekend drills, annual training requirements, and sudden short-term deployments can interfere with class schedules, making it difficult to maintain steady academic progress.[3] Additionally, training exercises and mobilizations often require relocation, forcing students to withdraw from

[1] Mobley, C., Lord, S. M., Main, J. B., Brawner, C. E., & Murphy, J. (2022). "Stepping Out" for Miliary Service: Challenges Experienced by Students Serving in the Reserves or National Guard. Journal of Veterans Studies, 8(3), pp. 222–238. DOI: https://doi. org/10.21061/jvs.v8i3.346
[2] Ibid.
[3] Ibid.

courses or navigate incomplete coursework with little institutional support. Unlike active-duty personnel who may have more predictable service schedules, National Guard and Reserve members can be called to duty with little notice, leaving them scrambling to adjust their academic and financial plans.

For over ten years, SVA has partnered with the Veterans of Foreign Wars (VFW) to mentor and empower student veterans through the VFW-SVA Legislative Fellowship. The 2024-2025 fellows have championed this legislation from campus to Capitol Hill through efforts including social media campaigns, podcasts, petitions, roundtables, and educational outreach. Alongside VFW, we remain committed to advancing this critical issue and urge Congress to pass this legislation to ensure National Guard and Reserve members earn the GI Bill benefits they rightfully deserve for every day they serve.

Providing parity of educational benefits can ease the financial strains of pursuing higher education, enabling National Guard and Reserve members to better manage both their military service and academic ambitions, without having them to forego one over the other. SVA would like to thank Chairman Moran and Ranking Member Blumenthal for reintroducing this legislation and for their continued commitment to better the lives and career pathways for our National Guard and Reserve members.

S. 1543, the Veterans Opportunity Act of 2025

SVA supports S. 1543, *the Veterans Opportunity Act of 2025*, which would establish the Veterans Economic Opportunity and Transition Administration within the Department of Veterans Affairs (VA).

Elevating VA's economic opportunity programs, such as the GI Bill, home loan guaranty, and Veteran Readiness and Employment (VR&E), out of the broader Veterans Benefits Administration, where they often compete for resources and visibility. Creating a dedicated administration with senior-level leadership would ensure these programs receive the focus and coordination they deserve, as they are often key pillars of a successful transition and long-term well-being for veterans.

SVA would like to thank Senators Banks, Hassan, Scott, and Cortez Masto for their continued leadership on this legislation, as it helps ensure that veterans are one step closer to being recognized for their full potential.

S. 605, the CHAMPVA Children's Care Protection Act of 2025

SVA supports S. 605, *the CHAMPVA Children's Care Protection Act of 2025*, which would extend the age of eligibility for 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,

SVA

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 veteran parents are disabled or who have died from a service-connected disability. This legislation would ensure that the health coverage of CHAMPVA beneficiaries are more aligned with most employer-sponsored health care plans and have parity with those in TRICARE[4] 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 Chairman, Ranking Member, and the Committee Members for your time, attention, and devotion to the cause of veterans, military-connected students, their families, caregivers and survivors.

[4] TRICARE, TRICARE Young Adult Plans, https://tricare.mil/Plans/HealthPlans/TYA (last visited May 20, 2025).

STATEMENT OF

KRISTINA KEENAN, DIRECTOR
NATIONAL LEGISLATIVE SERVICE
VETERANS OF FOREIGN WARS OF THE UNITED STATES

FOR THE RECORD
UNITED STATES SENATE
COMMITTEE ON VETERANS' AFFAIRS

WITH RESPECT TO

Pending Legislation

Washington, D.C. May 21, 2025

Chairman Moran, Ranking Member Blumenthal, and members of the committee, on behalf of the men and women of the Veterans of Foreign Wars of the United States (VFW) and its Auxiliary, I would like to thank you for the opportunity to present our views on legislation pending before this committee.

S. 219, Veterans Health Care Freedom Act

The VFW does not support this legislation to create a pilot program to allow veterans to receive primary care through arrangements outside the Department of Veterans Affairs (VA). When veterans enroll in VA health care, they have chosen VA as their care provider.

When in the military, service members use the military health system, and when direct care is unavailable or unfeasible, the military provides highly coordinated care in the community. Veterans expect the same level of coordination from VA, not fractured care.

The VFW advocates for veterans to receive their care within the VA medical system, which provides veteran-centric health care and creates an environment where veterans feel understood and comfortable. While VA's Community Care Network is an essential supplement when care cannot be provided within VA, it should not replace VA care.

Recent articles published in the *Journal of General Internal Medicine* and the *Journal of the American College of Surgeons* conducted a systematic review of studies on VA health care, concluding that it is consistently as good as, or better than, non-VA health care. VFW surveys also indicate that veterans who use VA care have high satisfaction rates and would recommend it to others.

S. 585, Servicemember to Veteran Health Care Connection Act of 2025

The VFW supports this legislation that would establish a process to provide VA with health care

enrollment information of members of the armed forces within 180 days before leaving service. VA would use this information to evaluate eligibility and contact veterans within 30 days after separation to assist and facilitate enrollment, and schedule initial primary care appointments for authorized veterans. This legislation aims to simplify the process of enrolling in the VA health care system at the earliest moment. The VFW sees this as a positive step to ensure transitioning service members have access to health care, creating a seamless transition from military to civilian life.

S. 599, Driver Reimbursement Increase for Veteran Equity (DRIVE) Act of 2025

The VFW supports this legislation to increase the payment of mileage reimbursement for veterans traveling for medical care under the VA Beneficiary Travel program. This legislation would ensure that veterans are fairly compensated for their travel expenses related to medical care, thereby alleviating potential financial burdens caused by delayed reimbursements.

S. 605, CHAMPVA Children's Care Protection Act of 2025

The VFW supports this legislation to extend the age limit for children eligible for medical coverage under the Civilian Health and Medical Program of VA (CHAMPVA). This legislation aims to expand health care access for these young adult children of veterans, ensuring continuity of care during a crucial life stage and reducing coverage gaps for military families. This initiative aligns with current health insurance standards and is a legislative priority for the VFW.

S. 635, Veterans Homecare Choice Act of 2025

The VFW supports the intent of this legislation to expand eligible care providers under the Veterans Community Care Program by formally recognizing nurse registries. This change would increase home-based care options for veterans and broaden their access to home- and community-based services. By allowing veterans to receive care from a larger pool of qualified caregivers, especially in areas where traditional providers are limited, this legislation promotes greater flexibility and choice in health care delivery for veterans.

However, there are concerns about the proposed definition of "nurse registry," which includes both health professionals and homemakers/companions. While homemakers and companions should be recognized, they should be listed separately in subsection (c) with a distinct definition provided in subsection (q). VA already has a program that offers homemaker services—the VA Caregiver Support Program—that could serve as a model for the proposed bill.

Participants in these contracts should possess qualifications equivalent to those of VA employees in similar roles, with each state responsible for verifying their reliability and certification. Utilizing contract vehicles, such as the Community Care Network, would help ensure that the care delivered meets VA standards and maintains patient safety. Licensed and certified providers should be distinctly separate from non-licensed providers in the definition, which should specify the types of care that non-licensed individuals are authorized to provide.

S. 649, Guard and Reserve GI Bill Parity Act of 2025

The VFW strongly supports this legislation to allow any day in uniform for which military pay is received to count toward Post-9/11 GI Bill eligibility, creating parity for National Guard and Reserve members. Currently, Post-9/11 GI Bill eligibility is based on active duty service for at least 90 days. For those in the reserve components, initial skills and training periods are deemed non-qualifying service. Also, full-time National Guard service and certain responses to national emergencies do not qualify.

The sacrifices of these reserve component members have continued to be overlooked for decades despite an increase in deployments since September 11, 2001. Though they have served alongside active duty service members during increasingly frequent activations both domestic and abroad, they do not always earn their VA education benefits at the same rate. This inequity has been highlighted during the frequent activations due to natural disasters, the COVID-19 pandemic, and border security missions as National Guard and Reserve members have stood on the front lines administering relief and services.

The VFW has a long-standing partnership with Student Veterans of America (SVA), and for more than a decade we have mentored student advocates through the VFW-SVA Legislative Fellowship program. The 2024-2025 fellows have advocated for this legislation on their campuses around the country, hosting roundtables, speaking on podcasts, collecting support through petitions, and bringing public awareness through social media campaigns. Our organizations will continue to bring attention and momentum to this important issue. We urge Congress to pass this legislation to allow reserve component members to rightfully earn GI Bill benefits for every day served.

S. 778, Lactation Spaces for Veteran Moms Act

The VFW supports this legislation to mandate all VA medical centers provide safe, accessible, and private spaces for breastfeeding and expressing breast milk. This initiative promotes the health and dignity of veteran mothers by ensuring an inclusive environment at VA facilities nationwide, and reflects the increasing recognition of the unique needs of women veterans.

S. 784, Rural Veterans Transportation to Care Act

The VFW supports this legislation that would expand eligibility for the Highly Rural Transportation Grant (HRTG) program. It would also grant as much as $80,000 to state and county veterans service agencies, tribal organizations, and Veterans Service Organizations to purchase vehicles, including those compliant with the *Americans with Disabilities Act of 1990* (Public Law 101-336) to provide innovative transportation options for veterans in rural or highly rural areas traveling to and from medical treatment.

Unique to the HRTG program is the definition of "highly rural" as a location that contains no more than seven persons per square mile, which is a highly restrictive criterion. Other VA rural programs use the Rural-Urban Commuting Areas (RUCA) coding system to assess rurality. This

bill would expand eligibility by including veterans who reside in either rural as defined by RUCA, or highly rural areas as defined by HRTG.

Public transportation options, taxis, and ridesharing companies that urban dwellers take for granted are virtually non-existent in rural America, severely disadvantaging ill or injured veterans or those who do not drive or own a vehicle. This expanded program would satisfy a pressing need and ensure veterans could use their earned benefits regardless of where they live.

S. 800, Precision Brain Health Research Act of 2025

The VFW supports this legislation to advance critical research of brain injuries caused by repetitive low-level blast exposure and related conditions like dementia and pituitary dysfunction. This bill would expand VA research, strengthen data sharing between VA and the Department of Defense, and launch large-scale studies on evidence-based treatments, including the potential use of growth hormone replacement therapy, to improve diagnosis and care for affected veterans. It would also formalize collaboration with the National Academies of Sciences, Engineering, and Medicine to validate biomarkers and guide future action. The VFW has long advocated for protecting service members from preventable injuries and ensuring veterans receive the best possible care. This legislation is a vital step toward that goal.

S. 827, Supporting Rural Veterans Access to Healthcare Services Act

The VFW supports this legislation to extend and expand the VA transportation grant program. This program is designed to improve health care access for rural veterans and includes tribal organizations, Native Hawaiian organizations, and veterans from underserved communities. By enhancing transportation options, this bill would enable veterans to access VA health care facilities and travel to their appointments more easily, particularly those residing in rural, tribal, and remote areas. This legislation maintains the existing eligibility criteria and allows for reauthorization of the program every five years. Additionally, it promotes equitable access to care for underserved populations.

S. 879, Veteran Caregiver Reeducation, Reemployment, and Retirement Act

The VFW supports this legislation to expand medical, employment, and other benefits for individuals serving as family caregivers for certain veterans. When caregivers' services are no longer needed, they often require assistance to re-enter the workforce. For those who have left their careers to become full-time caregivers, providing proper training, counseling, and support for reintegration into employment is crucial. This transition period is when support is most needed. Employment assistance is a valuable service and should be prioritized when caregivers conclude their roles in the program.

S. 1318, Fallen Servicemembers Religious Heritage Restoration Act

The VFW supports this legislation that would facilitate identifying the several hundred graves of American-Jewish service members buried overseas mistakenly under a Latin cross. It would also confirm the decedent's religious affiliation enabling descendants to apply for a replacement

headstone without unduly burdening them with doing this painstaking research themselves. American-Jewish service members who fought and died for our country deserve to have their religious heritage properly recognized and honored. The VFW advocates rectifying this long-standing error to properly commemorate our war dead. An attractive feature of the bill is contracting with experienced nonprofit organizations rather than assigning the job to the relatively small staff of the American Battle Monuments Commission—the organization that administers, operates, and maintains these overseas cemeteries.

The large number of casualties and the chaos of war directly contributed to burials with inappropriate headstones. During World War I, more than 100,000 Americans fell abroad during the country's first large scale overseas combat deployment, and administrative errors were not uncommon. Complicating the situation during World War II, some American-Jewish service members who served in the European Theater deliberately concealed their religious affiliation to avoid torture or death if captured by the Nazis.

S. 1320, Servicewomen and Veterans Menopause Research Act

The VFW supports this legislation to address gaps in medical research and health care for military women and veterans who are experiencing menopause, perimenopause, or mid-life health issues. As more women serve in the military, the number of female veterans eligible for health care continues to grow. Women veterans have unique needs that should be considered throughout various stages of their lives. However, limited research on menopause and its effects restricts the development of effective treatment options and the training available for health care providers.

S. 1441, Service Dogs Assisting Veterans (SAVES) Act of 2025

The VFW supports this legislation to require VA to establish a pilot program to grant funds to nonprofit organizations to provide service dogs to eligible veterans. Service dogs can assist veterans who have various physical, visual, auditory, and trauma-related disabilities or conditions, and help them regain independence. The service dogs would be provided at no cost, along with veterinary insurance policies. This legislation would enable more veterans to receive these support companions.

S. 1533, VA License Portability Act

The VFW supports this legislation to permanently authorize license portability for contracted health care professionals to perform VA disability examinations. The disability examination system has evolved and expanded over many years. In 1996, VA established a pilot program to allow contracted physicians to assist with these examinations and granted temporary license portability. Since the fall of 2016, VA has transitioned from VA-conducted examinations in VA facilities to contracted examinations in non-VA settings for nearly all disability examinations. Exceptions are examinations that by law must be performed specifically by VA personnel. This legislation would build upon this program by making license portability permanent, and expanding the categories of eligible health care professionals authorized to conduct disability examinations pursuant to contract specifications. The resulting increase in available providers

would benefit all veterans by accelerating the initial stage of the disability claims process, and would be of particular assistance to rural and tribal veterans who often have few medical options near their homes.

S. 1543, Veterans Opportunity Act of 2025

The VFW supports this proposal to establish the Veterans Economic Opportunity and Transition Administration within the Department of Veterans Affairs. VA is comprised of three administrations—the National Cemetery Administration (NCA), Veterans Health Administration, and Veterans Benefits Administration (VBA). VBA oversees not only compensation and pension, but also the GI Bill, vocational rehabilitation, housing and business loans, and the broadly defined Transition Assistance Program, which is shared with the Departments of Labor, Defense, and Homeland Security.

The VFW believes our nation's focus on the economic opportunities of our veterans must be permanent. In reality, not all veterans seek VA health care when they are discharged, they do not need assistance from NCA, and they do not all seek disability compensation. However, the vast majority are looking for gainful employment, education, or training. Congress should recognize the value of these programs by separating them into their own administration focused solely on their utilization and growth.

The VFW has long proposed that Congress create a fourth administration under VA with its own under secretary whose sole responsibility is the economic opportunity programs. This legislation would permit the new Under Secretary of Veterans Economic Opportunity and Transition Administration to focus resources, provide a champion for these programs, and create a central point of contact for Veterans Service Organizations and Congress. This would ensure that the GI Bill, Veteran Readiness and Employment, home loan, and other benefits centered on economic opportunity receive the attention they deserve.

Chairman Moran and Ranking Member Blumenthal, this concludes my statement. Again, thank you for the opportunity to offer our comments on these issues.

STATEMENT FOR THE RECORD

Senate Committee on Veterans' Affairs

Full Legislative Hearing to Hear Pending Legislation

May 20, 2025
by the
Veterans Healthcare Policy Institute

Chairman Moran, Ranking Member Blumenthal, and distinguished committee members:

The Veterans Healthcare Policy Institute—a non-partisan research organization focused on veterans' healthcare and benefits—appreciates the opportunity to submit this statement regarding today's hearing on pending legislation. Our organization includes veterans, family members of veterans, and professionals and health care experts with extensive careers serving veterans through research, publication, testimony and journalism. We commend your leadership and dedication to ensuring veterans receive exceptional care both within the Veterans Health Administration (VHA) and, when necessary, through supplementary private sector services.

While 20 bills are under consideration today, we will focus our comments on the "Veterans Health Care Freedom Act" (S. 219), which aligns most closely with our expertise.

The "Veterans Health Care Freedom Act" would fundamentally transform veterans' healthcare by enabling unfettered access to private sector care. This legislation proposes a three-year pilot program covering approximately a quarter of the country that would allow all VHA-enrolled veterans to obtain hospital care, medical services, psychological services, and extended care through the Veterans Community Care Program (VCCP)—regardless of wait times or travel distances, and without VHA authorization. The VHA would be reduced to simply paying invoices, relinquishing its vital authorization, referral, and oversight functions. The program includes no utilization limits and would eventually expand nationwide after the pilot period.

The bill transparently aims to convert VHA from a world-class healthcare provider into primarily a funding source for private sector care. Its language ensures that every dollar spent on unlimited, unmonitored private sector care directly reduces VHA hospital and clinic budgets, stating: "No additional funds are authorized to be appropriated to carry out this section, and this section shall be carried out using amounts otherwise made available to the Veterans Health Administration." This approach would wind up depriving innumerable veterans of the high-quality care delivered by a system with decades of specialized expertise in treating veterans' complex health conditions.

The unprecedented diversion of essential VHA funding without supplemental allocations will force reductions in VHA clinical and support staff, specialized programs, clinics, and hospitals. This creates a dangerous downward spiral: as more veterans are pushed into community care, additional funding drains from VHA facilities, triggering further cutbacks. Independent healthcare experts warned last year that the VA system's very survival is already at risk if

runaway community care spending–growing 15-20% annually – isn't significantly slowed. This bill instead accelerated that spending.

The bill's author states that it will "provide veterans with greater autonomy to access the care they need." But that's not really the case for most veterans. When VHA programs, units, clinics, and facilities close due to diverted funding, veterans will face fewer—not more—healthcare choices. This particularly impacts millions of veterans with service-connected conditions who rely primarily or exclusively on VHA care. Many live with catastrophic war-related injuries, including lost limbs, traumatic brain injuries, and toxic exposures that civilian providers are ill-equipped to address. These veterans will lose the autonomy to choose VHA care when the specialized program choice they depend on disappears.

Under this insurance-model transformation, the VHA's unique and essential elements would gradually fade: integrated team-based care, comprehensive prevention screenings, wrap-around services, veteran-centric specialization, homelessness initiatives, VA registry enrollment, specialized provider training, and critical research on veterans' conditions.

By allowing veterans to use private providers without VA authorization, referral, or oversight—with the VA merely paying the bills—this legislation invites profit-driven overutilization. No other healthcare system or third-party payer operates without utilization review because such a model is financially unsustainable.

The bill's author states that it will "improve veterans' access to health care." However, it will not decrease the time or distance faced by veterans accessing care. Currently, veterans who must wait 20/28 days or travel 30/60 minutes for VHA care are eligible for VCCP care. If the VA turns into an insurance agency and reduces direct care, veterans will be cast out to locations where there are long-standing shortages in primary, mental health, inpatient and emergency care providers. Half of U.S. counties, and 80 percent of rural counties, lack even a single psychiatrist. Nearly 200 rural hospitals have closed, with over 700 more–a third of all rural hospitals nationwide–on the brink of collapse.

When unfettered community care was first proposed in 2016, calculated annual costs ranged from $96 billion to $179 billion. Present day figures would likely be substantially higher, making a Congressional Budget Office score for this bill urgently necessary.

We respectfully thank you for the opportunity to provide our perspectives on these essential matters. We look forward to working with the committee to ensure that veterans can receive timely, high-quality compassionate care in the VHA and the community now and in the future.

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