S. HRG. 119–334

LEGISLATIVE PRESENTATION OF THE AMERICAN LEGION AND MULTI VSOs: PARALYZED VETERANS OF AMERICA, AMVETS, NATIONAL ASSOCIATION OF STATE DIRECTORS OF VETERANS AFFAIRS, WOUNDED WARRIOR PROJECT, TRAGEDY ASSISTANCE PROGRAM FOR SURVIVORS, NATIONAL GUARD ASSOCIATION OF THE UNITED STATES, MISSION ROLL CALL

JOINT HEARING

OF THE

COMMITTEE ON VETERANS' AFFAIRS

BEFORE THE

UNITED STATES SENATE

AND THE

HOUSE OF REPRESENTATIVES

ONE HUNDRED NINETEENTH CONGRESS

SECOND SESSION

MARCH 4, 2026

Printed for the use of the Committee on Veterans' Affairs

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WEDNESDAY, MARCH 4, 2026

U.S. SENATE, AND
U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The Committees met, pursuant to notice, at 9:45 a.m., in Room SD–G50, Dirksen Senate Office Building, Hon. Jerry Moran, Chairman of the Committee, presiding.

Present from the Senate:

Senators Moran, Boozman, Cassidy, Tillis, Tuberville, Banks, Sheehy, Blumenthal, Murray, Hassan, King, Gallego, and Slotkin.

Present from the House:

Representatives King-Hinds, Takano, Pappas, McGarvey, Conaway, and Morrison.

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

Chairman MORAN. [Raps gavel three times.] Good morning. [Laughter.] What did we do? Commander, I need an explanation. What did I do wrong?

[Laughter.]

Mr. WILEY. You rapped the gavel and for us, that is to stand three times.

Chairman MORAN. Ah.

[Raps gavel again.]

Chairman MORAN. There is a fourth one.

[Laughter.]

Chairman MORAN. Thank you for the explanation. With the sound of the gavel, I call this hearing to order this morning. Good morning and welcome to everyone. I would like to thank Chairman

Bost along with Ranking Members Blumenthal and Takano and the rest of the Senate and House colleagues for joining us here today in this year's final joint hearing between the House and Senate Committees on Veterans' Affairs in this year, 2026.

And I want to specifically welcome Commander Dan Wiley and his wife Sonia from my home State of Kansas, along with the leaders of the other veterans service organizations who will be testifying later this morning.

I also would like to extend a special hello, as my colleagues will do for their home states, but particularly today with Commander Wiley as the lead witness today, I want to express my gratitude to the Kansans who are present here, who are watching at home, and who have been in my office numerous times, including this week. I appreciate the Kansans' presence in the room and I am grateful for my relationship I have with American Legion members from across my state.

I am grateful for the work that veterans service organizations do every day to support veterans and their families, caregivers, and survivors to advocate for timely, high-quality health care and benefits that they have earned and deserve.

The work we do in our Committees, in these Committees, would not be possible without the tireless work and dedication of organizations like the ones here today and the ones we will be hearing from this morning. I look forward to hearing from Commander Wiley and his fellow veteran leaders how your legislative priorities advance veteran success and what more these Committees, the Committee that I chair and the others, can do to make certain that VA policies translate into real improvements in the well-being of veterans we are all here to serve.

With the Commander from Kansas's presence, I would like to take a sidenote and express my appreciation and gratitude for everyone's service. I am not a veteran. This is not what I normally say at a hearing in this room. I was in high school when Vietnam was occurring. I watched what happened when you, those who served in Vietnam, returned home and how they were treated. If you are a year older than I am, and certainly if you are two years older than I am, you served in Vietnam. And I saw how my classmates at home in Kansas were treated upon their return to the United States shores following their service, their honorable service in Vietnam. And I told myself, as a 16-year-old kid, I am going to do everything I can to pay my respects and honor those who served.

I never expected, fellow Kansans, to ever be a Member of Congress, to serve in the House of Representatives, to serve in the United States Senate. And with that responsibility of that service came doing something more than just saying thank you. Something comes more than just saying I respect you.

So I take it seriously, as do Members of this Committee, Members of the Senate, Members of the House of Representatives, Republicans and Democrats, we take it seriously to try to make certain we do the things that keep our promises to those who served in Vietnam and those who served elsewhere, around the globe and in the United States.

So I am honored to have the opportunity to be here with a fellow Kansan, now the National Commander of the American Legion.

I yield to the Ranking Member, Senator Blumenthal, for his opening statement.

OPENING STATEMENT OF HON. RICHARD BLUMENTHAL, RANKING MEMBER, U.S. SENATOR FROM CONNECTICUT

Senator BLUMENTHAL. Thank you, Mr. Chairman, and thank you to Commander Wiley and the American Legion leadership who are here today. I am a proud member in Connecticut, and I know we have some Connecticut members here. Welcome to you and thanks for visiting with me yesterday. Your perspectives and your advocacy are invaluable to what we do. You are the reason that we have the PACT Act today, just to take one example.

Yesterday I went to the floor of the United States Senate and asked for unanimous consent to pass the Major Richard Star Act.

[Applause.]

Senator BLUMENTHAL. Unfortunately, it was blocked. I asked, as a fallback, for a simple vote on the bill before August. It was blocked, as well. The individual Senator blocking unanimous consent is part of a small minority in the United States Senate. The vast bipartisan majority of my colleagues support the Richard Star Act, because they know it is unacceptable that tens of thousands of combat-injured veterans are denied the full military benefits they deserve.

The Chairman just talked about promises. Promises are meaningless unless they are kept. We made a promise to these veterans that they would receive both retirement and disability benefits. We owe them both, and I promise you, I will not stop fighting until we pass the Richard Star Act in this Congress.

[Applause.]

Senator BLUMENTHAL. And I want to add that support for it is bipartisan. I thank the Chairman, Senator Moran, for his support, as well as others on this Committee, including the House Ranking Member, Mr. Takano.

Yesterday *The New York Times* published an article entitled "Despite Promises, Veterans Affairs Department Cut Thousands of Roles for Doctors and Nurses." In fact, thousands of positions have been left vacant. The numbers of doctors and nurses, physicians, has declined by significant percentages, which is a disservice to all of you here and the many, many veterans around the United States who depend on the VA for their medical care.

At our hearing last month, Secretary Collins said the VA needs more doctors, and yet he has eliminated thousands of physician jobs.

We need your help. We need your advocacy. We need your voices and your faces, which is why it is so important you are here today, so that we can maintain, restore, and even grow the numbers of doctors, nurses, counselors, psychiatrists, all of the team at VA health care that is so important to making sure that we have sufficient workforce to serve the needs of our veterans. Our veterans deserve nothing less than the best world-class medicine. Thank you all for being here today.

Chairman MORAN. Senator Blumenthal, thank you. Representative Takano, the Ranking Member.

OPENING STATEMENT OF HON. MARK TAKANO, RANKING MEMBER, U.S. REPRESENTATIVE FROM CALIFORNIA

Mr. TAKANO. Thank you, Mr. Chairman. Good morning, everyone. It is truly great to see all of you here, ensuring that my fellow Members of Congress and Americans tuning in from the country hear directly from you. So I thank all the veterans who have traveled here today, including those who have made the trip from my home State of California. Where are you?

[Cheers.]

Mr. TAKANO. Thank you, California. Welcome. And welcome to everyone from the American Legion. I would especially like to welcome American Legion National Commander Dan Wiley of Kansas. Mr. Wiley, Commander Wiley, you and I have had personal conversations about how I actually spent time in Lawrence, Kansas, one summer, so welcome.

Auxiliary National President Pam Ray of Illinois, and Sons of the American Legion National Commander Bill Clancy of New York, and I offer a hearty welcome to the representatives from all of the organizations on our second panel of witnesses. Very good to see all of you, and I look forward to engaging in an enlightening conversation.

Just two weeks ago, Secretary Collins published an interim final rule to cut veteran disability compensation benefits for veterans whose service-connected conditions were improved by medication. Thanks to a public outcry from VSOs, Members of Congress, and many of you here today, Secretary Collins paused enforcement and eventually rescinded the rule. Senator Blumenthal and I led the effort here in Congress against this rule, but our Republican colleagues were unwilling to join us. Protecting veterans' benefits should be a bipartisan issue, and my colleagues across the aisle should be willing to stand with us in holding VA accountable when veterans and their benefits are on the line.

In addition to the Secretary's harmful interim final rule, VA is also carrying out a massive—massive—reorganization of the Veterans Health Administration. This reorg effort warrants bipartisan oversight—oversight. Now, VA does need improvement. No doubt about that. But VA leadership appears to be trying to align VA with developments in for-profit health care.

VA is not a business, and it should not mirror business models. Following that business mindset, this VA aims to, quote, "do more with less," end quote. Now, that approach has never really served veterans, in my opinion, and the data suggests VA is already struggling with the less. *The New York Times* reported yesterday that VA cut thousands of clinical positions that were filled before the Administration and DOGE started pushing staff out. VA told us that these were unneeded COVID-era positions. But VA's own damning data tells us that that is not true.

As was reported by *The New York Times*, about 73 percent of the 10,500 vacant positions VA just eliminated were filled just sometime in 2025 or 2026, well after the COVID era. These were recent vacancies, and rather than filling them, Secretary Collins just

wiped those clinical positions off the books, clinical positions that the medical centers said that they needed.

Expanding care and benefits for veterans requires people, doctors and nurses, claims processors, social workers, researchers, police officers, and support staff. All these roles help VA fulfill its mission.

I know each of you sees the value in securing veteran care and improving the VA because each of you has served, and today you continue to serve your fellow veterans and their survivors. When you raised your hand and put on that uniform, you set yourself apart. That commitment came when our Nation promised that you and your family would be taken care of afterwards. You fulfilled your duty. We must fulfill ours.

We sit here just days after President Trump committed our Nation's most precious resource, our young men and women in uniform, to another conflict. Several servicemembers have already been killed or wounded. Our servicemembers are carrying out difficult and dangerous missions far from home. They deserve the full support of a grateful nation. That support cannot end when they take off the uniform.

So I ask, has this Administration planned and budgeted for the long-term costs of this conflict? Is VA prepared to provide a lifetime of medical care, disability compensation, mental health services, prosthetics, and caregiver support to the new generation of wartime veterans?

President Trump and this Republican Congress have added $150 billion for the Department of Defense in the so-called "Big Beautiful Bill," but it did not include a cent for VA. If this Administration is willing to send Americans into harm's way, it must be willing to fully fund and strengthen the VA system that will care for them for decades. That means passing the Caring for Survivors Act. That means passing the Love Lives On Act. And that means passing the Major Richard Star Act, as well.

[Applause.]

Mr. TAKANO. Just a little bit of history. I was Chairman of the House side of the Committee when I passed the Vietnam Blue Water Navy Bill out of the House for the second time, unanimously. And why I had to do it a second time is that the previous Chairman, a Republican Chairman, passed it also. I think it was unanimous, as well. But procedures in the Senate blocked it. Just a couple of Senators ran out the clock at the end of that session.

And look, the politics in both houses, it is procedure that is stopping the Major Richard Star Act. It is the will of the majority of both houses of Congress, and I will be damned if we allow procedure to stand in the way of passing the Major Richard Star Act, and you should be damned as well. Keep the pressure on.

And with that, with that belief, Senator Blumenthal yesterday went to the floor to ask for a vote on this bill, and shamefully it was blocked. Procedure again. In objecting to a vote on the Major Richard Star Act, Senator Ron Johnson of Wisconsin lamented how much it would cost, arguing that we needed to prioritize funding for ongoing defense capabilities. I say this is unconscionable. We are talking about compensation for combat-injured veterans. This is a cost of war. And as we sit here watching the President drag

us into another conflict, we must reckon with the long-lasting impacts it will have on our servicemembers, our veterans, and their families.

Paying for the true cost of war means investing in VA now!

Mr. Chair, I thank you for bringing these organizations before us today, and I look forward to frank and fruitful discussions, and I thank you, and I yield back.

Chairman MORAN. Ranking Member Takano, thank you.

INTRODUCTION BY HON. JERRY MORAN, U.S. SENATOR FROM KANSAS

Chairman MORAN. I now have the honor of introducing a Kansan and a friend, the National Commander of the American Legion, Mr. Dan Wiley. Dan, of course, has a long history of serving veterans, particularly those in the neighborhood of his hometown, Leavenworth, Kansas. He has also been a trusted advisor to me on issues impacting veterans at home and across the country.

Dan served his nation in the United States Air Force, and following his service he obtained a law degree from the University of Kansas. He told me this morning he is a K State fan. He used all his skills as an attorney to establish the Leavenworth County Veterans Treatment Court. He was a district court judge in the State of Kansas, and he used that opportunity to find a new way to care for veterans who appear before his and other courts in Leavenworth and across our state.

During his service with the Legion, Dan has pretty much done it all. He has held 24 different positions within the American Legion, making certain that veterans have a friend who will listen to them and advocate for them. I have seen that in my own circumstance at pancake feeds and American Legion events in my hometown and across the state as he has been there for every veteran of our state.

Dan, like many veterans, has faced his own challenges and hurdles in his life. After service, but rather than hide or shy away from the challenges, he has shared them openly, letting veterans know that they are not alone. I respect Dan for being vulnerable and honest about mental health and using his experience to reach out to veterans.

As National Commander he is a strong advocate for the American Legion's "Be The One" campaign, to prevent veteran suicide. Thank you for working to extend hope to veterans who are struggling with their mental health and helping reduce the stigma around asking for help.

Outside the American Legion, Dan is very involved in his community back home, where he has worn many different hats, helping organize and be the master of ceremonies at the Leavenworth County Veterans Day Parade, to serving on his local Board of Education.

Commander Wiley, you have been a friend to me and a friend to veterans, and I have no doubt that your vision and experience is strengthening the mission of the American Legion and making certain that the voices of veterans are heard and that their needs are met with honor and with respect. I thank you for those things. I thank you for your dedication to serving veterans in Kansas and

across the country and for being here to testify today. I appreciate your family's sacrifice for your service in this capacity, and I look forward to working together on our shared mission of improving the lives of veterans across the country and back home in our home state.

With that, Commander Wiley, you are now recognized.

PANEL I

STATEMENT OF DAN WILEY, NATIONAL COMMANDER, THE AMERICAN LEGION ACCOMPANIED BY JOSEPH SHARPE JR., DIRECTOR, VETERANS EMPLOYMENT AND EDUCATION; PAUL ESPINOZA, CHAIRMAN, VETERANS EMPLOYMENT AND EDUCATION; MARIO MARQUEZ, EXECUTIVE DIRECTOR, GOVERNMENT AFFAIRS; COLE LYLE, DIRECTOR, VETERANS AFFAIRS AND REHABILITATION; LINDEN DIXON JR., CHAIRMAN, VETERANS AFFAIRS AND REHABILITATION; AND MATTHEW JABAUT, CHAIRMAN, NATIONAL LEGISLATIVE COMMISSION

Mr. WILEY. First, thank you, Senator, for that kind introduction. Thank you, Chairman Moran, Ranking Member Blumenthal, Chairman Bost, Ranking Member Takano, and distinguished Members of these Committees. On behalf of the 2.5 million members of the American Legion family, I appreciate the opportunity to discuss our legislative priorities for the second session of the 119th Congress.

I would like to begin by introducing the members of the American Legion family here with me today. Please stand if you are able as I recognize you. Our National Officers serving with me this year, please stand. Our past National Commanders, please stand. Pam Ray, National President of the American Legion Auxiliary; William Clancy III, National Commander of the Sons of the American Legion; and my daughter, Christy, my son, Austin, and his wife, Jesse, with their son and my grandson, Noah. And of course, the most important person in the room, without a doubt, my wife Sonia. Thank you.

[Applause.]

Mr. WILEY. Our written testimony contains our complete list of legislative goals, and they are all important. With limited time, however, I will focus on several critical issues.

This is a pivotal time for our country. Recent military action reminds us of the cost of service, shouldered by a shrinking minority of American families. In our all-volunteer force, military service has become a family business. And while average time in uniform is just 4 to 8 years, the costs can potentially last a lifetime. And as we mark the 250th anniversary of our Nation's founding, it is essential we examine those costs and make sure they are **paid in full**.

That is precisely why Congress chartered the American Legion after World War I, to promote a strong national defense, encourage civic education, and to create a community of veterans to support one another, whose voices are heard by our Nation's leaders. Since 1919, the Legion has been instrumental in landmark changes, like

the GI Bill, creation of the modern VA, appeals modernization, and the MISSION Act. We created programs like the American Legion Child Well-being Foundation, legacy scholarships, and Boys Nation. Our mission, every single day, is to serve those who served us.

At the post level, legionnaires serve their communities in times of crisis. Just last year, after the tragic floods in Kerrville, Texas, Legion Post 208 provided urgently needed resources for those who had lost everything, and served as a relief point for aid workers who came from across the country.

American Legion service officers assist veterans with disability claims, and in 2025 alone, processed $29.5 billion in claims for veterans. This was free of charge, regardless of whether they were members of the American Legion or not.

Nationally, we partner with VA on the Buddy Check Week, and our Be The One campaign to reduce stigma, provide critical training, and ultimately save lives. Our System Worth Saving (SWS) and regional office actuary review programs provide policymakers with on-the-ground feedback regarding health care and benefits. And we have continued to work with Congress to ensure that while the Administration seeks bold change, there is no reduction in accessibility of services and benefits to any veteran or their family.

Just two weeks ago, the American Legion spoke against a proposed rule that would change the way VA rates a veteran's disability based on medication management. We were glad to see Secretary Collins listen to the veteran community and ultimately rescind the rule. We will remain vigilant, and we will give you all of our feedback on what is working and what needs to change.

The Legion's number one priority is ending veteran suicide. VA estimates more than 17 veterans die every day by suicide. Traditional approaches to this problem, pills and therapy, have objectively not worked. We need stronger transition programs, innovative therapies, and improved safeguards to medication management. That is why we support things like the Fox Grant Program, the BEACON Act, the Written Informed Consent Act, and other bills that seek to address this problem. It is also why, after a decade of legion advocacy, I was proud to be in the Oval Office as the President signed an Executive order reclassifying cannabis as a Schedule III drug. This allows for Federal research on how it can reduce drivers of suicide. The American Legion does not support use of illegal drugs, but we strongly support research that could result in new, effective treatments.

An important part of suicide prevention, and ultimately VA's core mission, is access to timely, quality health care. And while most veterans prefer to receive from VA their care, because it is a one-stop shop, community care has exploded since the passage of the MISSION Act. Congress must provide the necessary funding to ensure the VA system remains strong, without curtailing a veteran's access to community care if it is in the veteran's best interest. It is a difficult balance, but one we are committed to helping Congress achieve. Ultimately, veterans should get the care they need, when they need it. But we must remain the center of all veteran health care in the VA.

As we discuss VHA reorganization, the Next-Gen Community Care contract, and acceleration of electronic health record deploy-

ment, Congress must also address aging infrastructure and give the VA authorities and funding it needs to compete with the private sector job market.

As we all know, the veteran population is changing, and so are its needs. Women veterans, the largest-growing subpopulation in our community, experience homelessness, depression, infertility, migraines, and other issues at a higher rate than their male counterparts. This is attributed to military sexual trauma and domestic violence. Congress should pass legislation to improve research on how issues unique to women veterans, including menopause, affect outcomes, and increase the availability of gender-specific rehabilitation programs.

Enabling veterans to thrive in a civilian life is a huge task. Congress can make it easier by ensuring our servicemembers do not experience financial uncertainty prior to separation. When I served in the United States Air Force, I never worried about getting paid on the 1st and the 15th of the month. But as government shutdowns become more frequent, that is no longer guaranteed. Not long ago, the Legion provided over $1 million in grants to Coast Guard families because Congress failed to do its job and ensure they were paid on time. We need iron-clad protections to ensure uninterrupted pay for all servicemembers in our all-volunteer force.

Finally, consider Major Richard Star, who deployed multiple times and was diagnosed with lung cancer linked to burn pit exposure. Before his death, he endured the indignity of a wounded veteran's tax, an offset of his disability compensation against his pension because he was medically retired before 20 years. **This is wrong**.

[Standing ovation.]

Mr. WILEY. Collecting both benefits is not double dipping. Retirement is for time served. Disability compensation is for harm caused during service. Congress must pass the overwhelmingly supported, bipartisan Major Richard Star Act.

[Loud applause.]

Mr. WILEY. Chairmen Moran and Bost, Ranking Members Blumenthal and Takano, and Members of the Committees, the way America treats its veterans directly influences whether the next generation raises the right hand to define our 250-year legacy. On behalf of the entire American Legion family, thank you for this opportunity to share our priorities, and my staff and I welcome your questions.

[Applause.]

[The prepared statement of Mr. Wiley appears on pages 55–93 of the Appendix.]

Chairman MORAN. National Commander, thank you for your testimony. We will now turn to questions of you and your colleagues at the desk.

The Richard Star Act, let's start there, for my first question. Would you share perhaps a member's experience, a real-world example of a veteran and their family who would directly benefit if the Major Star Act was passed? Explain how it would change the quality of their life. Give us an example of why it matters.

Mr. WILEY. Thank you, Senator, and without naming the individual, you and I both know an individual that suffered harm while he was on active duty. He was in a Ghillie suit and he was burned by that active-duty service, and because of that was medically retired. So he receives that medical retirement for that time in service. Also, you would not find surprising because of the burns on his body he was entitled to disability compensation for the harm caused. However, because of the fact that he did not have the 20 years in time and service he has to waive dollar-for-dollar his retirement for the disability compensation he receives. And quite obviously, this takes funds away from his family that would benefit his family for a lifetime, and he has got a lifetime of care and a lifetime of loss as a result of those injuries.

I appreciated the opportunity last month, as I said in your office, and we talked about the Major Richard Star Act. And you know me, I am probably more passionate than I am articulate. But to that extent it just frustrates me that Congress cannot get this passed, when we have 316 members in the House that have signed on, and approximately 75 members in the Senate who have signed on, and yet we cannot get it to a vote on the House floor. The buck stops with leadership. They need to get a vote on this, up or down, because our veterans are entitled to know whether your Congressman supports our disabled and wounded veterans or your Congressman is against us. That is what we believe we are entitled to a vote on this, on the House and Senate floor. Thank you.

Chairman MORAN. Commander, thank you for answering my question. I would use this moment to again, as I told you in our office when we last visited, that I am committed to trying to do everything I can to accomplish that. Folks in this room probably know, but should know, the jurisdiction of this bill does not rest with the Committee on Veterans' Affairs, it rests with our Armed Services Committee. But we are working with the leadership of the Armed Services, I am working with the leadership of the Armed Services Committee to find a path forward. And I spoke yesterday on the Senate floor about this topic, and I have also spoken to my colleagues in the Senate, that there is no opportunity for the sponsoring of a bill that you are not willing to vote for when the time comes. Sponsoring is insufficient. We want you to do that. But if the time is right, we want to make certain that the votes occur, and there is no hypocrisy demonstrated by Members of Congress.

You mentioned community care. It is a topic that I have significant interest in. In large part, when I was a Congressman, I represented a congressional district the size of the State of Illinois. Not a VA hospital in that congressional district, and distance was often the enemy of a veteran in being able to access quality care at the VA.

Would you elaborate on—well, let me again say that American Legion is a strong supporter of the ACCESS Act, that Senator Blumenthal and I are trying to work out our differences to see that we get it passed. Would you explain to the Committee the importance of the ACCESS Act and why the American Legion is supportive?

Mr. WILEY. Absolutely. Thank you, Senator Moran, for that question. Community care is obviously important for our veterans. Most

of our veterans, as I said in our opening remarks, are very happy with the care they get at the VA, and they prefer that. But as you know, just like Kansas and much of this country, there is a lot of distance between VA hospitals. You are in western Kansas you might be four hours from a VA hospital, so we have transportation issues. We have issues with regard to obtaining care from a specialist. And ultimately, we believe that the veteran should receive the care that is in their best interest, and we believe that this ACCESS Act will provide more oversight. We need to continue to have VA oversight of community care, but community care is obviously important for the best interest of our veterans. Thank you.

Chairman MORAN. I recognize Ranking Member Blumenthal.

Senator BLUMENTHAL. Thank you, National Commander, for calling attention to some of the most pressing needs of our veterans. Obviously, the Richard Star Act is a priority for me, not only as the Ranking Member of this Committee but also as a member of the Armed Services Committee. And you have correctly identified where the point of persuasion has to be with the leadership, the leadership of the United States Senate and the House of Representatives. So I urge every member here, if you think the Richard Star Act ought to be passed, contact the leadership of the United States Senate. And again, I thank Senator Moran for his advocacy and his support.

I want to call attention to your advocacy on behalf of women veterans. As you say in your testimony, "they are the fastest growing cohort of veterans." They are serving right now in harm's way in the Middle East. Tragically, one of the fallen is a woman National Guard member. We owe them the same kind of health care and compensation benefits that our male veterans receive.

What kinds of specific measures, if you could talk about them, would you advocate to expand the service that we provide to our women veterans?

Mr. WILEY. Thank you, Ranking Member Blumenthal, for that question. And again, I appreciate your time as we had an opportunity last month in your office to discuss these very issues, and I know they are of concern to you.

Obviously, the women veterans is the single biggest growing demographic. And I can tell you that VA care has improved significantly in the 30-plus years I have been a member of the American Legion. I have visited VA hospitals throughout this country. We now have hospitals—not all; we need to do a lot more—that have separate entrances, for example, for women veterans. And I know there are a lot of bills that impact women veterans, so I am going to ask our Veteran Affairs and Rehabilitation Director, Cole Lyle, to expand on that answer.

Senator BLUMENTHAL. Thank you.

Mr. LYLE. Thank you, Commander, and thank you, Ranking Member Blumenthal. The American Legion has publicly supported the SAVES Act, which would expand the evidentiary standard for VA to be able to consider non-VA evidence, lay statements, nexus letters, things like that, in disability process claims. As the Commander alluded to, infrastructure at a lot of VA facilities, specific for women veterans, residential rehabilitation programs, secure

areas in VA facilities for them to feel safe if they have experienced military sexual trauma or intimate partner violence.

Also, Congresswoman Brownley has a bill to expand research on menopause. There is not a lot of evidence. There is a lot of anecdotal evidence. There is not a lot of research on menopausal links to certain things that drive suicide. And as we know, women veterans experience suicide at a much higher rate than their civilian counterparts.

Senator BLUMENTHAL. That is a great answer, and I want to just volunteer my services, my office, on this issue and others that you have raised, Commander, most especially the continuing scourge of veteran suicide, the need to expand the PACT Act, the importance of recognizing the next generation of toxic exposures, very, very important.

And I want to just commend the American Legion for a program that is very close to my heart. In Connecticut, and I do not know how many of the other states have it, we have a Boys State and Girls State program, which fosters future leadership. Young people are chosen—it is a very competitive program—to participate in a nearly weeklong series of sessions, in usually it is a school location. They live in dormitories. They participate in mock Senate and House sessions. I think their conversations are considerably more erudite and informed than I often find around here.

But I just want to say to the American Legion, providing the role models, fostering the leadership, is so important. We need to develop our future veterans. My son, who served in the United States Marine Corps, as an infantry officer in Afghanistan, my other son, who served as Navy SEAL, had you as role models. And they, in turn, will be role models for others. But you, in the American Legion, whatever your age, are role models for our future leadership. Thank you for being there for our great country. Thank you.

Chairman MORAN. To what office were you elected at Boys State?

Senator BLUMENTHAL. I did not participate, but my sons did, and it had an impact on them.

Chairman MORAN. I am quite certain I was never a Senator at Boys State. Representative Takano.

Mr. TAKANO. I was at Boys State California. I did not get elected to anything, either.

[Applause.]

Mr. TAKANO. Commander Wiley, one thing that I have heard loud and clear from the veteran community this month is veterans should never be punished for following medical advice. When VA issued changes to how medication effects would be treated in disability evaluations, did the Legion receive advance notice or a chance to weigh in?

Mr. WILEY. Thank you, Ranking Member Takano, and again, I appreciate your time and having the opportunity to meet with you last month. The simple answer is no. But I will also tell you that was an aberration for this Administration and the VA, because we have been fortunate enough in the American Legion to have been advised of most things. But we were not advised of this, and if we had been we would have told them exactly what we told them in the end, and that it was a terrible idea. So we are glad they rescinded it. But thank you.

Mr. TAKANO. Thank you. Do you think VSOs like the American Legion should be brought in early before policies are rolled out, so that they are not surprised and trust is not shaken?

Mr. WILEY. Absolutely. The veteran community is entitled and needs to be heard, yes.

Mr. TAKANO. There are several important bills pending that would radically improve benefits for veterans, their families, and their survivors, like the Major Richard Star Act, or Representative Hayes's Caring for Survivors Act. Commander, you have been very clear that these are earned benefits, not favors. I see you are nodding your head. On bills like the Major Richard Star Act and survivor reforms, do you agree that Congress should not force veterans or survivors into a tradeoff where one group's earned benefit is paid for by cutting another group of veterans' benefits?

Mr. WILEY. Yes.

Mr. TAKANO. Do you think Congress should put the burden of paying for veterans benefits increases on other veterans or on the American people as a whole?

Mr. WILEY. No, not on other veterans.

Mr. TAKANO. Not on other veterans.

Mr. WILEY. There is an obligation to pay for what a veteran has earned, and that is incurred at the time of service and they time they were put in harm's way. So yes, the American people and the American government, when they do that they have an obligation, but it should not be put on the shoulders of other veterans.

Mr. TAKANO. Thank you. That was the point. I think the American people are very much willing to honor the obligations that we made to them.

Commander Wiley, I sponsored the PACT Act, which has certainly helped many veterans gain access to VA benefits and health care that they have earned through their service. But even as we were writing the PACT Act, we knew that the PACT Act was only a step and that there would be more work left to do in the future. Where should Congress push next, and what exposures or cohorts are most urgent to address a PACT Act follow-on?

Mr. WILEY. Thank you again, Ranking Member Takano, and obviously the PACT Act, when it was passed, there is a mechanism in there for identifying future toxins that has not been adequately used. But to further elaborate, I am going to call on our VA&R Director, Cole Lyle, to answer.

Mr. LYLE. Thank you, Commander, and I see time is short so I will try to be brief. Yes, the mechanism that the Commander was talking about existed because Congress did not want to have to legislate individual presumptive conditions going forward. That process has been slow, and sometimes the process has been opaque. So I think if there were mandatory timelines requiring VA to review prospective presumptive conditions within, let's say, 180 days, mandate some sort of external review if presumptives were removed or an external review right after they were finalized, and then codify that presumptives could probably only be removed if there is overwhelming evidence that contradicts the existing science that was used in the approval process.

Mr. TAKANO. Well, is the Secretary fully leveraging the authorities granted by Congress to establish new presumptives, in your view, or could he be more assertive?

Mr. LYLE. I think Secretary Collins and the VA, as I said, there are some conditions, that particularly like with K2 veterans, Red Hill, that could be advanced more quickly.

Mr. TAKANO. What would be more helpful, faster presumptive decisions, clearer transparency on where conditions are in the process, or better access to exposure record so veterans are not left guessing?

Mr. LYLE. Sir, I would say all three. I think the DoD, the ILER, the Individual—I am forgetting what the acronym stands for—but basically the individual record of exposures to servicemembers while they are on active service, that the DoD could track and then give to VA. That was supposed to be made available, I think, a year ago, and we are still waiting on that. There are definitely things that could improve in that process.

Mr. TAKANO. Well, thank you. I yield back, Mr. Chairman.

Chairman MORAN. Senator Tillis.

HON. THOM TILLIS,
U.S. SENATOR FROM NORTH CAROLINA

Senator TILLIS. Thank you, Mr. Chairman. Thanks, everybody, for being here today. I always like it when my colleagues ask for people that are from California or whatever state. I would like to know if we have got anybody here that either is from North Carolina or spent a little quality time there in your past, if you will please raise your hands.

[Hands raised.]

Senator TILLIS. There you go. First off, an explanation on the bolo. The Lumbee Tribe in North Carolina got recognized after 137 years of racism, neglect, and more recently as a target of the casino cartels. The reason I wear this today is because they have disproportionately, in spite of all those challenges, they are among some of the most courageous and disproportionately represented people in Armed Services in the State of North Carolina. So I am looking forward to them, now that they have been federally recognized, putting a mark in Lumbee and Robeson County focused on veterans and all those great Native Americans that have served this country, in the same way that you did. Thank you for your service.

You know, as I was looking at the written testimony and my staff this week, I was trying to think of what I can do in my remaining time here. It is 305 days. Now, some people think I am counting the days before I am out of here, but I am a project person, and I am always mindful of how much time I have left in my budget. So as a U.S. Senator I have got 305 days to do everything I can to help you guys.

One of the ways I want to help you is by having a frank conversation about how we address all the things the Commander has outlined, but not kill you with kindness. Because what we do here a lot of times is we rush to pass a bill, and we get it and we high five, and then about a year later we come back and figure out why it has failed to be executed properly.

And quite honestly, I will give you the best example of that. You all know that I voted, in spite of being an original co-sponsor, and in spite of having the TEAM Act and the Camp Lejeune toxics being written out of my office and promoted, I voted against the PACT Act. And the reason I voted against the PACT Act, even knowing that it was going to pass by overwhelming majorities, is because I thought we were going to come up short on the execution. And that, by God, is exactly what has happened.

So one of the things that I hope to do in my remaining time here, and my time is short on these comments, is to try and convene a meeting to figure out how we can get to all these priorities, past and future, Mr. Commander, but do it in a way that is honest, that is instructed by the reality of resources that we have here, to make sure that we can have maximum impact on you all. And not only kind of fulfill the promise by passing a law, but true to the state motto of North Carolina—it is Esse quam videri—it says "To be, rather than to seem." Instead of seeming to support you all by passing bills that get caught up in execution, I want to be somebody that helps you do that in my remaining tenure in the Senate.

So you will be getting a call from me, and we will get other veterans service organizations together, and we are going to figure out how to make the most out of the 305 days I have left to begin to make an installment on a debt we will never repay. Thank you.

Mr. WILEY. Thank you, Senator Tillis, and I will tell you, me and my staff are more than happy to contact with your staff and work together to accomplish just that.

Senator TILLIS. Thank you.

Chairman MORAN. Senator Tillis, thank you. Representative Pappas.

HON. CHRIS PAPPAS,
U.S. REPRESENTATIVE FROM NEW HAMPSHIRE

Mr. PAPPAS. Thank you very much, Mr. Chairman. Commander, thank you so much for your testimony here today, and I want to thank everyone from the American Legion family who is joining this hearing. Thank you for your service and sacrifice. It does not go unnoticed by Congress, and we certainly owe you all a debt, and have to work to repay that. And I think you have given us an important roadmap of how we can pursue our obligations to the veteran community and our Nation.

Thank you for highlighting veteran suicide as your number one priority. It is on the minds of every veteran I talk to in the State of New Hampshire, and a shout-out to all those from the "Live Free or Die" State of New Hampshire who are joining this hearing today.

I want you to know that this is important, and we need to focus on the kinds of alternative therapies that can help veterans manage pain and ensure that they are living with a high quality of life. We have got legislation called the NOPAIN for Veterans Act that can help reduce reliance on opioid-based treatments for veterans. And I am just wondering if you can kind of evaluate how we are doing at opening up the doors to some of these alternative therapies that can result in a better quality of life and less reliance on opioid-based medications.

Mr. WILEY. Thank you, Representative Pappas. I appreciate that question. It is no secret that far too long doctors have prescribed opioids, which are destructive and addictive, to our veterans. And the American Legion, by resolution, supports alternative therapies, which is one of the reasons why we were proud to be in the Oval Office on December the 18th when the President signed the Executive order reclassifying cannabis from a Schedule I to Schedule III. There are a lot of other therapies that we believe would be productive for veterans, and I am going to ask, again, our VA&R Director, Cole Lyle, to address those.

Mr. LYLE. Thank you, Commander, and thank you, Congressman. The NOPAIN for Veterans Act, right now the VA still treats many of these non-opioid pain management things, so long-lasting, topical pain cream, things like that, non-opioid injectables, as nonformulary, so it makes it harder for physicians to prescribe. They have got to go through extra red tape to do it. And it often costs more to the veteran out-of-pocket.

So the bill, and why it would fix that problem, is it would mandate that VA add these no-opioid alternatives as VA formulary, to make it easier for those providers to prescribe alternatives, which, as the Commander noted, obviously we had an opioid crisis in the United States. As the VA and other agencies have worked to kind of lower that or reduce the impact of that on the population, veterans still have to find a way to deal with things like chronic pain. So without alternatives, they turn to self-medication and things like that. This would provide realistic alternatives.

Mr. PAPPAS. Well, I appreciate those observations. We are committed to working with you on this, and on all the other priorities on the list. We have got to make some progress here. So let's get things moving. Your presence here in Washington is a big show of support for priorities that are going to positively impact the lives of veterans and their families all across our country. So thanks for being here, and let's keep up the pressure. I yield back.

Chairman MORAN. Thank you, Congressman. Representative King-Hinds.

HON. KIMBERLYN KING-HINDS,
U.S. REPRESENTATIVE FROM NORTHERN MARIANA ISLANDS

Ms. KING-HINDS. First of all, I want to say thank you for your advocacy and for your leadership, and I want to thank all the members of the American Legions for being here, and for your continued work to be able to get Congress to move on some of these priority legislation. I appreciate all the hard work.

I read your testimony, and I appreciate the clarity and the urgency in the testimony that you submitted. One of the things that I want to get a better understanding of, after reviewing your testimony, is from the priorities that you have outlined, what do you believe is the single biggest systematic failure in how we currently deliver benefits to veterans, and what specific legislative action should we be prioritizing to address it?

Mr. WILEY. Thank you, Representative King-Hinds. I am going to ask, again, our VA&R Director, Cole Lyle, to address that question.

Mr. LYLE. Thank you, Commander. I think if we are going to talk specifics in the benefits process it is the high rate of remands from the Board of Veterans Appeals, and that has directly resulted from the quality of CMP exams in that process. The VA largely utilizes contractors to conduct those CMP exams, and there is fairly consistent, in our regional office action review site visits we find inadequate DBQs that are submitted for CMP exams, that result in appeals, delays, things like that. So I would say that is the biggest——

Ms. KING-HINDS. Point of failure?

Mr. LYLE [continuing]. Point of failure. And there are several bills, to include the MDEO—I am forgetting on what the specific bill number is off the top of my head—to improve the oversight of those contractors and ensure there is quality in those CMP exams.

Ms. KING-HINDS. Okay. Where do you see is the widest gap, then, between some of these legislation that have been enacted, going back to the point that Senator Tillis was making with regards to delivery, in terms of connecting legislation and the actual delivery and the way that the VA currently does its job?

Mr. LYLE. It is a great question. From a 30,000-foot view perspective, I would say really education and advocacy, and educating veterans, many of whom often feel like if they apply for disability compensation they are going to be taking something away from another veteran. So I would say from a top-level view that is the biggest thing, between legislation and actual delivery of benefits is educating veterans.

Ms. KING-HINDS. I would like to continue working with the American Legion to figure out how to actually address those systematic failures. Thank you. I yield my time.

Chairman MORAN. Senator Hassan.

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

Senator HASSAN. Thank you, Mr. Chair, and to you and Chairman Bost and Ranking Members Blumenthal and Takano, thank you for this hearing. And to everyone here today, to Commander Wiley and everyone from the American Legion, including the Granite Staters who are in attendance, thank you for your service.

I also just want to note that as the country is at war, our troops in harm's way are in all of our hearts today, as are the families of our fallen heroes.

Our country owes all of you a debt of gratitude, not just for your service in uniform but also for your service to your fellow veterans.

Commander Wiley, I wanted to start with a question about how we are handling services for women who are, of course, the fastest-growing group of veterans. They obviously deserve easy access to care that is specific to them and their needs. Senator Blackburn and I are working on this issue, and we are going to introduce a bill soon that would codify the ability of women veterans to directly schedule gender-specific care without having to get a primary care referral first. But we know we need to do more.

Commander, what else can Congress do to ensure that women veterans have easy, reliable access to the care that meets their specific needs?

Mr. WILEY. I think a couple of things that they can do specifically. As I suggested, or saw in one of the VA hospital visits, is having a separate access for women veterans. It is also having a sufficient number of doctors that can treat women veterans. You know, 20 years ago you would never have heard of an OB-GYN in a VA, and we have, obviously, veterans that are having babies. And we need more women physicians and more of those types to treat women veterans. So those are the big things we can do right off the bat, I think, to help women veterans.

Senator HASSAN. Thank you for that, and I look forward to working with you and your members on that issue.

Another question concerning families of veterans. It is not just to care for our veterans, we also owe a debt to their families. And after a veteran passes, surviving family members may encounter financial strains. Some can qualify for monthly payments under Dependency and Indemnity Compensation (DIC), but those payments can be much smaller than what a veteran was receiving for VA disability.

Commander, what are some potential options that Congress should consider to help these families through this adjustment period, so that they do not have to immediately worry about money while they are grieving for their loved one?

Mr. WILEY. Thank you again, Senator Hassan. I agree with you 100 percent on the premise, and I am going to ask our VA&R Director Cole out to address that specifically.

Senator HASSAN. Thank you.

Mr. LYLE. Thank you, Commander, and thank you, Senator. I think the American Legion has supported the Caring for Survivors Act and the Love Lives On Act specifically to raise the DIC, the Dependency and Indemnity Compensation, because as you pointed out, while their servicemember is alive they rely on a certain level of income for the quality of life and standard of living, and when it gets significantly reduced that is a pretty big financial shock.

Senator HASSAN. Sure. Thank you very much. I yield.

Chairman MORAN. Senator Sheehy.

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

Senator SHEEHY. We are veterans, not victims. Veterans, not victims. And we are not entitled to anything. We have earned the benefits that we deserve, and we deserve those benefits in the form that they should come. And I think the best thing we can do for our veterans when we get home from war—and I will talk to Mr. Sharpe and Espinoza about this—is make sure that they can serve again, and that can be as law enforcement officers, that can be as a firefighter, that can be as a small business owner, a machinist, a welder. Right now America has a skills gap. We do not have enough pilots, police officers, firefighters, welders, electricians, and these careers are actually well suited for veterans. Probably the best careers as veterans even is agriculture. We do not have enough producers, ranchers, and farmers, and we are not afraid of getting up early and working until the sun goes down. And these jobs are important for the future of America. They sustain our economy and they feed our Nation.

So Mr. Sharpe and Mr. Espinoza, I would like to hear from you what you think we can do to make sure that when our veterans come home and take that uniform off they do not spend the rest of their life talking about how great it was to be veteran. They spend the rest of their life achieving new great heights as veterans and make us proud yet again.

Mr. SHARPE. Thank you for that question. The American Legion has always supported expansion of the TAP program. We believe TAP program should be a way for veterans to find employment and also be gainfully employed. Currently not all our veterans are aware of the various services that are out there for veterans as far as finding employment, so the American Legion has, for our resolution, we believe that there should be a transition app with an AI component to it, to put all veterans that are leaving the military on a level playing field. Because depending on what installation that you are leaving from it may not have all the services for everyone. So we believe that transition app is the one thing that will level the playing field, keep veterans informed of all the services and programs that the TAP office currently has, but also keep an eye on what is happening in the private sector, as well. Thank you.

Senator SHEEHY. What I say one thing I could use all of your help with is one of the requirements to receive your DD 214 upon discharge should be a full transfer of your health records to the VA, a VA disability physical has been completed, and you are ingested into VA before the DoD lets go of you. That would solve this chasm that too many veterans fall into, which is they step off active duty and they spend months or years or the rest of their lives trying to get into the VA, trying to get the disability claims adjudicated. That should be a condition of discharge, and I think the sooner we adopt a clear transfer of health records and health status from the DoD to the VA will solve that problem. Thank you.

Chairman MORAN. Thank you, Senator Sheehy. Senator King.

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

Senator KING. Thank you, Mr. Chairman. I do not want to throw shade at you guys but you were talking about Boys State. I was Governor of American Legion Boys State.

[Applause.]

Senator KING. Now, the tricky part, Boys State was Virginia, and later I was elected Governor of Maine, and the people of Maine are still trying to figure that out.

[Laughter.]

Senator KING. And also I want to congratulate you on Matt Jabaut being your Legislative Director. But it is pretty sneaky because he lives a mile away from me. Having your chief legislative guy as my neighbor, I think that is, you know, come on, man.

I want to follow up on Senator Sheehy. There is a bill we are hoping to get in markup that would allow, and in fact mandate, the registration of people into the VA health system before they leave active duty. So I hope that is something we can work on together, because I think that is a really good idea.

One of the things I have been focused on since I have been here is transition. My rule is very simple. The government should spend

as much money, time, and effort on transition out as they do on recruiting in, and they do not do that. So I hope that is something we can work together on. TAP promotion, I think we almost made it last year, giving the VSOs access to people during the TAP process. The whole idea is to give people leaving active duty more information about what is available. You are nodding. I hope you agree, Mr. Wiley.

Mr. WILEY. Senator King, we absolutely agree with you. To have the VSOs have access will make that transition to the community much easier because we can provide them the information necessary so they can make that transition into the community.

Senator KING. Something else that I am working on in the area of veteran suicide, which is one of the great tragedies of this country, is for the VA to provide free lockboxes for firearms, to any veteran. Seventy-five percent of veteran suicides, almost 75 percent, are with firearms, and as we have learned, the data shows that if there is any gap between the idea and execution, self-execution, that that can be a real help to somebody who is thinking about this terrible act. So I hope that is something you can also help us with. It is based on a pilot program in Utah that has been very effective. We are not taking any names. This is not gun control. This is safety for veterans. So I hope you can help us on that one.

Mr. WILEY. Senator King, we absolutely support that.

Senator KING. And then, finally, staffing issues at the VA. We all know that the VA has lost a lot of people in the last year. The number, I have heard 30,000. I have heard more. What I want from you is reports from the field as to whether or not that is having an impact on service for veterans. We have gotten the word from the VA. They feel, the Secretary, you heard him the other day, everything is good and wait times are down. But I would like some feedback from people in the field as to whether that is the case. Because you are the ones that are actually experiencing this, and we are looking to fix problems here, but we cannot fix the problems if we do not know what they are.

So I look forward to working with you on that, as well. And thank you very much for your leadership, and I look forward to continuing our work together on behalf of American veterans. Thank you, Mr. Chairman.

Chairman MORAN. Governor, thank you for your questions.

[Laughter.]

Chairman MORAN. Senator Boozman.

HON. JOHN BOOZMAN,
U.S. SENATOR FROM ARKANSAS

Senator BOOZMAN. Thank you, Mr. Chairman. Thank you for being here. I thank all of you for being here. In the last several years, Congress has been able to step forward and again, as somebody whose dad did 20 years, I understand that these are, as Senator Sheehy just said, "these are certainly earned benefits." And we have been able to accomplish a lot, but the only reason we have been able to accomplish it is because of you all. And so there is nothing more heartwarming to sit here and look out and see a full chamber. People on the wall, that is a good thing. There is no substitute for you being here, talking to the people that represent you,

telling them how important these things are and why they are needed. And because of your help, like I said, we have been able to do a lot of good things, and we will continue to do that in a very bipartisan way. That is really what it is all about.

So, the VA recently released its annual Veteran Suicide Prevention Report with the date 3/20/23. It shows that veteran suicide crisis, as you all know, continues to rage. The report highlighted the success of the Staff Sergeant Fox Grant Program, making more than 24,000 referrals and 854 lifesaving emergency service-connections for veterans.

Mr. Wiley, what have you heard from your members regarding the program and aspects that need to be changed or improved?

Mr. WILEY. Thank you, Senator. I appreciate the question. I think there are several things that can be done with regard to the epidemic of veteran suicide. As you know, this is our number one mission in eliminating the stigma. But more resources, number one, are needed for mental health. We need more resources for things to combat homelessness, like the HUD-VASH program. And we need basically—I lost my train of thought. I apologize.

I am going to ask Cole Lyle to elaborate on that. Thank you.

Mr. LYLE. Thank you, Commander.

Senator BOOZMAN. You are just trying to make me feel better. That happens to me more often than not [laughter].

Mr. LYLE. Thank you, Senator Boozman. I think the success of the Staff Sergeant Parker Gordon Fox Grant Program, over the years we have seen the VA move closer and closer to the community, from medical centers to CBOCs to vet centers, and now things like the Fox Grant Program, that are not VA organizations but leverage VA funding to provide that outreach to veterans, which is crucial because less than 50 percent of veterans use the VA. The number of veteran suicides with the declining population has stayed stagnant, so the rate of suicide, if you look at the data, has actually increased.

And these types of programs are local programs that veterans trust, that are in their community, that provide that outreach, and deal with the upstream factors of suicide, like transportation, relationship issues, acute financial stress, any number of different things. So we want to get to the veteran before there is a critical mass of despair, and programs like that are really helpful.

Senator BOOZMAN. Thank you, Mr. Chairman. Again, thank you all for being here, and the fact that you are pushing hard and together, we are getting a lot done.

Chairman MORAN. Senator Boozman, thank you. Senator Murray, former Chairman of the Committee.

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

Senator MURRAY. Thank you very much, Mr. Chairman. Thank you to all of you who are here today and everyone in this country who has served our Nation. We all owe you, and we all say this, a debt of gratitude for your service, but it is more than that. We owe you to keep the promise that when you come home we will be there for you in any way, both to the current veterans and to the ones who we will see in the future.

I think it is really important today, Mr. Chairman, and this has kind of been glossed over, this point of time that we are in, where we have a President who is taking us to war in Iran, who seems to have no problem sending other kids off to a war but seems to have a problem in picking up the tab when it comes right by doing our servicemembers when they come home. With a VA right now that has waiting lines, that veterans cannot get served, that we see doctors and nurses who are not being hired, and no thought has been given to that. What we hear from Trump is that he is saying that this bombing campaign in Iran could go on indefinitely. He is saying the death of our servicemembers in a war of choice is, quote—and he said this—"just the way it is." He is saying he will not rule out putting American boots on the ground in Iran. I think it is a very serious time for our country.

I have served on this Committee for more than 30 years. I know the consequences of war, as each and every one of you does in front of me. And to go to war without preparing for the future, and making sure that we are there for the men and women whose service, and we thank them for that, but when they come home, as well. And, Mr. Chairman, we are not ready for that today.

This has to be a consequence that we consider. For numerous reasons I am going to be using my voice today to vote "no" on the war in Iran. But it is the responsibility of this Committee and every Member of Congress to think about all the consequences of war and take that into account and hold this Administration accountable and make that clear when we make our choices, moving forward. I felt it was really important to say that today, with all of you who have served our country, and know what those sacrifices mean.

So, Mr. Chairman, I only have a few seconds left, and with that I want to change the subject and thank you, Commander Wiley, for saying the word "menopause." Having been on this Committee for more than 30 years, this is the first time I have heard it, and I think I counted four times.

For our women whose service in this country, we know that they experience early menopause after having served in the military, more than women in the general population. We need to know why, and we need to be able to make sure that we are doing the right thing for those women. I did introduce a bill last year for the VA to do more research on that. That, along with all the other things that you were talking about today have as serious a consequence today as we are in this time, where a President has taken us to war in Iran without congressional consent, as any other time.

And I want to thank every one of you for being here. And my promise to all of you is I will fight to make sure, no matter what goes forward, that this Committee and this Congress will do, for our veterans who serve us, the right thing when they come home, and we have to take that cost into account as we make these decisions.

Thank you, Mr. Chairman.

Chairman MORAN. Senator Murray, thank you. Now I recognize Mr. McGarvey.

HON. MORGAN MCGARVEY,
U.S. REPRESENTATIVE FROM KENTUCKY

Mr. MCGARVEY. Thank you, Mr. Chairman. Thank you all for being here today. Thank you for your continued service to our country. Mr. Wiley, thank you guys. The American Legion, you all have spent generations making sure that our veterans are taken care of when they come home, that they continue to have meaningful lives after their service. And I know everyone on this Committee shares that same goal of making sure that we get our veterans the care that they have been promised, that they have earned, and that they deserve.

I think one area where the VA could be doing much more right now is getting innovative ideas off the ground. You heard Senator Murray talk about the need for research, particularly among our women veterans right now. Look what the VA has at its disposal. It is the largest patient population of any hospital system in the country, by multiples, 9 million patients. We are the largest longitudinal dataset of any health system in the country. Think about it. We get you oftentimes when you are 17 or 18 years old. We keep you until the day you die. Seventy-five percent of physicians do some sort of training or work in the VA right now. And what are we doing with this treasure trove of talent and information? Not enough. Not nearly enough.

Right now, even really good ideas can sit around for years before veterans are able to see them, because the VA does not have the tools or the flexibility that other agencies use. We have the stuff there but we have structural impediments to it. At places like the Department of Defense and NASA, they can partner quickly with early stage companies that guarantee a market for promising technologies, and they can move these good ideas and these research things from concept to real-world use, without getting buried in red tape. The VA does not have those same authorities. And the veterans are the people who feel the impact of that delay and that bureaucracy every day.

It does not have to be this way. We can empower the innovation team at the VHA to conceive and test new solutions that go after the hardest problems that our veterans face. And think about this, we solve these problems for our veterans, we can start solving them for everyone in the country.

So, I want to go to you, Mr. Wiley, and just say if the VA had flexibility and authorities to test and scale these types of new care models quickly, what kinds of innovative programs would you want them to prioritize first to better meet the needs of your members?

Mr. WILEY. Thank you for that question, and absolutely, we are always looking for different methods of treatment to treat our veterans that might be more successful than those have been in the past, because we believe that is one of the main ways to combat the epidemic of veteran suicide.

But with regard to the specifics, again, I am going to ask our VA&R Director, Cole Lyle, to address that.

Mr. LYLE. Thank you, Commander, and thank you, Congressman. I think some basic programs like digital matching tools, I think there is a pilot program for identifying substitute caregivers that could be directly expanded and utilized nationally, so care-

givers could have trusted resources for substitutes to come and care for their servicemember. Hybrid, in-person telehealth type things, where there is a remote monitoring with the wearables and home sensors. So for rural veterans that have to travel long distances for chronic pain management and things like that, they only have in-hospital visits for severe issues that are not routine, and they can do telehealth appointments for things that are pretty routine. So it would reduce readmittance rates, wait times, things like that, that the VA could utilize pilot and expand rapidly if they had those authorities.

Mr. MCGARVEY. Thank you so much. I am out of time, Mr. Chairman. I yield back.

Chairman MORAN. Thank you. Representative Conaway.

HON. HERB CONAWAY,
U.S. REPRESENTATIVE FROM NEW JERSEY

Mr. CONAWAY. Thank you, Mr. Chairman. And I tell you, I like Senator King because as it turns out I was Boys State Governor, as well, in New Jersey, in 1980.

[Applause.]

Mr. CONAWAY. I have not gone on to become a Governor, but it certainly was a very impactful time of my life that certainly has paved my way to going into elected office.

Thank you, Commander Wiley, for your testimony, and thank you to the American Legion and this panel for your advocacy and leadership. I wanted to take this time to shout-out to my local American Legion post, of which I am a member, Slade-Valentine Post in Burlington City, 336. Where are you guys? I think they are here. New Jersey folks, there you are. I am happy you are here with us in the audience, as well.

As a physician and veteran, I have been extremely disappointed with the VA's decision to shrink its medical workforce. We all know that in order for the VA to continue to provide quality care it must be fully staffed. Just yesterday, the VA reported 1,500 vacancies among its physician workforce, and 4,900 vacancies with respect RNs in the VA. Our veterans depend on these medical professionals. Quality care depends on quality, fully staffed workforce.

What would you say are the biggest barriers, and particularly given your emphasis, rightly, on mental health services for veterans? And here, I want to thank Senator King who is working with us on trying to get telehealth services in a pilot to veterans who are incarcerated, and also for his effort, and he has mentioned it here today, to lift the cap so that we can help the VA recruit more physicians into the service. But what would you say are the biggest barriers to veterans trying to access mental health services within the VA?

Mr. WILEY. Thank you. I appreciate that question. And I am going to ask our VA&R Director, Cole Lyle, to address that question.

Mr. LYLE. Thank you, Commander, and thank you, Congressman. I think, obviously, outreach is a huge thing. The VA's budget for mental health and suicide prevention outreach I think is hovering around $600 million right now, which sounds like a large number. A big portion of that is going to the Fox Grant Program,

and advertising things like that. That represents less than 1/10th of 1 percent of VA's overall budget.

So outreach could definitely improve. I think utilizing VSOs, things like the Fox Grant Program, making it easier for local and state-level organizations to access those funds and expand those funds, primarily authorize the program, would be very helpful.

Mr. CONAWAY. Thank you. Mr. Chairman, I yield back.

Chairman MORAN. Thank you. Senator Slotkin.

HON. ELISSA SLOTKIN,
U.S. SENATOR FROM MICHIGAN

Senator SLOTKIN. All right. You are almost done, I think. I am Senator Elissa Slotkin from Michigan, a former CIA officer. I did three tours in Iraq alongside the military. And I want to associate myself with Senator Sheehy's comments, but particularly mention a piece of legislation he and I are working on, on making sure that the GI Bill gives the same benefits for a veteran choosing an apprenticeship versus going into education of some kind. Right now you get dinged every six months if you are in an apprenticeship, and your benefit just does not go as far.

We have talked to the Legion about this. I think we are on the same page. But I just want to put a marker down that at a time when our country needs, again, so many specific career types—a lot of those career types that Senator Sheehy mentioned, especially skilled trades, are apprenticeships, and you should not be dinged because you want to go into a successful career in the trades versus going to a four-year university. So I just wanted to put that marker down.

But as a part of this kind of post-9/11 generation, I want to raise a separate issue, and if not get an answer, get this community thinking about this, artificial intelligence in deciding what benefits our veterans get or do not get. There is a lot of discussion about bringing artificial intelligence into the VA. I am working on legislation right now debating this. And there are lots of pilot programs being looked at.

What I am concerned about is that before we hardly know what is happening, we are going to let software decide if a veteran gets a benefit or not. And I have got a problem with that. And we understand that AI can do amazing things and can amalgamate data and figure out if a veteran has got all their paperwork in, but does the Legion have thinking on this? Who is the thought leader that is trying to help our veterans organizations think through this new, hot issue that is coming to a theater near us?

Mr. WILEY. Thank you, Senator. I appreciate your question. And let me give you an example of a recent visit I had to a regional office and explain, in my mind, how artificial intelligence can be productive.

What they do is use artificial intelligence for administrative tasks such as organizing records and putting those all together for a reviewer or rater. What should not happen, and what we cannot allow happen, is for artificial intelligence to substitute for judgment.

Senator SLOTKIN. Right.

Mr. WILEY. Judgment has to be a human being that can review all of the evidence and make an independent determination using everything they know. Artificial intelligence is not a replacement for that.

Senator SLOTKIN. Yes, so thank you. And, Mr. Chairman, I just think this is an issue we are going to have to deal with as a Committee, both Chairmen here and Ranking Members, of just how much power are we going to give to AI to decide if a veteran gets reimbursed for something, if a veteran qualifies for something. I just think we are moving very fast and there are some real benefits, I know, but a human being needs to be in the decision tree before we start making life-and-death decisions for veterans.

So I appreciate everyone's work here, and thank you. I yield back.

[Applause.]

Chairman MORAN. Senator, thank you. Representative Takano has an additional question I am going to allow him to ask, and then we are going to turn to the Senator, and then we are going to conclude this panel. There is a vote that started in the Senate, and we will have a change to our second panel during that vote. Senator? Representative?

Mr. TAKANO. Thank you, Mr. Chairman. You know, with *The New York Times* article yesterday, I wanted to quickly ask a question about staffing. Veterans' care does not happen without staff, and Commander, are you hearing from legionnaires about appointments being pushed out or services getting harder to access?

Mr. WILEY. Anecdotally, the answer is yes.

Mr. TAKANO. So anecdotally. For the legionnaires here today, I just want a show of hands. Are you experiencing delayed care or longer wait time because a clinic, a CBOC, did not have enough staff? Just raise your hand, by show of hands.

[Hands raised.]

Mr. TAKANO. All right. So a number of hands have been raised. Thank you. I yield back.

Chairman MORAN. Thank you, Ranking Member. Senator?

HON. JIM BANKS,
U.S. SENATOR FROM INDIANA

Senator BANKS. Thank you, Mr. Chairman. First of all, welcome to the many Hoosier legionnaires who are in the audience. I am very proud to be your Senator. I am a member of the American Legion Post 98 in my hometown, Columbia City, Indiana, and I am very proud of it.

[Applause.]

Senator BANKS. Our veterans count in the American Legion and all of our great veterans service organizations to advocate for the very best possible health care, education, and disability benefits for our veterans every day, and I want to thank all of you for the important work that you do.

Commander Wiley, I strongly agree that veterans deserve a claims and appeals system that is simple, efficient, and worthy of their service. I appreciate the Legion's support for my Veterans Appeals Efficiency Act that I have introduced, that we worked with you on. Can you talk about the bill and why it would be helpful?

Mr. WILEY. Thank you, Senator Banks. It is something that is important to us, and I am going to ask our VA&R Director, Cole Lyle, to specifically address that.

Mr. LYLE. Thank you, Commander, and thank you, Senator. The act you cited is a great idea. There are a lot of specific provisions in there, reporting requirements from the VA, making the process more transparent.

I know there have been concerns in the veteran community about aggregation of data. I think obviously, as mentioned earlier, there is a high remand rate from the court. Aggregation, particularly for presumptive conditions, could be a good thing, if granted. I understand we have had conversations with your office about an opt-out if they choose not to, because one of the big concerns would be the veteran losing their individual POA, and that would be particularly difficult to deal with if it was an aggregated claim that got denied. It would just kind of clutter the system.

So if we could work with your office on improving the language for the bill, just discussing some of the concerns and make it more effective, if passed.

Senator BANKS. I am glad to work with you on that. Thank you for that explanation.

Commander, the VA's legal authority to care for homeless veterans expired during the government shutdown last fall. We can never let that happen again. And I am introducing legislation to make the Health Care for Homeless Veterans (HCHV) Program permanent, so that it cannot shut down during a shutdown. Can I count on the Legion's support to help pass that bill?

Mr. WILEY. Yes.

Senator BANKS. Very good. All right. Well, thank you for that. Again, thank you for all that you do, each and every one of you in the room, and your leadership. I am a big fan of the American Legion. I am proud to be a member. With that, Mr. Chairman, I yield back.

Chairman MORAN. Senator Banks, thank you very much. National Commander, thank you for you and your team's testimony. I will use a moment to recognize the National Commander of the Sons of the American Legion. I am a member of the Sons of the American Legion, and use this as an opportunity to indicate to others like me that there is an opportunity to serve veterans and to be a part of the American Legion program.

With that we close out this panel and transition to our second panel. Again, Commander Wiley, thank you. I will see you in Kansas at some point in time. But thank you to your entire team of American Legion advocates and workers on behalf of our Nation's veterans and their families.

We will take a brief recess to allow the American Legion panel and the audience members to depart, and our second panel organizations and members to get situated. We are pausing. Thank you.

[Recess.]

HON. TOMMY TUBERVILLE,
U.S. SENATOR FROM ALABAMA

Senator TUBERVILLE [presiding]. Welcome, everybody. You can take your seats. We will get started. Welcome to our second panel of witnesses and audience members. Thanks for being here today.

In our second panel today we have Mr. Robert Thomas, National President for Paralyzed Veterans of America; Mr. Paul Shipley, National Commander for AMVETS; Mr. Terry Prince, President for National Association of State Directors of Veterans Affairs.

[Applause.]

Senator TUBERVILLE. You have a pretty good contingent here, Terry.

Lieutenant General Walter Piatt, Chief Executive Officer for Wounded Warrior Project. Thanks for being here. Ms. Anita Sullivan, surviving spouse of Navy Petty Officer Third Class Michael Sullivan, testifying for Tragedy Assistance Program for Survivors; Major General Frank McGinn, President for National Guard Association of the United States; and Mr. Jim Whaley, Chief Executive Officer for Mission Roll Call.

Thank you all again for being here and for your organizations' hard work and dedication. You provide tremendous value to our Committee.

So we will start now. Mr. Thomas, you are recognized for 5 minutes, and we will just go down the line.

PANEL II

STATEMENT OF ROBERT THOMAS JR., NATIONAL PRESIDENT, PARALYZED VETERANS OF AMERICA

Mr. THOMAS. Chairman Moran, Chairman Bost, and Members of the Committees, thank you for the opportunity to speak with you today on behalf of the tens of thousands of veterans with spinal cord injuries and disorders who rely on VA's benefits and care.

The VA is the best health care provider for veterans with catastrophic disabilities. The Department's Spinal Cord Injuries and Disorders System of Care provide a coordinated, life-long continuum of services. There is no comparable private system of care in the community. Thus, preserving and strengthening VA's specialty care system remains PVA's highest priority, and it should be for you too.

When I appeared before these Committees last year, I spoke about the ways that ongoing staffing deficiencies and infrastructure problems were undermining not just VA's SCI/D System of Care but VA's specialized services in general. Now, much has changed since then, and it is frustrating to have to bring up this, year after year, without resolution.

Unfortunately, the previous administration's practice of simply eliminating unfilled positions continues. This is extremely concerning because it presents the illusion that staffing levels are better than they really are, and I must call a "foul" on this. Because at the same time positions are being eliminated, it could be difficult to fill them due to the staffing caps and funding limitations. I urge

you to continue to press VA for answers regarding how it plans to care for the tens of thousands of veterans with SCI/D who are on its registries and depend on VA for quality, timely, direct care. This cannot be allowed to continue for another year.

Access to lifelong services and supports continue to be crucial for PVA's members. We are very appreciative of Congress' passage of the Senator Elizabeth Dole Act. VA says the VA's Directed Care program is now available at all major facilities. But the feedback we have suggests some programs exist in name only or serve few veterans. Congress must ensure that the Elizabeth Dole Act's provisions are carried out as intended.

Another important aspect of lifelong support is VA's Bowel and Bladder program. For veterans with SCI/D, support for neurogenic bowel and bladder dysfunction is a crucial aspect of their care. Unfortunately, VA's current Bowel and Bladder program is fraught with challenges for caregivers. Timely reimbursement and the tax treatment of payments are the two chief complaints I hear. Codifying the program would provide the opportunity to fix many of these problems. I thank Chairman Moran for his bill, the Disabled Veterans Dignity Act, which would help to address these issues. We also appreciate the interest from the House in introducing a similar bill that includes the provisions addressing the taxability issue.

Another area of concern is transportation to VA care. We are very concerned about new VA guidance that ends facility prepayment of round-trip common-carrier airfare for veterans traveling to VA SCI/D facilities. This change requires veterans to arrange and pay for travel up-front and seek reimbursement after their appointments, effectively preventing many from receiving necessary care. We appreciate that the VA is attempting to figure out a solution to this problem, and call on Congress to provide VA any resources, including clear statutory authority, to ensure veterans can access specialty care.

Finally, Special Monthly Compensation (SMC) is arguably the most important ancillary benefit for veterans with severe service-connected disabilities. Given the extreme nature of the disabilities incurred by most veterans in receipt of SMC, we do not believe that the impact on the quality of life can be totally compensated for. However, SMC does at least provide these veterans a financial resource to help accommodate their individual needs.

In similar fashion, survivor benefits are intended to protect veterans' families from impoverishment after the death of a service-disabled veteran. Unfortunately, they do not always do that, and many survivors who, in many cases, were once caregivers, face a financial cliff. Congress established the baseline rates for these programs decades ago. They must be updated now. We urge Congress to quickly pass the Sharri Briley and Eric Edmundson Veterans Benefits Expansion Act.

Thank you for the opportunity to testify. I would be happy to answer any questions.

[The prepared statement of Mr. Thomas appears on pages 94–118 of the Appendix.]

Senator TUBERVILLE. Thank you, Mr. Thomas. I would like everybody to pull your microphone just a little closer. You have got people in the back. Make sure that you speak into it, because we are a government entity. We do not run real well up here, as you all well know.

Mr. Shipley from American Vets, you have 5 minutes.

STATEMENT OF PAUL SHIPLEY,
NATIONAL COMMANDER, AMVETS

Mr. SHIPLEY. Chairman Bost, Chairman Moran, Ranking Members Takano and Blumenthal, and distinguished Members of the Committees, on behalf of AMVETS thank you for the opportunity to present our legislative priorities and for your continued commitment to the men and women who have served our country. AMVETS represents more than 20 million veterans, from every era of service, including active duty, National Guard, Reserve, and those who have transitioned to civilian life.

This past year marks a new chapter for our organization. After more than 80 years in the National Capital region, we relocated our National Headquarters to Washington, Pennsylvania, where we also established the AMVETS Family Service Center. This 35,000 square foot facility will serve our homeless veterans and their families. Our veterans will be able to remain with their spouses and children while they secure employment, permanent housing, and long-term stability.

Through the Center, we administer Department of Labor Homeless Veterans Reintegration Program grants in Salt Lake City, Utah, and Phoenix, Arizona, along with workforce programs and Veteran Stand Downs across the Nation. These efforts reflect what experience has taught us—housing, employment, mental wellness, and family stability are interconnected. Effective policy must reflect that reality.

Mental wellness and suicide prevention remain our top legislative priority. Despite significant Federal investment, suicide continues to take an unacceptable toll on the veteran community. We have seen strong, evidence-driven results from community-based efforts supported by the Staff Sergeant Fox Grant Program, which often reach veterans for whom traditional care has not worked.

As Congress considers reauthorizing the Fox Grants, we urge expanding proven models and continuing to focus on measurable outcomes. Our current approach spends billion while delivering minimal improvement in reducing symptoms and suicide.

After two and a half decades following 9/11 and more than 140,000 veteran deaths, the time has come to invest in programs where outcomes are front and center. Congress and the VA must embrace a proactive, outcome-driven approach and move beyond an expensive, reactive system that is not working for the vast majority of veterans.

Wellness interventions must begin earlier and be embedded throughout a servicemember's career. The real antidote to suicide is not slogans or billboards telling veterans to seek help. It is ensuring that the men and women who serve are equipped with the tools to build meaningful lives and know where to turn when times become difficult.

A similar forward-looking approach is needed in the treatment of traumatic brain injury. Since 2000, more than 500,000 servicemembers have been diagnosed with TBI. Many face lasting cognitive and emotional effects that disrupt employment, relationships, and overall health. Legislation such as the BEACON Act and the Veterans TBI Adaptive Care Opportunities Nationwide Act will allow the VA to evaluate and expand innovative, patient-centered therapies. We are also thankful to Chairman Moran's leadership on the Precision Brain Health Research Act of 2025, which would help broaden our understanding of the impacts of repetitive, low-level blast injuries on veterans' mental health. Veterans deserve care that evolves with science and focuses on meaningful recovery.

We must also honor our commitments to surviving families. Dependency and Indemnity Compensation has not kept pace with the comparable Federal survivor benefits. Modernizing DIC through the Sharri Briley and Eric Edmundson Veterans Benefit Expansion Act, the Caring for Survivors Act, and the Love Lives On Act is a matter of fairness and dignity for families who have already sacrificed so much.

Modernization with the VA is equally essential. A fully interoperable electronic health record between the Department of Defense and the VA reduces duplication, improves patient safety, and ensures continuity of care. As the rollout continues next month, sustained oversight and disciplined execution are necessary for success. Failure is not an option.

Fairness also requires passage of the Major Richard Star Act. For decades the Federal Government has reduced military retirement pay simply because a servicemember was wounded badly enough to receive disability compensation. This has been framed as concurrent receipt, suggesting veterans are double dipping. They are not. Military retirement is earned through years of service. Disability compensation addresses injuries sustained in that service. When the government offsets one against the other, it is taking away retirement that was already earned.

Let me be clear. It is time to stop stealing from our servicemembers. Congress needs to immediately end this injustice and pass the Major Richard Star Act.

Finally, AMVETS supports the development of a coordinated national veterans strategy focused on measurable outcomes. This nation invests hundreds of billions of dollars each year in veteran-related programs. Those resources must be expended around clear goals, accountability, and results that improve health, employment, and quality of life. As the men and women who defend our Nation are once again placed in harm's way, we depend on this body to ensure that we are cared for when they return home. Our veterans and their families deserve more than promises. They deserve measurable progress in their health, their opportunities, and their quality of life.

Thank you for your continued commitment to those who have served. I look forward to answering any questions you may have.

[Applause.]

[The prepared statement of Mr. Shipley appears on pages 119–129 of the Appendix.]

Senator TUBERVILLE. Thank you, Mr. Shipley.
Next is Mr. Terry Prince.

STATEMENT OF TERRY PRINCE, PRESIDENT, NATIONAL ASSOCIATION OF STATE DIRECTORS OF VETERANS AFFAIRS

Mr. PRINCE. Ranking Member Takano, great to see you again visiting LaSalle last year. Senator Tuberville and Ranking Members, distinguished Members of the Committees, my name is Terry Prince. I am a 31-year veteran of the United States Navy, Hospital Corpsman, and currently serving as the President of NASDVA, the National Association of State Directors of Veterans Affairs.

That crowd in yellow you heard behind me is the distinguished members of 50 secretaries, directors, and commissioners that lead the states, territories and the District of Columbia veterans affairs. Collectively, these veteran leaders make up the membership of NASDVA, and together they are the second-largest provider of veteran services in our Nation, second only to the Federal VA. These are your government-to-government partners who have worked together since 1946, to serve veterans where they live and work. They should be your first point of contact for constituent issues and ensuring that the Nation's 18 million veterans and their families and survivors receive the benefits and services they have earned in order to improve the quality of life and their overall well-being.

In our testimony, we cover a lot in our written testimony. A few of important items. One is our State Veterans Homes, that provide more than 50 percent on the total VA long-term care in 175 operational veterans homes and 30,000 beds. We recommend $600 million to provide Priority Group 1 construction projects, where the overall costs to fund all the necessary need to build and maintain our veterans homes is nearly $1.3 billion.

On a separate note, the State Veterans Homes are having to pay for high-cost medications for veterans in their care. This needs to be addressed by passing H.R. 1970, so that VA reimburses our State Veterans Homes that, for medications that exceed 8.5 percent of the per diem rate, which is what the VA pays to private nursing homes that are contracted by VA to provide health care.

The other grant program is the National Cemetery Administration's Veterans Cemetery Grants Program. One hundred twenty-four cemeteries across 47 states. The number far exceeds the amount of funding. The establishment just to cover Priority 1 and 2 for establishment and maintenance of cemeteries is in the neighborhood of $220 million, and NASDVA recommends addressing at least these groups for fiscal year 2027.

It was mentioned earlier about VA health care, and for the 9 million veterans receiving care, we also recommend they continue to emphasize enrollment, better access, and quality care at the VA. Regardless of gender and whether it is provided by the VA or Community Care programs, which accounts for nearly 40 percent of that care and is, in all essence, is VA care.

On to health records, we support the need for congressional oversight to ensure that the VA modernizes the electronic health record. It currently costs nearly $16 billion, with a projection of over $40 billion, with full deployment not expected until 2031.

The American Legion mentioned TAP class. As a military servicemember I am very familiar with this process, and I can tell you that every servicemember describes it in a different way. What I do know, as a corpsman and married to a psychologist, that transition from anything in life, especially the military, is one of the most dangerous periods in a servicemember's history, especially toward suicide and other things. Our state directors need to be a part of the TAP program. They need to be brought in early and often, to ensure that these veterans are connected with their state benefits.

The Major Richard Star Act, it is time. This is a wounded veterans tax. NASDVA strongly recommends that this Congress pass this critical legislation for these deserving disabled veterans.

Veteran homelessness, we commend what the VA is doing. However, we would like them to expand eligibility to any veteran who is homeless, at risk of homelessness, or receiving assistance through another housing program.

And I am going to close out my testimony with the number one issue that hits home to me and everybody in this room—suicide. Every 11 minutes in America, a family loses a loved one to suicide, and NASDVA believes that the prevention of veteran suicides requires a whole-of-government engagement, with fresh ideas and approaches. Your state directors and Veterans Affairs play a crucial role in suicide prevention by connecting veterans to their earned benefits back home, where they live, working with their state and human services and the Governor's Challenge.

We also recommend new treatment modalities to eliminate pharmacological intervention and other issues that do not allows veterans to explore non-traditional methodologies.

Your partnership with NASDVA is as important to our veterans as it is to us. It is a promise kept to those who once stood the watch for all of us, and together we can ensure that their service is honored, not just in words but in action, through strong policy, sustainable funding, and unwavering commitment. All of us sincerely respect and appreciate your work to improve the well-being of our Nation's veterans, and we are honored to be a part of that noble mission with you. Thank you.

[Applause.]

[The prepared statement of Mr. Prince appears on pages 130–148 of the Appendix.]

Senator TUBERVILLE. Thank you, Mr. Prince.

Next we have General Piatt from Wounded Warrior.

STATEMENT OF LTG WALTER E. PIATT, U.S. ARMY (RET.), CHIEF EXECUTIVE OFFICER, WOUNDED WARRIOR PROJECT

General PIATT. Chairman Moran, Chairman Bost, Ranking Member Blumenthal, and Ranking Member Takano, and distinguished Members of the House and Senate Committees on Veterans' Affairs, thank you all for today's hearing and for the honor to join you on behalf of Wounded Warrior Project and the warriors and families we serve.

First, all of us at Wounded Warrior Project are deeply saddened by the recent loss of servicemembers, and we stand ready to serve all those impacted by current military operations.

Twenty-three years ago, Wounded Warrior Project was founded on a promise, a promise to be there, no matter what, for those who defend our freedom. It is that same promise that grounds the work we do today.

Our nation's military remains engaged globally, fighting to keep the world and our Nation safe. We should never allow the strategic purpose for war to mask the toll it takes on those asked to fight it.

For the dangers our military is asked to face, we cannot accept the warrior simply coming back as the final tally of successful transition out of military service. We must see them fully home—mind, body, and soul. This is not captured in one moment in time, but through a process of hope, healing, and reconnection to a life of renewed purpose.

Last week, 125 of our warriors visited many of you Members of Congress. They were honored to tell you their stories and share the living, breathing impact of why your support matters.

We discuss three priorities with you.

The first, a passionate plea to do right by our past, current, and future combat veterans by passing the Major Richard Star Act this year. Finally allowing for those who were forced to medically retire due to combat-related injuries to receive the benefits they earned in blood.

Second, on ending veteran suicide. In 2023, we lost more than 6,000 veterans to suicide. We must explore advanced treatments for those who are suffering. The time is now to push forward evidence-based solutions, like psychedelic-assisted therapies for PTSD, traumatic brain injury, and substance use disorder. We must explore all alternative treatments, coordinate research, expand access to clinical trials, and ultimately make these treatments accessible to all veterans.

Third, ending veteran homelessness. VA and supportive communities are making historic progress, with nearly 52,000 veterans moving into permanent housing last year. Let's finish the Housing Unhoused Disabled Veterans Act to ensure no veteran's disability compensation is counted against them.

Your time spent with these warriors last week and your genuine appreciation for their service touched them deeply, and reminded them that their sacrifice is a big reason why our Nation remains free. With the continued support of Congress and that of our grateful nation, Wounded Warrior Project will continue to push the boundaries of what is possible, as we pursue the path to save a million more lives, cure PTSD, end veteran suicide, and end veteran homelessness.

Warriors are the foundation of our freedom. They have done, and continue to do, their part. It is now time to do ours. We must keep the promise and find every warrior, everywhere, and bring them home, mind, body, and soul.

I am honored to be of service to this distinguished Committee and for the opportunity to testify. Thank you for helping our Nation keep the promise to our veterans, and I welcome your questions.

[Applause.]

[The prepared statement of General Piatt appears on pages 149–187 of the Appendix.]

Senator TUBERVILLE. Thank you.

Next we have Anita Sullivan from TAPS. Anita.

STATEMENT OF ANITA SULLIVAN, SURVIVING SPOUSE OF U.S. NAVY PETTY OFFICER THIRD CLASS MICHAEL SULLIVAN, TRAGEDY ASSISTANCE PROGRAM FOR SURVIVORS

Ms. SULLIVAN. Chairmen Moran and Bost, Ranking Members Blumenthal and Takano, and distinguished Committee members, thank you for the opportunity to share my family's story.

Seven years ago, on February 9, 2019, I became a widow, a title no one pursues. My husband, the father of our three children, Navy Petty Officer Third Class Michael Sullivan, died by suicide after faithful service to our Nation and decades of physical and mental health battles that plagued him during and after his time in the Navy.

Much has changed in the seven years since he passed, but one thing has not. I am, and always will be, his widow. No passage of time will change that, not my 55th birthday, or the becoming someone else's wife.

I met Michael in 1999, while he was stationed in Jacksonville, Florida. He was funny and captivating, and we married quickly. But soon he became seriously ill. He was diagnosed with cyclic vomiting syndrome, which landed him in the hospital every six weeks, like clockwork. When he returned from his last deployment in June 2003, we welcomed our first child. His physical health had impacted his career and his mental health, and by that July he officially separated from the Navy.

His health worsened, and over the next 16 years he was hospitalized approximately 35 times. I became the primary breadwinner while caring for our three children and becoming Michael's caregiver. I could not leave his side during those hospital stays because he wouldn't know where he was, would often rip out IVs, and even try to leave the hospital.

On his good days, he coached our kids' baseball teams, volunteered his time to youth activities, was involved in our church, but on his bad days he truly suffered, and so did we.

His suicide, in 2019, ended his physical and mental health battles, but it was just the beginning of new challenges for our grieving, traumatized family. I was at a TAP seminar when I learned that Michael's suicide was deemed service-connected. After going for Michael's 100 percent VA disability compensation to zero overnight when he died, we would only have 43 percent reinstated.

Our eigth-month process was fast by VA standards. The wait for DIC is financially devastating for many survivors, and the month-to-month stress continues for families, mine included. Raising DIC from 43 percent to 55 percent may seem insignificant to some, but for surviving spouses like me, who struggle to maintain a career, because it always came second to military service and caregiving, it makes a meaningful difference. Passing the Caring for Survivors Act would provide long overdue breathing room and ease financial pressures. Surviving families face drastically reduced income, the lasting impact of career limitations, ongoing therapy costs, and the

full responsibility of providing opportunities for our children in single-parent households.

As the only living parent of our now 11-, 16-, and 22-year-old, CHAMPVA health benefits are critical to our family's stability. Under current law, my oldest son will age out of CHAMPVA in just a few months, despite being a full-time college student. Unlike most other health insurance programs, CHAMPVA does not extend to age 26.

Seven years after Michael's passing, I am still his widow, and we are still dependent on the benefits he earned to support our family. After a three-year-and-counting engagement, I am still waiting to marry a man that I love, who will never replace him as a husband or father, but cares deeply for the four of us. My youngest child, Sophia, was just four when her Daddy died. She is growing up without a legal father in her life, which can be confusing for her and her friends, as she goes around and is sharing so much of her life with him. But knows that if Love Lives On does not pass, she will be almost an adult before she can officially call him her stepdad.

John is sitting beside her today, here supporting us both as we advocate for benefits that were earned through service and sacrifice, benefits that dissolve under current law if I remarry before age 55. Marrying John does not mean that we should become his financial responsibility. He is already doing so much, bringing happiness back into our lives. But I will not become his financial burden.

When my late husband joined the military, our country made a promise to support his family if anything happened to him. There were no restrictions attached to that commitment.

My family's story is one of many. I hope that my voice is loud enough to bring attention to long-overdue legislative changes, like finally ending remarriage penalties, treating suicide as a presumptive condition, increasing DIC, and bringing CHAMPVA in line with civilian insurance.

Thank you for the opportunity to share my story today.

[Applause.]

[The prepared statement of Ms. Sullivan appears on pages 188–235 of the Appendix.]

Chairman MORAN. Thank you.

Next we have General McGinn of the National Guard Association.

STATEMENT OF MAJOR GENERAL FRANK MCGINN, U.S. ARMY (RET.), PRESIDENT, NATIONAL GUARD ASSOCIATION OF THE UNITED STATES

General MCGINN. Chairman Moran, Ranking Member Blumenthal, Chairman Bost, Ranking Member Takano, Senator Tuberville, and distinguished Members of the Committees, on behalf of the National Guard Association of the United States and the 435,000 Soldiers and Airmen with the Army Air National Guard, thank you for the opportunity to discuss some important issues affecting today's National Guard. We appreciate your bipartisan support in recognition of the Guard's vital role in our national security.

Over the past two decades, the National Guard has evolved from a strategic reserve into an operational force. Guard members deploy globally, strengthen alliances through the State Partnership Program, and provide key capabilities to the total force at less than 4 percent of the defense budget. At home they remain the Nation's first military responder, supporting disaster response, protecting critical infrastructure, and assisting civilian authorities.

As missions have expanded, policies have not kept pace. Today I will focus on three priorities: duty status reform, GI Bill parity, and the development of a Reserve Component-specific track within the Transition Assistance Program.

First, duty status reform. As of this week, more than 40,000 Guardsmen are on orders serving at home and abroad. They frequently operate alongside active component forces under identical conditions. Yet while their service is equal, compensation and benefits are not. The common system of over 30 duty statuses was created piecemeal over the decades. In fact, six additional statuses were created between 1999 and 2013. It is overly complex, confusing for servicemembers, and difficult for states to administer.

In the fiscal year 2016 NDAA, Congress directed the then Department of Defense to submit a Duty Status Reform legislative proposal. While studies and discussions have continued over the years, legislative proposals have not yet advanced. We are grateful to finally have some momentum this year, with bicameral and bipartisan support of the Duty Status Reform Act, this bill aligns authorities with how Guard and Reserves are employed today and ensures fair treatment when members are mobilized. The new framework would provide equities in pay and benefits, efficiency in programming and budgeting, and streamlined accessibility to the Guard and Reserve.

Duty status reform is our top priority for fiscal year 2027. We strongly ask for your support of H.R. 6976, and introduction of a Senate companion bill.

The next point I want to discuss is GI Bill parity. The Post-9/11 GI Bill remains one of the most powerful recruitment and retention tools. It provides those who serve with access to education and the opportunity to build a successful future. However, many periods of Guard and Reserve service still do not qualify for GI Bill benefits. Title 32, including annual training and drill weekends, are left out, which falsely implies lesser value. Each day in uniform should count as a day of service to our country. The benefits earned should reflect that sacrifice.

The GI Bill Parity Act corrects this inequity. We thank Chairman Moran, Ranking Member Blumenthal, Congressmen Takano, Levin, and Kelly for leading on this issue, and request swift passage of S. 649 and H.R. 1423.

The third and last issue I want to address is the Reserve Component—Transition Assistance Program track. The Transition Assistance Program is critical to preparing servicemembers for civilian life. However, most Guard members return to their civilian employment and normal routine. This presents unique challenges not fully addressed in the traditional TAP model.

Guardsmen receive limited counseling tailored to retirement points, TRICARE coverage, GI Bill benefits, and the VA claims

process. Transition assistance without these topics is a misuse of time and resources. We are grateful for your support on this issue. The fiscal year 2025 NDAA directed development of a Reserve Component-specific track. Continued oversight is necessary to ensure that this is tailored to the Reserve and not simply a modified active model. We respectfully request updates on this implementation and stand ready to assist.

In closing, thank you for your continued leadership and commitment to those who serve. These are not abstract policy concepts. They are tangible issues that affect readiness, retention, and the long-term well-being of the National Guard members and veterans. The National Guard stands ready to meet the Nation's needs, and in return our servicemembers ask only for fairness, clarity, and recognition of their service. We look forward to working with you to address these issues and ensure that National Guard service is treated with the equity and respect it deserves.

Thank you for the opportunity to testify today, and I welcome your questions.

[The prepared statement of General McGinn appears on pages 236–243 of the Appendix.]

Mr. TAKANO [presiding]. Thank you, Major General McGinn.

Mr. Whaley, you are now recognized for 5 minutes.

STATEMENT OF JIM WHALEY, CHIEF EXECUTIVE OFFICER, MISSION ROLL CALL

Mr. WHALEY. Chairmen Bost and Moran, Ranking Members Takano and Blumenthal, and distinguished Members of both Committees, thank you for the opportunity to testify today.

Mission Roll Call represents veterans by doing one thing consistently: listening. We survey veterans, their families, and caregivers nationwide, and we bring that data directly to policymakers, so decisions are grounded in lived experiences.

Our 2026 priorities come straight from those surveys. Veterans told us four issues should guide the work ahead: access to quality health care, support for service-connected injuries, suicide prevention, and housing stability.

For veterans, these priorities are connected. When access falters, injuries worsen. When injuries go untreated, mental health risk increases. Without stable housing, even effective care becomes difficult to sustain.

First, access to quality health care, both VA and non-VA. Veterans define access by timing, distance, and follow-through. In May 2025, Mission Roll Call surveyed more than 1,200 respondents in all 50 states on the ACCESS Act. Sixty-seven percent said the legislation would improve health care outcomes overall. Among rural veterans, 71 percent said it would improve timely access. Mental health access is central to this discussion. Sixty percent of veterans told us they are comfortable receiving mental health care from a non-VA provider. Seventy-nine percent said allowing veterans to access mental health or substance use care in the community without a VA referral would improve access.

Veterans are not voting against the VA. In fact, many we speak to report very positive experiences. But they are asking for options

that reduce delays, shorten travel burdens, and help them get care before a problem becomes a crisis.

Second, support for service-connected injuries and conditions, including traumatic brain injury.

In our 2025 TBI survey of more than 2,500 veterans, family members, and caregivers, 14 percent reported a TBI diagnosis in their household. Among those seeking TBI-related care, more than 70 percent said accessing appropriate treatment is somewhat or very difficult. Distance, wait times, and fragmented care remain consistent barriers.

Mild to moderate TBI is where we see the greatest gap. Symptoms persist, but care pathways are often unclear, and coordination between VA and non-VA providers remain inconsistent.

This is the space the BEACON Act seeks to address. The legislation creates a structured, evidence-based framework to evaluate innovative approaches for veterans with chronic mild-to-moderate TBI, with rigorous outcome measurement and independent evaluation. Veterans are not asking for lower standards. They are asking the VA to test promising therapies responsibly, publish results transparently, and expand access when evidence supports it.

This urgency is reinforced by the VA's 2025 suicide report, which shows the suicide rate among recent VHA users with a TBI diagnosis was nearly 94 percent higher than among those without a TBI. Early intervention in TBI care is not separate from suicide prevention. It is part of it.

Third, veterans tell us the current trajectory of veteran suicide is unacceptable. In July 2025, Mission Roll Call surveyed more than 2,100 veterans, family members, and caregivers nationwide. Sixty-seven percent of veteran respondents said they have struggled with suicidal thoughts or mental health challenges themselves, or know someone who has. Nearly one-third described access to mental health care as difficult or very difficult.

Veterans also told us the barriers are not only clinical. They pointed to isolation, stigma, and loss of purpose as early warning signs.

We have come to describe this as working "Left of Clinical." Not instead of care, but before crisis. Earlier engagement. More on-ramps to stability. Fewer veterans reaching a breaking point before help arrives.

Fourth, and lastly, housing stability. Housing is foundational. Without stability at home, treatment adherence, employment, recovery, and family life suffer. Veterans consistently rank housing access and homelessness prevention among their top priorities because instability magnifies every other challenge.

Across all of our surveys, veterans are asking Congress to do a few consistent things: expand access where delays persist, strengthen community care pathways, treat TBI and chronic conditions as long-horizon rehabilitation challenges, invest in earlier suicide prevention strategies, and protect housing stability as a core element of veteran wellness.

None of these priorities replace the VA. They strengthen it by recognizing that veteran wellness is built upstream, long before prescription drugs, an emergency room, or an inpatient bed is involved.

Veterans are speaking clearly. We are listening. Mission Roll Call is here to ensure their voices remain central to the work of these Committees.

Thank you. I look forward to any questions.

[The prepared statement of Mr. Whaley appears on pages 244–248 of the Appendix.]

Mr. TAKANO. Thank you, Mr. Whaley. I will now recognize the former Boys State Governor of Virginia and former Governor of Maine, Senator Angus King, for questions.

Senator KING. That refers to the prior hearing. Sorry about that.

General Piatt, one of the provisions that I have been pushing is preregistering for VA health care before you leave active duty. It is called the Servicemember to Veteran Health Care Connection Act. Is this something the Wounded Warrior Project is interested in?

General PIATT. Thank you, Senator. We are extremely interested in this. I think if we get transition early, we are doing a lot of work ourselves, registering members in the Wounded Warrior Project while on active duty. We feel if they are registered before they transition, the higher success rate we will have during transition. So we appreciate this bill. We fully support that.

Senator KING. I appreciate that. And my position on transition is very simple. The government should spend as much money on transition out as they do on recruiting in, because right now, I think transition, although it has been improved in the last several years, I do not think people realize what a dramatic moment that is in a veteran's life. And suicide rates are higher among people in the first two or three years.

Mr. Whaley, I very much appreciate your comments on TBI. We had a tragic case in Maine, as you may know, several years ago, that involved TBI, and I think that is something we have to focus upon.

Something I have been looking at is a bill that would have the VA provide free lockboxes for firearms. No lists. This is not a gun control bill. No names taken. But the data shows that if there is any gap between the idea and carrying out a suicide, that can help. And 75 percent of veteran suicides take place by firearms. Is that safe storage something that you could support at Mission?

Mr. WHALEY. Senator, yes, it is. I think all of us on this panel are concerned about the continuing rise of suicide and our inability to really bring those numbers down. So any effort to reduce those numbers is something all of our members and all veterans and their families can get behind.

Senator KING. Thank you. Mr. Prince, we passed a provision in the defense bill last year that will increase the number of people who are leaving the service whose contact information is shared with your representatives across the country, at the State Veterans Offices. It used to be you had to opt in in your paperwork. Now you have to opt out. And we expect that will significantly increase the people whose contact information is made available.

I hope that your organization and your members are getting ready for what I suspect will be a very large number of contacts so that the purpose of this law, which is to have people met at the

airport, to advise them of their rights and what options are available to them. I do not want those names coming to your offices and sitting in a file somewhere. I hope you will work with the VSOs to develop a system whereby veterans emerging from service, you will reach out to them, not wait for them to reach out to you.

Mr. PRINCE. Thank you, Senator, for that very much appreciated comment. Our membership is receiving additional information. We are getting the VA to work even closer with the Department of War. Because the sooner we can get in, even while they are on active duty, as a former master chief it was my intention to get to sailors a year or two before they got out of the military and start the conversation then and connect them with services.

So you can absolutely count on NASDVA to be a player in that and making sure that we are at the front of the line when it comes to getting that information into the hands of our VSOs and our local communities.

Senator KING. Thank you very much. Thank you to all of you for the work that you are doing on behalf of our veterans.

And one final comment. It is about damn time we passed the Richard Star Act.

[Applause.]

Mr. TAKANO. Thank you, Senator King. I will now recognize myself for questions.

General Piatt, what is the urgency on, and why Congress should pass the Major Richard Star Act, now?

General PIATT. Because these young warriors have been asked to go to war to defend the freedom of this country, and in the course of that they were wounded, and they spilled blood in foreign countries. The reason we are free is because they serve. Most of them, sadly, are young men and women that are serving, not even close to retirement years. So they have to accept the end of the life they thought they were going to have, and it brings a whole different life they did not think was possible. And we cannot punish them for their sacrifice on combat fields.

Mr. TAKANO. I wholeheartedly agree with you. I am very moved by your answer. And it needs to happen as soon as possible. It needs to happen this Congress, and this Congress and its leaders need to be held accountable for getting it done.

Now, do you agree that this is also about fairness? That ending a wounded veteran's taxed and that Congress should not pay for it by reducing other earned benefits?

General PIATT. I think veterans should get the benefits they earned in combat.

Mr. TAKANO. And what about, we should not be asking other veterans to pay for it by reducing their benefits.

General PIATT. I think all veterans deserve the benefits they earned in the course of their service.

Mr. TAKANO. And so you would agree with me that the American people and this Congress, that it is part of our obligation to take care of the veterans, not to ask one veteran group to pay for another veteran group's benefits.

General PIATT. We appreciate the service and support of this Committee and getting veterans their benefits they deserve.

Mr. TAKANO. Thank you. Ms. Sullivan, there has been a lot of discussion over the past several months on disability indemnity compensation, and I read the moving testimony from survivors such as yourself in TAP's written statement, about the impact a full DIC benefits increase would have on their lives. Can you give us a quick snapshot of the reason why Congress needs to do this full increase and why it needs to happen, now?

Ms. SULLIVAN. Yes. Thank you for the question. So our military and veteran survivors currently only receive 43 percent of what 100 percent disabled veteran receives. All other Federal survivors currently receive that 55 percent. So we are asking for parity. That is simply bringing us in line with all other Federal programs, to bring that from 43 to 55 percent, or an additional $454 per month.

Our base rate currently, the actual number is $1,699.36. And for most of our survivors, myself included, that is the only surviving benefit we receive. So that increase could have a very large impact on our families.

And for some of us, it is the difference in providing for families in ways that can include keeping their homes, being able to really do what is necessary to raise grieving children, and to do just critical care for their families. So this is something that ultimately we believe is fulfilling a commitment to saying that our sacrifice and our loved ones' service is just as important as other Federal benefits, Federal employees' sacrifice.

Mr. TAKANO. I agree with you, and the wait has been long enough, and it is urgent we get it done now. Thank you.

I want to now recognize Mr. McGarvey for his three minutes of questioning.

Mr. MCGARVEY. Thank you, Mr. Chairman. Thank you all for your service, your continued service here today. I want to echo something that Senator King said earlier. Right now we have an Administration who is coming to us asking for billions upon billions of dollars to send people into war again, but are unwilling to find the money to take care of those who served in those wars prior to this. The money for the Major Richard Star Act, the money for widows and widowers—Ms. Sullivan, thank you so much for your courage and your testimony—who have sacrificed and served. These are benefits they have earned, they have deserved. We will keep fighting for them.

I want to switch gears a little bit, Mr. Thomas, and come to you. Talk about your testimony. We were talking about how the VA does not have enough staff in the Spinal Cord Injury and Disorder System of Care. Many of the buildings are old but they are not designed for the care of our veterans that they need right now, and that more than a third of the jobs in these units are unfilled. That means that beds are staying empty even though veterans are waiting for them currently. It is our veterans who feel this neglect every single day.

So what should our VA medical centers be doing right now to fill these critical spinal cord injury and disorder positions and keep beds open for the veterans who depend on them?

Mr. THOMAS. The VA should prioritize the hiring for the SCI/D System of Care as well as the other specialty care systems within the VA. Currently there is no other system out in the community

that can take care of the unique needs that you have when you have a spinal cord injury. So they need to prioritize hiring that. And also they should, for the infrastructure, they should prioritize some of the projects within the SCI/D System of Care to ensure that they have the most modern equipment to take care of us, with our unique needs.

Mr. MCGARVEY. Yes. I totally agree. And, of course, part of the reason we need to do this is it is both a legal and a moral promise we have made our veterans. We said if you come in and you serve us and you are willing to sacrifice everything for us, we will take care of you. And I think we are falling short of that with this issue.

You also described facilities that are decades old, with outdated layouts, with long construction delays. Where do you think Congress needs to focus first to modernize spinal cord injury and disorder facilities so that veterans are receiving care in safe, accessible, and up-to-date spaces?

Mr. THOMAS. Currently there is only one long-term care center west of the Mississippi, and the long-term care, as we all age, we need to have these long-term care facilities, because again, in the community there is no nursing homes that can take care of us.

Mr. MCGARVEY. Thank you. That is very helpful. Very quickly in my remaining time, General, I just want to talk to you. Thank you for highlighting the struggles of mental health that our veterans are still experiencing, particularly post-9/11. Quickly, where should we focus first if we want veterans to have timely access to effective mental health treatments through the VA, not just in the private sector?

General PIATT. First, I would say residential rehabilitation treatment programs. We need more beds. We need more states to have them. And second, I would say pursue alternative medication. Do the research. Get the trials going. We are seeing real promise here. Warriors should not have to travel to other countries to get the treatment that they think works. They should get it here. We are the best country in the world for medical care. That is where I would start.

Mr. MCGARVEY. Thank you so much. I agree with you on that, General. I appreciate you bringing it up. Mr. Chairman, I yield back.

Mr. TAKANO. Thank you, Mr. McGarvey. Now I recognize Dr. Morrison for questions.

HON. KELLY MORRISON,
U.S. REPRESENTATIVE FROM MINNESOTA

Ms. MORRISON. Thank you, Ranking Member Takano, and thanks to Chairman Moran and Chairman Bost and Ranking Member Blumenthal for convening our hearing today. Thank you so much to all the witnesses for being here today and the work that you all do every day, advocating on behalf of fellow veterans and servicemembers.

A special shout-out to any Minnesotans in the crowd today? Come on, you all. Are you out there? Well, I met with some of them earlier and it was a pleasure to see them here in Washington, advocating on behalf of their fellow vets.

General Piatt, my team has been working with yours back in Minnesota to partner on supporting our women veterans, and we have been very impressed by all the work that you are doing. As you know, women are the fastest-growing group of veterans, and as an OB/GYN myself it is important to me that women veterans can receive top-quality menopause and infertility care.

In your view, where can Congress act to ensure that VA is equipped to meet the needs of a growing women veteran population in 2026 and beyond?

General PIATT. Thank you for the question and your help with our work there. First, I would say women veterans are veterans, and our country needs to recognize that. Munitions do not discriminate by gender. They need the same care. But their medical care is gender specific. We need to meet them where they are, allow them to choose the provider of their choice, allow them the care they need, where they want it. If it is at home, if it is via telemed, but meet their needs. Don't just consider their needs the same as the counterpart male veterans, because they are very different. And we support going forward with more work on the Menopause Care Equity Act. We think that is the right way to go. Because their core set of services, their medical challenges will be different later in life, and we need to get the research now so we can provide them the support they need later on in life.

Ms. MORRISON. Thank you, General. I appreciate that answer.

Ms. Sullivan, thank you so much for being here today. I just want to take a moment to recognize the immense sacrifice you and Sophia and the rest of your family have made, and I just want to share my admiration for your advocacy on behalf of survivors everywhere. And I am excited for your future, as well.

It is such an injustice to me that surviving spouses risk losing their benefits if they choose to remarry before age 55, and that is why we need to pass the Love Lives On Act. Ms. Sullivan, can you share a little bit more about what it would mean to you to eliminate the remarriage penalty for surviving spouses?

Ms. SULLIVAN. Thank you so much for your support and the question. At its most basic tenet, to myself and to others here with us, it would mean that the government is keeping its promise. It would mean that it is keeping its promise to myself and to Michael and to our children, that if something were to happen to him as a result of his service that we would be taken care of.

We did not expect that there would be some limitation on that. We did not expect that in the indemnity portion of that, that there would be an end to that simply because of a decision to not replace him—that could never happen, not as a spouse and not as a father—but to choose to also carry on with our life and our love, that that could end, and could end some things that are very critical to our family.

So, it would mean that we no longer have to choose between doing what feels very right for myself and John or for our families and financial security. And in the end, it would mean that we would marry fairly soon after it passes and that we would really, truly celebrate that love does live on.

Ms. MORRISON. Thank you, Ms. Sullivan, and thanks to all of you for your ongoing service.

[Applause.]

Mr. TAKANO. Thank you, Dr. Morrison. I would now like to recognize Senator Gallego.

HON. RUBEN GALLEGO,
U.S. SENATOR FROM ARIZONA

Senator GALLEGO. Thank you, Chairman. And, General, I was rude. I walked in and you were talking a little bit about the veterans being penalized when it comes for their VASH vouchers because of a disability. Was that correct?

General PIATT. Yes, as far as on housing and how veterans access it. But we support it, so they will not be disadvantaged by their disability compensation.

Senator GALLEGO. That is great. So in the ROAD to Housing Act, I authored a portion of the bill, which is going to permanently exclude veterans' disability compensation from the annual income calculations under HUD-VASH programs, so that way veterans will not have to make this decision going forward. So it is in the bill. It was actually moving through the Senate. We just need some friends on the House side to make it.

But just to assure you that we have thought about this. It is in that bill, and I have kept it in both times that it has gone over the side. So we are definitely looking into that, actually are trying to fix it. Hopefully we will have it fixed by next week or so. So I just want to make sure we have some progress on that. Obviously it is not everything we need, but it is definitely moving in the right direction.

Mr. Whaley, you also mentioned the American Legion's support for expanding innovative therapies for veterans and the use of MDMA for treatment of PTSD. As you may know, I am working to introduce Innovative Therapies Centers of Excellence Act in the Senate. I want to continue to push it to get it to the point where it is across the finish line.

Mr. Whaley, can you please discuss the current use of innovative therapies like MDMA at VA, and why centers of excellence are important to ensure veterans have access to these therapies, with proven success at reducing PTSD symptoms?

Mr. WHALEY. Right. Did you ask me that, sir, or General Piatt?

Senator GALLEGO. Mr. Whaley. And I am sorry. I need to get some readers pretty soon. Whaley. I apologize.

Mr. WHALEY. Yes, no worries. No worries. We support that because we know right now that the number of TBIs across the Nation, but certainly among veterans, is much higher than we think. We do not have the ability right now to treat all those TBIs.

The TBI issue affects not only that servicemember but their family, as well. We have a number of children in our country that are primary caregivers to veterans because their mother or father needs that service.

We need to make sure that we are partnering with the very best in the civilian world, hospitals that are doing cutting-edge research when it comes to TBIs.

Senator GALLEGO. I do not want to interrupt to be rude, but I just want to make sure we communicate that. There are some veterans that are actually getting MDMA therapy, but it is not nec-

essarily guided. Some of it is overseas. Some of them are paying out-of-pocket. Is that correct?

Mr. WHALEY. It is correct, and, of course, I agree with General Piatt that that is unfortunate and should not be happening in a country such as ours, and we should know that these issues have long-lasting effects and we need to make sure they get the health care when and how they need it. And we need to explore different ways to solve TBI or mitigate it, using a variety of different methods.

Senator GALLEGO. And General, do you want to jump in on my thought. One of my concerns is that whoever gets good MDMA therapy now is basically connected to how much money you have, if you get to one of those really good programs. I know there are a couple programs in Mexico. There are some actually in Europe that some veterans that had the wherewithal or can bundle the money from donors are able to do.

But then there are also some veterans, unfortunately, that I know personally, that are so desperate that they are using any type of program that they hear is good, and, of course, when you have desperation you have potential fraudsters, peddlers, and people that will try to take advantage of these men.

So by having some kind of regulated, VA-approved therapies we could potentially be saving these guys, and saving these guys money, and potentially from some damage they may incur. Correct?

General PIATT. Absolutely correct. We have done initial research on our Warrior Care Network already on MDMA use with already evidence-base to other therapies and seen great results. We are going to help with trials next year, and I think the more we do that in this country, it will be done correctly, we will be able to follow the science. The treatment may not be for everybody, but it is showing that it is working for some, and we should not send them to a different country where we do not know, where it is not regulated.

But you are seeing great promise here, and we fully support the Centers of Excellence Act, because I think that will help the VA tie all that science together and promote quicker trials, that we can get more in. Our numbers that signed up for initial trials that we advertise far exceed the numbers that we will be able to do. There is a big appetite there for it, and I think the Centers of Excellence will help tremendously. Thank you.

Senator GALLEGO. Thank you, Mr. Chair, and I really hope that we can push this. This is more of an issue of a cultural resistance, actually, using this versus an actual medical resistance. And with proper therapy, training, licensing, there are so many veterans that could actually benefit from this. I think people have to get over the ickiness of the idea, MDMA or other types of therapies.

Thank you, Mr. Chairman.

Mr. TAKANO. Well, thank you, Senator. I am aware that there were some trials done in Loma Linda, which is near me. I have not checked into where VA is on it recently. I will have to say, also, regarding this whole area of TBI and traumatic brain injury and PTSD, I was with some neurologists recently. I am concerned about the State of VA research, the number of research positions that have been left vacant. That is a topic I want to explore further, be-

cause it also bears on the research capacity of VA to be able to move this forward. But thank you. I share your concerns.

Senator GALLEGO. Thank you, Mr. Chair.

Mr. TAKANO. I now recognize myself for some more questions before we conclude. General McGinn, I saw your testimony on duty status reform, and I will be following the Armed Services Committee's progress closely, as that greatly impacts VA benefits for our Reserve Component servicemembers.

I would like to focus on one benefit specifically, and that is the Post-9/11 GI Bill eligibility. National Guard and Reservist servicemembers are serving in the same uniform, taking the same risks as their active-duty counterparts, yet not getting the same GI Bill eligibility. Three out of the four Chairs and Ranking Members on the Veterans' Affairs Committee are lead sponsors or co-sponsors of the Guard and Reserve GI Bill Parity Act, which would fix this inequity.

As we are watching our country enter another overseas conflict, how imperative is it that Congress get this bill done?

General MCGINN. Yes, thank you for the question. It is imperative. We have been working this issue for years and years, and Congress has been great. The GI Bill really initiated years ago from Congress. But again, it is an inequity. If you are flying a UH–60 Black Hawk helicopter during your weekend drill or your two weeks of annual training, how is that different service than flying it off an active-duty base? It is the same service, it is the same risk, and we think a day in uniform, regardless of what your status is, should be a day that counts toward Post-9/11 GI Bill, and early retirement, as well, early retirement credit.

So we think it is imperative that this finally gets passed. And we appreciate what Congress has done thus far, but we think it is time to take it to that next level. And if they are serving in whatever status they are in, other than stay at active duty, that time should count.

Mr. TAKANO. Well, Major General, here is my point. As National Guard and Reserve servicemembers are on the front lines and under threat right now, that is what I am hearing. So that is my point, that there is an urgency now to deal with this inequity, because we have Guard and Reserve right now. It is not the Guard and Reserve that we knew back in the Vietnam War days, right. Sometimes they have been called up for service and deployed many, many times. It is not a safe haven. And I think Americans understand that, and we need to make sure we update how we administer the GI Bill accordingly. Would you agree with that?

General MCGINN. I completely agree. I enlisted in 1981 and I had a front row seat of the transition of the Guard and Reserves from the 1-weekend a month and the 2-weeks in the summer, to where we are today. We have got, as you know, Guardsmen and women that have done multiple deployments. They are coming on and off active duty a lot. And that is why the whole TAP issue is a concern, too.

My colleague here with me today has been through the TAP process, I think, four times, and she just comes off active duty, comes back to her regular job. But she has to do 12 hours of this mandatory transition training. And I just got an email from

Djibouti, somewhere in AFRICOM, from a servicemember over there, having to put his whole unit, brigade-sized unit, through the TAP program. And none of it is really relevant to what they are going to experience when they come back off active duty.

So we really have got to get these benefits right, rightly aligned, and to your point, this is the time to do it. As I mentioned, 40,000 of us are deployed today, somewhere, either in the homeland or overseas. So it is time to make equities in those benefits.

Mr. TAKANO. Well, I hope you and the other VSOs and veterans themselves will hold the Chairs', Ranking Members' leadership accountable to getting this legislation passed and signed into law without delay. And, of course, we wish Godspeed to all of our servicemembers abroad.

Commander Shipley, this will be my final question for the day and we will bring this to a close. Your written testimony highlighted the need to equality the disability indemnity compensation rate with that of other Federal survivor programs, taking it from the current 43 percent to 55 percent, a monthly increase of $450. I am a co-sponsor of Representative Hayes's bill, the Caring for Survivors Act, which would do just that. We have even offered it as an amendment to a bill last month that would only increase the DIC rate by $24. Unfortunately, our majority rejected the full increase.

From my direct interactions with my constituents and nationwide polling, I believe that the American people are willing to pay for the full increase and are willing to do it without taxing other veterans to do so. In other words, without creating a pay-for that we diminish the benefits of other veterans. I am strongly opposed to doing that.

Do you think that the American people are willing to pay for, or would ask their Members of Congress to pay for the full DIC increase and live up to the promises made to our servicemembers and veterans?

Mr. SHIPLEY. Thank you for this question. I absolutely believe that the American public would support this. It is bringing the fairness of the promise that is made to the servicemembers to take care of our families, no matter what, especially those that have made the ultimate sacrifice for this Nation.

Mr. TAKANO. I agree with you. I agree with you 100 percent, and I think we ought to apply that in this policy space, that we, in order to make sure that we resolve the inequities—and here we are talking about the survivors of veterans being paid less for their survivor benefits than those that are survivors of Federal employees. And that gap simply does not make sense when you kind of explain it to the American people. It is kind of complicated, this percent versus this percent.

Mr. TAKANO. But we need to take care of that inequity, and I believe that we need to do it without asking other veterans, who will, in many cases, say we want to help other veterans. But here is my point about that. We should not be asking veterans to do it. We, as Members of Congress, should take it upon ourselves to make sure that we find a way to take care of these inequities in veterans' benefits.

And with that I will just say, before we gavel out of this hearing today, I want to thank our second panel for everything, our second group of panelists, for everything that you do each and every day to support not only the members of your individual organizations but all veterans and their families. Your work and your advocacy does matter, and we thank you for that advocacy.

And with that this hearing is adjourned.

[Applause.]

[Whereupon, at 12:29 p.m., the hearing was adjourned.]

A P P E N D I X

Prepared Statements

TESTIMONY

OF

DAN K. WILEY

NATIONAL COMMANDER

THE AMERICAN LEGION

BEFORE THE

JOINT HEARING

OF THE

COMMITTEES ON VETERANS' AFFAIRS

UNITED STATES SENATE AND UNITED STATES HOUSE OF REPRESENTATIVES

MARCH 4, 2026

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March 4, 2026

Chairmen Moran and Bost, Ranking Members Blumenthal and Takano, and members of the joint committee, thank you for inviting The American Legion to testify before you today and share our priorities on behalf of the 1.5 million Legionnaires nationwide.

The American Legion is guided by active Legionnaires who dedicate their time and resources to serve veterans, servicemembers, their families, and caregivers. As a resolutions-based organization, our positions are guided by 107 years of advocacy and resolutions originating at the post level. Every time The American Legion testifies, we offer a direct voice from the veteran community to Congress.

The American Legion deeply appreciates your committees' commitment to our nation's veterans and their families, especially as the country celebrates 250 years of our great American experiment. Older than our democracy, however, is our Armed Forces. 251 years ago, men and women risked their lives to fight for a country that did not yet exist. They did so for an idea. Since then, generations of Americans raised their right hand to protect our democracy and fight for freedom all over the globe. As we live in the aftermath of the longest conflict in American history, we must—in earnest—reframe how we repay service.

The Committees are no doubt aware of recent newspaper articles reporting on the Department of Veterans Affairs' (VA) benefits process and the accounting of veterans who purportedly "take advantage" of the system. This narrative is as ineffective as it is unoriginal; the process of distributing veterans' benefits has been critiqued ever since its creation. Instead of focusing on systematic challenges, however, the narrative is focused on the veterans who are seeking out the benefits.

Today, only about six percent of American adults have served, and research shows 80 percent of our service members have an immediate family member who served. Military service is a family business. And while the average time in uniform is just four to eight years, the costs to veterans and their families can last a lifetime. As our nation marks the 250th anniversary of its founding, it is essential that we examine the full costs for the freedom and way of life our veterans have secured.

The Department of Veterans Affairs exists to care for those who have borne the battle. Of course, there is always room for improvement, and over time, our government has evolved to meet veterans' changing needs. That is precisely why Congress chartered The American Legion in 1919:

to ensure the needs of our nations' veterans are met as wars evolve and research advances. Our mission remains unchanged – to serve our veterans, their families, their communities, and indeed our great nation, every single day, from the individual post to our national office.

The American Legion, alongside its partner Veteran Service Organizations (VSOs) have worked tirelessly to support veterans through their post-service journey—no matter what that may look like. There have been significant strides made in how we approach mental health, how we treat pain, and how we promote accessibility. Overcoming stigma within a population who were trained to "tough it out" is a continual, daily fight. When veterans are publicly belittled for seeking treatment for their conditions, we undo progress that saves lives.

We sit here at a momentous time for veterans in our country. As Congress debates and considers important topics like Veteran Health Administration reorganization, a NextGen Community Care contract, and acceleration of Electronic Health Record deployment, Congress must ensure VA has the necessary resources – and provide adequate oversight – to accomplish its core mission.

We will continue to work with Congress to ensure there is absolutely no reduction in the quality of services, or reduction of benefits, to any veteran. As the largest veteran service organization in the country, we will remain vigilant in our advocacy, giving Congress feedback on proposed changes and necessary improvements that must be made.

In the age of an all-volunteer force, how our country cares for those who served will directly impact the next generation who feel the call to serve. Our forefathers understood this 250 years ago, and we need to hold true to it today.

As we embark on the second session of the 119th Congress and enter into an election season, it is imperative that we continue to collaborate on the pressing issues that veterans and their families struggle with every single day. Today, we present our priorities regarding **Veterans Affairs and Rehabilitation, Veterans Employment and Education**, and **National Security**. The veterans affairs and national security pillars have guided a large portion of The American Legion's work since our founding and have evolved as the nature and impact of warfighting has changed.

We urge the committees to prioritize the following issues:

VETERANS AFFAIRS AND REHABILITATION

Winning the War Within

The American Legion is a leader in advocating for improvements in mental health care and peer support – not only through our flagship Be the One mission, suicide prevention training and Buddy Check programs – but through all our advocacy efforts. The American Legion takes a holistic approach to suicide prevention where each systemic improvement to the veteran experience can save a life. The American Legion encourages everyone to own the issue, understand at-risk behavior, and know what to do if one encounters someone wrestling with the thought of suicide.

The veteran suicide epidemic continues to be the No. 1 concern of The American Legion. While the suicide rate for all Americans has risen since 2001, veteran rates have increased by 52%, now more than double that of civilians.[1] Suicide is the second leading cause of death among veterans under the age of 45,[2] and while the VA estimates 17.5 veterans die by suicide per day, other reliable sources suggest the number may be as high as 44.[3]

Suicide is caused by a multitude of factors. Veterans grappling with mental health issues are more likely to take their own lives. The American Legion is actively combating the "broken veteran" narrative and believes trauma can be a source of strength. Post-Traumatic Growth (PTG) is a recent theory exploring alternative outcomes for Post-Traumatic Stress Disorder (PTSD) treatments. PTG therapies pursue new experiences to take advantage of the increased neuroplasticity of patients who have experienced trauma. However, due to the untraditional nature of PTG therapies, it has been difficult for VA to implement systemwide programs.

The vacuum created by this need has been increasingly filled by non-profit entities focusing on peer support and allow veterans to be mentored by those with shared experience. In response to this need, the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program (SFSPGP) was created to seek and fund community partners that deliver a variety of services and programs for veterans, including financial readiness, family counseling and faith-based PTG programs.[4] We must continue to raise awareness of these mental health issues in a way that normalizes these challenges and provides hope for those affected.

While the SFSPGP final report detailing the effectiveness of the program is not yet available as of January 2026, the interim report shows great promise. One promising metric is that 24% of program participants become new Veterans Health Administration (VHA) enrollees[5] The partnership between VHA and SFSPGP grantees is vital because suicide rates among veterans who receive mental health treatment decrease by almost 40%.[6]

The American Legion supports alternative options for pain medication. Opioid-dependent veterans are 90% more likely to die by suicide. The American Legion also advocates for an improved Military Sexual Trauma claims process; veterans who have experienced sexual trauma have a 75% higher rate of suicide.

Another emerging suicide comorbidity is Chronic Brain Encephalopathy (CBE). CBE is a type of brain injury often caused by multiple mild Traumatic Brain Injuries. These are often seen in professional athletes and in many military occupations, such as artillery crew and small watercraft crew. CBE is linked to higher suicide rates and overdose rates alike. However, as CBE can only be diagnosed post-mortem; much is still unknown.[7]

The American Legion encourages Congress to continue exploring and expanding alternative and breakthrough therapies, especially those that treat issues more likely to affect the veteran community such as TBIs, CBE, Post Traumatic Stress Disorder and chronic pain. Current studies have shown a 67% success rate in reducing PTSD symptoms when using MDMA in conjunction with talk therapy.[8]

What Congress Can Do:

1. Pass **S. 800 – Precision Brain Health Research Act**, or similar legislation, to advance knowledge on how military brain injuries affect veteran suicide.
2. Pass **S. 3346 – Freedom to Heal Act** to improve alternative therapy access.
3. Pass **H.R. 2623 – Innovative Therapies Centers of Excellence Act** of 2025 to designate centers of excellence for complimentary alternative medicine and breakthrough therapies.
4. Permanently authorize the **Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program**.
5. Pass legislation which fast-tracks non-opioid alternatives for chronic pain.

Enhance and Protect Earned VA Benefits

Congress established a new veterans' benefits system for disability compensation, insurance and vocational rehabilitation, with the intent to make the veteran "whole" again when transitioning after military service. Congress must take prompt action to ensure that VA benefit programs reach disabled veterans as intended and not suffer from any degradation or delays for veterans and their dependents. Therefore, it is imperative to provide VA Office of General Counsel (OGC) with robust enforcement mechanisms to hold unaccredited claims agents/agencies accountable, allow federal employees to advocate for veterans, and strengthen medical care for veterans residing overseas.

Unaccredited persons and agencies have been poaching veterans' monthly pension benefits since 2006, when VA ceased the enforcement of fines or jail time for filing VA claims without proper VA credentialing. In blatant violation of federal regulations, unaccredited agents and agencies charge disabled veterans for assistance with simple filing of initial claims and are collecting prospective fees for any future benefits awarded. This continues to occur despite federal regulations that only allow fee collection for past-due benefits awarded after successful appeals representation.[9] Moreover, these unaccredited bad actors are charging exorbitant fees far exceeding the 20% cap fee guideline outlined for accredited agents in both 38 CFR § 14.636(f) and Title 38 USC section 5904. During a March 2025 House hearing, one such unaccredited agency admitted it has been coaching and assisting with VA claims filing since 2017, and to date still has not completed the VA accreditation process, garnering the ire of the subcommittee chairman. The witness then claimed he has not gone through the lawful process because being fully accredited would force his agency to abide by current codes and procedures, such as not charging fees for initial claims filing.[10]

While the VA Office of General Counsel (OGC) monitors which agencies, claims agents and veterans service organization representatives have agreed to the code of standards and completed the VA-accredited process, a useful additional safeguard would be to publicly list an exclusion list of those agents barred from processing claims. This approach is similar to that maintained by the U.S. Department of Health and Human Services (HHS) OIG, which allows consumers to look up agents/agencies which are barred from federal participation.[11] As bad actors remain undeterred under current laws and lack of enforcement, The American Legion urges proper staffing of VA's OGC to provide proper oversight of bad actors, the adaptation of an exclusion list on the VA OGC portal, and the reinstatement of stiff penalties for unaccredited agencies charging unauthorized fees.

In the spirit of improving the support for disability claim filing, federal employees should be allowed to advocate for veterans. The American Legion has more than 3,500 accredited service officers that provide no-cost services to veterans. This pool could be significantly larger if current restrictions under 18 U.S.C. § 205, which prohibits federal employees from representing any individual seeking benefits before the Department of Veterans Affairs, were amended. Moreover, 38 C.F.R. § 14.629 also restricts employees of any civil or military department or agency of the United States from serving as accredited representatives before VA. As of 2024, there are approximately 700,000 veterans, many of them members of The American Legion and other VSOs, employed in various federal departments and agencies who are statutorily disqualified from being able to assist disabled veterans with filing for their earned VA benefits, simply due to their employment status.[12] Allowing accredited federal employees to provide pro bono claims work could surge the number of veterans service officers and help alleviate the need for veterans to turn to predatory claims agencies for assistance.

Another priority for The American Legion is improving the VA Foreign Medical Program (FMP). Created in 1959, the FMP provides medical care for service-connected conditions for veterans living overseas, either temporarily or permanently. A February 2025 GAO report outlined many flaws in the program's reimbursement system. Partially due to VA's current hiring freeze, systemic staff vacancies, and use of mailed paper checks, VA has been able to meet its goal of reimbursement within 45 days only 14% of the time in FY2024 and 37% of the time in FY2025.

While VA is piloting an e-transfers system for the FMP to make international payments to over 240 countries in 150 different currencies through a web-based application, GAO found that VA still overwhelmingly mailed hard-copy checks. This paper system leaves mail susceptible to getting lost, damaged, stolen or checks being fraudulently cashed. Due to other countries' unreliable road infrastructure and antiquated postal services, GAO estimated that the number of "undeliverable" checks is around 2,600 a year.[13] During VA-VSO partnership meetings in 2025 with service officers stationed overseas, VA announced that their electronic funds transfer plan for international payments should be rolled out between May and June of 2026. With FMP's reimbursement processing time slipping from 4-6 weeks to roughly 4-6 months,[14] it is imperative for VA to improve both its staffing model and reimbursement modernization efforts. As a result, Veterans on a fixed monthly income are experiencing long processing times and other related reimbursement impacts, such as exchange-rate losses, accrued medical debt and unforeseen out-of-pocket expenses.

Finally, a disparity exists in Priority Group 1 veterans (those with at least a VA disability rating of 50% or more) CONUS-based veterans are not required to pay copays for care related to service-connected or non-service-connected medical conditions, while OCONUS veterans may only receive VA-reimbursed medical care for service-connected injuries. Additionally, services offered stateside, such as family planning, home health aide/companion caregiver services, assisted living facilities, and many more, are inaccessible for overseas veterans. Of particular note, the recently passed COMPACT Act waives the co-pay for the first three outpatient mental health visits per year for CONUS veterans, but OCONUS veterans do not receive the same benefit.[15] The American Legion seeks parity so that the 80,631 veterans enrolled in VA FMP receive the same level of care regardless of their location.

What Congress Can Do:

1. Reestablish and enforce meaningful civil and criminal penalties, including potential terms of imprisonment, to deter unaccredited individuals or entities from charging unauthorized and excessive fees. Properly fund staffing level of VA's Office of General Counsel to support robust investigation and enforcement actions against predatory claims agents/agencies. Further, require VA to publicly list unauthorized individuals and entities on its OGC accreditation portal to promote transparency and clear notice to veterans and their families.
2. Waive restrictions to allow federal employees to serve as accredited representatives before the Department of Veterans Affairs.
3. Address the VA Foreign Medical Program's current staffing and modernization needs to prevent veterans from accruing medical debt. Establish parity so that veterans residing overseas with a disability rating of 50% or higher receive the same medical care coverage and benefits as those residing stateside.

Improving the Claims and Appeals Process

Compensation and Pension (C&P) examinations are the most vital part of VA's disability claims process because they determine veteran eligibility to obtain compensation and healthcare. These exams are used by claims adjudicators in the Veterans Benefits Administration to determine whether veterans' illnesses, injuries or conditions are connected to their active-duty military service. With the surge in disability claims created by PACT Act provisions, the need for accurate, thorough and fair medical evaluations has never been more critical. Unfortunately, The American Legion's service officers nationwide have reported serious problems with VA-contracted C&P exams. Troubling issues include poorly trained examiners, unqualified practitioners, questionable "medical facilities" and inadequate medical opinions – which lead to an almost 45% denial rate for PACT Act claims.[16]

Despite efforts for improved quality and processes, VA has increasingly relied on contractors over VHA providers to perform disability exams every year since 2018 (an increase from 55% in FY 2018 to 93% by FY 2024), at the cost of $5 billion per year. Over 90% of C&P exams since 2017 have been contracted.[17] The Office of Inspector General continues to report ongoing challenges in VA's ability to enforce accountability measures for contracted examiners – specifically holding them accountable for delivering exams of acceptable quality. VA's oversight of contracted examiners focuses too narrowly on timeliness and form completion, and not on the quality of the exams. The American Legion is unaware of any instance in which VA has canceled or substantially modified a contractor's contract resulting from documented poor performance, despite repeated deficiencies identified in OIG reports. The American Legion urges Congress to pass S.2493, the Medical Disability Examination Improvement Act of 2025, to address these serious shortcomings. Congress must explore legislative solutions to hold vendors accountable for accurate and timely evaluations.

Military Sexual Trauma (MST) disability claims remain a significant concern. The Military Sexual Trauma Claims Coordination Act (Pub. L. 117-303) was signed into law in December 2022 to mandate that VA improve claims coordination between the Veterans Health Administration (VHA) and the Veterans Benefits Administration (VBA) within 18 months of enactment. Despite

the deadline written in statute, VA took two years to complete the rollout.[18] Currently, MST claims are among the most frequently denied claims due to issues such as a lack of evidence (military and non-military), duty to assist and the incorrect processing of claims. This most notable challenge includes miscommunication between the Compensation Services, the Office of Field Operations, and Regional Offices.[19] Additionally, many survivors lack traditional military records documenting their assaults, leading to wrongful denials under the unimproved claims process. VA classifies MST as a subset of post-traumatic stress disorder (PTSD), but the high denial rate of these claims (57%) due to incorrect processing is alarming.[20]

During a 2024 System Worth Saving (SWS) town hall hosted by the American Legion Post 1 in Phoenix, many veterans expressed their concern with the poor communication and lack of updates on their MST claims. A veteran reported not receiving any VA correspondence for eight months and waiting for more than 250 days for a decision on their claim.[21] This frustration was also identified during a March 2025 Regional Office Action Review (ROAR) site visit to the San Juan Regional Office in Puerto Rico. While the Regional Office (RO) itself exhibited high morale and work productivity, The American Legion was surprised to learn that the center responsible for handling all MST claims was relocated from San Juan to Montgomery Regional Office in Alabama. This was especially concerning, considering the San Juan RO staff exhibited great work productivity and experience in handling MST claims. Significant logistical challenges combined with staff inexperience contribute to the MST claim backlog and contribute to MST remaining one of the most denied service-connected disabilities. The American Legion supports passage of H.R. 2576, the Servicemembers and Veterans Empowerment and Support Act of 2025 (SAVES), which seeks to correct the long-standing and well-documented claims deficiencies in VA's MST claims process. The American Legion urges quick passage of the necessary MST claims reforms to ensure that survivors receive the dignity, care and justice they deserve.

The American Legion's Veterans Service Officers (VSOs) have often noted issues with the Board of Veterans Appeals (BVA) being excessively stringent on the interpretation and application of 38 U.S.C. § 7107. where they believe the legal standard of "good cause" for priority placement on the docket was met by the client, yet it was denied by BVA. For instance, VSOs report the situation of clients who are temporarily staying with friends or family after an eviction or inability to pay rent. While these veterans are technically not homeless, their circumstances fall squarely within the intent of section 71017, but BVA denied priority placement. Other examples include veterans with accrued medical debt for the cost of treatment of primary/secondary conditions still pending adjudication regarding service-connection, pushing veterans further into dire financial distress. To reduce BVA's appeals backlog, The American Legion supports passage of H.R. 3835, the Veterans Appeals Efficiency Act of 2025, to improve the priority placement process and prevent pushing veterans further into dire financial distress.

During The American Legion's ROAR site visits, we noted that the average professional experience for Veteran Service Representatives (VSRs) and Rating Veteran Service Representatives (RVSRs) is about three years, which is considerably lower than expected. This lack of experience is concerning, as this staff performs pivotal work that has life-changing ramifications for veterans and their families. VA staff continue to struggle under shifting guidance, inconsistent training, outdated development standards, and rotational leadership. Recognizing all these challenges, Congress introduced H.R. 3854, the Modernizing All Veterans and Survivors

Claims Processing Act, to modernize the system and streamline workflow. VA testified that it was already piloting or fielding automation and AI capabilities as early as 2021 with great success.[22] Most legislation is primarily focused on efficiency, but true success will depend on continued investment in the human workforce and clear oversight to ensure technological solutions are transparent, ethically grounded and supported through accountability.

RVSRs interviewed during ROAR visits at the San Juan and Louisville ROs expressed significant concerns regarding the effectiveness of automation in the claims adjudication process – common feedback that The American Legion hears frequently in the benefits arena as well. Staff reports that automation is often unable to accurately interpret handwritten information submitted by servicemembers on VA form 526EZ. As a result, critical data is not being extracted or auto populated into the system, requiring the RVSRs to spend additional time manually reviewing and inputting information that should otherwise be automated.

The limitations of automation are especially visible in the translation of benefits letters, particularly English to Spanish correspondence. The current AI translation method performs literal, word-for-word translations which do not consider regional dialects, cultural nuances, or colloquial phrasing.[23] Automation and artificial intelligence have theoretical promise but have also introduced more layers of inefficiency rather than resolving existing workflow problems. The American Legion urges Congress to reform the claims-automation process to restore trust, improve rating outcomes, and ensure veterans receive timely and accurate decisions.

What Congress Can Do:

1. Pass **S. 2493 – Medical Disability Examination Improvement Act** of 2025 to increase oversight and accountability of third-party C&P vendors.
2. Pass **H.R. 2576 – Servicemembers and Veterans Empowerment and Support Act** of 2025 (SAVES) to correct the well-documented deficiencies in VA's MST claims process and remove barriers to care and compensation.
3. Pass claims modernization legislation such as **H.R. 3835 – Veterans Appeals Efficiency Act** of 2025, or **H.R. 3854 – Modernizing All Veterans and Survivors Claims Processing Act.**
4. Pass **H.R. 3983 – Claims Quality Improvement Act** of 2025, to address training, claims policy and improvements in BVA appeals.

Champion Women Veterans Health

Women have served this country since the American Revolutionary War, and there are approximately 2.3 million women veterans in the United States, with 870,000 enrolled in VA healthcare.[24] Women are the fastest growing cohort of veterans, and these numbers are projected to increase over the next few years.[25] The majority of women veterans who use VA medical care served during the Gulf War and in post-9/11 operations.[26]

Women veterans experience specific challenges to their mental health that are unfortunately manifested through their higher rates of suicide. Between 2020 and 2021, women veteran suicide rates increased by 24.1%, while male veteran suicide rates increased by 6.3%. VA can be lauded for efforts to enhance knowledge and research, such as the creation of the Women's Health

Research Network (WHRN) and the Women Veterans Suicide Prevention Research Work Group, but more can be done. Because women veterans face unique challenges related to their service, such as higher rates of MST, it is essential that focused, specific solutions are developed for this population. The suicide rate for women veterans is 166.1% higher than the rate for non-veteran women.[27] It is important to note that firearms were used by women more often than all other methods combined, and the rate of women veterans dying by firearm suicide was 281.1% higher than for non-veteran women.[28] Special attention to women veterans' mental health is critical for their well-being.

In addition to mental health needs, women veterans also use VA for gender-specific care and to address all stages of their reproductive health. VA provides various infertility treatments for veterans enrolled in VA health care, including infertility assessments and counseling, laboratory tests, genetic counseling and testing, surgical correction, intrauterine insemination, tubal ligation reversal, oocyte cryopreservation and sperm cryopreservation, and sperm retrieval. However, in vitro fertilization (IVF) and other assistive reproductive technology (ART) procedures are not covered unless caused by service-connected medical issues. Previously, this policy covered only those who were in legal heterosexual marriages, but VA announced in January 2024 that it would follow the Department of Defense's lead to broaden coverage to single servicemembers and same-sex couples, both married and unmarried.[29] By April 2024, VA amended VHA Directive 1334(1): In Vitro Fertilization Counseling and Services Available to Certain Eligible Veterans and Their Spouses, to reflect this change.[30] Despite the expansion, VA still does not pay for donor eggs, donor embryos or surrogacy for veterans. Additionally, after an Alabama Supreme Court ruling in February 2024 suspended IVF treatment services across the state, access to IVF care is even more critical to monitor and examine, as reproductive rights and access to referred care (for IVF services) now vary by state.[31]

Almost half of women veterans enrolled in VA care are between the ages 45 and 64, making this middle-age group the largest among women enrolled in VA healthcare.[1] 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.[2] The symptoms of menopause are often exacerbated in women veterans due to their military experiences that have led to chronic physical and mental health conditions.[3] The American Legion applauds VA's efforts on this issue to date, but there is still room for improvement. The American Legion is in full support of age-inclusive research. Research related to menopause, perimenopause or mid-life women's health for veterans is imperative, and VA must ensure that women veterans are able to have an optimal quality of life. Although the journey of menopause is a natural stage in a woman's life, women veterans should not have to "tough it out"[5] without proper diagnosis and treatment.

While intimate partner violence (IPV) affects all genders, women veterans may be disproportionally impacted by IPV.[32] According to the VA IPV Assistance Program, IPV affects veterans of all races, ethnicities, incomes, ages, sexual orientations, gender identities, cultures, religions and abilities; yet LGBTQ+ veterans are two-to-three times more likely to experience IPV than heterosexual women veterans.[33] While Congress can be lauded for addressing violence prevention nationwide, VA's IPVAP Coordinators noted during an August 2022 VA Advisory Committee on Women Veterans that VA has many underused resources to develop partnerships

with local shelters, courthouse services, law enforcement and community services. The most critical need for IPV survivors is still securing safe housing. Survivors of IPV commonly report housing instability related to their experience, warped definitions of housing safety and security, and reduced ability to access housing and support programs due to their experiences.[34]

Per VA's Military Sexual Trauma Data, one in three women report that they have experienced MST.[35] In 2022, H.R. 2724, VA Peer Support Enhancement for MST Survivors Act, and H.R. 7335, MST Claims Coordination Act, were signed into law. While the former delineates that MST peer-support specialists are not responsible for adjudication of claims, the latter requires VA to provide coordinated dissemination of information about available support services. Women veterans report MST at significantly higher rates than their male counterparts, and those who identify as LGBTQ+ report it at even greater rates. While VA has conducted MST research, their findings show great variation in the experiences and health outcomes of MST survivors.[36] VA does offer services such as designated MST Coordinators at all VA facilities, but further expansion of health care is imperative for women veterans.

Many veterans find it challenging to transition between VA care and care in the community after a cancer diagnosis.[37] There is often limited information exchange between VA and community care providers, which can lead to missed medical information such as important medication and diagnosis histories. Breast cancer is one of the leading cancers in women veterans,[38] and there are several preventative therapies for women who are at increased risk of breast cancer, including chemoprevention, prophylactic surgery and enhanced screening. In 2021, VA established the Breast and Gynecologic Oncology System of Excellence (BGSoE), to provide women veterans with the best possible cancer care.[39] Through BGSoE, veterans can access telehealth oncology services, which are exceptionally advantageous for veterans in rural communities, and a comprehensive cancer-navigation program. Cancer-care services in VA are monitored by the Center for Oncology Outcomes Review and Gender (COURAGE). COURAGE was developed to improve women's cancer care in VA, with the goal of more equitable outcomes in cancer treatments for women.[40]

What Congress Can Do:

1. Pass **S. 1245 – Servicemembers and Veterans Empowerment and Support (SAVES) Act.**
2. Pass **S. 609 – Building Resources and Access for Veterans' Mental Health Engagement (BRAVE) Act.**
3. Pass **H.R. 219 – Improving Menopause Care for Veterans Act.**
4. Reauthorize the Women Veterans Task Force and ensure the inclusion of the Veterans Service Organization (VSO) community.
5. Address and ensure comprehensive fertility coverage for veterans to include IVF and continue to mirror DOD IVF protocol.

Recognizing the Next Generation of Toxic Exposure

The Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics Act (PACT Act), passed in 2022, successfully helped thousands of veterans exposed to toxic environments receive the healthcare care that they have earned. Since then, The American

Legion has been pushing for full recognition of the diseases and conditions caused by veterans' service to the country.

While the nation still grapples with the medical consequences of the midcentury conflicts to our veterans, the PACT Act has significantly improved the Presumption Decision Process (PDP). Prior to the PACT Act, it was the responsibility of veterans to prove their conditions were "more likely than not" caused by their service. The PACT Act removes the burden of proof from veterans and their families and places it with VA, in partnership with DOD and the National Academies of Science, Engineering, and Medicine (NASEM). When VA recognizes there may be a disease cluster, NASEM then conducts epidemiological studies to determine who is affected, then provides recommendations on presumptive service connection to VA. If there is not enough evidence to determine if a connection exists, VA has the authority to add the presumptive service connection to those conditions and veteran cohorts. While this is a scientifically sound process, it can take a considerable amount of time – time that some veterans might not have.

Environmental exposures include more than just burn pits and Agent Orange; military service is an inherently dangerous business, which we learn more about every day. Blast injuries caused by explosions, or overpressure, can injure the brain and lungs.[41] Per- and polyfluoroalkyl substances (PFAS), chemicals commonly used for fire suppression on bases, can cause long-term kidney injuries.[42] Imaging equipment installed on aircraft can cause radiation injuries, including cancer.[43] Each Military Occupational Specialty, each era served, and each location comes with its own unique hazards, and The American Legion pushes Congress and VA every day to keep the promise to care for America's veterans when they come home.

While many of these conditions are perfect for NASEM epidemiological studies and similar avenues opened by the PACT Act, others are not. Cohorts with low populations or unique military occupations do not have enough data for epidemiological studies to be effective or efficient, and it is the responsibility of VA and Congress to ensure these veterans receive the care they have earned.

Part of the challenge is expecting each veteran to know what toxins they were exposed to. The DOD maintains Individual Long Exposure Records (ILER) which could inform veterans of the risks of their service. DOD officials promised Congress that veterans would have access to their ILERs by September 2024, a task that remains incomplete, leaving many veterans in the dark about their own health.[44]

One of the most significant recent mass-exposure incidents involving U.S. servicemembers occurred during Operation Tomodachi, the U.S. military's humanitarian response to the 2011 Tōhoku earthquake and tsunami in Japan. More than 24,000 personnel participated in providing critical aid and logistical support in the aftermath of the disaster and many were exposed to nuclear reactor meltdowns releasing radioactive material into the air and sea. In 2014, DOD completed an initial dose reconstruction that concluded deployed personnel were not at increased risk of cancer.[45] However, more than a decade later, a comprehensive epidemiological follow-up study is urgently warranted to assess potential health outcomes among those who served during Operation Tomodachi.

Finally, in recognition of the sacrifices families have made serving beside military personnel, The American Legion urges Congress to address health-care support for families exposed to toxins while living on military bases. This would consider the health impacts to many families, including those in Red Hill, Hawaii, who were exposed to petroleum in their drinking water supply, and families stationed in Atsugi, Japan, who were exposed to toxic incinerator smoke.

What Congress Can Do:

1. Pass legislation which covers health care for military families exposed to toxins.
2. Pass **S. 800 – Precision Brain Health Research Act,** or similar legislation, which seeks to advance our knowledge on how military brain injuries affect veteran suicide.
3. Pass legislation which provides veterans with access to their own Individual Long Exposure Records.
4. Pass legislation which provides transparency about where cohorts, conditions and toxins are in the Presumptive Decision Process.
5. Intervene and directly provide small cohorts with presumptive coverage.

Healthcare Modernization

The Electronic Health Record Modernization (EHRM) program is set to resume implementation this year, with 13 VA Medical Centers planned for FY2026 rollouts. Secretary of Veterans Affairs Doug Collins said in a June 2025 hearing that, "Acceleration of the EHRM rollout is now a top VA priority."[46] This resumption makes oversight by governmental organizations and VSOs like The American Legion more important than ever.

The EHRM rollout was paused in July 2022 after being implemented at six sites over two years. VA has used the interim time to work on issues that have plagued the system, as well as making upgrades to IT infrastructure at launch sites. These actions will hopefully ensure that when the EHRM project rollout resumes, it can continue forward at a steady pace.[47]

A major issue with the initial round of rollouts was the number of performance incidents with the Oracle-Cerner system. Performance incidents relate to system degradations, meaning that key services were out of operation or degraded. From the start of the first EHRM implementation until early 2024, there were 826 major performance incidents with the system.[48] This improved substantially at the latest launch at Chicago Lovell Federal Health Center. According to VA reports, this has been the most successful rollout for the EHRM project to date.[49] The American Legion saw the success of the Lovell rollout firsthand during an August 2025 System Worth Saving visit to the facility.

VA should continue to focus on promising new medical innovations for treating patients, such as precision (or personalized) medicine. In precision medicine, treatments are tailored to an individual's medical needs using information about their DNA, environment, lifestyle, and more to generate a personalized plan. This data is then used to prevent, treat and diagnose different diseases.

VA has long been at the forefront of medical advancements, with such achievements as implementing the world's first clinically successful pacemaker, performing the first liver

transplant, and leading in the ideas that led to the development of the CAT scan.[50] Continuing this innovative leadership through the rest of the 21st century and beyond will ensure veterans can expect to continue receiving world-class healthcare through VA for decades to come.

What Congress Can Do:

1. Provide robust oversight, holding VA and other relevant parties accountable for the implementation and continuous functioning of the electronic health record system.
2. Provide resources for VA to improve infrastructure and staff training to prepare for the new health record system.

Balance Community Care with Veteran Needs

Access to community care is essential for veterans, particularly those living in rural areas and with unique needs. An estimated 4.6 million veterans reside in rural communities, with 58% of them enrolled in VHA, compared to 38% for urban veterans,[51] underscoring the need for accessible healthcare options. The American Legion firmly believes that VA should remain the cornerstone of veteran care.

One of the largest changes in VA medical care in the past few decades was the passage of the CHOICE Act, later updated as the MISSION Act, after the Phoenix wait-list scandal made it clear that veterans needed the ability to access community health-care providers. Congress' intent with MISSION was clear: While strengthening VA's ability to provide direct care by improving recruiting and retention of VHA providers and addressing aging VA infrastructure though the Asset and Infrastructure Review (AIR) Commission, the VHA was directed to increase access to community providers when it could not provide care in a reasonable time and/or distance, or if access to an outside provider was in the best medical interest of the veteran.

From a broad perspective, the integration of community care to supplement the VA direct-care system has been an important relief valve to ensure a tragedy like Phoenix never happens again and has played a large role in ensuring veterans get the care they need, when they need it. However, despite large increases in VA FTEs, disregard for the AIR Commission recommendations[52] and the patchwork approach to VA's infrastructure needs, the budget for community care has ballooned. This has naturally resulted in debates on balancing funding for VA's direct-care system and adherence to eligibility requirements.

The Legion acknowledges the natural friction between funding the VA direct-care system and the demand for community care, particularly in a world of budget uncertainty, aging infrastructure and a declining veteran population. Congress must address the infrastructure gaps while also ensuring the VA direct-care system is strengthened. In the absence of adequate VA capacity, the needs of the individual veteran must be prioritized. Since MISSION passed, there have been credible reports of VA administrators overruling decisions by VA providers and patients to keep veterans inside the VHA system rather than referring them to community care.

The American Legion strongly supports keeping the VHA as the coordinator of care for veterans, but if VA cannot provide veterans the care they need, when they need it, community providers are the only realistic solution in the best interest of the individual veteran. The American Legion

supports the new provision VA has implemented from the Senator Elizabeth Dole 21st Century Veterans Healthcare and Benefits Improvement Act which removed VA's requirement for a second doctor to approve referral for care in the community,

The FY2025 VA near-miss budget shortfall highlighted a significant concern with community care costs. Although The American Legion strongly supports community care as a vital service to veterans, over $150 billion has been spent on community care providers since 2015.[53] Costs for care in the community have grown approximately 20% annually since 2019,[54] whereas internal VA costs have remained stable.[55] This increase is primarily due to expanded eligibility under legislation such as the MISSION Act, the Dole Act, the PACT Act, and the COMPACT Act. This legislation contributed to an increase of VA patients to roughly 8,346,327 in 2024 which includes Gulf War and Vietnam Era Veterans.[56] This influx of patients increased community care cost estimates to $17.6 billion in 2021,[57] prompting discussions on how this negatively impacts resourcing the VA healthcare system overall.

The increased demand for community care and eligibility expansion was intended to help veterans schedule appointments in a reasonable amount of time. However, there are a growing number of veterans who express displeasure with this process, citing that there is no difference between VA and community care wait times.[58] Since Aug.10, 2022, 739,421 veterans have enrolled in VA health care. This includes 333,767 enrollees from the PACT Act alone,[59] which is 50,000 more enrollees than the previous year.[60] Although this expansion requires continued attention, the balance between community care and VA care appears stable for now.

The American Legion supports allowing VA providers to provide telehealth appointments to patients outside of the state they are licensed in. To help alleviate high demand, VA released a rule allowing this in 2018.[61] An additional rule allowing physicians to prescribe across state lines was released in 2020 to offset the effects of the COVID-19 pandemic.[62] However, these rules are not yet codified into law. The American Legion supports H.R. 1107, the Protecting Veteran Access to Telemedicine Services Act of 2025, which would permanently codify these rules.

Billing and reimbursement have historically been pain-points for community care. Delays in payment to community providers discourages partnerships with VA.[63] However, VA is introducing External Provider Scheduling (EPS), a new system that allows VA staff to book appointments directly into community providers' schedules. This eliminates staff making multiple phone calls to confirm preferences and availability. While EPS shows promise, its current limited rollout means that most veterans are not yet experiencing its benefits.

Rural veterans face unique challenges when it comes to obtaining care at VA and in the community. For instance, the lack of internet connectivity makes it difficult for rural veterans to attend telehealth visits.[64] It is critical that rural broadband access be expanded and veteran transportation programs be improved. Transportation to appointments in the community remains an issue for veterans, particularly rural veterans. The American Legion supports the improvement of transportation programs to alleviate this issue, as well as VA reimbursement for emergency care flights for veterans.

What Congress Can Do:

1. Pass **S. 275/H.R. 740 – Veterans ACCESS Act.**
2. Pass **H.R. 1107 – Protecting Veteran Access to Telemedicine Services Act.**
3. Ensure veterans receive any bills for copays quickly and do not receive surprise bills months after treatment.
4. Pass legislation codifying rules VA is currently using to allow doctors to treat and prescribe remotely for patients outside the state in which the provider is licensed.

Enhance Caregiver and Survivor Support

The aging veteran population is expanding rapidly, presenting critical long-term planning challenges for today's caregivers. There are an estimated 8.1 million veterans age 65 or older, with the largest cohort made up of males between 74 and 76 years old.[65] Veterans advanced in years often face challenges with gaining access to medical care, navigating mobility issues, and being able to live independently. Additionally, those advanced in age face steeper medical care costs than younger cohorts.[66] Despite wishing to remain and age in place, the National Council on Aging found that 60% of older American adults have not financially secured enough to afford two-years' worth of long-term service and support.[67] Compounded with service-connected injuries and illnesses requiring more around-the-clock monitoring and care, the ability to honor a veteran's preference to age in place will be financially difficult. Correlation studies show that those provided with autonomy to age in place experience fewer hospital visits and fewer complications from facility-spread infections.[68] Additionally, veterans suffering from chronic conditions have better health outcomes with personalized home-based care and assistive technologies.

Aging in place does have its share of challenges. Veterans presenting declining physical health, cognitive changes, or other disabilities are often challenged to maintain safety and independence in the home. Hazards, such as improper medication management, barriers to access to medical services, and falls can lead to increased risk of injury or hospitalization. It is imperative that these challenges are addressed through home modifications that assist veterans with their independent living needs. Professionals like occupational therapists and physical therapists can help people improve their mobility and perform certain activities of daily living (ADLs). Additionally, being granted access to a visiting nurse for primary medical care needs and home-health aides to assist with mobility, medication management and meal preparation can greatly improve the overall well-being of these veterans. Providing these necessary resources to help caregivers keep taking care of veterans in their homes promotes dignity, independence and overall well-being while also reducing the strain on healthcare systems and long-term care facilities.

To address the growing needs of the aging veteran population, the Senator Elizabeth Dole 21st Century Veterans Healthcare and Benefits Act (or the 21st Century Dole Act), enacted in January 2025, expanded home and community-based care initiatives to support veterans who choose to age in place. The 21st Century Dole Act also includes a pilot program to hire nursing assistants for in-home care in underserved regions. Additionally, section 120 increases the reimbursement cost of VA's home nursing cost from 65% to 100%, making essential home medical services more accessible.[69] The 21st Century Dole Act increases the days VA can offer in respite care to no less than 30 annually for a veteran's assigned family caregiver.

Lastly, section 123 mandates VA to address its Veteran Directed Care (VDC) staffing models and directs the Secretary of VA to ensure that VDC and the VA Homemaker and Home Health Aide programs are administered through each VA Medical Center within two years. The 21st Century Dole Act also requires the VDC program to be made as practically available in remote areas such as American Samoa, Guam, the Commonwealth of the Northern Mariana Islands, Puerto Rico, U.S. Virgin Islands, and any other U.S. territories; the same requirements are to be provided for Native American veterans receiving care and services furnished by the Indian Health Service. VA must fully implement these changes to ensure VDC is available at all VA Medical Centers, as the program is available at 95 VAMCs, as of spring 2025.[70]

Caring for a loved one who has served in the military presents a unique set of challenges. Caregivers played a major role in a veteran's time in service, and their support often continues after military duty ends. Caregivers frequently assist with medical appointments, rehabilitation, and activities of daily living for veterans coping with physical or psychological disabilities. With so many home-based care initiatives offered through VA, Congress needs to remain vigilant to ensure that VA can administer the various funded programs.

In efforts to support Caregivers, VA offers the Program of Comprehensive Assistance for Family Caregivers (PCAFC), a clinical-based program requiring a veteran to have a 70% VA-disability rating first to be eligible. PCAFC provides an array of specialized services and support offered to assigned family caregivers, such as a monthly stipend, CHAMPVA health insurance, family therapy coverage, and other training resources. However, many American Legion service officers report that PCAFC's in-home assessment and years-long appeals process are confusing and discouraging, where veterans would receive a more favorable disposition when applying for VA's other in-home assistance programs, such as VA Aide and Attendance (A&A) or VDC. One American Legion service officer in the central Virginia area stated that the application to be approved for veteran's self-directed care program and A&A could be approved within 60 days (vs. year-long wait times for appeals after a PCAFC denial). As section 124 of the 21st Century Dole Act requires VA to provide a veteran or family caregiver who does not qualify for PCAFC with the option of obtaining clinically appropriate services under any other available home- and community-based services managed by VA, this provision requires congressional oversight to ensure compliance.

In 1993, VA established the Dependency and Indemnity Compensation (DIC) benefit to support an eligible spouse, child or parent of a servicemember who died in the line of duty or for a survivor of a veteran who died from a service-related injury or illness or who had a VA disability rating of 100% total for at least 10 years prior to the veteran's death. DIC is offered to about 438,691 survivors nationwide, as of 2021,[71] and is a lifeline for families working to rebuild after loss. However, The American Legion recognizes that the program is well overdue for an update.

Notably, the stringent "10-year" rule is unjust – especially for veterans living with Amyotrophic Lateral Sclerosis (ALS) and whose average life expectancy is much shorter, ranging from 2-5 years. Caregiving is just as difficult for these veterans, but most will not survive their serious condition to even meet half of the length of disability requirement to qualify for DIC. Furthermore, other inequalities exist where VA's monthly DIC rate only provides 43% (or $1,653) of a single 100% disabled veteran's compensation, compared to 55% ($2,107) when a former spouse of a

federal employee or retiree files for Basic Employee Death Benefit under the Federal Employees Retirement System.

In addition to this inequity, DIC recipients lose their benefits if they remarry before the age of 55. This remarriage rule penalizes surviving spouses who are forced to choose between financial stability or personal happiness. Congress must take action to end this archaic policy that underscores the need to ensure the surviving spouses of those who paid the ultimate sacrifice for our nation receive adequate financial support and stability – especially given their higher likelihood of being widowed at a younger age.

What Congress Can Do:

1. Provide close oversight of the Dole Act implementation so that qualified disabled veterans wishing to age in place, and their caregivers, can obtain the long-term, home-based support they have earned.
2. Provide oversight or direct intervention to the Program of Comprehensive Assistance for Family Caregivers to correct the eligibility criteria.
3. Pass **H.R. 680 – Caring for Survivors Act**, to remove the 10-year rule and bring parity with other federal benefits programs like the Basic Employee Death Benefit received under the Federal Employees Retirement System by increasing the amount of DIC compensation for survivors.
4. Pass **H.R. 1004 – Love Lives on Act** of 2025, to remove the arbitrary remarriage penalty.

Underserved Veterans

Black Americans, American Indians and Alaskan Natives have long demonstrated high propensity to serve in the U.S. military, providing exceptional service and sacrifice. In particular, American Indians and Alaskan Natives have one of the highest per-capita representations in military service. Similarly, Black Americans have served in every major conflict since the Revolutionary War and continue to be a vital part of the veteran community. Despite their contributions, these underrepresented groups often face systemic barriers in accessing the benefits and care they have earned.

Underrepresented veterans face a number of challenges utilizing the benefits afforded to them for their service to this country. Veterans living in rural America, for example, face unique struggles related to travel, telehealth, community care and the digital divide. To meet their needs, Congress must prioritize equitable travel reimbursement policies, expand local care options and invest in broadband infrastructure to ensure rural veterans can access timely and quality care. Furthermore, culturally competent care must be a cornerstone of VA services. This includes robust training for VA staff to understand and respect the diverse backgrounds of veterans, as well as improved outreach to historically underserved populations.

For Native communities, tribal health is considered rural health, and care access is often hindered by geographic isolation, limited infrastructure and cultural disconnects. PL 116-315, the Johnny Isakson and David P. Rose, M.D., Veterans Health Care and Benefits Improvement Act of 2020, established the VA Advisory Committee on Tribal and Indian Affairs to advise on all matters related to Indian tribes and organizations. Since then, VA has developed partnerships to enhance

access to services and benefits. However, these largely rural veterans still face challenges in accessing health care due to location, digital divides and cultural barriers. Improvements in VA data collection and cultural competency training will help address these disparities and improve access to services for American Indian and Alaska Native veterans and their families.

Black veterans, meanwhile, frequently encounter disparities in health outcomes, mental health support and disability claims processing – issues compounded by historical inequities and implicit bias. Congress must continue addressing the disparities these veterans face when attempting to utilize their benefits and recognize the need for cultural competency training within VA. To address these disparities, Congress should support enhancements in VA data collection and analysis, including the development and refinement of health disparity dashboards. These tools are essential for identifying trends, allocating resources and crafting targeted interventions.

VA works with nearly 200 minority-serving institutions (MSIs), to include Historically Black Colleges and Universities, Hispanic Serving Institutions, Tribal Colleges and Universities, and Asian American and Pacific Islander Serving Institutions. To strengthen partnerships between MSIs and VA, the department conducted a Minority Summit in 2021; the goal of this summit was to increase diversity in VA's workforce. VA trains about 20,000 health professionals from MSIs each year. This collaboration is exemplified in the partnership between Atlanta VA Medical Center and Morehouse School of Medicine. Through this partnership, the institutions participate in a VA pipeline initiative known as the CORE Recruiting site.[72] This program focuses on recruiting and retaining scientific researchers from the institution. VA has established partnerships with Historically Black Colleges and Universities (HBCUs) to support this pipeline.

Regarding LBGTQ+ veterans, The American Legion recognizes that the process for upgrading unlawful discharges for former service members during the "Don't Ask, Don't Tell" (DADT) era has not been streamlined and must be addressed. Ensuring that all veterans – regardless of race, ethnicity, sexual orientation or geographic location – receive fair treatment and full access to benefits is not just a policy goal; it is a moral imperative. The American Legion urges Congress to streamline and simplify this process and ensure that the grave injustice done to LBGTQ+ veterans during this era is corrected.

What Congress Can Do:

1. Support legislation and funding to strengthen VA data collection and analysis systems, including the continued development and refinement of health disparity dashboards.
2. Authorize and fund the expansion of VA mobile units equipped with specialized tools and culturally responsive resources to improve outreach and access to care for Native veterans in remote and rural areas.
3. Ensure sustained support for VA programs that build and maintain education and workforce pipelines through Minority-Serving Institutions, fostering diversity in the VA workforce, and improving cultural representation in veteran care.
4. Direct VA to identify and address systemic disparities in healthcare access and outcomes for minority veterans, ensuring equitable care across all facilities and programs.
5. Require and fund expanded cultural competency training for staff to better serve diverse veteran populations.

VETERANS EMPLOYMENT & EDUCATION

End Veteran Homelessness

Ending veteran homelessness, along with mitigating its root causes, is essential to ensuring the well-being and dignity of veterans and their families. Veteran homelessness is driven by a variety of complex, interrelated conditions, ranging from substance-abuse disorders and untreated mental health conditions to unemployment, financial instability and legal challenges. The convergence of these factors underscores the need for a multifaceted approach to effectively address and resolve veteran homelessness.

The Department of Housing and Urban Development's (HUD) annual Point-In-Time (PIT) count provides an estimate that approximately 33,882 veterans are currently experiencing homelessness in the United States, including Puerto Rico and the District of Columbia.[73] Veterans make up a disproportionate share of the homeless adult population, representing about 5.3% of all homeless adults across these regions.[74] Despite significant progress made since 2009, with both sheltered and unsheltered veteran homelessness decreasing by 49%, considerable work remains to be done to ensure that no veteran is left without stable housing. The persistence of this issue highlights the need for continued efforts and innovative solutions in addressing the root causes of homelessness among veterans.

To more effectively combat veteran homelessness, it is imperative to implement policies that provide comprehensive support to at-risk and homeless veterans and their families. These policies should include access to tailored advice and counseling, assistance in navigating the complex processes of obtaining care and benefits, financial aid and career-development programs, as well as workshops focused on business development and entrepreneurship. By offering these essential resources and interventions, the nation can better equip veterans to overcome the barriers they face, ensuring they have the tools needed to rebuild their lives and regain stability and self-sufficiency.

What Congress Can Do:

1. Provide a higher allocation of project-based HUD-Veterans Affairs Supportive Housing (VASH) vouchers for homeless veterans.
2. Ensure enhanced use leasing specifically provides permanent benefits, resources and services to the veteran community.
3. Permanently authorize the Supportive Services for Veteran Families program with an adequate funding of ~$800 million per year.
4. Fully fund the Grant Per-Diem program as authorized by the Senator Elizabeth Dole 21st Century Veterans Healthcare and Benefits Improvement Act at $350 million per year.

Pass Guard and Reserve GI Bill Parity

National Guard and Reserve servicemembers play a critical role in defending our nation's borders, responding to public health crises, and supporting local law enforcement. These servicemembers frequently face unique challenges on the home front, often leaving behind their families and

civilian jobs for extended periods, sometimes at a considerable financial loss. Despite their significant contributions, they are often denied a fundamental benefit: the GI Bill.

Under current law, National Guard and Reserve servicemembers accrue GI Bill entitlement only when activated under federal orders. When activated under state orders, they do not qualify for GI Bill benefits, creating a significant disparity in access to these crucial resources. This issue became particularly apparent during the COVID-19 pandemic when many National Guard units were activated in response to the public health emergency. 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 the thousands who responded to civil rights protests in 2020 did not.

The arbitrary distinction between federal and state orders in determining GI Bill eligibility is unjust and should be eliminated. 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. It is time for Congress to rectify this discrepancy and extend GI Bill eligibility to all National Guard and Reserve servicemembers, regardless of the nature of their activation.

What Congress Can Do:

- Pass **H.R. 1423 – Guard and Reserve GI Bill Parity Act** of 2025.
- Pass **H.R. 6975 – Duty Status Reform Act** to simplify Guard and Reserve pay and benefits accounting.
- Hold DOD and the National Guard Bureau accountable for notifying National Guard and Reserve servicemembers regarding their GI Bill eligibility.

Support Access to Capital for Veteran Owned Small Businesses

Currently, there is no platform, grant or funding mechanism that permits direct lending to a veteran through the Small Business Administration (SBA). As a result, veterans who have limited access to credit or capital often struggle to qualify for certain SBA loan programs, particularly if they just need startup and operational capital to launch and stabilize their businesses.

Most businesses are built and driven with the assistance of professional networks, relationships and familiarity within the community in which they reside. Veterans present a unique challenge, as they are often less likely to have established local relationships following military service or sufficient initial capital to fully fund their business ventures.

A new VA-style pilot program is needed, compared to current systems, because existing small-business capital programs still rely heavily on private lenders, exclude many veterans due to strict credit requirements, and do not provide mentorship, business plan vetting or milestone-based support. Current SBA programs only offer loan guarantees rather than direct lending, which limits accessibility for veterans who lack collateral or credit history.

What Congress Can Do:

1. Introduce legislation, regulatory reforms or pilot programs that reduce financial barriers.
2. Strengthen the economic outlook for veterans seeking to start or grow businesses.
3. Maintain appropriate safeguards for fiscal responsibility and long-term program sustainability.

Prioritizing Veterans in Federal Contracting

All federal agencies must prioritize veteran-owned small businesses in their procurement strategies to foster robust veteran entrepreneurship and strengthen public-sector supply chains. While the federal government has a 5% SDVOSB contracting goal, performance remains uneven across agencies and consistent implementation is still needed. In FY2024, the federal government awarded 5.14% of contracts to Service-Disabled-Veteran-Owned Small Businesses (SDVOSBs).

To strengthen results across the federal enterprise, agencies must make sustained efforts to expand the pipeline of SDVOSB prime awards and ensure fair access to set-aside and sole-source opportunities when appropriate. The Department of Veterans Affairs (VA) provides a proven model through the Veterans First Program (Vets First), which has helped VA lead all agencies in SDVOSB utilization. Through its verification authority, Vets First increases SDVOSB participation in federal procurement and creates clearer pathways for qualified firms to compete and win.

What Congress Can Do:

1. Hold agencies accountable for meeting prime and subcontracting procurement spending goals for SDVOSBs.
2. Codify safeguards to mitigate the negative impacts of category management and ensure that SDVOSBs can compete fairly in the federal marketplace.
3. Include language in the National Defense Authorization Act directing the Department of Defense to adopt the Vets First procurement model.
4. Require every federal agency to apply the Rule of Two when market research indicates at least two capable SDVOSBs can compete.

Increase Military Tuition Assistance

The Department of Defense (DOD) first introduced Tuition Assistance (TA) to service members in the 1950s as part of an effort to cultivate a more educated military force and to provide servicemembers with opportunities for career success after their military service. This initiative aimed to improve both the personal development of individuals and the overall capability of the military. In 1985, the National Defense Authorization Act (NDAA) granted DOD the authority to fund voluntary education programs, including TA. Then, in the fiscal year 2001 NDAA, Congress further expanded this authority by allowing the secretary of a military department to pay the full tuition expenses for servicemembers pursuing higher educations.

Despite receiving the authority to cover these educational costs, the individual branches of the military chose to implement caps on the amount of TA funding they would provide. As a result,

today, TA covers up to $250 per credit hour or $166 per quarter hour, with a maximum annual limit of $4,500.[75] In contrast, the average cost of college tuition has significantly increased. For instance, the average annual cost at private colleges is $44,961, while out-of-state tuition at public universities averages $25,415, and in-state tuition for public schools is typically $11,371.[76]

Although the financial assistance provided through TA has remained the same since 2002, the rising costs of tuition have created a widening gap between the support offered by DOD and the actual expenses incurred by servicemembers pursuing their degrees. As a result, many servicemembers are finding it increasingly difficult to complete their educational programs before separating from the military, given the growing financial burden and the limited scope of TA funding.

What Congress Can Do:

1. Appropriate funding specifically for Military Tuition Assistance in all service branches to prevent reappropriation for other purposes.

Support the Modernization and Adoption of Digital TAP

An estimated 200,000 servicemembers separate from the military every year, and public law 101-510 authorized comprehensive transition assistance services and benefits for separating service members.[77] However, the Government Accountability Office (GAO) found in its 2022 study that 70% of servicemembers did not start TAP 365 days in advance of separation.[78] With the lack of participation prior to separation, veterans who are not able to attend TAP are left at a significant disadvantage. This is especially true if they do not have access to critical resources and services. By adopting a digital platform to house resources, services, contacts and other information, veterans can close the gap on services and information they did not receive prior to separation.

Operational requirements often prevent servicemembers from completing TAP. The GAO found 22% of Tier 3 participants did not complete required coursework, and 70% failed to begin TAP one year before separation.[79] Commanders prioritize mission readiness over transition preparation, leaving many veterans unprepared for civilian life. This is an unfortunate challenge that could be resolved if commanders had the ability to place a servicemember in a transitional status within a unit that would not affect their readiness efforts, similar to the framework of wounded warrior battalions. This would allow servicemembers to be able to participate in transitional programs, such as DOD SkillBridge.

Current TAP content is designed primarily for active-duty members and does not adequately address the distinct needs of National Guard and Reserve components. While there are programs like the Yellow Ribbon Reintegration Program (YRRP), there needs to be a set standard for all components of DOD to be able to complete, delivering information necessary for a veteran's success post-transition. There are more than 125,000 servicemembers serving in the Reserve and National Guard components that have prior active-duty service, highlighting an additional need for tailored services rather than a single model for Reserve and active-duty personnel.

What Congress Can Do:

1. Pass **H.R. 1845 – The TAP Promotion Act**, to require that pre-separation counseling under the Transition Assistance Program include a presentation that promotes the benefits available to veterans from the Department of Veterans Affairs.
2. Authorize the development of a digital "for-life" product that veterans can reference at various points during their transition and in civilian life.

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Fund The Armed Forces Retirement Home

In 1851, the Armed Forces Retirement Home (AFRH) began providing housing, residential care and support services to thousands of former enlisted service members, warrant officers and limited-duty officers of all branches of the U.S. Armed Forces. Today, the AFRH operates two communities, which comprise a 272-acre community in Washington, D.C., and a 40-acre community in Gulfport, Miss. With a combined 312 acres of operating space, there is ample opportunity for The American Legion to facilitate partnerships with the AFRH – ensuring that those living in these communities continue to receive the care and support that they deserve; however, the lack of funding provided for the AFRH precludes the expansion of its services to other veterans and places great risk to the hundreds of veterans currently residing in these communities.

As it stands, the AFRH is funded through a trust fund, resident fees, revenue sharing and leasing agreements from building and property assets, and fines and forfeitures from active-duty personnel.[80] Despite this, funding covers only 60% of the cost of care, requiring the AFRH to be subsidized.[81] Given the difficulties that the AFRH faces in acquiring funding, The American Legion supports policies that increase resources to the AFRH – to make certain that the care and support provided by the AFRH are available to those who depend on it.

What Congress Can Do:

1. Enact legislation to increase funding and resources for the AFRH, to ensure its continued support to aging veterans.

NATIONAL SECURITY

Major Richard Star Act

The Major Richard Star Act is bipartisan legislation intended to correct a long-standing inequity affecting medically retired, combat-injured veterans.[82] The bill would authorize full concurrent receipt of Department of Defense (DOD) medical retirement pay and Department of Veterans Affairs (VA) disability compensation for eligible veterans who were medically retired prior to completing 20 years of service due to combat-related disabilities.

Under current law, certain combat-injured veterans who are medically retired with fewer than 20 years of service are required to waive or offset their earned DOD medical retirement pay in order to receive VA disability compensation.[83] This policy creates an inequitable, two-tiered system that arbitrarily distinguishes veterans based solely on length of service rather than the severity or cause

of their injuries. As a result, veterans whose military careers were involuntarily cut short by combat-related wounds are financially penalized for circumstances beyond their control. The Major Richard Star Act would restore fairness by ensuring these veterans receive the full benefits they have earned through honorable service and sacrifice.

What Congress Can Do:

1. Pass **H.R. 1282/S. 344 – Major Richard Star Act,** to authorize full concurrent receipt for medically retired combat-injured veterans.
2. Eliminate statutory offsets that unfairly penalize veterans wounded in combat.

Protect Coast Guard Pay and Entitlements

U.S. Coast Guard personnel carry out missions vital to our national security. Still, they are the only military servicemembers to have had their pay interrupted during the 2019 government shutdown due to their assignment under the Department of Homeland Security instead of the Department of Defense. The repeated and common threat of government shutdowns brings severe and unnecessary hardship on these men, women and Coast Guard families because their branch remains the most vulnerable to pay and benefit delays. Even so, all military members risk pay stoppages during government shutdowns, which can result in unnecessary financial burdens and significant degradation in readiness. During the 2019 shutdown, The American Legion stepped up and issued more than $1 million in expedited Temporary Financial Assistance grants to Coast Guard personnel and their families. Moreover, if the 2025 government shutdown extended much longer, all military members risked going unpaid. To diminish the additional pay and benefit vulnerabilities of the Coast Guard, The American Legion urges Congress to introduce legislation to guarantee that its members are paid, like members of all other military branches, in the event of a government shutdown.

What Congress Can Do:

1. Approve and continue to increase the Coast Guard's budget annually to meet national security requirements and funding priorities such as restoring readiness and recapitalizing legacy assets and infrastructure.
2. Pass **HR. 5401/S. 3030 – Pay Our Military Act** of 2025.

Deported Veterans

Too often, immigrants serve America with honor only to find their rightful path to citizenship cluttered with obstacles. It is time for Congress to improve the naturalization process for patriots who volunteer to serve their adopted nation. Certain non-citizens lawfully present in the United States, including lawful permanent residents, are eligible for military service provided they satisfy all statutory and accession requirements. Between 2019 and 2023, almost 40,000 servicemembers became naturalized citizens while serving in the military. Unfortunately, non-citizen servicemembers have been deported due to the expiration of their green cards, difficulties completing the citizenship application, or for having a felony conviction after honorable discharge. Deportation limits the ability of veterans and dependents to access their earned VA benefits.

Non-citizen veterans who were honorably discharged, had no felony conviction, and were not convicted of a crime of moral turpitude should not be subject to deportation, and should be repatriated immediately. The American Legion supports the reintroduction and passage of the Veteran Service Recognition Act of 2025, which honors the sacrifices of immigrant servicemembers by giving them greater opportunities to become U.S. citizens and preventing their unjust deportation from the country they swore an oath to defend.

What Congress Can Do:

1. Pass **S. 3142 – I-Vets Act** to direct communications between DHS and DOD.
2. Pass **S. 3144 – Veterans Visa and Protection Act** of 2025 to direct the return of eligible veterans deported from the U.S.

Citizenship for Military Service

U.S. citizenship offers greater stability for servicemembers and their families, providing access to benefits and ensuring long-term security for those who volunteer to serve and risk their lives in defense of the nation. However, some veterans are still discharged as non-citizens, without completing the full process to apply for their U.S. citizenship. Challenges with operational tempo, lack of information at the unit level, or misunderstanding of the process often result in these servicemembers departing with their honorable discharges, but no naturalized citizenship.

Those who volunteer to serve this nation should be provided with an expedited avenue to apply for the naturalization process while still serving. Congress must amend policies to allow immediate family members access to an expedited citizenship process, ensuring the family unit is secure and supported. Cooperation between Department of Defense and Department of Homeland Security is essential to sharing information and creating an expedited pathway to citizenship for military service.

What Congress Can Do:

1. Pass **H.R. 5535 – Veteran Service Recognition Act** of 2025

Access to Quality Healthcare for Servicemembers and their Families

Access to reliable health care (TRICARE) is vital to maintaining the military readiness and the well-being of military-family community. Servicemembers and families stationed overseas are challenged with unreliable access to TRICARE services, such as limited specialty care, leading to disparities in care.

The Defense Health Agency (DHA), which manages TRICARE, must continue to adapt and provide robust health care services regardless of location. This includes ensuring that medical facilities and providers abroad meet U.S. standards of care and that telehealth options are available to beneficiaries in remote areas. Across U.S. territories, TRICARE Prime access remains limited due to the lack of accessible military hospitals and clinics. According to a 2024 report, 50% of U.S. military bases are located within federally designated health professional shortage areas.[84]

Access to maternal, OB-GYN, and behavioral health specialists is inconsistent across military bases. Congress should take action to ensure that essential healthcare services remain accessible to servicemembers and their families.

What Congress Can Do:

1. Pass legislation that will strengthen TRICARE services in federally designated health professional shortage areas by allowing beneficiaries to access a wider network of civilian providers.
2. Pass **H.R. 2730 – Military Moms Act**.
3. Pass **H.R. 4769 – Health Care Fairness for Military Families Act of 2025**.

CONCLUSION

Chairmen Moran and Bost, Ranking Members Blumenthal and Takano, on behalf of The American Legion's 1.5 million members, we thank the committees for their commitment to our nation's veterans. As we continue to address the impacts of war and support the readiness of our Armed Forces, I look forward to continue working with the 119th Congress to advance robust, bipartisan, and meaningful legislation. Questions regarding this testimony can be directed to Bailey Bishop, Deputy Director, at b.bishop@legion.org.

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Dan K. Wiley

Dan K. Wiley was elected national commander of The American Legion on August 28, 2025, in Tampa, during the 106th National Convention.

An Air Force veteran, Wiley is a retired state district court judge who raises cattle in Leavenworth, Kan. Following his Air Force service, Wiley obtained a bachelor's degree in business at the College of Great Falls in Montana. He returned to his hometown of Lawrence, Kan., and earned a law degree at the University of Kansas.

Wiley has held many leadership positions at The American Legion post, department (state) and national levels. He is a paid-up-for-life member of Byron H. Mehl American Legion Post 23 in Leavenworth and is a past department commander of Kansas. He also represented the state as a member of The American Legion's National Executive Committee.

Appointed by the Kansas governor as a district court judge in 2008, Wiley helped establish and preside over the Leavenworth County Veterans Treatment Court. He has been active in his community and is a past president of the Leavenworth / Lansing Chamber of Commerce, a past chairman of the Leavenworth County Veterans Day Parade Committee and a former member of the Unified School District 453 School Board.

As national commander, Wiley is a strong advocate for The American Legion's Be the One mission to prevent veteran suicide. He emphasizes inclusivity in the American Legion Family through the theme, Better Together!

Wiley and his wife, Sonia, have two children, Austin and Christy, and one grandson.

JOSEPH C. SHARPE JR.
DIRECTOR
VETERANS EMPLOYMENT & EDUCATION DIVISION
THE AMERICAN LEGION

Joseph C. Sharpe Jr. became the Veterans Employment and Education Division Director in April 2009 and previously served as Director of the National Security Division, Deputy Director of the Economic Division, Health Care Field Representative, and Assistant Director of the Veterans Affairs and Rehabilitation Commission.

He graduated from The Johns Hopkins School of Advanced International Studies in Washington, DC, earning an M.A. in International Relations and Economics. He also has two Graduate Certificates in International Business and Trade and Health Care Management from Georgetown University. Joseph earned his B.A. in Sociology from the University of Maryland, College Park, MD.

In 1982, he entered the United States Army. After completing initial training at Ft Sill, OK, and Ft Sam Houston, TX, he served as a Drug and Alcohol Counselor with the 2nd Infantry Division in South Korea. He also worked as a Mental Health Counselor in Ft Benning, GA, worked as a Behavioral Science Research Specialist at the Walter Reed Institute of Research, Heidelberg, Germany, and was appointed as the Non-Commissioned Officer in Charge of Inpatient Social Work and Psychiatry Service, Walter Reed Army Medical Center, in Washington, DC. In addition to his active-duty service, Joseph served with the 354th Civil Affairs Brigade, U.S. Army Reserve, Riverdale, MD, as the Non-Commissioned Officer in Charge of the Brigade's Economics and Commerce Team, and finally, before retiring with the 108th Civil Affairs/PSYOP battalion as a Civil Affairs instructor, Ft Bragg, NC.

During Mr. Sharpe's military service with the Army Reserve, Sergeant First Class Sharpe was deployed twice overseas, in Operation Joint Forge, Bosnia-Herzegovina, and recently for the Global War on Terrorism, in which he received the Bronze Star Medal for work completed in the restoration and improvement of public and private financial institutions and banking services in Iraq.

Originally from Chicago, Illinois, he and his family reside in Alexandria, Virginia.

Chairman Bio

Paul L Espinoza is the Chairman of The American Legion's National Veterans Employment and Education Commission. Chairman Espinoza hails from the state of New Mexico. He has been a member of The American Legion for 22 years. Paul served in the US Army for 22 years. He is an Iraq Veteran (4 years active with the 82nd Airborne, 18 years NM National Guard). Was National Vice Commander of The American Legion 2016-2017. Now sits on the AD-HOC 250th Celebration Committee for TAL. Has held Chairman positions for Legislative Council and National Security. 2011 National American Legion College graduate, 3-time Facilitator for NALC. Held Commander and Vice Commander positions for Post, District and Department levels. Currently Dean for 6 years for New Mexico American Legion College. Held Membership and Oratorical Department Chairman positions. 5-time Gold Brigade for recruiting new members to the American Legion. Involved with the Southwest Small Business Association. Has held many Job Fairs thru out New Mexico for the last 10 years. Also involved with many Veterans Service Organizations assisting with disability claims to suicide prevention. Serving on the New Mexico Workforce Development State Board appointed by the Governor of NM for 5 years. Sat on the Board for the VA Hospital to the new VA Hospital Director and attends monthly meetings. Retired 20 years from the United States Postal Service, 15 years Union Shop Representative, 5 years Vice President for the western Letter Carriers Union for New Mexico.

AMERICAN LEGION

Mario Marquez
Executive Director
Government Affairs
The American Legion National Headquarters
Washington, D.C.

Mario Marquez currently serves as the Executive Director of Government Affairs for The American Legion National Headquarters. His responsibilities include: managing a staff dedicated to the timely and compassionate delivery of benefits earned by U.S. military veterans; overseeing the daily functions of employees who support the commissions and committees of The American Legion (i.e. Legislative, National Security, Veterans Affairs and Rehabilitation and Veterans Education and Employment); and serving as the Legion's liaison to the President of the United States, Vice President, heads of the executive departments and other cabinet-level officials, members of Congress, and organizations with an interest and impact on military veteran and service member issues. Mario's previous assignments in the Legion include: Director, Veterans Affairs and Rehabilitation Division and Director, National Security Division.

Mario retired from the U.S. Marine Corps as a Sergeant Major after more than 31 years, where he served in multiple positions across expeditionary, ground combat, aviation, and logistics organizations. His duties included serving as a landing support specialist, drill instructor, combat service support chief, company gunnery sergeant, operations chief, first sergeant, and sergeant major. The pinnacle of his career was serving as the III Marine Expeditionary Force sergeant major, the largest overseas-positioned Marine Corps combat force. During his military service, Mario spent 20 of 31 years deployed or stationed overseas, participating in four combat tours in Iraq (OIF), Operation Southern Watch, Operation Enduring Freedom and supported Operations Inherent Resolve in the Middle East; earthquake disaster relief in Kobe/Osaka, Japan (1995), Operation Tomodachi (earthquake, tsunami, Tohoku Region, Japan-2011), Peace Keeping during Operation Dynamic Response in Kosovo and other exercises / operations in Central America and Africa. His personal decorations include two Legions of Merit, one Bronze Star, two Meritorious Service Medals, three Navy and Marine Corps Commendation Medals, and five Navy and Marine Corps Achievement Medals.

Mario is an Executive Board Member of The Veterans Consortium Pro Bono Program. He is a member of American Legion Post #28 in Okinawa, Japan, and the Marine Corps Association. He is a life member with the Veteran of Foreign Wars Post 1503 in Virginia, Marine Corps League, Disabled American Veterans and Naval Order of the United States.

Mario received his Bachelor of Arts, Summa Cum Laude, in East Asian Studies and Associate of Arts from the University of Maryland Global Campus. He is currently a graduate Student in Syracuse University's Executive Master's in International Relations Program in partnership with the Center for Strategic and International Studies. Mario currently resides in Virginia with his wife.

Cole Lyle
Director
Veterans Affairs & Rehabilitation Division
The American Legion National Headquarters
Washington, D.C.

Cole T. Lyle currently serves as Director of the Veterans Affairs & Rehabilitation (VA&R) Division in the American Legion, directly leading a team of 40 in the Washington, D.C. office, and thousands of volunteers nationwide. Cole's team provides subject matter expertise and recommendations for the White House, VA, and Congress on Health Policy, Claims and Benefits, Memorial Affairs, and Service Officer Accreditation. In 2025, the VA&R Division submitted [x] testimonies to Congress, reviewed [x] pieces of legislation, and led service officer training and accreditation for over 3,000 volunteer service officer which led to $29.5B in total disability compensation awarded to veterans. Cole is also the staff lead for the Legion's Be The One program, aiming to reduce veteran suicide through peer-support, crisis intervention training, and strategic partnerships.

Prior to his work in veteran advocacy, Cole served as a Special Assistant at the U.S. Department of Veterans Affairs, where he served as a liaison for VA to Congress, gathering information and identifying issues that would affect the agency in its mission to provide healthcare and benefits to veterans.

Before VA, Cole worked as a Military Legislative Assistant in the U.S. Senate, handling billions of dollars in defense and VA appropriations and providing oversight of military training, operations, budgets, and acquisitions.

In his advocacy work, Cole has appeared on FOX News, CNN, NPR, Washington Post, and authored a regular column discussing veteran policy at the Dallas Morning News. He was awarded "Advocate of the Year" in 2025 by the U.S. Forces in Business Association.

A U.S. Marine Corps and Afghanistan veteran, Cole earned a master's degree from the U.S. Army War College, a Certificate in Non-Profit Management from Harvard Business School, and a bachelor's degree from Texas A&M University.

Linden B Dixon Jr.- Short Bio

Linden B. Dixon Jr. is a proud Virginian and longtime member of The American Legion. Raised in the suburbs of Washington, D.C., and later in the shadow of Shenandoah National Park, he grew up in a family defined by military service. His grandfather served in Coastal Artillery prior to World War II and later as a machinist's mate aboard the destroyer, USS Boyd during World War II. A great aunt served in England with the Women's Army Corps, an uncle served in Special Forces in Vietnam after his brother was killed in action, and his stepfather served in Vietnam as a door gunner with the Americal Division. The son of a father killed in action in the Republic of Vietnam, he is a Gold Star family member and experienced firsthand the impact of VA survivor benefits before beginning his own military service.

A 1982 delegate to Virginia Boys State - a week he credits with shaping a lifetime of service - Linden went on to serve honorably in the United States Army from 1983 to 1990, including service in the Republic of Panama and deployments to Central America.

For more than three decades, he has remained active in The American Legion, serving in a variety of leadership roles at the post, district, department, and national levels. He currently serves as Chairman of the Veteran Affairs and Rehabilitation Commission and

continues to support leadership development and youth programs, including Virginia Boys State.

Linden resides in Manassas with his wife, Audrey, and their twins, Abigail and Alexander. Their family shares a deep commitment to The American Legion and its mission of service to veterans, youth, and community.

Matthew D Jabaut
120 Dyer RD
Lewiston, ME 04240
mdjabaut@gmail.com
253-226-1227

Currently serving as the Chair of the National Legislative Commission;

Matthew Jabaut was born in Farmington, raised in Durham, and graduated from Lewiston High School.

Matt served in the US Army from 1997- 2005 as a combat medic. During his service, he led Evac and Treatment squads, served as Retention, EEO, and UPL NCO. He was an instructor at the Joint medical training center in Fort Lewis, WA, earned the Expert Field medical badge, and completed a combat tour in the middle east.

After transitioning out of the military Matt attended Point Park University under the VA Voc Rehab program completing his BS in Human Resource Management and continued under the GI Bill completing a Masters in Organizational Leadership.

Shortly after returning to Maine, Matt joined the Legion at Post 202 in Topsham. Since joining he has served as Judge Advocate, 2nd vice and as Commander. Matt has also served as Dept Chaplain, Judge Advocate, 2nd Vice Commander, 1st Vice Commander, Department Commander, NEC Alternate and on various Dept and National Committees, including Dept Legislative, Post 9/11, resolutions, and National 21st Century committee, Legislative Council, a consultant to the National Internal Affairs Commission, the National Membership and Post Activities Chairman, Veteran Employment & Education Chairman.

In 2015 Matt attended National American Legion College and graduated at the top of his class. He has also worked with his fellow NALC alum to deliver a Dept level Legion college and has also facilitated at the National American Legion College.

Matt looks forward to continuing to serve the Legionnaires and Veterans of his community.

Paralyzed Veterans of America

1875 Eye Street NW, Suite 1100,
Washington, DC 20006
(O) 202.872.1300
www.PVA.org

501(C)(3) Veterans Non-Profit

ANNUAL LEGISLATIVE PRESENTATION

ROBERT THOMAS

NATIONAL PRESIDENT PARALYZED VETERANS OF AMERICA

BEFORE A JOINT HEARING OF THE HOUSE AND SENATE COMMITTEES ON VETERANS' AFFAIRS

MARCH 4, 2026

Chairman Moran, Chairman Bost, Ranking Member Blumenthal, Ranking Member Takano, and members of the committees, I appreciate the opportunity to present Paralyzed Veterans of America's (PVA) 2026 policy priorities. For nearly 80 years, PVA has served as the lead voice on issues that affect severely disabled veterans. Throughout the years, we have championed critical changes within the Department of Veterans Affairs (VA) and educated legislators as they consider important policies that impact the lives of paralyzed veterans.

Today, I come before you with our views on the current state of veterans' programs and services, particularly those that affect our members—veterans with spinal cord injuries and disorders (SCI/D). Access to VA's specialized systems of care is the center of their universe because they rely on it perhaps more than any other group of veterans served by the VA. As I have testified several times in recent years, we are very concerned about the status of VA's SCI/D system of care due to ongoing staffing deficiencies and the lack of investment in infrastructure to support these services. Thousands of PVA members and their families, caregivers, survivors, and supporters have signed a petition opposing any efforts to dismantle the VA's SCI/D system of care and the life-saving services it provides. Our members want Congress to know that they choose VA for their care.

BACKGROUND—Our organization was founded in 1946 by a small group of returning World War II veterans, all of whom were treated at various military hospitals throughout the country because of their injuries. Realizing that neither the medical profession nor the government had ever confronted the needs of such a population, these veterans decided to become their own advocates and to do so through a national organization.

From the outset, PVA's founders recognized that other elements of society were neither willing nor prepared to address the full range of challenges facing paralyzed individuals, whether medical, social, or economic. They were determined to create an organization that would be governed by the members themselves and address their unique needs. Being told that their life expectancies could be measured

in weeks or months, these individuals set as their primary goal to bring about change that would maximize the quality of life and opportunity for all people with SCI/D.

Over the years, PVA has established programs to secure benefits for veterans; reviewed the medical care provided by the VA's SCI/D system of care to ensure our members receive timely, quality care; invested in research; promoted education; organized sports and recreation opportunities; and advocated for the freedoms of paralyzed veterans and all people with disabilities. Our mission is simple—to empower our brave men and women to regain what they fought for: their freedom and independence.

The Role of Community Care for Veterans with SCI/D

The overwhelming majority of veterans with SCI/D choose to receive their care at VA facilities. Unlike the VA, few facilities in the private sector have highly trained personnel on staff to properly care for SCI/D patients. A few private sector health care facilities do a good job of providing acute SCI/D recovery care, but only VA provides the full, lifelong continuum of services for veterans with SCI/D.

The VA exists to ensure that veterans can receive the care they need; so, the department alone bears the responsibility to treat, heal, and rehabilitate the men and women who served in our military and suffered injury or disease as a result. We have stated on multiple occasions that care delivered in the community is an essential component of VA's health care system; however, it is just a component. Congress must take the steps necessary to ensure that VA's direct care system is not weakened to the point where care in the community becomes the only choice for catastrophically disabled veterans.

My statement addresses many specific priorities PVA hopes you will pursue this year, but it is not inclusive of every area of concern for our members. Some interests not covered here include increasing access to VA dental care, improving employment services for veterans with catastrophic disabilities, VA's electronic health record modernization, and extending the eligibility age for the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA). We continue to work on these and other areas of interest for paralyzed veterans and the broader veterans community. We look forward to working with you on matters of mutual concern.

PVA PRIORITY: STRENGTHEN THE FOUNDATIONS OF VA'S SPECIALIZED HEALTH CARE SERVICES

VA's SCI/D system of care uses a hub and spoke model. The 25 SCI/D centers are the hubs and each center has highly trained and experienced providers, including doctors, nurses, social workers, therapists, psychologists, and other professionals who can address the unique problems that affect veterans with SCI/D. Protecting this system of care is PVA's number one priority, because access to the

care it provides is the difference between life and death for our members. I would personally like to thank these committees for your continued interest in protecting the SCI/D system of care.

Staffing Vacancies—When I appeared before these committees at the joint hearing last year and the Senate Veterans' Affairs Committee (SVAC) in September, I spoke about the ways that insufficient funding, the lack of sufficient staffing, and infrastructure problems were undermining not just VA's SCI/D system of care, but VA's specialized services in general. Staffing has literally become a perennial concern as I and my four predecessors have cited it as a top concern every year since 2014. Frankly, we find it rather exasperating to have to bring it up year after year without resolution.

Using the levels prescribed in Veterans Health Administration (VHA) Directive 1176 as our guide, our calculations show a 36 percent staffing shortage on the acute care side and an 11 percent shortage on the long-term care side. These shortages mean the VA can only operate 565 out of its 980 available acute care beds. Another 96 beds are unavailable due to construction or other reasons. In similar fashion, VA can only operate 148 of its 167 available SCI/D long-term care beds. It's important to note that in accordance with 1176, the department is required to maintain 181 operating long-term care beds at SCI/D centers. As evidence by the department's responses to questions for the record stemming from SVAC's September 17, 2025, hearing on VA's SCI/D system of care, the previous Administration's practice of eliminating unfilled positions continues. This is extremely concerning because it artificially presents the illusion that staffing levels are better than they really are. And I must call a "foul" on this, because at the same time VA is saying they are getting rid of positions that weren't being filled, their hiring freezes and other policies prevented them from being filled. Vacancies coupled with steady losses in SCI/D trained staff have prevented untold veterans with SCI/D from receiving needed care. I urge you to continue to press VA for answers. This cannot be allowed to continue for another year.

Recently, VA announced plans to change the structure of the VHA. PVA has long raised concerns about how administrative bloat has hindered health care decision-making and made it difficult for VHA to hire the staff needed to deliver health care services more effectively. We believe reorganizing the department to eliminate, or at least significantly reduce, these unnecessary barriers is long overdue. We look forward to seeing how this reorganization will improve catastrophically disabled veterans' care. While critical vacancies persist within the VA SCI/D system of care, the VA Secretary has reassured us that local VA leaders are authorized to fill these important positions. However, individual medical centers continue to drag their feet on getting this done. Increased accountability is needed to resolve these staffing challenges, and individual medical centers must make filling these positions a top priority.

Infrastructure—In reviewing VA's infrastructure priorities, decision-makers must remember that VA's SCI/D system of care provides a coordinated, life-long continuum of services for veterans with SCI/D that is unique, unmatched, and not replicated outside of the VA.

Summary of SCI/D Centers

VA's SCI/D system of care is comprised of centers with an average age of 40 years old. Renovating older buildings (pre-1980s) often exposes, disturbs, and releases microscopic asbestos fibers from materials like insulation, flooring, and ceiling tiles. This creates severe health risks for veterans and health care staff. Key complications that directly affect SCI/D projects include high abatement costs, project delays, strict regulatory compliance, and the need for professional, specialized hazardous abatement handling companies to prevent contamination with other construction debris.

Fourteen of the 25 SCI/D centers continue to use four-bed patient rooms, accounting for 61 percent of the mandated available inpatient beds. Five of the six long-term care SCI/D facilities continue to use two-bed resident patient rooms, accounting for 40 percent of the mandated available long-term care beds. Four-bed patient acute care bedrooms and two-bed long-term care bedrooms do not meet VA requirements and represent an antiquated and outdated patient-care philosophy in modern health care environments due to infection control concerns.

New SCI/D Center Construction Projects

Construction of a new acute and long-term care SCI/D center at the Jennifer Moreno VA Medical Center in San Diego started in April 2021. Due to the diligent and collaborative efforts of the VA Medical Center, VA's Office of Construction and Facilities Management, and the US Army Corps of Engineers, the state-of-the art project is scheduled to be open to veterans this summer. When completed, the new SCI/D center will triple the total amount of available SCI/D long-term care beds located west of the Mississippi River for the thousands of veterans with SCI/D that reside in this area of the country.

Phase one of a new SCI/D long-term care facility at the Dallas Campus of VA's North Texas Health Care System started in November 2023. Despite unanticipated delays, the first phase of 30 new long-term care beds is now expected to be completed in September 2027; however, funding for the second phase (30 additional long-term care beds) has not been authorized. Furthermore, the number of long-term care beds for veterans with SCI/D is woefully inadequate for an aging veteran population with care needs not readily met in the community. We call on Congress to fund the additional 30 beds in Dallas this year.

Prioritize Minor and Non-Recurring Maintenance (NRM) Projects

PVA applauds VA's return to the past practice of placing greater priority on funding more Minor and NRM projects within the VA's Strategic Capital Investment Planning (SCIP) process. Greater investment

in areas like SCI/D care would strengthen VA's specialty care services and ensure their future availability.

Unfortunately, many SCI/D system projects are caught in the design and construction delays inherent in the VA SCIP project funding and delivery system. There are currently four super-major, three major and 17 minor SCI/D center projects either awaiting funding, in design, or pending approvals to proceed beyond their current status. The majority of SCI/D focused SCIP-submitted projects were initiated through our annual in-person site assessment recommendations by our PVA Medical Services and Architecture staff.

VA has spent a significant amount of money, resources, and support staff time on projects throughout the entire design process that were shovel-ready only to be abandoned by the VA. Year-after-year, VA requests, and Congress provides a fraction of the actual funding needed to sustain the physical infrastructure of VA's SCI/D system. As the cost of repairing or replacing these facilities rises, it's long-past time to examine the viability of other options, such as leasing the facilities needed to ensure the system's physical footprint remains sound.

Increase Staffing at the Facility Management Level

Even with a comprehensive strategy and adequate infrastructure funding, VA's internal capacity to manage a growing portfolio of construction projects is limited by the number and capability of its construction management staff. To manage a larger, more complex capital asset portfolio, VA must have sufficient personnel with appropriate expertise—both within VA Central Office and onsite throughout the VA system. Thus, PVA strongly supports legislation that would improve staffing to manage construction of VA assets and ensure that there are concrete plans to improve the planning, management, and budgeting of VA construction and capital asset programs.

Importance of Accessibility

Buildings that are not accessible are of little use to veterans with catastrophic disabilities. PVA strongly supports passage of the Veterans Accessibility Advisory Committee Act (H.R. 1147) to ensure that VA complies with federal disability laws and makes its programs accessible for people with disabilities. The bill would establish the Advisory Committee on Equal Access to evaluate and report on VA's compliance with federal disability laws. It would also issue recommendations for how VA can improve the physical accessibility of VA facilities, as well as the accessibility of technology, such as websites and apps.

Access to Inpatient Mental Health and Substance Use Disorder Treatment—In the last Congress, there was a significant increase in conversations around residential rehabilitation treatment programs (RRTP) but there was little discussion around the limited access to RRTP for veterans with SCI/D. When a veteran incurs an SCI/D, their identity and place in the world shifts dramatically, and it is common for veterans to experience a range of negative mental health outcomes as a byproduct of catastrophic

injury or illness. Significant medical comorbidities are also expected because of injury or trauma, which is especially true when discussing the lifecycle years beyond acute injury. These complexities make the holistic treatment of veterans with SCI/D critical for their independence and well-being. However, if a veteran needs assistance from a caregiver with an activity of daily living (ADL), they are unable to access RRTP, even within the VA.

Substance use disorders (SUD) are prevalent among SCI/D veterans, and while research is limited on the impacts of SUD for veterans living with SCI/D, data suggests that individuals living with SCI/D are disproportionately at-risk of SUD. Because of the risk factors associated with SCI/D veterans, it is critical that VA ensure these veterans can engage in residential SUD programs tailored to at-risk veterans.

The loss of identity associated with SCI/D, particularly for servicemembers separated due to injury or illness, can be a factor that leads to significant SUD among vulnerable veterans and increased risk of suicide. Among the SCI/D veteran population, there is an increased prevalence of suicidal ideation, suicide attempts, and suicide deaths. In U.S. studies, civilians with spinal cord injury (SCI) were reported to be three to five times more likely to die by suicide than individuals without an SCI. Newly separated veterans are already a high-risk cohort for suicide, compounding that with an SCI/D makes these veterans particularly at risk and all VA resources should be available to them.

We strongly believe VA should be a leader in access for disabled veterans, so we appreciate language in the Senate version of the Veterans' Assuring Critical Care Expansions to Support Servicemembers (ACCESS) Act of 2025 (S. 275) requiring the department to establish a pilot program to address the lack of access to RRTP for veterans with SCI/D. This has been a longstanding problem for PVA members, and we thank Chairman Moran for attempting to ensure veterans with SCI/D are able to access this life-saving treatment.

Title 38 Protections for Community Care—PVA remains deeply concerned about the exclusion of protections for injuries that occur because of community care. Title 38 U.S.C. § 1151 protects veterans if medical malpractice occurs in a VA facility and some additional disability is incurred or health care problems arise by providing clinical appeal rights, no-cost accredited representation, and congressional oversight and public accountability. However, if medical malpractice occurs during community care, the veteran must pursue standard legal remedies and is not privy to VA's non-adversarial process. If these veterans prevail on a claim, they are limited to monetary damages instead of having access to the other ancillary benefits available under Title 38 intended to make them whole again. Congress must ensure that veterans who receive care in the community retain current protections unique to VA health care under 38 U.S.C. § 1151.

Research Funding—I would be remiss if I didn't talk about the importance of adequate funding for research. Recent discoveries have significantly advanced the understanding and treatment of veterans

with SCI/D. The development of advanced prosthetics and orthotics have aided their recovery, helped to restore function, and improved their quality of life. Advances in regenerative medicine show real promise to restore nerve and spinal cord function. The discovery of biomarkers that predict the body's response to treatment have aided the selection of the best medications for those with amyotrophic lateral sclerosis (ALS) and multiple sclerosis (MS). Other emerging treatments show real efficacy in slowing the progression of both diseases which could lead to a cure. Last year's decision by Congress to strip funding for SCI and MS from the Congressionally Directed Medical Research Program (CDMRP) undermined some of the progress that was being made with the treatment of and potential cures for SCI/D. Some of the money for CDMRP research for SCI and MS was restored this fiscal year (FY) with the passage of the Consolidated Appropriations Act, 2026 (P.L. 119-75) and I cannot thank you enough for making that happen. Still, if we are going to be serious about finding a cure for these conditions, we must see a more concerted effort to support research through funding, staffing, and other necessary supports.

PVA PRIORITY: MAXIMIZE VA LONG-TERM SERVICES AND SUPPORTS FOR VETERANS WITH SCI/D

Insufficient Long-Term Care Beds and Services for Veterans with SCI/D—Our nation's lack of adequate long-term care options is an enormous problem for people with catastrophic disabilities who, because of medical advancements, are now living longer. As of last month, only 148 VA SCI/D long-term care beds were available, which is a reduction of another five beds since last year. This number fluctuates depending on several variables like staffing, women residents, isolation precautions, and deaths. When averaged across the country, that equates to about three beds available per state. Many aging veterans with SCI/D need VA long-term care services, but because of the department's extremely limited capacity, veterans sometimes remain in the acute setting for months or years at a significant cost because other placements are simply not available. Others must reside in nursing care facilities outside of VA that are not designed, equipped, or staffed to properly serve veterans with SCI/D. As a result, veterans staying in community nursing facilities often develop severe medical issues requiring chronic re-admittance back into an acute VA SCI/D center.

In addition to ensuring access to VA SCI/D long-term care beds, we support expanding access to assisted living options. Currently, the VA can refer veterans to assisted living facilities, but it cannot directly pay for that care. Last year's passage of an amended version of the Expanding Veterans' Options for Long Term Care Act, which was included in P.L. 118-210, created a three-year pilot program in two Veterans Integrated Service Networks (VISNs). Each of the VISNs must have at least one program site in a rural or highly rural area and one in a State Veteran Home to test the benefit of having VA pay for this care. Veterans eligible for the pilot would include those already receiving nursing home-level care paid for by the VA and those who are eligible to receive assisted living services or nursing home care. We believe improving access to assisted living facilities would help veterans and reduce costs for long-term care,

allowing more veterans to receive needed assistance. We urge the committees to conduct oversight regarding the pilot's status to ensure Congress's intent is fully addressed.

Improve Availability of VA's Home and Community-Based Services (HCBS)—We remain very appreciative of Congress's passage of the Senator Elizabeth Dole 21st Century Veterans Healthcare and Benefits Improvement Act (P.L. 118-210). This bill made critically needed improvements to VA HCBS, such as lifting the department's cap on the amount they can pay for home care, increasing access to the Veteran Directed Care (VDC) program, and improving support to caregivers of veterans. From improving access to mental health and long-term care for the veterans who need it, to supporting those who care for them, as well as their survivors, this bipartisan and bicameral measure will have a tremendous impact on the entire veteran community.

One of the most important provisions in that bill raised the cap on how much the VA can pay for the cost of home care from 65 percent of the cost of nursing home care to 100 percent, and even more if it's in the veteran's best interest. This was extremely helpful for families with service-connected veterans on ventilators who were bearing a significant part of the cost of care—financially, physically, and emotionally—for their loved one. VA officially announced the change early last month, and they estimate that up to 200 veterans will benefit from the higher expenditure cap in FY 2026.

Another section of the bill requires the VA to administer its VDC program, the Homemaker and Home Health Aide program (H/HHA), the Home-Based Primary Care program, and the Purchased Skilled Home Care program at all medical centers within two years of the date of enactment of this legislation. Our members are particularly interested in VDC because it allows them to prioritize their own care needs and select their own care providers from their local communities.

VDC is particularly effective in rural areas that have limited or no access to home health agency care, since veterans enrolled in the VDC program can hire and supervise their own workers in their communities. Additionally, VDC enables the VA to better meet the needs of veterans that are at high-risk for hospitalizations and nursing home admission. Veterans that require more care than what is traditionally offered through H/HHA care are often offered the option to self-direct their care through the VDC program. In addition, VDC serves veterans of all ages, including younger veterans with serious illnesses and injuries like SCI/D.

According to the VA, VDC programs have been established at all major VA facilities, but the feedback we have received from the field suggests some of them exist in name only or serve few veterans. We continue to receive reports of members being told their facility does not offer the program. This may simply be the result of a readily correctable training deficiency with the facility's Geriatrics and Extended Care (GEC) coordinators. Other sites say they would love to offer the program to more veterans but lack the funding to do so. The department continues to have a difficult time finding

agencies willing to participate in the program, especially in the southwestern part of Minnesota. Unfortunately, this is a pretty common problem as many VA facilities do not have the appropriate Aging and Disability Network Agencies within their catchment areas to support veterans as they plan for and direct their long-term services and supports. VA is currently examining ways to execute Veteran Care Agreements (VCA) with alternative VDC providers. We encourage Congress to support those efforts and make sure VA has adequate funding for the proper expansion of this important program.

To date, we've had little insight into how the H/HHA, Home-Based Primary Care, and Purchased Skilled Home Care program expansions are going. Last year's moves to reduce the federal workforce and proposed reorganization have created confusion about the status of these programs and if they will be appropriately staffed. We would appreciate an update from VA about the changes directed by the Elizabeth Dole Act for these critical programs.

Address Direct Care Workforce Shortages—I consider myself to be extremely lucky to have my wife as my primary caregiver. For more than 30 years, LaShon has been at my side to offer me the care I need and her prolonged presence has been a source of great comfort to me. Some PVA members do not have family members close by, or their physical needs are so great that they must secure direct care workers to support them in home and community settings.

Direct care workers provide a wide range of supportive services to veterans with SCI/D including habilitation, health needs, personal care and hygiene, transportation, recreation, housekeeping, and other home management-related supports, so veterans can live and work in their communities and live productive lives. Finding the right candidate who understands the unique nature of the job and possesses the right combination of hard and soft skills can prove to be a formidable challenge.

The shortage of caregivers or home care workers doesn't just affect disabled veterans. Across the country, there is a tremendous shortage of direct care workers, and a national effort is needed to expand and strengthen this workforce. Increasing the amount veterans can pay for essential caregivers is a necessary component of attracting and retaining a diverse set of people to provide HCBS but raising pay alone is not sufficient to solve the crisis we face. VA should develop a pilot program that retains the former caregivers of veterans to care for other veterans. These individuals are familiar with the unique needs of veterans and the many nuances of the VA health care system, making them a provider of choice for other disabled veterans. Utilizing multiple strategies, such as raising public awareness about the need and value of caregiving jobs, providing prospective workers quality training, and developing caregiving as a sound career choice are a few of the other changes that could help turn this problem around.

Caregiver Support for Hospitalized Veterans—Prior to April 2023, veterans with high-level quadriplegia and other disabilities were required to pay out of pocket for their caregivers or caregivers

donated their time, as veterans could not receive caregiving assistance through VA programs while in an inpatient status. PVA raised this issue to the attention of VHA's GEC National Program office. In 2023, GEC issued guidance to the field stating if a veteran is assigned Case Mix "V" or who has a score of "K" they may continue to receive VDC services during inpatient hospitalization, if it is clinically indicated and in support of the veteran's care needs. The Case Mix Tool is specifically designed to assist clinicians in determining the appropriate budget to best support veterans' home care needs.

While we greatly appreciated this change, it benefits a very limited number of veterans. Plus, it excludes many deserving veterans with catastrophic disabilities who rely on caregivers but are not assigned into Case Mix "V" or have a score of "K." Section 124 of P.L 118-210 would address this problem, and we urge you to compel VA to implement this change immediately.

Assistance for Family Caregivers—Executing the Program of Comprehensive Assistance for Family Caregivers (PCAFC) continues to be challenging for the VA. VHA recently published a portion of its long-awaited rulemaking to make changes to the PCAFC. PVA is appreciative of the extension granted to legacy caregivers, but we are eagerly awaiting the second half of the proposed rule. PVA is eager for VA to adopt the positive changes that have been proposed, to include removing the requirement that a veteran require assistance with an ADL "each time" it is performed, the inclusion of veterans receiving Individual Unemployability, the removal of the requirement to need "hands-on" assistance, and the reduction in frequency of reassessments. However, we believe more must be done to meet the needs of the veteran and caregiving community. Specifically, the VA must provide clear, concise definitions and standards and eliminate overly strict eligibility criteria that does not reflect either the language of the statute or the day-to-day realities of caregiving. Furthermore, we understand that the change in administration requires additional time for the regulatory review process, but we are one year past the closing of the comment period on the proposed rule, and VA has yet to issue a final regulation. Caring for a severely disabled veteran can make every day unpredictable, and our caregivers deserve a supportive and consistent program.

An area not addressed in the pending rule is the appeals process for PCAFC. The lack of a defined appeals process in the current caregiver program has led to inconsistencies in eligibility. Rather than addressing the process in their proposed regulations, the department has chosen to address it through policy. This denies veterans, their caregivers, and other stakeholders an opportunity to provide comments on it. In PVA's response to the proposed changes, we urged VA to reconsider its decision and either publish an appeals process proposal as a supplemental proposed rule or in an interim final rule, which would allow for public comment.

VA has introduced another element of uncertainty to the current appeals process with the announced VHA restructuring that will lead to major changes to the VISNs. When a caregiver appeals their decision, it is reviewed by the Centralized Eligibility and Appeals Teams (CEATs), which sit at the VISN level. PVA

has many concerns about where the CEATs will end up, staffing levels, and their ability to provide comprehensive, accurate, and timely responses.

Although Congress has made many improvements to PCAFC since it was established in 2010, the program does not fully 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 on CHAMPVA for their health care lose this coverage within 90 days of leaving PCAFC through the death or discharge of the veteran. Users of other insurance programs have 180 days to transition their health insurance benefits. The Veteran Caregiver Reeducation, Reemployment, and Retirement Act (H.R. 2148/S. 879) seeks to strengthen the PCAFC by addressing these, and other common problems that many caregivers face. We strongly support this bill and urge Congress to pass it quickly.

Codify VA's Bowel and Bladder Program—SCI/D can significantly impact a person's quality of life, and support for neurogenic bladder and bowel dysfunction is a crucial aspect of their care. These conditions affect many veterans with SCI/D and can lead to severe complications. Therefore, managing neurogenic bladder and bowel requires specialized attention and is essential for maintaining veterans' health and well-being. VA's Bowel and Bladder program is administered by VHA's SCI/D National Program office. Veterans with SCI/D who qualify for bowel and bladder care may receive that care through a home health agency, a family member, or an individually employed caregiver. The clinic of jurisdiction, or VA medical facility, authorizes bowel and bladder care under the Office for Integrated Veteran Care (IVC), to enrolled veterans with SCI/D who are dependent upon others for bowel and bladder care while residing in the community. As soon as designated caregivers successfully complete training from the VA, all necessary forms are forwarded to IVC for approval. Additionally, the caregiver must obtain a National Provider Identifier, complete a VCA, track the amount of time needed to perform the veteran's bowel and bladder care daily, and submit it along with a VA Form 10-314, Request for Payment of Bowel and Bladder Services, to be reimbursed.

The current program is fraught with challenges for caregivers and is unevenly applied across the VA system. Timely reimbursement and the tax treatment of payments are the chief complaints of PVA members who must rely on bowel and bladder care to meet their needs. For example, unlike virtually all other VA payments, including those provided through the PCAFC, Bowel and Bladder program reimbursements are taxable. Even family caregivers are considered federal contractors for providing this care and must pay self-employment tax.

Another compelling reason to make the Bowel and Bladder program a statutory requirement is that the current program fails to offer veterans due process. There is no formal notification to the veteran, caregiver, or the provider that a VCA agreement is coming up on its three-year renewal and that it must be re-signed. Hence, due to the lack of notification, veterans and caregivers continue to file monthly claims, but payments stop and they don't know why. Getting the program reinstated is a tremendous challenge, and due to lack of payment, the veteran may lose the caregiver. The whole process starts all over again, with the veteran having to find, train, and formally designate a caregiver which can take weeks or months to complete, putting the veteran with SCI/D at risk of not receiving timely bowel and bladder care. In similar fashion, neither the veteran nor the caregiver is notified if they file a monthly claim that has errors or missing information. They just simply don't get paid, and it is up to the veteran or caregiver to reach out to the IVC to find out why.

The Bowel and Bladder program is a life-sustaining program providing support to veterans with SCI/D. Codifying the program would fix many of these problems and I thank Chairman Moran for the recent introduction of his bill, the Disabled Veterans Dignity Act (S. 3647) to do just that.

PVA PRIORITY: FORTIFY THE FINANCIAL SECURITY OF VETERANS WITH SCI/D, THEIR FAMILIES, AND SURVIVORS

Veterans with SCI/D generally require a range of services and benefits, including health care, specially adapted housing, adaptive equipment for their vehicles, insurance, and compensation that are tailored to their needs. Those with service-related medical conditions are entitled to compensation benefits under the law. The Veterans Benefits Administration (VBA) administers these tax-free compensation benefits through their Compensation Service, which determines the appropriate percentage rating, whether the veteran is entitled to dependency pay, and the date the veteran was entitled to start receiving this compensation. The percentage assigned to a veteran is designed to offset a veteran's loss of earning capacity that is caused or exacerbated by these conditions.

Many veterans, especially those with catastrophic disabilities, like SCI/D, rely on these payments for a substantial portion of their income. For these reasons, we are deeply concerned whenever we see attacks on the system that threaten to undermine this critical safety net for our members. Proposals like VA's recently published interim final rule regarding disability claim ratings decisions is a perfect example. We are relying on you to protect the entire VA system which is intended to support those who serve the nation in uniform. Every one of them deserves the comprehensive health care and benefits that VA is supposed to provide. Any actions that could be viewed as reneging on the nation's promise to them sends the wrong message to the future young men and women we need to maintain the viability of the all-volunteer force.

Special Monthly Compensation (SMC) Aid and Attendance (A&A) Rates— In extreme cases, where the profoundness of the condition goes beyond just earning potential, the VA uses Special Monthly Compensation (SMC) to cover costs that arise from the impact on the veteran's quality of life. SMC is arguably the most important ancillary benefit for veterans with severe, service-connected disabilities. The benefit is unique in that it is dependent on non-economic factors such as the profoundness of the disability, personal inconvenience, and social inadaptability. For example, a veteran who lost the use of their lower extremities in service to their country is compensated not just for the loss in their future earnings potential, but also all future hardships and costs associated with the disability. VA considers entitlement to SMC based on the medical evidence when adjudicating a claim for service connection or an increase in an evaluation. VA considers it an "inferred issue." To be clear, given the extreme nature of the disabilities incurred by most veterans in receipt of SMC, we do not believe that the impact on quality of life can be totally compensated for; however, SMC does at least offset some of its loss.

Some of the most seriously disabled veterans who, because of their disability, can no longer take care of themselves without aid, may be eligible for A&A. There are three rates for A&A within special monthly compensation. If the veteran has a single 100 percent schedular-evaluated disability and requires the aid of another person to perform the personal functions required in everyday living, the veteran would be considered for A&A under 38 U.S.C. § 1114 (r). If the veteran is entitled to the maximum rate under either 38 U.S.C. § 1114 (o) or (p), and needs regular A&A, the veteran would be considered for A&A under 38 U.S.C. § 1114 (r)(1) or SMC R1. If the veteran meets the requirements for R1, and then clearly establishes the need for supervised, daily, skilled health care on a continuing basis, the veteran would be considered for a higher A&A benefit under 38 U.S.C. § 1114 (r)(2) or SMC R2. These veterans live with the most severely disabling conditions and might be bedridden due to a traumatic SCI or a disease such as ALS. Currently, the SMC rates of R1, and R2 are $9,826.88 and $11,271.67, respectively. Meanwhile, SMC T is provided to veterans with severe medical residuals related to a service-connected traumatic brain injury (TBI). These veterans often need additional care, and SMC T is provided at the SMC R2 rate.

Even with additional financial support, many of our most severely disabled veterans are struggling. They often spend more on daily home-based care and other disability-related needs than they receive in SMC benefits, which generates a tremendous financial strain on them. Eventually, some are forced to opt for care in an institutional setting, which is even more costly to the taxpayer. This problem is due in part to SMC's baseline rates, which haven't been adjusted in decades, so they are inadequate to offset the burden placed on veterans by their disabilities.

Most veterans receiving SMC are spending it directly on their care. Some veterans are fortunate to have family members who can provide for many of their care needs. It may cost $30-$35 an hour for a veteran to hire someone to attend to such needs. If the veteran needed skilled care nursing, the cost would be much higher. Even veterans who have family members to help provide daily care, or receive

home-based supports from the VHA, often need to hire additional assistance. Bringing someone in for just six hours a day could cost $180 per day or $5,400 a month. That's about half of the SMC a veteran with R2 receives.

The higher direct and indirect costs of living with a disability are well documented. A 2020 study determined a household containing an adult with a disability that limits their ability to work requires, on average, 28 percent more income (or an additional $17,690 a year) to obtain the same standard of living as a similar household without a member with a disability. Many PVA members have examples of additional costs for daily living due to their disability that many of us take for granted. They run the gamut from the mundane to life threatening. For example, owning an accessible vehicle is costly despite the funding offered through the VA's auto grant program. A PVA member in West Virginia lives in a rural area, and air travel is challenging and potentially even dangerous for him. So, he relies extensively on his adapted vehicle. It's easy to think that an eligible veteran receives their auto grant and then the issue is resolved, but that isn't the case. The auto grant amount is currently $27,074.99, which might sound like a lot, until you realize an adapted vehicle can cost anywhere between $50,000 for a sedan to upwards of $90,000 for a van. Adapted vehicles are also usually larger and heavier which causes them to consume more fuel and require additional maintenance. To maintain an adapted vehicle means to acquire unique costs that the average vehicle owner does not encounter. Our member in West Virginia says the increase in his SMC over the past few years was erased by a single purchase of new tires for his vehicle because of increased costs.

Damage to the spinal cord or nerves often makes veterans more susceptible to temperature. For those with MS, inflammation in the nervous system causes damage to the myelin sheath, a fatty coating around nerve fibers that helps them send electrical signals. This damage and myelin loss (demyelination) impairs the nerves' ability to send electrical signals and makes it harder for them to regulate their body temperature. Roughly three-fourths of all veterans with MS find their symptoms get worse in response to heat, so they rely heavily on air conditioning to help manage their condition. In similar fashion, many veterans with high level SCI (above T-6) experience difficulties because their heat dissipating and heat conserving mechanisms are interrupted. This can trigger Dysautonomia, a nervous system disorder that disrupts body processes, and in the severest cases, Autonomic Dysreflexia, a dangerous situation that requires immediate medical attention.

While SMC receives a modest annual cost-of-living adjustment, it does not account for actual increases in the types of services our members require. For example, retail electricity prices have increased faster than the rate of inflation since 2022, and the U.S. Energy Information Administration expects this trend to continue for at least another year. Some veterans who are kept alive by a ventilator have reported electricity bills of more than $1,000! Another veteran has had modifications made to their very rural home to include electrical door openers, electrical sinks, adapted lights, etc. However, due to the unreliable power grid in the area, VA also installed generators to ensure the veteran is not put in a life-

threatening situation. These generators need maintenance and fuel, which are costly and not covered by the VA.

In 2007, after studying veterans' benefits for two and a half years, the Veterans' Disability Benefits Commission, which was established by P.L. 108-136, the National Defense Authorization Act of 2004, released its long-awaited report that addressed the benefits and services available to veterans, servicemembers, and their families. In their concluding recommendations, they stated succinctly that, "Congress should review the profound impact of disabilities on a veteran's quality of life and consider increasing SMC payments and determine if additional ancillary benefits are warranted."

Being disabled is costly, both financially and otherwise. Thus, we are pleased to support the Sharri Briley and Eric Edmundson Veterans Benefits Expansion Act (H.R. 6047), which would increase the amount of R1, R2, and T, SMC rates by $10,000 annually. For paralyzed veterans who are in receipt of the highest levels of SMC, time is a luxury they do not have. Many have gone years without an increase in compensation while their disabilities and their bodies have only worsened with age. While Congress debates how to give adequate increases, the disabled veteran waits to see if they can afford the rising electricity bill that powers their ventilator, or the rising gas prices that fuel their adapted vehicle that gets them to their hospital visits. The wait has already been too long, and we thank the supporters of this bill for seeking to address this issue now.

Military Sexual Trauma (MST)—During the 118th Congress, very little attention was paid to the important area of MST. An alarming number of servicemembers and veterans report unwanted sexual harassment, attention, and other behaviors that our men and women in uniform should not have to tolerate. Despite legislation being enacted that was intended to improve the claims process for survivors of MST, veterans are still encountering barriers and excessive backlogs when it comes to MST claims.

A May 2025 Congressionally Mandated Report (CMR) analyzed FY 2024 VBA data related to MST claims. In FY 2024, the VBA received MST claims for more than 36,000 unique veterans. Of that total, 69 percent were from women veterans and 30 percent were from male veterans. From those numbers, 33 percent of female MST claims were denied, and a staggering 42.5 percent of male MST claims were denied. The CMR highlights that the most common denial reasons were: 1) no diagnosis – or no diagnosis of record for the claimed condition resulting from MST; 2) not incurred in or caused by service, meaning there was no corroborating evidence, including markers; and 3) not aggravated by service, which means a disability diagnosed prior to service did not increase in severity due to events incurred during service. A key factor to consider within this data is that more than 10 percent of MST claims denied were due to a veteran's failure to report to a medical examination.

For years, veterans service organizations have demanded that Congress and VA take measures to improve the claims process, including Compensation and Pension (C&P) examinations for MST claims. If a veteran is filing an MST claim and they are required to attend a medical examination, there is no shortage of reasons why a veteran may miss it. Veterans are often given only one opportunity to reschedule their appointment, and if something prohibits them from attending, the examiner sends the claim back to VBA, which drags out the process for many veterans. This becomes especially relevant for many women veterans who may have family obligations that impede their ability to attend an appointment. For this reason, PVA supports the Review Every Veteran's Claim Act (H.R. 2137/S. 1657), which would authorize that a veteran's claim could not be denied due to missing a medical appointment.

It is critically important for VBA to adjudicate MST claims correctly. PVA assisted a veteran with an appeal of an MST claim that was recently approved. This veteran filed the initial claim in 2005, and after more than 20 years of fighting, it was approved, and the entire appeal resulted in a retroactive payment of more than $700,000. The years of anguish this veteran experienced are tragic, and no amount of compensation can fully redress that harm. To improve the claims process for MST survivors, PVA supports the Servicemembers and Veterans Empowerment and Support (SAVES) Act (H.R. 2576/ S. 1245), which creates a working group focused on improving language around MST communication and authorizes reports to identify gaps in services, and annual training, as well as other aspects in the decision-making process, to improve the quality of the MST claims process for veterans. We urge Congress to pass these pieces of legislation to ensure MST survivors do not have to wait in limbo because of antiquated processes.

Concurrent Receipt—The issue of concurrent receipt falls under the purview of the Armed Services Committees but it is closely linked with the VA committees' efforts. A pair of changes approved by Congress in the mid-2000's allowed military retirees with over 20 years of service and VA disability ratings of 50 percent or greater to receive their military retired pay and VA disability compensation payments without offset. A lone exception to the 20-year requirement was granted for servicemembers retired under the Temporary Early Retirement Authorities Congress granted to the Department of Defense (DOD) in the National Defense Authorization Acts for FY 2012 and FY 2017 (P.L. 112-81 and P.L. 114-328). Despite these reforms, thousands of military retirees continue to have their military retirement offset by VA disability payments today. Congress should pass legislation like the Disabled Veterans Tax Termination Act (H.R. 333) and the Retired Pay Restoration Act (H.R. 303) allowing all military retirees to retain their full military retired pay and VA disability compensation without any offsets. In addition, Congress should make every effort to allow combat disabled veterans to keep those same benefits that were earned in war. PVA urges Congress to pass the Major Richard Star Act (H.R. 2102/S. 1032), which would allow medically discharged veterans whose injuries were incurred in combat to receive their full disability retirement pay from the DOD and their VA disability compensation.

Benefits for Surviving Spouses—Our oldest veterans are passing away, and in the case of many of our members, their surviving spouses were their primary caregivers for 40 years or more. For many of these spouses, being a caregiver was their primary occupation. So, when their loved one passes away, the monthly compensation that may have been upwards of $10,000 a month stops, and the spouse receives roughly a fifth of that per month in Dependency and Indemnity Compensation (DIC), creating a tremendous hardship on those left behind. Adjusting to this precipitous drop of revenue into the household can be too difficult for some surviving spouses who may be forced to sell their homes and move in with friends or family members.

Losing a spouse is never easy but knowing that financial help will be available following the death of a loved one can ease this burden. DIC is intended to protect against survivor impoverishment after the death of a service-disabled veteran. In 2026, this compensation starts at $1,699.36 per month and increases if the surviving spouse has other eligible dependents. DIC benefits last the entire life of the surviving spouse except in the case of remarriage before a certain age. For surviving children, DIC benefits last until the age of 18. If the child is still in school, these benefits might go until age 23.

The rate of compensation paid to survivors of servicemembers who die in the line of duty or veterans who die from service-related injuries or diseases was established in 1993 and has been minimally adjusted since then. In contrast, monthly benefits for survivors of federal civil service retirees are calculated as a percentage of the civil service retiree's Federal Employees Retirement System or Civil Service Retirement System benefits, up to 55 percent. This difference presents an inequity for survivors of our nation's heroes compared to survivors of federal employees. DIC payments were intended to provide surviving spouses with the means to maintain some semblance of economic stability after the loss of their loved one.

PVA strongly believes the rate of compensation for DIC should be indexed to 55 percent of a 100 percent disabled veteran's compensation. We urge Congress to pass the Caring for Survivors Act (H.R. 2055/S. 611), which would increase the rate of compensation for DIC payments to achieve parity with similar compensation federal employees' survivors receive. Also, a provision in H.R. 6407 would increase the baseline amount of DIC by 1.5 percent over a period of two years. PVA strongly supports this increase, but it only represents an initial downpayment on what is truly owed to veterans' survivors, and we are committed to continuing to work to bring DIC in parity with other federal survivor benefits.

Additionally, if a veteran was rated totally disabled for a continuous period of at least eight years immediately preceding death, their eligible survivor can receive an additional $360.85 per month in DIC. This monetary installment is commonly referred to as the DIC "kicker." Unfortunately, surviving spouses of veterans who die from ALS rarely receive this additional payment. ALS is an aggressive disease that quickly leaves veterans incapacitated and reliant on family members and caregivers. Many

spouses stop working to provide care for their loved ones who, once diagnosed, have an average lifespan of between three to five years, making it very difficult for survivors to qualify for the kicker.

The VA already recognizes ALS as a presumptive service-connected disease, and due to its progressive nature, automatically rates any diagnosed veteran at 100 percent once service connected. The current policy fails to recognize the significant sacrifices these veterans and their families have made for this country. We urge Congress to pass the Justice for ALS Veterans Act (H.R. 1685/S. 749), which would provide the DIC kicker to eligible survivors of veterans who died of service-connected ALS.

Home Modification Grants—Despite PVA's persistent advocacy to increase the amount available to veterans through the Home Improvements and Structural Alterations (HISA) grant program, Congress still has not passed legislation that would raise the grant amount. HISA grants are available for modifications such as improving entry and exit to a veteran's home through the installation of a wheelchair ramp, improving electrical systems due to home medical equipment, and installing handrails in a bathroom to increase safety.

Recently, PVA had the honor of testifying at an SVAC hearing on adaptive sports and ancillary benefits that facilitate a veteran's independence which allows them to engage with adaptive recreation opportunities. In our testimony, we shared the importance of VA adaptation programs like the HISA grant, and our support of the Autonomy for Disabled Veterans Act (H.R. 2245/S. 1644). This legislation would authorize an increase to the HISA grant program. Rates for this important grant program haven't increased since 2010 despite the rising costs of construction. H.R. 2245 seeks to raise the HISA grant to $10,000 for service-connected veterans and $5,000 for non-service-connected veterans while tying the amount to the Consumer Price Index (CPI). S. 1644 increases the HISA grant to $10,000 for veterans with disabilities who apply after the bill becomes law, helping to cover the true cost of home improvements like accessible bathrooms. It also increases the grant amount from $2,000 to $6,800 for veterans with non-service-connected disabilities who applied before the bill is enacted but are subsequently service connected, ensuring they also get better support. Finally, it requires VA to adjust the grants annually using a construction index, so the grant amount stays relevant as the cost of home modification prices change.

Since our testimony in early February, we have received several personal accounts from our members that highlight some of the recent shortcomings in the administration of another crucial housing modification program, the Specially Adaptive Housing (SAH) program. We understand that current staffing rates in the SAH program are at alarmingly low levels. Without appropriately trained staff, the SAH program is struggling to aid our most vulnerable veterans.

Currently, some veterans, including those with ALS, are being sent a checklist that needs to be submitted to the SAH program for approval. It covers 28 different lines of various pictures, dimensions,

and other information for an SAH agent to understand the amount of work that needs to be done to make a home accessible and safe for a disabled veteran. One veteran was attempting to fill out the checklist and fell in the process of collecting the required measurements. These veterans re not trained contractors, they have no experience doing this type of assessment, and frankly this veteran is quite lucky that they did not injury themselves. Adding insult to injury, once they finished collecting the information for their SAH agent, they were informed it would have to be done again since the photos and measurements were not considered to be accurate.

In catchment areas lacking an SAH agent, PVA service officers have been volunteering to assist with pictures, measurements, and collecting the necessary information required of veterans to begin the process of adapting their homes. This work was previously done by SAH agents who are trained to walk a veteran through their homes and discuss possible adaptations.

This spits in the face of the promise this country made to disabled veterans in 1946 when the SAH program was established. SAH agents sat with veterans and their families, their caregivers, and explained this program, as well as other VA programs that exist to help them improve their independence and quality of life. Now, veterans are on their own to work through the most complicated and difficult process of SAH approval. VA benefits are not transactional yet the lack of trained SAH agents, and the VA's expectation that our nation's most severely disabled veterans could accomplish this check list on their own, is ridiculous. It is our understanding that the checklist was established during the COVID pandemic when remote work was prioritized for the safety of VA staff. That is no longer a concern, and VA should prioritize staffing the SAH program to ensure smooth delivery of this critical benefit.

SAH agents are only supposed to handle a caseload of 25 veterans per agent. The current staffing ratio, however, is more than double that, and the situation is made worse with VA's decision to eliminate travel funds for SAH agents to physically visit the homes of these veterans. Congress should press the department to increase staffing rates to effectively oversee the SAH program and to restore travel funds so agents can perform necessary pre-design documentation on site and conduct physical inspections during all phases of construction. Catastrophically disabled veterans should not be burdened with performing functions under the purview of the VA.

PVA PRIORITY: INCREASE SCI/D VETERANS' ACCESS TO HEALTH CARE SERVICES

Transportation Programs and Supports—Just like every American, access to safe and reliable transportation is essential to the mobility, health, and independence of catastrophically disabled veterans. Thus, addressing transportation concerns is a top priority for PVA.

First, the Veterans AUTO and Education Improvement Act of 2022 (P.L. 117-333), which Congress passed in late 2022, allowed eligible veterans to receive a second automobile allowance and changed the definition of "medical services" to include certain vehicle modifications. Specifically, it amended the definition of "medical services" under 38 U.S.C. § 1701(6) to include the provision of medically necessary van lifts, raised doors, raised roofs, air conditioning, and wheelchair tiedowns for passenger use. The change was intended to codify VA's existing practice of furnishing certain items, like van lifts and wheelchair tiedowns, to all catastrophically disabled veterans. However, where the VHA has used these items as examples, the statute defines them as the only types of modifications that are permissible. Like the VA, we agree that a technical amendment to 38 U.S.C. § 1701(6) is needed to give the department greater flexibility in making the necessary modifications to veterans' vehicles to ensure they can safely enter or exit the vehicle and transport needed equipment, including power wheelchairs. PVA strongly supports the Automotive Support Services to Improve Safe Transportation Act of 2025 (H.R. 1354/S. 1726), which addresses this oversight to ensure that seriously disabled veterans are getting the equipment and modifications needed to travel safely.

Next, PVA is deeply concerned about the effect of VA guidance issued on January 16, 2026, that ends facility prepayment of round-trip common-carrier airfare for veterans traveling to VA SCI/D facilities. The new policy requires veterans to arrange and pay for travel up front and seek reimbursement after their appointment, effectively preventing many from attending necessary, scheduled specialty care appointments. This change creates a barrier to medically necessary services, disproportionately affecting veterans with disabilities and limited resources. Already it has cause veterans who could not afford out-of-pocket airfare to cancel essential appointments, interrupting the continuity of their care. The change will also likely result in higher costs for taxpayers because prepayment and planned bookings allow VA to obtain lower negotiated fares.

The new guidance is based on VA's view that the statute does not provide affirmative authority for VA to obligate funds in advance for common-carrier transportation and concerns about implicating the Anti-Deficiency Act. To their credit, VA is actively seeking a solution to the problem, and we ask that you assist them with that. If it's determined that a legislative solution is needed, we ask that you introduce and pass legislation quickly that authorizes VA to prepay common-carrier transportation for eligible veterans. Such authority will restore the department's ability to book cost-effective travel on behalf of veterans who cannot pay up front, protect veterans from undue financial burden, and ensure uninterrupted access to critical SCI/D care.

VA provides some ground transportation services directly to veterans through its Veterans Transportation Service. Veterans must live within a VA medical center's catchment area to receive transportation to and from medical appointments. Unfortunately, it is not available at all VA facilities and cannot help veterans who live beyond a certain distance from the medical center. We also hear

complaints about medical centers that cannot meet their veterans' transportation needs due to insufficient transportation vendors.

Sometimes, the problem is with the VA-contracted transportation company (CTC). Some CTCs always seem to be short-staffed and sometimes the drivers are needed in the local area, so there have been times when the drivers do not want to drive such long distances. According to publicly available contracting documents, it does not appear that VA has a metric to hold CTCs accountable for late cancellations and failing to have proper staffing to service all eligible veterans. PVA would like to see VA take steps to ensure their contracts meet the requirements of all veterans in the catchment area.

Additionally, we often hear about problems in getting wheelchairs to veterans when they must travel by stretcher. The wheelchair might be at the veteran's home because the veteran traveled by ambulance to the medical facility or at the medical facility, but the veteran must be transported home on a stretcher. Wheelchairs are not optional equipment; they are our members' primary and essential means of mobility. This problem is not isolated to a single facility or region. It is occurring throughout the SCI/D system, including spoke sites. For individuals who depend on a wheelchair for mobility, being separated from it is equivalent to depriving them of the very ability to move, function, and safely navigate their environment. Despite repeatedly documenting this issue over a period of several years in our SCI/D site visit reports, we have seen no meaningful effort to correct the problem. This persistent failure places veterans at risk and must be addressed systemwide.

Finally, for those eligible for beneficiary travel, the rate of reimbursement is too low. Fifteen years ago, Congress passed P.L. 111-163, which set the mileage reimbursement rate at a minimum of $0.41 per mile which at the time was comparable to rates federal employees were reimbursed for work-related travel. This law also gave the Secretary the authority to increase rates going forward to be consistent with the mileage rate for federal employees for the use of their private vehicles on official business, as established by the Administrator of the General Services Administration (GSA). Since that time, VA's travel mileage reimbursement rate has remained stagnant, even while gas prices and other costs like auto insurance and vehicle maintenance costs have increased significantly. GSA's current mileage reimbursement rate is $0.72.5 per mile. PVA urges Congress to pass the Driver Reimbursement Increase for Veteran Equity Act (H.R. 1288/S. 599) to ensure the beneficiary travel reimbursement rate is at least equal to GSA's.

In 2017, Congress amended the beneficiary travel rule to authorize travel for any veteran with a vision impairment, a veteran with a SCI/D, or a veteran with double or multiple amputations. To be eligible for beneficiary travel under this change, the travel must be in connection with care provided through a special disabilities' rehabilitation program of the department (including programs provided by SCI/D centers, blind rehabilitation centers, and prosthetics rehabilitation centers) and if such care is provided on an in-patient basis; or during a period VA provides the veteran with temporary lodging to make such

care more accessible to the veteran. Unfortunately, the language of that amendment excluded catastrophically disabled veterans from beneficiary travel when traveling to a special disabilities' rehabilitation program for outpatient services. Veterans, service officers, and VA staff consistently cite the lack of travel reimbursement as a major impediment for veterans to get the care they need. The exclusion of travel reimbursement for outpatient care may well have been a cost saving move, but it results in higher health care costs for the VA and poorer health outcomes for veterans due to delayed treatment or diagnosis.

Health Care and Benefits for Women Veterans—Women veterans are the fastest growing cohort of enrolled veterans at the VA, and they make up more than 17 percent of the active duty ranks and almost 22 percent of the guard and reserves. The VA has made commendable progress in ensuring that women veterans can access gender specific care across the country; however, there is still plenty of work to do to ensure equal access to care and benefits.

PVA's women members have consistently encountered accessibility barriers when utilizing VA health care. It is critical that the VA recognize that while catastrophically ill and injured women veterans may be a small population in the greater veteran community, their needs are still real. Guaranteeing that exam tables are accessible, ensuring access to mammography exams and other preventative screenings, and building the trust required to maintain dignity for our women veterans is our duty.

To help our women members feel confident in their role within our organization and in their communities, PVA has made the commitment to invest in them. PVA hosts an annual Women Veterans Empowerment Retreat (WVER) that allows them to build community with other women from across the country, to learn skills in advocacy at the national and local levels, and other important skills that will set them up for success. Additionally, we host ongoing webinar series for them with various topics throughout the year including a session on MS and ALS awareness, adaptive sports and the National Veterans Wheelchair Games, and accessible home design. Our women members often express to us that they struggle with recognition of their veteran status, not just in their communities, but at times even at VA. It is critical that the VA recognize the contributions of women veterans and ensure their safety while they access their earned health care and benefits. For the women members of PVA, this also means that the VA needs to be accessible for veterans with catastrophic injuries and illnesses. Expecting VA to provide accessible, gender specific care to our women veterans should not be up for debate, women have selflessly served this country for centuries. They are owed the same access to health care and benefits as their male counterparts.

We continue to support increased access for women veterans to mammography screening. The Mammography Access for Veterans Act (H.R. 7411/S. 3395) would permanently authorize the telescreening mammography pilot program that was authorized with the passage of Making Advances in Mammography and Medical Options (MAMMO) for Veterans Act (P.L. 117-135). Only half of the

states in the country have in-house mammography access at VA facilities and this bill would fill critical care gaps for veterans.

Assisted Reproductive Technologies (ART)—For many veterans, especially for PVA members, their service-connected disabilities may impact their ability to grow their families. For the last decade, the VA has offered in vitro fertilization (IVF) services for eligible veterans, however, eligibility for IVF is very narrow, barring many veterans from accessing this critical benefit. Access to IVF is the only medical service barred to veterans who are rated 100 percent, total and permanently disabled. PVA is disappointed that we have made little progress on improving the access to IVF for disabled veterans.

In 2024, the VA updated its regulations to allow the coverage of costs of donated genetic material for eligible veterans, which PVA applauded. However, that protection is not covered in statute. PVA is concerned that this expansion could subsequently be retracted.

Several bills would address this concern, as well as improve access to IVF for disabled veterans. The Veterans Infertility Treatment Act (H.R. 220) would allow appropriate infertility treatments to be authorized as part of the medical benefits package. Another piece of legislation is the Veteran Families Health Services Act (H.R. 4855/S. 2534), which would codify a veteran's ability to purchase donated genetic materials, increase the financial support for the adoption of a child, and include access to IVF within the medical benefits package for enrolled veterans. It is our hope that Congress passes legislation like this to protect access to IVF for veterans with SCI/D who are struggling to build their families.

Chairman Moran, Chairman Bost, Ranking Member Blumenthal, Ranking Member Takano, and members of the committees, I would like to thank you once again for the opportunity to present the issues that directly impact PVA's membership. We look forward to continuing our work with you to ensure that veterans get timely access to high quality health care and all the benefits that they have earned and deserve. I would be happy to answer any questions.

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

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

Fiscal Year 2026

Department of Veterans Affairs, Office of National Veterans Sports Programs & Special Events— Grant to support rehabilitation sports activities — $368,500.

Fiscal Year 2025

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

Fiscal Year 2023

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

Disclosure of Foreign Payments

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

ROBERT L. THOMAS JR.
PVA NATIONAL PRESIDENT & CHAIRMAN OF THE BOARD

"PVA has changed my life by introducing me to things that I believed to be over when I became injured, such as the National Veterans Wheelchair Games, and showing me that you can still live a fulfilling life although you have sustained a catastrophic injury."

Robert Thomas grew up in Cleveland, Ohio and played football and basketball. He enlisted in the U.S. Army shortly after graduating high school in 1987. Thomas served as a power generation equipment specialist at Fort Sill, Oklahoma; Camp Humphreys, South Korea; and Fort Bragg, NC. While on active duty, in 1991, Thomas had a diving accident that severed his fifth and sixth vertebrae. He was introduced to PVA through the Cleveland VA Medical Center. PVA helped him navigate his new life by working to obtain his earned benefits through the VA, and reintegrating him back into society through social outings with the recreational therapist.

Thomas joined PVA in 1993 as a member of the Buckeye Chapter of PVA in Ohio, and a little while later, began volunteering with the chapter. He took some time off to earn his associate degree in Information Technology, and returned to the Buckeye Chapter of PVA board in 2010. He served as the chapter's vice president from 2012-2015, and as the chapter's representative on the national Field Advisory Committee and the Resolution Committee.

Thomas was reelected in May 2025 during the organization's 78th Annual Convention, and began serving his third one-year term as President and Chairman of the Board on July 1, 2025. He initially joined PVA leadership at the national level in 2015 as the parliamentarian, and was elected to serve on the Executive Committee in 2017.

Thomas continues to serve PVA because he wants to help lead the organization well into the future. "My inspiration to serve stems from PVA's past and present leadership," Thomas says. "Being a member for 30 years and seeing how unselfishly each leader, member, employee, and volunteer gives of themselves makes me want to continue to serve an organization that does so much for veterans and the disabled community."

In addition to serving as the President and Chairman of the Board for PVA, Thomas currently serves as the chair of PVA's Education Foundation. He was also appointed to the VA's Family Caregiver and Survivors Advisory Committee. Thomas and his wife, LaShon, live in Macedonia, Ohio. Thomas enjoys reading, watching sports, and playing adaptive sports like power soccer, bowling, air guns, and scuba diving.

Statement for the Record

Paul Shipley
National Commander
AMVETS

Before a Joint Hearing of the
House and Senate Committees on Veterans Affairs

March 4, 2026

Chairman Bost, Chairman Moran, Ranking Member Takano, Ranking Member Blumenthal, and distinguished members of the House and Senate Committees on Veterans Affairs,

On behalf of AMVETS, thank you for the opportunity to present our legislative priorities during this annual hearing of veterans service organizations. We appreciate the Committees' continued engagement and bipartisan leadership in advancing policies that directly affect millions of Americans who have worn the uniform.

As the nation's most inclusive Congressionally chartered veterans service organization, AMVETS represents more than 20 million veterans from every era of service, including Active Duty, National Guard, and Reserve components. Our departments and local posts operate nationwide, and our national leadership works daily with veterans navigating health care access, employment challenges, housing instability, family transition, and mental health concerns. We see firsthand how federal policy decisions shape real-world outcomes for veterans and their families.

AMVETS has also entered a new chapter of institutional growth and modernization. Last year, after more than 80 years in the Washington, D.C., region, AMVETS relocated its National Headquarters to Washington, Pennsylvania. This move reflects our commitment to serving veterans in communities across the country while strengthening operational efficiency and expanding direct service capacity.

That commitment is reflected in tangible action. In 2024, AMVETS National Charities purchased and began renovating a 35,500 square foot former school building in South Strabane,

Pennsylvania, to create the AMVETS Family Service Center. The Center addresses a critical gap in the homelessness response system by allowing veterans to remain together with their spouses and children while they work with the Department of Veterans Affairs (VA), the Department of Labor (DOL), and state and county agencies to secure employment, permanent housing, and long-term stability.

The Family Service Center is also administering two newly awarded Homeless Veterans Reintegration Program DOL grants, with active programs operating in Salt Lake City and Phoenix focused on employment placement and workforce development. In addition, AMVETS recently received a DOL grant to conduct a Veterans Stand Down in Tampa, the first of several planned this year, all administered through the Family Service Center team. Together, these initiatives reflect a coordinated approach that integrates housing stabilization, workforce reintegration, and federal partnership.

We share these developments because policy and implementation must reinforce one another. Housing instability, unemployment, mental health challenges, and family stress are interconnected, and sustainable solutions require coordination across systems. We look forward to working with members of both Committees to expand and replicate initiatives like those underway in Pennsylvania in partnership with federal, state, and local stakeholders.

The legislation and oversight before the Committees this year align directly with AMVETS' top priorities, including strengthening mental health and suicide prevention, ensuring fairness for surviving families, modernizing veterans' health care systems, reinforcing institutional accountability, and advancing a more coordinated national approach to serving veterans.

We respectfully offer the following priorities and recommendations for the Committees' consideration.

Strengthen Mental Health and Suicide Prevention Across the VA and Armed Forces

Mental health and suicide prevention remain the most urgent challenges facing the veteran and military community. While Congress has invested over $195 billion on VA mental health and suicide prevention over the past 25 years,[1] suicide continues to take an unacceptable toll on veterans and their loved ones. The scope and persistence of this crisis demand a strategy that prioritizes prevention, early intervention, accountability, and innovation.

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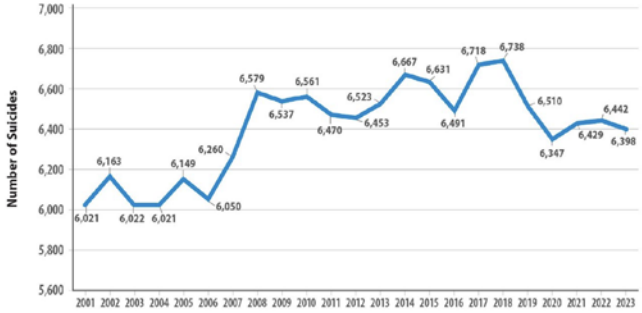
[1] Data aggregated from U.S. Department of Veterans Affairs, FY 2003–FY 2026 Congressional Budget Submissions, Volume II: Medical Programs and Information Technology; see specifically the "Mental Health" and "Suicide Prevention" program obligations across 24 consecutive budget cycles. For annual suicide mortality data, see U.S. Department of Veterans Affairs, National Veteran Suicide Prevention Annual Reports (2019–2024), and Government Accountability Office (GAO), VA Health Care: Spending for Mental Health Strategic Plan Initiatives, GAO-07-66.

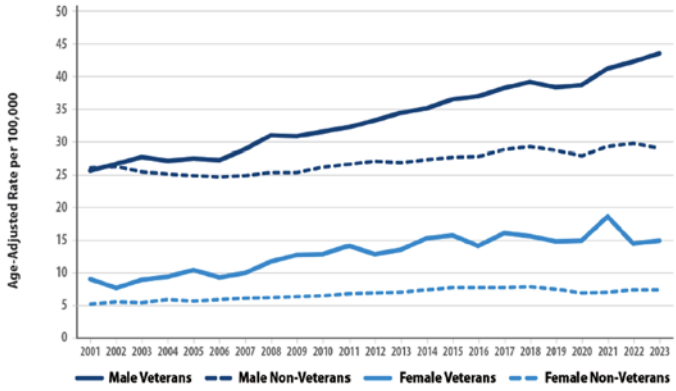
Recent data from the newly released National Veteran Suicide Prevention Annual Report underscore the urgency of sustained congressional engagement:[2]

Figure 2: Veteran Suicide Deaths, 2001-2023



Particularly when compared to the non-veteran population,[3] our brothers and sisters in arms need meaningful action and evidence-driven outcomes now:

Figure 5: Age-Adjusted Suicide Rate, Veteran and Non-Veteran U.S. Adults, by Sex, 2001-2023



[2] U.S. Department of Veterans Affairs, Office of Mental Health and Suicide Prevention, *2025 National Veteran Suicide Prevention Annual Report* (Washington, DC: Department of Veterans Affairs, 2026), Part 2, 11, https://www.mentalhealth.va.gov/docs/data-sheets/2025/2025_National_Veteran_Suicide_Prevention_Annual_Report_PART_2_FINAL.pdf.

[3] VA, *2025 National Veteran Suicide Prevention Annual Report*, Part 2, 17.

AMVETS was proud to support passage of the Commander John Scott Hannon Veterans Mental Health Care Improvement Act, which expanded community-based grant programs and authorized pilot initiatives to test new approaches to suicide prevention. A central component of that law was the creation of the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program. We have monitored its implementation closely and have observed promising results from organizations that are reaching veterans who might not otherwise engage with traditional systems of care. These programs emphasize peer connection, post-traumatic growth, and non-traditional therapeutic models that complement clinical services.

As Congress considers the reauthorization of the Parker Gordon Fox grant program, we urge thoughtful consideration of how to strengthen and expand it. Consultation with veteran service organizations and current grantees will ensure that funding levels, program structure, and evaluation metrics reflect real-world experience and measurable outcomes. Reauthorization should allow proven models to scale responsibly and reach veterans in underserved communities, including those who may not be enrolled in VA care.

Beyond reauthorization, AMVETS encourages continued oversight of VA suicide prevention efforts, including greater transparency regarding how veterans who die by suicide previously interacted with VA services. Congress should ensure that prevention resources are directed toward strategies that demonstrate measurable reductions in risk and improvements in quality of life.

We also encourage Congress to support policies that require the Department of Defense (DOD) to take a more proactive role in preparing servicemembers for long-term mental wellness before they transition to civilian life. Suicide prevention cannot begin after discharge; it must be embedded throughout the lifecycle of service.

Expand and Modernize Neurorehabilitative Care for Veterans with Traumatic Brain Injury

Traumatic brain injury (TBI) remains one of the signature wounds of modern warfare. Since 2000, more than 500,000 servicemembers have been diagnosed with at least one TBI.[4] Many veterans continue to experience long-term cognitive, emotional, and behavioral effects that disrupt employment, family stability, and overall health. In some cases, untreated or inadequately treated TBI contributes to increased suicide risk and co-occurring mental health conditions.

The VA's traditional treatment models have provided essential care, yet emerging science suggests that additional, innovative approaches may improve long-term outcomes. AMVETS strongly supports the BEACON Act of 2026 and the Veterans TBI Adaptive Care Opportunities Nationwide Act of 2025. These bills would establish grant programs within the VA to expand access to innovative, non-pharmacological, and patient-centered treatments not widely available through the department today.

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[4] Defense and Veterans Brain Injury Center, "DoD Worldwide Numbers for TBI," Health.mil, accessed February 13, 2026, https://health.mil/Military-Health-Topics/Conditions-and-Treatments/TBI/DOD-TBI-Worldwide-Numbers.

Both pieces of legislation promote partnerships with academic institutions, nonprofit organizations, and non-VA providers to test and evaluate emerging therapies. They also prioritize independent research focused on recovery, suicide prevention, and long-term rehabilitation. By authorizing dedicated funding streams for innovation and evaluation, Congress can help ensure that promising therapies are rigorously studied and, where effective, integrated into standard VA clinical practice.

Modernizing TBI care is not a departure from the VA's mission. It is an extension of it. Veterans living with brain injury deserve a system that remains responsive to evolving science and committed to improving functional outcomes, not merely managing symptoms.

Increase Dependency and Indemnity Compensation for Surviving Families

Surviving spouses and families carry the enduring cost of service-connected loss. Dependency and Indemnity Compensation (DIC) has not kept pace with comparable federal survivor benefits or the economic realities facing military families today. The gap places many surviving spouses in prolonged financial insecurity despite the ultimate sacrifice made by their loved one.

AMVETS strongly supports the Sharri Briley and Eric Edmundson Veterans Benefits Expansion Act and the Caring for Survivors Act. These proposals seek to modernize DIC benefits and address longstanding structural inequities. Aligning DIC more closely with other federal survivor programs is not simply a fiscal adjustment. It is a reaffirmation that the nation stands behind the families of those who died in service or from service-connected causes.

Congress has an opportunity to correct this inequity and provide survivors with the stability and dignity they deserve. These men and women deserve immediate action, and we encourage these Committees to see this country's promises kept.

Achieve Successful, Interoperable Implementation of the VA Electronic Health Record

AMVETS has consistently supported the deployment of the Federal Electronic Health Record (EHR). For decades, fragmented systems have led to lost information, duplicative testing, and delayed treatment.

We look forward to VA resuming its rollout of the Federal EHR at 13 VAMCs in 2026, beginning in April in Michigan and continuing throughout the year at facilities in Ohio, Indiana, Kentucky, and Alaska.

For our members, this is about accountability, access, and better outcomes for the veterans we serve. A 21st century, interoperable EHR ensures that a veteran's medical history follows them seamlessly from the DOD to the VA and across facilities, reducing errors, delays, and duplicative tests while improving coordination of care.

Simply put, modernizing the VA's EHR is more than an IT upgrade; it is a commitment to delivering the safe, timely, and high-quality care that our veterans have earned.

The success of this effort will depend on stable leadership, disciplined project management, transparent reporting, and sustained congressional oversight. The focus must remain on effective execution and measurable progress.

With strong oversight and accountability, a modern EHR can improve patient safety, strengthen care coordination, and enhance long-term health outcomes. We have been encouraged by the commitment shown to this initiative by VA Secretary Doug Collins, and we look forward to seeing these efforts demonstrate meaningful progress for our veterans.

Pass the Major Richard Star Act

The Major Richard Star Act addresses a longstanding inequity affecting certain combat-injured retirees. Current policy reduces military retirement pay for some veterans who also receive VA disability compensation, even though these benefits serve distinct purposes. Retirement pay reflects years of service, while disability compensation addresses injury sustained in that service.

AMVETS strongly supports immediate passage of this legislation, standing alongside our fellow veteran service organizations and advocates. Combat-injured veterans should not face financial penalties because of wounds incurred in defense of the nation. Correcting this injustice reflects fairness, consistency, and respect for sacrifice.

Pursue a Coordinated National Veterans Strategy Focused on Outcomes

The United States invests more than $300 billion annually in programs serving veterans across federal, state, nonprofit, and philanthropic sectors.[5] Despite this substantial investment, there is no comprehensive framework that aligns resources around measurable outcomes or identifies gaps and duplication.

AMVETS strongly supports the National Veterans Strategy Act and thanks the Senate VA Committee for showing bipartisan unity on this effort. Requiring the development of a coordinated national strategy every four years would align efforts across sectors, establish clear performance indicators, and direct resources toward programs that demonstrate measurable success. A strategy focused on outcomes rather than inputs will strengthen accountability and ensure that taxpayer dollars produce meaningful improvements in health, employment, and quality of life.

A coordinated approach is essential not only for veteran well-being but also for national security, workforce development, and civic leadership.

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[5] U.S. Senate Committee on Veterans' Affairs, "Chairman Moran, Ranking Member Blumenthal Introduce Legislation to Develop a National Veterans Strategy," January 29, 2026, U.S. Senate Committee on Veterans' Affairs, https://www.veterans.senate.gov/2026/1/chairman-moran-ranking-member-blumenthal-introduce-legislation-to-develop-a-national-veterans-strategy.

Enhance VA Workforce Stability to Improve Veterans' Access to Care

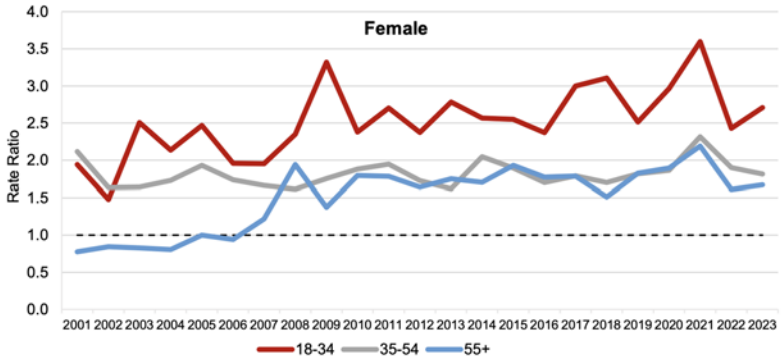
Access to high-quality care depends on a stable and well-supported workforce. Persistent staffing shortages, recruitment challenges, and retention difficulties continue to affect VA facilities nationwide. Workforce instability can limit appointment availability, strain providers, and reduce continuity of care.

AMVETS supports legislative efforts that strengthen recruitment and retention, improve workforce planning, and enhance accountability within the VA system. Community care can play a supportive role in addressing localized shortages, but it should always complement rather than supplant a strong federal health care workforce. Sustained investment in workforce stability is essential to preserving institutional expertise and maintaining trust in the VA system.

Advance Policy Solutions for Women Veterans

Women veterans are the fastest-growing segment of the veteran population and face distinct health care challenges. The most recent suicide prevention report indicates that the suicide rate among women veterans remains significantly higher than among non-veteran women.[6]

Figure 7: Ratios of Age-Group-Specific Suicide Rates, Veterans: Non-Veteran U.S. Adults, by Sex, 2001-2023[31]



In addition to mental health concerns, women veterans report gaps in access to gender-specific primary care, reproductive health services, maternity care, and specialty treatment. Addressing these barriers is essential to improving outcomes and building confidence in the VA system. AMVETS will continue working with Congress and VA leadership to advance policies that ensure equitable, comprehensive care for women who have served.

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[6] VA, *2025 National Veteran Suicide Prevention Annual Report*, Part 2, 19.

Strengthen Readiness, Resilience, and Long-Term Health Across Service

Military readiness and long-term veteran well-being are part of the same continuum. A force that is physically and mentally prepared to serve is more capable in uniform, and veterans who maintain health and resilience after service are better positioned to succeed in civilian life. Strengthening this continuum requires policies that address physical fitness, metabolic health, injury recovery, mental wellness, and sustained engagement over time.

Recruitment challenges in recent years have drawn attention to rising rates of obesity, preventable chronic conditions, and mental health stressors among service-age Americans. Addressing these trends requires a comprehensive approach. Structured physical training, nutrition education, behavioral health support, and, when clinically appropriate, medical or pharmacological interventions all have a role to play.

AMVETS believes adaptive and functional fitness programs represent an important component of that broader strategy. The AMVETS Adaptive Sports and Fitness Program operating in Hawai'i offers one example of how structured, inclusive training environments can reinforce both readiness and reintegration. The program serves active-duty service members, veterans of all eras, wounded and disabled veterans, and military families. Participants train together regardless of physical ability, with movements modified as needed to support functional strength, mobility, and daily living skills.

For active-duty participants, programs of this nature reinforce conditioning, injury prevention, and unit cohesion. For veterans, particularly those recovering from injury, navigating chronic health conditions, or experiencing isolation, structured group-based training restores routine, accountability, and peer connection. These elements are often critical to sustaining long-term health outcomes and complement clinical care provided through the DOD or the VA.

Importantly, adaptive fitness is not presented as a substitute for medical treatment. Veterans struggling with obesity, metabolic disease, or service-connected injury may require comprehensive care that includes primary care management, specialty services, nutrition counseling, behavioral health support, and in some cases medication or surgical intervention. Community-based fitness programs should be viewed as complementary tools that reinforce engagement, improve functional capacity, and enhance overall well-being alongside evidence-based medical care.

The Hawai'i model operates primarily through trained volunteers, maintains clear safety and attendance accountability measures, and partners with VA Recreational Therapy and other veteran organizations to ensure participants are connected to appropriate services when needed. With modest federal support, including a VA Adaptive Sports Grant, the program has expanded capacity while maintaining low overhead.

AMVETS believes scalable, community-based models that promote movement, connection, and resilience can strengthen both national readiness and long-term veteran reintegration when integrated thoughtfully with clinical systems of care. Investing in prevention and structured engagement today reduces long-term health costs and strengthens outcomes tomorrow.

Strengthening the health of those who serve, before, during, and after service, is not solely a recruitment issue or a veterans issue. It is a national security issue and a long-term public health priority.

Conclusion

The issues before the Committees this year are serious, interconnected, and consequential. They reflect both the progress that has been made and the gaps that remain in how our nation fulfills its obligations to veterans and their families. Suicide prevention, TBI care, survivor equity, health record modernization, retirement fairness, workforce stability, strategic alignment, and readiness are not isolated policy matters. Together, they define whether the system built to serve veterans delivers measurable outcomes and earns sustained trust.

Congress has demonstrated bipartisan commitment to veterans in recent years. That leadership must continue, particularly in areas where implementation, oversight, and accountability are just as important as statutory authorization. Authorizing programs without evaluating outcomes, funding initiatives without measuring effectiveness, or modernizing systems without sustained oversight will not produce the durable improvements veterans deserve. Success requires coordination between the VA, the DOD, and Congress, as well as a willingness to make adjustments when data shows that policies are not achieving intended results.

AMVETS stands ready to work with both Committees, the Administration, and our partners in the veterans community to advance these priorities. With focused oversight, disciplined implementation, and bipartisan resolve, meaningful progress is achievable. Veterans and their families deserve nothing less.

About AMVETS

AMVETS is the most inclusive congressionally chartered veterans service organization in the United States. Our membership is open to all active-duty service members, reservists, guardsmen, and honorably discharged veterans. As a result, AMVETS members have played a vital role in defending our nation in every conflict since World War II.

Our dedication to these men and women dates back to the post-World War II era, when countless returning service members sought access to the health, education, and employment benefits they had earned. Navigating the government bureaucracy to secure these benefits proved challenging for many, prompting experienced veterans to form local groups to assist their peers. As the veteran population surged into the millions, it became evident that a national organization was needed—one distinct from groups that had been established to serve veterans of previous wars. The emerging generation of veterans sought an organization of their own.

With this vision in mind, 18 delegates from nine veterans' clubs convened in Kansas City, Missouri, on December 10, 1944, to establish The American Veterans of World War II. Less than three years later, on July 23, 1947, President Harry S. Truman signed Public Law 216, officially recognizing AMVETS as the first congressionally chartered organization for post-World War II veterans.

Over the years, our congressional charter has been updated to welcome veterans from subsequent conflicts. AMVETS has also evolved to better meet the needs of newer generations of veterans and their families. To further this mission, we maintain partnerships with other congressionally chartered veterans' organizations as part of the "Big Six" coalition. Additionally, we collaborate with newer groups such as Iraq and Afghanistan Veterans of America and The Independence Fund. Our commitment to veterans' well-being is further demonstrated through our partnership with the VA's Office of Suicide Prevention and Mental Health, working to combat the tragic epidemic of veteran suicide.

As AMVETS looks toward the future, we remain steadfast in our dedication to serving those who have defended our nation. We urge the 119th Congress to join us in this commitment by making policy decisions and casting votes that protect and support our veterans.

AMVETS National Commander, Paul Shipley

National Commander Paul Shipley was elected to the organization's highest office by his peers in August 2025 at the AMVETS National Convention in Greensboro, North Carolina. Commander Shipley is a U.S. Army Combat Veteran, having served from 2004 to 2014. He served in Iraq from 2006 to 2007 and was awarded the Combat Action Badge, Army Commendation Medal, and Iraq Campaign Medal. He lives in Uniontown, PA, with his wife and three daughters.

The National Association of State Directors of Veterans Affairs

NATIONAL ASSOCIATION OF STATE DIRECTORS OF VETERANS AFFAIRS

Joint Hearing of the House and Senate Veterans Affairs Committees

March 4, 2026

Presented by

Terry Prince

President, National Association of

State Directors of Veterans Affairs (NASDVA)

Director, Illinois Department of Veterans Affairs

The National Association of State Directors of Veterans Affairs

INTRODUCTION

Chairman Moran, Chairman Bost, Ranking Member Blumenthal, Ranking Member Takano, and distinguished members of the Committees on Veterans' Affairs, thank you for the opportunity to submit this written testimony on behalf of the **National Association of State Directors of Veterans Affairs (NASDVA)**. I am Director Terry Prince, President of NASDVA, and Director of the Illinois Department of Veterans Affairs.

NASDVA was founded in 1946, following the end of World War II, to unite leaders of Veterans Affairs agencies from all 50 States, the District of Columbia, and the five U.S. Territories: American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands. In the postwar era, Veterans earned both Federal and State benefits, creating a critical need for coordinated efforts to ensure they received their full entitlements.

Directors, as leaders of State and Territorial government agencies, are entrusted by their respective Governors, State Boards, or Commissions to meet the diverse and evolving needs of Veterans, regardless of age, gender, era of service, military branch, or circumstances of service. Although each State and Territory differs in structure, programs, and resources, we share a unified commitment to delivering effective, Veteran-focused services. Equally important, **NASDVA** maintains strong partnerships with the U.S. Department of Veterans Affairs (VA) to advance our shared mission of improving the lives of our nation's Veterans.

VA FUNDING and REORGANIZATION

NASDVA is committed to working with Congress and VA senior leaders to ensure that scarce resources are allocated to priorities that meet our Veterans' most pressing needs in a Veteran-focused manner. **NASDVA** applauds Congress's concerted efforts to improve VA funding accountability, provide adequate funding for health care, claims adjudication, and appeals processing, and address homelessness and suicide prevention. Likewise, continued emphasis is warranted on preparing for the aging Veteran population, the growing cohort of women Veterans, and on support for Caregivers and Survivors.

As the VA continues its transformational journey, **NASDVA** can support the concept and contribute to the VA's proposed significant reorganization of the Veterans Health Administration (VHA), intended to improve patient care, based on recommendations from the OIG (Office of the Inspector General) and the GAO (Government Accountability Office). The major structural change from eighteen (18) Veterans Integrated Service Networks

(VISNs) to five (5), along with shifting staff to high-demand areas and restructuring community care contracts, will affect the entirety of VHA's health care delivery. The stated goals to speed decision-making, ensure consistent policy application across all VA medical facilities, and improve access to VA care supplemented by Community care are desirable. More details are needed to evaluate the overall impact. The reorganization will require careful oversight across the VA to ensure effective and efficient execution and to maintain a continued focus on deploying resources where Veterans are best served. Ultimately, the reorganization needs to enhance VHA's role as the primary health care provider for Veterans.

In addition to organizational changes, VA plans to restart its *Electronic Health Record Modernization (EHRM)* rollout in 2026, targeting 13 new sites, beginning in Michigan in April. Evolutionary upgrades to the VA's Millennium software will enable clinicians to easily access a Veteran's medical history in one location. The system must address medical providers' operational concerns and enhance healthcare delivery for Veterans. Likewise, it is essential to address system deployment challenges and be prepared for future development issues. **NASDVA** supports Congress's efforts to hold the VA's EHRM Integration Office accountable for transitioning to the new system that tracks all aspects of patient care.

VETERANS HEALTHCARE

NASDVA is committed to meeting the healthcare needs of our 16-plus million Veterans through partnership with the Department of Veterans Affairs (VA). A major focus is expanding access to the VA healthcare system for Veterans and eligible family members. This is achieved through strong collaboration among VA and the Departments of Veterans Affairs of the States, five Territories, and the District of Columbia, ensuring streamlined enrollment and expanded care options. Efforts to improve access include expanding Community-Based Outpatient Clinics (CBOCs) and Vet Centers, deploying mobile health clinics, leveraging telehealth, and expanding Community Care. The VA's digital platform stands out for enhancing Veterans' ability to manage their health and benefits, including appointments, communications, prescriptions, vaccine records, and medical updates.

NASDVA applauds the VA's recent initiatives to address mental health and prevent Veteran suicides. Veterans experiencing an acute suicidal crisis can now seek emergency care at any VA or non-VA health care facility at no cost. This includes up to 30 days of inpatient or crisis residential care and up to 90 days of outpatient care. These benefits are available regardless of enrollment in the Veterans Health Administration (VHA). This

expanded access is integral to suicide prevention, providing timely, no-cost care during crises and increasing access for the estimated 9 million Veterans not currently enrolled in VA health care.

The VHA must secure sufficient funding to meet the growing complexity of care for over 9 million enrolled Veterans. Adequate resources are essential to recruit and retain qualified doctors, nurses, and other healthcare professionals. In some cases, it is both necessary and appropriate for Veterans to receive treatment from external providers through Community Care, which currently accounts for 40% of all VA healthcare delivery. However, delays in Community Care referrals and appointments have raised concerns among Veterans, underscoring the need for timely, efficient service. Prompt reimbursement for Community Care services is equally important, as slow payments may discourage healthcare providers from participating. **NASDVA** believes the overarching goal is to prioritize Veterans' well-being and choice while maintaining a healthy balance between in-house VA care and community-based options.

Oral health is an important factor in physical, emotional, psychological, and socioeconomic well-being. VA offers comprehensive dental care benefits to only 600,000+ qualifying Veterans, and dental issues must be directly related to military service to be eligible. A Veteran must typically have a service-connected dental disability, be rated 100% disabled due to other service-related conditions, or be a former POW. Veterans who do not meet eligibility criteria must obtain oral health care outside the VA. For many, this is difficult because of out-of-pocket expenses, travel distance, lack of transportation, or a shortage of dentists in their communities. Maintaining good oral health is directly linked to overall physical and mental health. **NASDVA** supports efforts to expand the pool of Veterans eligible for VA dental care services, which may, in turn, reduce other health care challenges.

NASDVA recognizes that the VA's leadership in telehealth is vital to the overall healthcare delivery system, especially in connecting rural and vulnerable Veterans to essential services. Rural Veterans may face barriers to timely mental health care due to travel distances or limited provider availability. Through collaborative outreach, we can help bridge gaps in mental health care access for rural populations, American Indian/Alaska Native communities, and other underserved minority communities.

Women Veterans are the fastest-growing cohort, comprising over 11% of the overall Veteran population and over 900,000 enrolled in VA health care. These numbers underscore the need to continue emphasizing their eligibility for the full range of Federal and State benefits, including robust health care programs. **NASDVA** applauds the placement of Women Veterans Program Managers (**WVPM**s) at medical centers to coordinate a full range

of specialized health care for women Veterans, including primary care, gynecological services, maternity care, and mental health services tailored to their needs. Key services should include Pap smears, mammograms, menopause care, reproductive health, gender-specific prosthetics and sensory aids, and mental health care to address depression and anxiety linked to Military Sexual Trauma (MST).

NASDVA applauds the Memorandum of Understanding (MOU) between the VA and the U.S. Department of Health and Human Services' Indian Health Service (IHS), which aims to increase access and improve the quality of health care and services for eligible American Indians and Alaska Natives. Native American Veterans on their tribal lands are chronically underserved and would prefer care from IHS, with the VA reimbursing IHS. This appears to be a working model and should be continued. This is especially true on large tribal lands and in Alaska, where distances are vast. We are aware that some Veterans are dual users of IHS, VA tribal health, or both. This allows the Veteran to choose the most convenient option for their care. Should there be a government shutdown, IHS should continue, as the VA does with medical care for our Tribal Veterans. Veterans in Island Territories have had significant issues with earned services and support due to their isolation. During natural disasters, such as hurricanes, the VA can often be the only available provider. During any catastrophic event, NASDVA recommends that all Veteran categories be accepted for urgent medical care.

STATE VETERANS HOMES

The ***State Home Construction Grant Program*** is the largest and most cost-effective partnership between the Federal and State governments. There are **175** State Veterans Homes (SVH) that provide more than 50% of total VA long-term care across the 50 States and the Commonwealth of Puerto Rico. These homes provide vital services to elderly and disabled Veterans, with over 30,000 authorized beds for skilled nursing, domiciliary, and adult day health care.

NASDVA and the **NASVH** (National Association of State Veterans Homes) maintain a strong, collaborative relationship. Both support continued funding for VA's grant program, the largest among the Federal and State VAs. The VA provides up to 65% of the cost of construction, rehabilitation, and repair, with States required to provide at least 35% in matching funds. The FY2026 Priority List includes 80 Priority Group 1 projects for which States have already secured matching funds, totaling approximately $1.25B in federal share. However, Congress appropriated $275M, which will cover only the first six of the pending projects. As Veterans' needs for long-term care services continue to rise, funding must increase to catch up and ultimately eliminate the backlog of pending requests.

Congress should appropriate at least **$600 million** in FY 2027 for this program to fund about half of the pending Priority Group 1 requests.

NASDVA also has concerns about behavioral health and the future incidence of PTSD, TBI, and other conditions among the aging Veteran population. While war-related traumas lead to PTSD in younger OEF/OIF Veterans, aging Veterans can be exposed to late-life traumas that can lead to the onset of PTSD or trigger reactivation of pre-existing PTSD. VA has limited care options for Veterans with a propensity for combative or violent behavior, and we have a responsibility to serve this population. NASDVA and NASVH recommend a new Grant Per Diem scale that reflects the staffing intensity required for psychiatric beds and medication management. SVH and VA Community Living Centers are unable to serve intensive-care psychiatric patients, resulting in a lack of step-down capacity in the community. This level of care is critically needed. VA is responsible for specialty care for Veterans in SVH, particularly when the care is in response to a service-connected condition. Often, when coverage requires specialized healthcare services such as psychiatric care, the VA does not cover the cost. Psychiatric services are outside the scope of primary care provided to SVH residents; however, they should be treated as allowed specialty care, similar to cardiology and urology.

The nationwide shortage of direct-care providers, including doctors, RNs, LPNs, and CNAs (Certified Nursing Assistants), is well documented. Fewer health care professionals are being recruited, and providers are leaving the workforce or retiring in large numbers. The national competition among providers is creating an untenable situation, worsened by burnout among nursing professionals due to the rigors of care and by the salaries offered by large, well-financed hospital groups. Maintaining the resident census at SVH is difficult amid chronic staff shortages that are projected to continue, resulting in fewer Veterans being served and providers unable to cope with financial losses from lower reimbursement rates tied to a lower census. Thus, vulnerable Veterans in need of care are being denied access because of insufficient staff and the inability to meet demand.

NASDVA and **NASVH** appreciate VA's ***Nurse Recruitment and Retention Grant Program,*** which promotes the hiring and retention of nurses. However, it applies only to RNs, LPNs, Licensed Vocational Nurses, and CNAs. Expanding the program to cover other critical staffing vacancies, such as physicians, physical and occupational therapists, dietitians, and social workers, could help SVH compete with private-sector employers that offer higher salaries and benefits. Expanding the program to additional clinical roles would increase the number and quality of providers needed to care for aging veterans. Congress should expand the Nurse Recruitment & Retention Grant Program to allow SVHs to use

these grants to address other hard-to-fill hiring and retention challenges, including dietitians, recreation therapists, and other support functions that impact activities of daily living (ADL).

VA is authorized to cover up to 50% of care costs through a per diem rate for residents receiving care at SVH. However, current basic rates cover less than a third of costs. Factors such as labor costs in a competitive environment, higher pharmaceutical costs, rising food costs, unfunded mandates, and overall medical inflation have diminished the value of per diem. Honorably discharged Veterans are eligible for a daily VA per diem payment. The FY2025 rates are as follows: Nursing Care $148.71 per veteran per day; Adult Day Healthcare $118.48 per veteran per visit; and Domiciliary Care $64.19 per veteran per day. Both NASDVA and NASVH recommend a new Grant Per Diem scale; the rates need to be increased. Veterans with a service-connected disability rating of 70% or higher are eligible for no-cost nursing care at the SVH. However, VA does not pay for high-cost medications for this cohort. Certain medications, such as chemotherapy, can cost thousands per month. Community contract nursing homes with the VA are reimbursed when these costs exceed a certain percentage (typically 8.5%) of the per diem rate. Bipartisan legislation, the ***Providing Veterans Essential Medications Act (H.R. 1970)***, has been introduced to require VA to reimburse State Veterans Homes for high-cost medications, similar to the arrangement many private contract nursing homes currently have with VA, to ensure that seriously disabled Veterans have the choice to spend their final years in an SVH with VA paying for their high-cost medications.

VA's ***Geriatrics and Gerontology Advisory Committee*** was established to advise the VA Secretary on all matters related to geriatrics and gerontology, including long-term care programs and policies that affect SVHs. The committee can also provide recommendations on the procedures and policies that govern SVHs. It would be beneficial for the committee to include a *"voting"* member who is a licensed nursing home administrator currently serving as an SVH Administrator or in a supervisory role over SVHs. Legislation has been introduced, and Congress should pass the ***Representing Our Seniors at VA Act of 2025 (H.R. 785)***, which requires that at least one member of the committee represent NASVH's perspective.

NASDVA and **NASVH** recommend that the SVH conduct a single annual VA survey acceptable to CMS. SVHs undergo an annual VA inspection survey that reviews clinical practices and life-safety protocols, as well as a financial audit. Many SVHs are also CMS-certified and undergo a separate CMS inspection survey to qualify for CMS reimbursement. The CMS inspection survey is nearly identical to the clinical and life-safety sections of the VA survey. The VA inspection survey also covers domiciliary and adult day health care

programs at SVH. Legislation would ensure that VA and CMS retain their oversight, enforcement, and compliance tools, enabling veterans to continue receiving safe, high-quality care while residing in SVH. The ***State Veterans Homes Inspection Simplification Act*** (***S. 3532)*** would allow homes to undergo a single annual inspection survey conducted by VA that is acceptable to CMS. Bottom line, this bipartisan legislation benefits SVHs and taxpayers without diminishing care for Veteran residents.

MEMORIAL AFFAIRS

NASDVA applauds the Veterans Cemetery Grant Program (VCGP) of the National Cemetery Administration (NCA), a collaborative partnership with States, Territories, and Tribal governments. It is the second-largest VA grant program for States. The **124 VCGP**-funded cemeteries complement NCA's 158 national VA-managed cemeteries for Veterans and their families, expanding access to memorial benefits that meet "*shrine*" standards. Importantly, the program supports NCA's goal of increasing access to burial options for more than 94% of all Veterans within a 75-mile radius of their home county. In FY2025, grant-funded cemeteries accounted for more than 43,705 of the total 174,705 NCA and VCGP interments, representing **25%**.

Since the program's establishment in 1978, VA has awarded more than $1.1 billion in grants to establish, expand, improve, operate, and maintain 124 Veterans cemeteries in 47 States, 14 Tribal trust lands, and 3 Territories (Puerto Rico, Guam, and Saipan). The latest grant, $16.7 million, will establish the Interior Alaska Veterans Cemetery in Fairbanks. The cemetery will serve more than 12,000 Veterans and their eligible family members. This will be Alaska's first state Veterans cemetery. The recently published FY2026 Priority List of program pre-applications is as follows:

- Priority Group 1 - Expansion or Improvement, 14 pre-applications totaling more than $45.7 million, needed to avoid disruption of burial services within 4 years of the pre-application date and to benefit 1,979,509 veterans in the area served by the cemeteries.
- Priority Group 2 - Establishment of New Cemeteries, 18 pre-applications totaling more than $175.1 million, benefiting an additional 121,182 veterans in new cemeteries.
- Priority Group 3 - Expansion or Improvement for Projects with more than 4 years of depletion, 7 pre-applications totaling more than $34.4 million, and benefiting 630,665 veterans in the area served by the cemeteries.

- Priority Group 4 – Operations and Maintenance or Other Improvements, with 11 pre-applications totaling over $27.1 million.

The total **VCGP** need is **$282.3 million**; however, the FY2026 budget proposal is **$150 million**. This amount is sufficient to address Priority Group 1 (Expansion and Improvement) pre-application projects, but will not cover the full need for Priority Group 2 to establish new veterans cemeteries. It is difficult for States to budget for land acquisition and set aside funds for a new cemetery only to remain in Priority Group 2 year after year, while existing, aging Group 1 cemeteries need expansion or improvement. There are insufficient funds available for the remainder of Priority Group 2 and for all of Priority Groups 3 and 4; thus, **NASDVA** recommends that FY2027 remain at the **$150 million** level.

NASDVA also recommends that the FY2026 budget fund the plot allowance at $1,002 and authorize it for eligible family members. The President's budget submission proposes expanding this benefit: "Expand plot allowance for certain individuals eligible for interment in a national cemetery: The proposal would amend 38 U.S.C. § 2303 to provide plot or interment allowances to VA grant-funded State and Tribal Veterans' cemeteries for interments of certain individuals eligible for interment in national cemeteries. This proposal aligns eligibility for the plot allowance in grant-funded cemeteries with eligibility criteria for interment in national cemeteries."

Extending plot allowance funds to Veterans' spouses and eligible family members would help offset higher operational costs across all VCGP cemeteries. It would also allow States to avoid charging for burial services, thereby maintaining parity with National Cemeteries, where family members are not charged. Currently, States cover operational costs by charging either the equivalent plot allowance or a flat fee. This would address the inequity between the federal and state systems.

The ***Burial Equity for Guards and Reserves Act*** was incorporated as Division CC of Public Law 117-103 (The Consolidated Appropriations Act for FY2022). The VA Office of General Counsel determined that the law allows VCGP-funded cemeteries to inter certain "non-veteran" individuals; however, it does not compel such interments. Those who elect to do so must bear the costs of the headstone and outer burial container or niche cover. Because there will be no plot allowance to help cover the interment costs, the state VCGP cemeteries will need to appropriate additional funds. This creates an inequitable situation between Veterans and Non-Veterans who receive full memorial benefits and are interred in the same cemetery. Although the number of those without federal active-duty service who qualify as "Veterans" is small, it is desirable for States and Tribal governments to provide interment. Local appreciation and respect for Guard/Reserve members who respond to

natural disasters in the community are strong. The average citizen is unaware of differences in eligibility and simply views military members as worthy of the same memorial honors.

In summary, **NASDVA** strongly supports the FY2026 VCGP budget proposal of **$150 million** and urges that the FY2027 budget remain at that level. The budget also codifies the **$1,002** Plot Allowance for Veterans and, importantly, authorizes the **Plot Allowance** for Spouses and Eligible Family Members.

VETERANS BENEFITS SERVICES

NASDVA applauds VBA's record-breaking FY2025 performance, processing more than 3 million disability and compensation claims, surpassing the previous high of 2.49 million set in FY2024. As a result, Veterans and their dependents received more than $195 billion in disability C&P benefits. VBA has been transparent in its up-to-date reporting on claims inventory, backlog, accuracy, and fully developed claims. Claims processing accuracy improved to 93.5%, and the backlog was reduced by more than 57%.

NASDVA is concerned about the lengthy backlog of appeals before the Board of Veterans' Appeals (BVA). This backlog comprises approximately 200,000 pending cases, while the BVA can reasonably adjudicate only about 120,000 cases annually. Veterans now routinely wait three or four years for a BVA decision. The bipartisan ***Veterans Appeals Efficiency Act of 2025 (H.R. 3835/S.1992)*** proposes several amendments to the process, including expanding the jurisdiction of the United States Court of Appeals for Veterans Claims (CAVC) and allowing the BVA to aggregate Veterans' appeals involving common questions of law or fact. **NASDVA** urges passage and enactment of the full slate of fundamental improvements in this bipartisan legislation during the 119th session.

To further reduce the appellate backlog, **NASDVA** encourages VBA to restore a crucial feature of its prior collaborations with State and Territorial Veterans Service Officers (VSO): a 48-hour pre-decisional review period before issuing a decision, during which the Veteran's representative could examine the proposed decision and identify any errors of law or fact. This pre-decisional review period was a hallmark of VBA's collaborative relationship with VSO, helping prevent errors before the decision letter reached the Veteran and avoiding lengthy, time-consuming, and costly appeals sparked by simple errors that VBA could address and correct. **NASDVA** would like to see this collaborative process return, as it will benefit both the nation's Veterans and the VA by reducing errors, increasing satisfaction, lowering costs, and improving efficiency.

NASDVA recognizes and appreciates that VBA has implemented a "Claim Accuracy Request" (CAR) pilot program in lieu of the 48-hour review period. However, the CAR pilot falls far short of the value the 48-hour review period once provided. For instance, the CAR pilot categorically excludes several types of claims, including *Nehmer* claims for Vietnam War Veterans exposed to Agent Orange. The previous 48-hour pre-decisional review process imposed no such exclusions. VBA also rejects CARs when a VA decision assigns a rating percentage lower than the schedule of ratings supports. This means an advocate cannot use a CAR to point out that the evidence of record meets the criteria for a higher rating. The advocate is therefore forced to resort to the longer, slower appellate processes to get such matters reviewed, leaving the Veteran frustrated. Again, none of these restrictions existed under the previous 48-hour pre-decisional review process. **NASDVA** encourages VBA to restore the 48-hour pre-decisional review period to improve the accuracy of claims decisions, reduce the BVA backlog, avoid unnecessary duress for Veteran claimants, enhance the efficiency of VBA's procedures, and maintain collaboration between VBA and VSOs across all States and Territories.

NASDVA notes that the most common errors in initial VBA rating decisions often stem from flawed Compensation and Pension (C&P) examinations. Title 38 of the United States Code requires VBA to grant disability compensation if a Veteran proves that a medical condition is "at least as likely as not" caused or worsened by military service. Far too often, VBA receives sufficient medical evidence from a Veteran claimant to meet this standard of proof yet still demands that the Veteran undergo a C&P exam. Furthermore, **NASDVA** observes that too many C&P exams are conducted by medical professionals who are not specialists in the field relevant to the Veteran's condition, leading to incorrect findings and inaccurate decisions that, in turn, contribute to the BVA backlog described above. For example, a C&P exam for PTSD conducted by urologists, a C&P exam for Parkinson's disease conducted by general practitioners without any neurological specialty, and a C&P exam for orthopedic conditions conducted by endocrinologists. **NASDVA** urges VBA to conduct a comprehensive review of its C&P exam process and, based on the review's results, revise its procedures to improve efficiency and effectiveness. In the interest of full procedural transparency and accountability, **NASDVA** also urges VBA to publish its contracts with all private-sector companies that conduct C&P examinations, ensuring that all Veterans and their advocates fully understand the expectations and standards to which C&P examiners are held, as well as the payment scales and payment processes for these companies.

NASDVA applauds VBA's tremendous efforts in adjudicating the historically large number of claims filed by Veterans and Military Families following the enactment of the

Honoring Our PACT Act of 2022. This life-changing legislation opened the door for an unprecedented number of Veterans to receive long-overdue medical and financial benefits for illnesses related to toxic exposures incurred during military service. **NASDVA** notes, however, that this vital mission of justice for Veterans suffering from toxic exposures related to their military service is not yet complete. For example, VBA has acknowledged that Veterans who served at Fort McClellan in Alabama, the longtime training ground of the U.S. Army's Chemical Corps and the Chemical/Biological/Radiological Agency, may have been exposed during their service at this base to radioactive compounds, chemical warfare agents, and airborne polychlorinated biphenyls (PCBs). Nevertheless, VBA repeatedly declines to recognize a presumption linking service at Fort McClellan to the medical conditions commonly associated with the exposures that VBA itself acknowledges occurred there.

NASDVA has observed this pattern in other locations and with other toxins. Panama, for instance, is not included in the ***PACT Act***, yet our members have worked with many Veterans who served in the Panama Canal Zone during the 1980s and were exposed to the remnants of toxic herbicides, including Agent Orange, as well as toxic pesticides mixed with diesel and sprayed from trucks. Numerous reports and testimonies confirm the presence and storage of Agent Orange in Okinawa during and after the Vietnam War, especially on and around military installations such as Kadena Air Force Base and Marine Corps Air Station Futenma. Yet VBA still declines to recognize a presumption of toxic exposure for Veterans who served during the Vietnam War in these areas of operation. Abundant reports verify the presence of Agent Orange along the Korean Demilitarized Zone (DMZ) during the Vietnam War, but VBA recognizes a presumption of Agent Orange exposure only for Veterans who served at the DMZ between the limited timeframe of September 1, 1967, and August 31, 1971. In Cambodia, where the United States Armed Forces sprayed Agent Orange and other tactical herbicides throughout the Vietnam War to disrupt enemy supply lines, VBA's presumption of Agent Orange exposure is even more inexplicably limited, confined solely to April 1969. The ***PACT Act*** accurately recognizes jet fuel (e.g., JP-8, JP-5) as a toxic substance and requires VBA to examine the impacts of jet fuel exposure more closely, yet VBA refuses to find any illness presumptuously linked to this toxic exposure.

NASDVA witnessed this pattern play out over many years as VBA denied any correlation between Agent Orange exposure and the medical conditions linked to it. Later, this history repeated itself with Veterans exposed to toxic water at Camp Lejeune, who were denied benefits for decades until VBA finally recognized the connections between this toxic exposure and medical conditions ranging from adult leukemia to bladder cancer. Even more recently, **NASDVA** advocated for many years on behalf of Veterans exposed to toxic fumes

from burn pits in the Middle East, highlighting medical connections that VBA neglected until the *PACT Act* finally forced these presumptions into existence. This history need not repeat itself. **NASDVA** encourages VBA to study toxic exposures not specifically covered in the *PACT Act* or any other legislation but that have been raised for many years by Veterans' advocates, including, but not limited to, toxic exposures and associated medical conditions related to Fort McClellan, the Panama Canal Zone, Okinawa, the Korean DMZ, Cambodia, and Veterans in all theaters whose service brought them within close proximity to jet fuel. **NASDVA** asks that VBA publish its findings in these areas to ensure full transparency on these important topics, and, most importantly, that VBA move quickly to establish a presumption of toxic exposure and to recognize the medical conditions that such exposure causes in all areas where the research findings warrant such a presumption.

NASDVA applauds VBA for its rapid adoption of the ***VA Home Loan Program Reform Act*** (**HLPRA**) (*Public Law 119-31*) following the termination of the Veterans Affairs Serving Purchase Program (VASP). While HLPRA still does not provide the protections VASP previously offered, the partial claim structure it established offers a useful option for some Veteran borrowers facing financial distress. However, **NASDVA** is concerned about VBA's lack of progress in rulemaking and implementing the HLPRA's terms. VBA has not yet promulgated the regulations necessary to implement these measures. Consequently, the process remains opaque to Veteran borrowers seeking to apply for and use HLPRA's partial claim structure. In helping Veterans navigate the HLPRA system, roadblocks arise from processes that are not yet fully in place. **NASDVA** encourages VBA to complete its implementation of this important program rapidly to bring the provisions described in the HLPRA into full effect.

The ***Major Richard Star Act (H.R. 2102/S. 1032)*** is bipartisan legislation that has garnered substantial support, with over 70% of Congress backing its passage. It clearly warrants enactment. It directly affects over 52,000 combat-injured Veterans who were medically retired with less than 20 years of service. These Veterans are subject to an offset, with their retirement pay reduced "*dollar-for-dollar*" by the VA disability compensation they receive, unlike disabled Veterans who serve more than 20 years. Retired pay is for completed years of service paid by the DoD, while disability compensation is for lifelong injury paid by the VA. These are two distinct payments for two distinct purposes, and reducing retirement pay because of a disability is unjust and, in essence, a "wounded Veterans tax." **NASDVA** strongly recommends that this critical legislation be passed by the 119th Congress for those most deserving disabled Veterans.

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NASDVA urges renewed focus on preventing the unscrupulous actions of individuals and groups (Claims Sharks) that violate Title 38 of the United States Code regarding the representation of claimants. This includes, but is not limited to, individuals and groups that claim the ability to represent Veterans before VBA despite lacking accreditation, and individuals and groups that breach federal law by charging fees for the initial preparation, presentation, and prosecution of VBA claims. The reach of these bad actors and the adverse impacts they cause have increased steadily in recent years, leading many Veterans and their families to pay exorbitant fees for minimal services and, as a result, lose significant portions of the benefits they rightfully earned. **NASDVA** recommends greater oversight of this process and stricter enforcement of applicable federal laws. It is not intended to restrain trade or limit the options available to Veterans. **NASDVA** does not advocate eliminating all for-profit actors in this space; it only advocates eliminating those that fail to comply with governing law. **NASDVA** seeks full enforcement of the provisions of Title 38 that Congress passed to protect Veterans from harm these bad actors can perpetrate. For-profit entities must follow the law governing their practices, just as the States, Territories, and VSOs must.

Many standardized forms that VBA requires a claimant to complete and file to receive earned benefits are lengthy and complex. While VBA updates many of these forms frequently, these updates rarely reduce the overall complexity of the paperwork required for a Veteran to file a successful claim. This is especially true for the standardized forms required to prepare, present, and prosecute a claim for non-service-connected pension, a process that sometimes requires a Veteran to complete more than twenty-five pages of paperwork to file the claim. Congress designed VBA's pension system to aid Veterans with low incomes, limited assets, and permanent and total disabilities. As boots-on-the-ground advocates across all States and Territories, **NASDVA** members can provide valuable feedback and ideas to VBA's leadership as they draft the latest editions of their standardized forms, which accomplish the due diligence of a proper claims review while eliminating redundancies and improving ease of access. This will improve the overall efficiency of VBA's processes and enable deserving Veterans to receive the benefits they earned more quickly and accurately.

NASDVA agrees with Secretary Collins' decision to stay the "effective immediately" of the Interim Final Rule (RIN 2900-aAS49) and to continue the comment period through April 20, 2026. The VA stated that the rule was necessary to clarify long-standing interpretations and correct judicial interpretations, specifically citing *Ingram v. Collins*. We are concerned that the VA is amending 38 CFR 4.10 to require that disability evaluations reflect a veteran's "actual functional impairment while on medication or treatment," rather than determining severity without it. Earlier precedent in *Jones v. Shinseki* holds that ratings must not take the ameliorative effects of

medication into account unless VA's schedule of ratings for that specific condition states that the adjudicator may do so. **NASDVA** cannot support any Interim Final Rule that reduces earned benefits simply because a Veteran follows prescribed treatment. Further, **NASDVA** supports efforts to ensure consistency in disability evaluations.

VETERANS HOMELESSNESS

NASDVA appreciates VA's ongoing commitment to ending Veteran homelessness. States remain dedicated to creating and supporting outreach programs that help VA achieve this important goal, particularly by improving the identification of homeless Veterans and bolstering efforts to prevent homelessness. Working with VA at the community level, we are addressing the factors that lead to Veteran homelessness, including medical and mental health challenges, legal concerns, job skills and work history, and affordable housing.

NASDVA urges continued support for specialized homeless programs, including the *Homeless Providers Grant and Per Diem (GPD), Health Care for Homeless Veterans (HCHV), Domiciliary Care for Homeless Veterans (DCHV), Supportive Services for Veteran Families (SSVF), and Compensated Work Therapy (CWT).* Continued collaboration between VA and community groups is essential to provide Veterans with transitional and permanent housing. Factors contributing to Veteran homelessness can be addressed through treatment programs, job training, and case management. Adequate staffing and consistent funding for these initiatives are necessary.

NASDVA commends VA and HUD for their collaboration in increasing the number of Veterans Affairs Supportive Housing (HUD-VASH) vouchers. In high-cost areas, voucher values may be insufficient to secure adequate housing for Veterans, warranting a cost-of-living adjustment tied to the local market to ensure VASH vouchers can cover the cost of affordable housing. Additional attention is needed for older homeless veterans, particularly Vietnam Veterans with disabling injuries or diseases, or who can no longer care for themselves. These Veterans are highly vulnerable and may require long-term care but may not have filed for service-connected disabilities or be able to navigate the system. **NASDVA** recommends that Congress review policy changes to allow these Veterans to use HUD-VASH vouchers for Residential Housing with services. Such a change could broaden access and clarify the distinction between assisted living facilities and skilled nursing facilities.

NASDVA recommends reestablishing a nationwide verification process through which Communities and States may receive federal recognition for their success in ending veteran homelessness. VA joined with HUD community continuums of care (COCs), which

coordinate community-wide services, resources, and expenses to end homelessness. The national Mayoral Challenge to End Veteran Homelessness added municipal efforts, as well as veteran-specific housing operators and advocates. For over a decade, the U.S. Interagency Council on Homelessness (USICH) provided an independent, interagency verification process to confirm that communities met the federal benchmarks. These confirmations were conducted jointly by VA and HUD, creating incentives for local governments, philanthropy, and public systems to sustain coordinated efforts toward "functional zero" or "effectively ending veteran homelessness." In March 2025, a White House directive titled "*Continuing the Reduction of the Federal Bureaucracy*" halted several non-statutory functions across agencies, including USICH's federal verification role. As a result, there is no federal entity validating communities that have met the criteria and benchmarks. **NASDVA** requests and will support legislation to amend Title 38, United States Code, to require the Department of Veterans Affairs to create a federal verification process for States and Communities that have effectively ended veteran homelessness.

SUICIDE PREVENTION

NASDVA and **VA** continue to place strong emphasis on Veteran suicide prevention, yet it remains a crisis, with roughly 17.5 Veteran deaths per day. The entire Veterans community must take on this critical task. The recently released VA "*annual suicide prevention report*" is informative and helpful. It states that the Veteran suicide rate remains twice that of the non-Veteran population. Even with a declining Veteran population, the 2023 suicide rate among non-Veterans was 16.9 per 100,000, while the rate among Veterans was 35.2 per 100,000, more than twice as high.

NASDVA's role is important in engaging community coalitions through the Governor's Challenge and the Mayor's Challenge on Veterans' Suicide Prevention, which can support the VA's efforts. The Governor's Challenge advances a public health approach by bringing together key state leaders to develop strategic action plans focused on preventing Veteran suicide. Teams receive support from the VA and SAMHSA, including technical assistance, consultation with subject-matter experts, and sharing best practices and innovations with other teams nationwide. These VA community-based interventions reach Veterans through multiple touchpoints, cross-agency collaborations, and community partnerships. As the annual report noted, there are Veteran populations that the VA and the Veterans community should consider targeting for prevention.

VA providers should be alert for suicidal warning signs among VA patients, particularly those with cancer, those being treated for mental health conditions or

substance abuse, those with TBI, and women Veterans who have experienced military sexual trauma. Everyone should be attentive to Veterans who are unemployed, have poor job histories, have limited income, are involved with the justice system, and are homeless. Veterans engaging with other Veterans through *"buddy checks"* can make a difference. Importantly, data indicate that 70% of Veterans who take their own lives do not engage with the VA. While access to VA health care has improved, outreach to inform Veterans about their benefits needs constant emphasis. Engaging Veterans in VA health care saves lives. As the annual report stated, VA officials said, "the findings indicate a need to ensure that suicide prevention resources are integrated throughout VA and in Communities," and "the importance of a public health approach to preventing suicide among Veterans cannot be overstated." **NASDVA** members can lead at the community level in the States and Territories through an "all hands-on deck" approach to outreach and help fight this complex problem.

TRANSITION ASSISTANCE PROGRAM (TAP)

The Department of Defense reports that approximately 200,000 Service Members (SM) leave the military each year and transition to civilian life. They face challenges in employment, education, finances, housing, health, and new relationships. **NASDVA** strongly encourages transition programs to support success during this stressful period. These programs are important for emotional well-being and for making a strong start on the next phase of a productive life.

SM are required to attend the multi-day Transition Assistance Program (TAP) at their military installation before separation or retirement. Spouses are also encouraged to attend as appropriate. TAP is a mandated, standardized workshop across all services and components, primarily delivered by the Department of Defense and VA. It focuses on earned benefits, employment opportunities, and education. Depending on the SM's plans, the TAP process may be inadequate to meet individual needs, and the volume of information can be challenging to absorb. As a result, many view TAP as something they need to get through to leave the service rather than a helpful resource. Regardless, **NASDVA** recommends increased emphasis on mandatory TAP participation.

It is often challenging for Transitioning Service Members (TSM) to connect with available earned State services, benefits, and support. Likewise, it is difficult for States to inform service members about these benefits and services, especially in their new communities. This lack of connectivity between TSM and the States creates significant barriers to employment and increases the mental stress associated with their transition. NASDVA applauds the recent change that allows pre-discharge documents to provide for

"opt-out" (instead of "opt-in") for the sharing of email addresses and contact information with the States. States are uniquely positioned to provide critical information that helps TSM access earned Federal and State services, benefits, and support. Post-service contact information on the electronic DD Form 214 discharge remains important for engaging and informing those retiring or separating service members with the States and community-based organizations.

NASDVA applauds the VBA's coordination and efforts to include a 45-minute instructional block in its 8-hour curriculum, enabling representatives from the States and VSOs to participate. We believe this important initiative by the VBA Under Secretary allows SDVA and VSOs to provide information on additional services and benefits available to those staying in their current location or relocating, further enabling TSM to make the best decision about their post-service careers. Ultimately, an effective TAP, across all partners at the federal, state, and local levels, makes a significant difference in helping the Veteran and their family experience a smooth transition.

CONCLUSION

NASDVA respects the important work Congress has done and continues to do to improve the well-being of our nation's Veterans. As stated, we are "government-to-government" partners (Federal-to-State) and are second only to the federal VA in delivering earned benefits and services to those who have served our great country, particularly through State Veterans Nursing Homes and State Veterans Cemeteries. State VA agencies serve as a vital link to Veterans where they live. We are an integral part of the "whole of government" in serving our nation's Veterans, their families, Caregivers, and Survivors. With your continued support, we can ensure that the needs of our Veterans remain a national priority. In doing so, we fulfill the promise to take care of those who "have borne the battle" and demonstrate a commitment to the nation's future Veterans.

Terry Prince – Director – Illinois Dept of Veterans Affairs

Terry Prince was appointed Director of the Illinois Department of Veterans' Affairs by Governor JB Pritzker on April 1st, 2021. As Director, he leads a team of 1,200 professionals, in partnership with numerous local and state organizations, to provide beneficial services for more than 650,000 veterans and their families across the state of Illinois.

Prior to this appointment, Director Prince served as the Superintendent of the Ohio Veterans Homes. In this capacity, he led 850 employees providing skilled nursing and domiciliary care for 801 veterans at three separate facilities including the 5th largest Veterans home in the country. At the conclusion of this assignment, he was awarded the department's inaugural Major General Manning Force Award, an honor that recognized his distinguished service in a position of significant responsibility.

Prince enlisted in the U.S. Navy in 1986 and went on to serve at 14 different duty stations around the world with tours as Command Master Chief at Naval Hospital Camp Lejeune, NC and the Walter Reed National Military Medical Center in Bethesda, MD. Later, he was handpicked to be the 1st Senior Enlisted Advisor at the Defense Health Agency in Falls Church, VA. He closed out his illustrious 31-year career in 2017 as the 14th Director of the U.S. Navy Hospital Corps and Force Master Chief of Navy Medicine.

Force Master Chief Prince's military awards include the Legion of Merit, Defense Superior Service Medal (two awards), Meritorious Service Medal (two awards), Navy and Marine Corps Commendation Medal (six awards), Navy and Marine Corps Achievement Medal (three awards) and the U.S. Army Order of Military Medical Merit. He is also triple warfare qualified as a Surface, Aviation and Fleet Marine Force Warfare Specialist.

Prince earned a bachelor's degree in organizational leadership from Chapman University and is a graduate of the National Defense University Keystone Leadership Fellowship, Navy Senior Enlisted Academy and the Navy Command Master Chief course. He served as a proud member of the National Association of State Veterans Homes and more recently, as secretary and junior vice-president of the National Association of State Directors of Veterans Affairs (NASDVA). He is also a proud Eagle Scout and finisher of the Ironman Hawaii Triathlon World Championship.

There is a strong history of military service in Director Prince's family, with his grandfather, three uncles and two brothers all having worn the cloth of our nation. He and his wife, Dr. Jennifer Prince, a 12-year Navy veteran, reside in Will County, Illinois.

Wounded Warrior Project
4899 Belfort Road, Suite 300
Jacksonville, Florida 32256
O 904.296.7350
F 904.296.7347

WOUNDED WARRIOR PROJECT

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Statement of
Walter E. Piatt
Chief Executive Officer

Legislative Hearing Presentation of Wounded Warrior Project

March 4, 2026

Chairmen Moran and Bost, Ranking Members Blumenthal and Takano, distinguished members of the House and Senate Committees on Veterans' Affairs – thank you for inviting Wounded Warrior Project (WWP) to submit the following written statement highlighting our promise to those we serve and the 2026 legislative priorities that will enable us to keep it.

Wounded Warrior Project is grounded on our promise to meet the needs of warriors and family support members no matter what. We remain committed to bringing every warrior home – mind, body, and soul. We believe it should not be harder to come home from war than it is to go, but unfortunately, that is the case for so many of our nation's veterans. They face a new war back home as they confront the visible and invisible wounds of military service. We must be willing to meet them in the pain and darkness and illuminate a path forward full of possibility.

For 23 years, WWP has helped warriors and their families heal from these wounds and embrace a life of hope and renewed purpose. Working alongside Congress, other veteran service organizations, community partners, and many others, we have made incredible progress, but there is so much work left to do. With your support and that of our grateful nation, we will push the boundaries of what's possible as we pursue the path to save a million more lives.

The following examples of impact from the past year (October 1, 2024, to September 30, 2025) demonstrate our enduring commitment to rebuild lives impacted by war and military service. They deserve our very best efforts – not just for today, but for many decades to come.

Last year, WWP hosted close to **7,000** virtual and in-person events and programming engagements. That is nearly 20 events every day. Through 18 life-changing programs – focused on connection, mental and physical health, financial wellness, and long-term support for the most critically wounded – we are keeping warriors and their families connected and out of isolation.

Mental health programs and resources continue to be a leading focus of our support. The invisible injuries and wounds of service are many and most are not seen until their life unravels into disorder. Central to our promise, WWP is leading efforts to find multiple treatments to cure post-traumatic stress disorder (PTSD). This past year, we provided warriors and family members with more than **76,000** hours of treatment for PTSD and other mental health conditions like traumatic brain injury (TBI), substance use disorder (SUD), and military sexual trauma (MST).

While we can never prevent traumatic things from happening, we can continue to work diligently to eliminate the disorder that can arise from those experiences.

To help mitigate psychological stress and improve resilience, WWP placed more than **11,460** emotional support calls to warriors and their families, providing resources and tools to help them make positive life changes. We have also seen the invaluable impact to mental health and wellbeing when fellow veterans come together to find connection, camaraderie, and new solutions to shared challenges. In support of this, we facilitated over **1,300** warrior-only peer-to-peer support group meetings, fostering stronger relationships within our warrior population.

To help warriors create a life grounded in financial wellness and stability, we help them address challenges with financial education, employment readiness, and disability compensation. WWP empowers those we serve with the skills and support to find meaningful employment opportunities. This past year, WWP helped place over **1,270** warriors and family members with new employers, connecting them with both a career path and a sense of rekindled purpose.

We also advocate for warriors as they navigate the disability claims process. For some, these benefits are their only source of income. In the past year, we helped **5,680** warriors obtain their disability compensation benefits from the Department of Veterans Affairs (VA), securing the entitlements they earned in service to our country.

For the most severely injured warriors, WWP delivered nearly **285,000** hours of in-home and local care through our Independence Program. This program provides personalized care and ongoing, innovative support to help these warriors remain at home and live more independent lives for as long as possible.

When we envision the highest quality support for warriors and their families, we fully embrace the tremendous opportunity partnership and collaboration bring to veteran service. We know we cannot meet the challenges of this generation of warriors alone. Through our Community Partners initiative, we extend the reach of our mission by investing in and partnering with best-in-class military and veteran-serving organizations that address critical needs across the post-9/11 community.

Through integration with a community of veteran service organizations, we are creating a coordinated network of support for those we collectively serve – one that addresses critical needs, fills gaps, and shares resources to provide unique, high-touch care. Since 2012, WWP has supported 221 military- and veteran-connected organizations through grants, and in FY 2024 alone, these partnerships reached more than **61,000** post-9/11 Service members, veterans, caregivers, family members, military-connected children, and members of the Special Operations community.[1]

We prioritize programs that improve quality of life, reduce suicide risk, and support high-need populations – focusing on connection and community integration, family resiliency and caregiver support, financial wellness, and wraparound services for those living with visible and invisible wounds. WWP also serves as a convener and data partner, sharing insights, research,

[1] To view our current Community Partners, please see Appendix at the back of the document.

and best practices that strengthen partner capacity and long-term impact. Through this integrated approach, WWP not only remains responsive and agile to evolving needs but anticipates them, ensuring we honor those who have served and equip them through high quality interventions long into the future.

None of this would be possible without Congress' support for veterans, their families, and caregivers. Congress plays a critical role by shaping our nation's policies, and WWP remains committed to helping your committees identify, develop, and pursue public policy changes that will have the biggest impact on the warriors we serve. We are forever indebted to our nation's wounded veterans, and it is an honor to commit ourselves to keeping the promise – to be there no matter what. Our 2026 priorities for Congress echo that promise. Outlined below are our priorities with impactful data illustrating their significance to the post-9/11 veteran community we serve. To address these priorities with courage, determination, and deep sense of gratitude, we can impact a generation … and bring every warrior home – mind, body, and soul.

- ***The Major Richard Star Act***: Do right by combat veterans by passing the *Major Richard Star Act*. (More on page 4)

- ***Mental Health & Suicide Prevention***: Almost 2 in 3 warriors (62.7%) responding to our 2025 Warrior Survey reported symptoms of one or more mental health conditions. The top three reported issues were anxiety (80%), depression (77%), and PTSD (77%). Our analysis of survey data suggests that these mental health conditions negatively impact warriors' quality of life. (More on page 5)

- ***Severely Wounded Service Members and Veterans***: Nearly 8 in 10 (78.8%) of warriors responding to our 2025 Warrior Survey reported a service-connected disability of 70% or higher. Among all responding warriors, about one in four (26.0%) reported needing aid and/or assistance from another person due to service-connected injuries or health problems. (More on page 9)

- ***Brain Health and Traumatic Brain Injury***: Nearly one in five post-9/11 veterans sustained at least one TBI, and over 500,000 TBIs have been diagnosed in Department of Defense (DoD) personnel since 2000.[2] For some veteran populations, TBI prevalence climbs even higher, with estimates showing that up to 67% of veterans have experienced at least one brain injury, making it one of the most consequential and under-addressed injuries in the veteran community.[3] (More on page 15)

- ***Toxic Exposure***: Since the *PACT Act* became law on August 10, 2022, VA has approved more than 2.2 million *PACT Act*-related claims and screened over 6.4 million veterans for toxic exposure harm.[4] This progress is significant, but we can still do more to address environmental exposures beyond burn pits. (More on page 18)

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[2] DEF. HEALTH AGENCY, U.S. DEP'T OF DEF., https://www.health.mil/Military-Health-Topics/Centers-of-Excellence/Traumatic-Brain-Injury-Center-of-Excellence/DOD-TBI-Worldwide-Numbers (last visited Jan. 9, 2026).
[3] Carrie Esopenko et al., *Studying TBI in Veteran Populations*, BRAIN INJURY ASSOC. OF AM., https://biausa.org/public-affairs/media/studying-tbi-in-veteran-populations.
[4] U.S. DEP'T OF VET. AFFAIRS, PACT ACT PERFORMANCE DASHBOARD, https://department.va.gov/pactdata/interactive-dashboard/ (last visited Feb. 23, 2026).

- ***Economic Empowerment***: Warriors completing our 2025 Warrior Survey reported unemployment (12.4%) at a higher rate compared to the country's general population with a disability (7.4%) and the overall veteran population (3.6%). Approximately 2 in 3 (67%) of all warriors reported that they did not have enough money to make ends meet at some point in the past 12 months. (More on page 23)

- ***Women Veterans***: In a recent poll of 7,000 VA health care users, 82% of women veterans reported being pleased with their VA provider – a notable increase over a period of years where gender-specific care has been a focus for VA. Even so, 37% reported not understanding benefits, and 27% reported not having enough information on how to use VA health care.[5] (More on page 27)

- ***Transition Support***: Every year approximately 200,000 Service members transition out of the military.[6] Longitudinal research conducted with 10,000 post-9/11 veterans found that at 6.5 years after separation, nearly 1 in 5 (19%) did not feel fully transitioned.[7] We can do more to help Service members make healthy transitions. (More on page 32)

Major Richard Star Act (H.R. 2102, S. 1032)

I. **Do Right by Combat Veterans**: Pass the *Major Richard Star Act*, which would allow veterans with less than 20 years of service who were forced to medically retire due to combat-related injuries to receive both their full DoD retirement pay and VA disability compensation.

When Service members retire from the military, they are entitled to both retired pay from the DoD and disability compensation from VA if they were injured while in service. Current law does not reflect our national commitment to that promise. Only military retirees with a minimum of 20 years of service and a disability rating of at least 50 percent can collect both benefits at the same time. For all other retirees, current law requires a dollar-for-dollar offset of these two benefits, and thousands of veterans are left to forfeit a portion of the benefits they earned from their military service.

Under the *Major Richard Star Act*, former Service members who were medically retired from the military with less than 20 years of service due to combat related injuries (under Chapter 61) – and who are eligible for Combat-Related Special Compensation (CRSC) – would no longer have their compensation reduced by the offset. This includes those medically retired for injuries sustained during combat operations and combat-related training.

DoD retirement pay and VA disability compensation are two distinct benefits established by Congress for differing reasons. WWP strongly believes that receiving both benefits should

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[5] Press Release, U.S. Dep't of Vet. Affairs, The Barriers for Women Veterans to VA Health Care 2024 (Dec. 2024), https://news.va.gov/136796/va-raises-the-bar-on-care-for-women-veterans/.
[6] *See, e.g.*, U.S. GOV'T ACCOUNTABILITY OFF., GAO-24-107352, TRANSITION TO CIVILIAN LIFE: BETTER COLLECTION AND ANALYSIS OF MILITARY SERVICE DATA NEEDED TO IMPROVE OVERSIGHT OF THE SKILLBRIDGE PROGRAM 1 (2024).
[7] VETERANNETWORK, PENN STATE UNIV., AN OVERVIEW OF THE TYPICAL VETERAN IN TRANSITION, https://veteranetwork.psu.edu/wp-content/uploads/2025/03/TVMI-VETS_Transitioning-Veteran-Infographic_2025Mar26.pdf (last visited Feb. 23, 2026).

never be considered "double dipping" and that those medically retired as a result of combat-related injuries should not be subject to the offset. Retirement pay is calculated to compensate a retiree for the years of service already sacrificed in defense of the nation, while VA disability compensation is calculated to make up for the loss of future earning potential due to the retiree's service-connected disabilities. Unprecedented congressional support reflects a similar vision as the House bill has received 316 co-sponsors and the companion bill in the Senate received 77 co-sponsors.

In 2026, WWP has joined other leading veteran and military service organizations in the Star Act Alliance to ensure this bill is passed – or at bare minimum offered for a vote in both chambers – before the conclusion of the 119th Congress. We invite and strongly encourage all members of the House and Senate Committees on Veterans' Affairs to share their support and ensure that this legislation is given whatever remaining support is needed to ensure it becomes law as soon as possible.

Mental Health & Suicide Prevention

I. **Innovative and Emerging Therapies**: Invest in new treatment approaches that provide personalized, effective care for mental health and substance use disorders, including psychedelic-assisted therapy.

- **Priority Legislation**: *Innovative Therapies Centers of Excellence Act* (H.R. 2623)

Psychedelic Assisted Therapy: Despite significant investments in care, outreach, and awareness across the public, private, and non-profit sectors, ending veteran suicide remains tragically elusive. Based on the most recent annual data shared by VA, our nation lost 6,398 veterans to suicide in 2023.[8] While risk factors including combat trauma, SUD, and transition stress abound within the veteran community, there are indeed "anchors of hope" including notable declines in suicide rates among veterans receiving VA health care for anxiety (-40.4%), depression (-43.9%), PTSD (-34.9%), and alcohol use disorder (-16.3%).[9] With more research and commitment, psychedelic assisted therapy – provided within U.S. borders and through VA – can become the next beacon of light for those hoping to overcome their mental health struggles.

High dropout rates from traditional outpatient mental health care[10], treatment-resistant diagnoses[11], and a one-size fits all approach to care[12] are among many factors driving WWP and others to call for accelerated access to evidence-based mental health treatments, expanded psychedelic research, and the elimination of policy barriers that prevent veterans from getting the care they deserve. Direct appropriations to the National Institutes of Health, VA, and DoD for

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[8] U.S. DEP'T OF VET. AFFAIRS, 2025 NATIONAL VETERAN SUICIDE PREVENTION ANNUAL REPORT PART 2 OF 2: REPORT FINDINGS 4 (2026), https://www.mentalhealth.va.gov/docs/data-sheets/2025/2025_National_Veteran_Suicide_Prevention_Annual_Report_PART_2_FINAL.pdf.
[9] *Id.* at 41.
[10] *See, e.g.*, Mark Olfson et al., *Dropout from Outpatient Mental Health Care in the United States*, 60 PSYCHIATRIC SVCS. 898, 904 (2009) (*available at* https://psychiatryonline.org/doi/10.1176/ps.2009.60.7.898).
[11] *See, e.g.*, Oliver Howes et al., *Treatment Resistance in Psychiatry: State of the Art and New Directions*, 27 MOLECULAR PSYCHIATRY 58, 65 (2022) (*available at* https://pmc.ncbi.nlm.nih.gov/articles/PMC8960394/).
[12] *See, e.g.*, Mariana Purgato et al., *Moving Beyond a 'One Size Fits All' Rationale in Global Mental Health: Prospects of a Precision Psychology Paradigm*, 30 EPIDEM. AND PSYCHIATRIC SCI. e63, 2–3 (2021) (*available at* https://pmc.ncbi.nlm.nih.gov/articles/PMC8518023/).

psychedelic assisted therapy addressing difficult-to-treat conditions in veterans and Service members can drive action across the federal system.

While the most effective solutions will involve coordination with stakeholders including the Drug Enforcement Agency and the Food and Drug Administration (jointly responsible for classifying substances under the *Controlled Substance Act*), Congress can make a downpayment on progress by passing the *Innovative Therapies Centers of Excellence Act*. This important legislation would require VA to designate at least five "innovative therapies centers of excellence" and direct them to conduct research on the safety and efficacy of innovative therapies including MDMA, psilocybin, ibogaine, and ketamine as treatments for PTSD, anxiety, depression, bipolar disorder, chronic pain, Parkinson's disease, PTSD, and SUD.

Upon establishing the centers of excellence, VA would then be required to submit a report to Congress on its findings and recommendations to improve the delivery of innovative therapies to veterans. While VA has recently expanded its psychedelic-assisted therapy trials and commitment to additional research, centers of excellence have the potential to confirm the agency's prioritization of exploring these encouraging new approaches and to create a foundational home for more investment to bring evidence-based, safe, and efficacious treatments to veterans sooner.[13] Success here can also drive further exploration into pilot programs at VA that could, for instance, allow for collaboration with academic medical centers with experience in psychedelic research to operate under modified Food and Drug Administration pathways.

II. **Access and Affordability**: Pursue policies that connect veterans to high-quality mental health care and close workforce gaps, so they experience shorter wait times and more consistent treatment. Strengthen care for co-occurring mental health and substance use disorders while reducing unnecessary prescriptions.

- **Priority Legislation**: *Veterans' Accessing Critical Care Expansions to Support Servicemembers (ACCESS) Act of 2025* (H.R. 740, S. 275)

Residential Rehabilitation Treatment Programs (RRTPs): VA's mental health RRTP provide residential rehabilitative and clinical care to veterans with mental health conditions like PTSD, depression, and SUD, and social needs such as employment and housing. Distinct from inpatient mental health care for those in crisis or struggling with severe mental illness, RRTPs provide an intense treatment option in a residential setting once a warrior is stabilized. RRTPs serve a small but high-need, high-risk population of veterans – approximately 32,000 veterans received RRTP treatment at VA or in the community in 2023.[14] For many of these veterans, RRTP provides life-changing and potentially life-saving care.

[13] *See, e.g.*, U.S. DEP'T OF VET. AFFAIRS, FY 2026 BUDGET SUBMISSION: MEDICAL PROGRAMS VOLUME 2 OF 5 476–77 (2026); Press Release, U.S. Dep't of Vet. Affairs, VA Funds First Study on Psychedelic-Assisted Therapy for Veterans (Dec. 2024), https://news.va.gov/press-room/va-funds-first-study-on-psychedelic-assisted-therapy-for-veterans/; Aaron Wolfgang et al., *Research and Implementation of Psychedelic Assisted Therapy in the Veterans Health Administration*, 182 AM. J. PSYCHIATRY 17, 17–20 (2025) (*available at* https://psychiatryonline.org/doi/10.1176/appi.ajp.20240751).

[14] Jennifer Burden, *Partnership Stakeholder Meeting January 2024: Mental Health Residential Rehabilitation Treatment Program*, U.S. DEP'T OF VET. AFFAIRS (digital slide deck) (2024).

Over the past several years, RRTP access has been a challenge for veterans because RRTPs – designated as domiciliary care[15] – have not been treated as mental health care under the *VA MISSION Act* (P.L. 115-182 § 104). As a result, regulations that would require community-based care options if access standards are not met have not been applied. In simple terms, if all VA RRTP beds are full and appropriate community-based providers are identified and available to provide treatment, veterans waiting beyond VA's policy-backed access standards have no dependable, consistent recourse to be referred for that care. [16]

In May 2024, VA presented data indicating that around 1,600 veterans are pending admission to RRTPs on any given day with only 6,500 total beds available nationwide. In the time since, VA has implemented new standards requiring that veterans be screened for RRTP care within 48 hours, and faster admission to RRTP care when it is needed (within 48 hours of screening in priority cases, and within 20 days in non-priority cases). However, only 41 of VA's 120 RRTP sites can treat PTSD, only 68 can address SUD, and only 33 out of 120 can address both conditions concurrently.[17] Five states (Maine, New Hampshire, Rhode Island, Delaware, North Dakota and South Carolina) currently have no RRTP facilities available for resident veterans.

We applaud VA's proactive steps to correct RRTP access challenges in 2026. VA's FY 26 budget proposal included plans and resources to enable faster RRTP screening and admission in both priority and non-priority cases, an increased budget for community referrals to help ensure expedited access, and commitments to build its internal capacity of RRTP beds and facilities.[18]

We believe that Congress can reinforce these positive changes by passing the *Veterans' ACCESS Act*. In addition to mirroring VA's current approach to screening and admission, the bill would go further by requiring robust performance tracking, quality oversight, and accountability measures. It would obligate VA to develop metrics for timely screening and admission, assess care quality (including evidence-based treatments and staffing ratios), and implement national standards for appeals when veterans face delays or denials. The bill would also mandate real-time tracking of bed availability and wait times, improved care coordination before and after discharge, transportation support, and annual reporting to Congress on program operations and outcomes. These reforms aim to ensure veterans receive timely, high-quality residential mental health care and continuity of care across VA and community settings.

We commend the Senate Committee on Veterans' Affairs for reporting this bill in July 2025 and appreciate House Committee on Veterans' Affairs Chairman Mike Bost's commitment to returning RRTP provisions (formerly Title II) to the version reported by the House Committee on Veterans' Affairs in July 2025 before the bill is presented for passage in the full House chamber. We believe that passing this legislation as soon as possible would represent progress towards ensuring that some of our most vulnerable veterans receive the care and support they have earned.

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[15] 38 CFR 17.30(b)(1)(ii); *see also Combatting a Crisis: Hearing Before the Subcomm. on Health of H. Comm. On Vet. Affairs, 118th Cong.* 4–6 (2023) (statement of T. Campbell, U.S. Dep't of Vet. Affairs) (*available at* https://docs.house.gov/meetings/VR/VR03/20230418/115655/HHRG-118-VR03-Wstate-CampbellT-20230418.pdf).
[16] *See* Veterans Health Administration Directive 1162.02.
[17] Burden, *supra* note 14.
[18] U.S. DEP'T OF VET. AFFAIRS, *supra* note 13, at 16, 103, 366–67.

III. **Suicide Prevention and Resiliency Building:** Expand access to non-clinical support, including peer networks and early intervention services that protect against suicide and support veterans' whole health.

- **Priority Legislation**: *HOPE for Heroes Act* (S. 1139), *PFC Joseph P. Dwyer Peer Support Program Act* (H.R. 438)

Suicide Prevention and Resiliency Building: Strengthening the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program through the bi-partisan *HOPE for Heroes Act* represents an important step toward sustaining and expanding VA's community-based, upstream suicide prevention efforts. This legislation would reauthorize the program through 2030, increase grant limits to $1 million with additional funding tied to veteran engagement, and improve coordination between grantees and VA suicide prevention coordinators to ensure continuity of care. It would also enhance training requirements, support transportation for appointments, and provide technical assistance to community organizations, ensuring veterans receive timely, comprehensive mental health support in trusted local settings.

Reauthorizing and strengthening this program are critical because community-based interventions improve mental health outcomes and overall well-being by addressing resiliency factors such as financial stability, social connection, and physical wellness.[19] Research shows these types of programs significantly enhance quality of life, while fostering collaborative networks that reduce barriers to care.[20]

While the impact of the Fox pilot program has proved hard to measure thus far, we believe that stronger conclusions can be made with more time. For example, America's Warrior Partnership has shared that of the 225 veterans assisted through its Fox grant, 21% expressed suicidal ideations, yet none of them had initially sought out mental health support.[21] This speaks to the broader issue that many veterans may not initially recognize their mental health challenges or may feel unable to ask for help. As the *HOPE for Heroes Act* includes provisions designed to enhance communication between VA Medical Centers and Fox grantees in their area, continuity of care and bidirectional referrals are two areas that can be tracked more closely. By extending the program and increasing flexibility, Congress can ensure that trusted local organizations can continue delivering support where veterans feel most comfortable seeking help.

Impact of Peer Support: Community-based organizations are often best positioned to connect with veterans who may not engage with traditional care systems. Their local presence, trusted relationships, and cultural competency enable them to reach veterans who might otherwise remain isolated. For this reason, WWP supports the *PFC Joseph P. Dwyer Peer Support Program Act*, which would provide grants to states and local entities to strengthen and expand peer support programs. These programs play a critical role in building trust, fostering connection, and ensuring veterans are not left behind simply because they fall outside conventional service pathways.

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[19] *See, e.g.*, Enrico Castillo et al., *Community Interventions to Promote Mental Health and Social Equity*, 21 CURRENT PSYCHIATRY REP. 1, 6–9 (2019) (*available at* https://pmc.ncbi.nlm.nih.gov/articles/PMC6440941/pdf/11920_2019_Article_1017.pdf).
[20] *Id*.
[21] *A Decade of Impact Through America's Warrior Partnership*, MISSION ROLL CALL (Sep. 26, 2024), https://missionrollcall.org/veteran-voices/articles/a-decade-of-impact-through-americas-warrior-partnership/.

Peer-led support has been a foundational element of WWP's outreach and engagement strategy. With peer support groups in 42 states and virtual peer support groups that reach rural and territory veterans, we strongly believe in the value of the bonds of shared service in a social setting. In FY 25, we facilitated over 1,300 warrior-only peer support group meetings, providing them with a safe, non-clinical, judgment-free environment to connect with their peers and strengthen the bonds of shared service in a social setting. Just as importantly, peer encouragement often serves as an entry point to additional support and assistance. Veterans who participate in peer-based and social programs are more likely to engage with other community resources, including mental health care, employment services, and wellness programs.[22] In this way, peer support not only strengthens social connection, but also acts as a catalyst for broader, life-stabilizing support.

Severely Wounded Service Members and Veterans

I. **Complex Case Management and Continuity of Care**: Make systems of federal, state, and local care easier to navigate for those with the most severe injuries and illnesses.

- **Priority Legislation**: *Coordinating Care for Senior Veterans and Wounded Warriors Act* (H.R. 668, S. 506)

Federal Recovery Coordination: Service members and veterans living with severe injuries or multiple comorbid conditions often navigate some of the most fragmented care systems in the country. Many rely on multiple federal and state programs at the same time, receiving care through Military Treatment Facilities (MTFs), TRICARE, VA, Medicare, Medicaid, private insurance, and local programs – each with its own eligibility requirements, coverage limits, and care-coordination processes. Without consistent, knowledgeable case management, transitions between these systems frequently lead to gaps in services, delayed treatment, and increased strain on caregivers. For veterans with TBI, spinal cord injury (SCI), or complex neurological conditions, these disruptions can undermine health, independence, and long-term stability.

In a pair of 2007 memorandums of understanding, DoD and VA launched the Federal Recovery Coordination Program (FRCP) and designated Federal Recovery Coordinators as the "ultimate resource" for monitoring the implementation of services for wounded, ill, and injured Service members. At the time, these actions recognized that because of the dramatic changes in military battlefield medicine and rapid evacuation from the combat theatre, many returning Service members, and subsequently veterans, have multiple complex medical and mental health problems, including TBI, SCI, amputations, burns, and PTSD. Due to the complex nature of their benefits and health care needs, these warriors may receive care from many providers in multiple facilities, including MTFs, VA Medical Centers (VAMCs), private hospitals, rehabilitation facilities, or through home health agencies. Transitions among these facilities and providers, absent coordination, can result in care and benefits gaps.

[22] Matthew Chinman et al., *Implementing Peer Support Services in VHA: Peer Specialist Toolkit*, U.S. DEP'T OF VET. AFFAIRS (2013), https://www.mirecc.va.gov/visn4/docs/peer_specialist_toolkit_final.pdf.

The challenges that existed then persist to this day, and health systems must remain committed to uniform training for recovery coordinators and medical and non-medical care/case managers, efficient tracking systems, and commitments to comprehensive plans for the seriously injured. As time has passed however, the FRCP was consolidated into the Federal Recovery Consultant Office (FRCO) in February 2018 in response to the Presidential Executive Order, "Comprehensive Plan for Reorganizing the Executive Branch." While this shift may have created some efficiencies, WWP encourages a fresh assessment of whether the FRCO is sufficiently resourced to address the reforms that have not been fully realized. Additionally, we believe that similar efforts can be undertaken to support a broader population of veterans with complex needs and should include steps to ensure central oversight of policy implementation.

Enhanced Case Management: 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. According to a 2024 survey of VA enrollees, half (50 percent) reported also having Medicare coverage.[23] 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. 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.[24]

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. 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. The proposed pilot program

[23] U.S. DEP'T OF VET. AFFAIRS, 2024 SURVEY OF VETERAN ENROLLEES' HEALTH AND USE OF HEALTH CARE (Jan. 2024), *available at* https://www.va.gov/VHASTRATEGY/SOE2024/SOE24.pdf.
[24] *Id.*

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*.

II. **Prosthetics and Adaptive Devices**: Strengthen DoD and VA prosthetic care to help Service members and veterans reintegrate back into military service and the community more quickly and effectively.

- **Priority Legislation**: *Veterans' SPORT Act* (H.R. 1971, S. 3138); *Automotive Support Services to Improve Safe Transportation Act of 2025 (ASSIST) Act of 2025* (H.R. 1364, S. 1726)

Removing Barriers to Adaptive Sports Participation: Participation in adaptive sports has repeatedly proven to deliver substantial benefits for veterans living with limb loss, improving mental health, physical health, and overall wellness while fostering connection and peer support. Research and programmatic outcomes consistently show that veterans who engage in regular physical activity report lower levels of depression and anxiety, improved self-esteem, and greater overall quality of life. Despite these well-documented benefits, VA regulations continue to impose restrictive barriers. Under 38 C.F.R. § 1701(6)(F)(i), VA does not include adaptive prostheses and terminal devices for sports and other recreational activities unless actively engaged in medical treatment and enrolled in a rehabilitation program. As a result, prosthetic limbs and terminal devices designed for sports and recreation are not recognized as clinically necessary, preventing many veterans from accessing the equipment required to fully participate in adaptive sports in their daily lives. The *Veterans' SPORT Act* would address this gap by expanding the statutory definition of "medical services" to include adaptive prostheses and terminal devices for sports and recreational activities, removing outdated regulatory barriers and enabling veterans with limb loss to pursue meaningful physical activity and improved health outcomes.

Transportation Access: Ensuring that the most disabled veterans can safely travel to medical appointments, work, caregiver support, and adaptive sports begins with modernizing access to medically necessary vehicle adaptations through the VA. WWP supports the *ASSIST Act*, which clarifies VA's authority to treat medically necessary vehicle adaptations as part of veterans' health services. Under current law, VA is limited to providing van lifts, raised doors, raised roofs, air conditioning, and wheelchair tie downs.[25] By allowing VA to cover modern equipment such as ramp and kneeling systems, lowered floors, mobility device lifts, ingress and egress accessibility modifications, wheelchair tie-downs, and adapted seating, this legislation would help veterans receive the equipment they need to travel safely and independently.

Notably, current law prevents many warriors from obtaining the necessary and specialized vehicle modifications they need to safely transport themselves and their adaptive equipment for the adaptive sports they choose to participate in. Some warriors participating in WWP programs like Adaptive Sports or Soldier Ride report having to choose between

[25] 38 U.S.C. § 1701(6)(I).

participation in recreational therapy and financial stability. As such, the *ASSIST Act* can help improve quality of life for some of most injured, ill, and wounded warriors on their journey towards independence and healthy active lifestyles – particularly when combined with passage of the *Veterans' SPORT Act*.

Separate Characterization for Amputees: VA's Prosthetic and Sensory Aids Service (PSAS) is the largest and most comprehensive provider of prosthetic devices and sensory aids in the world. In FY 2023, more than 55 percent of the veterans treated across the Veterans Health Administration (VHA) received 21.7 million prosthetic devices, items, and services.[26] VA's website highlights that, "although the term 'prosthetic device' may suggest images of artificial limbs, it actually refers to any device that supports or replaces a body part or function."[27] In fact, PSAS provides a full range of equipment and services to veterans, including artificial limbs as well as other items worn by veterans such as hearing aids; items that improve accessibility, such as ramps and vehicle modifications; and items surgically implanted in veterans, such as hips and pacemakers.

This generalized definition of "prosthetic device" has hindered VA's ability to care for veterans in need of amputee prosthetics who suffered amputation during or after their military service. The broad size and structure of PSAS leads to competing priorities, and unfortunately, does not prioritize amputee prosthetics. We believe that improvements can start with establishing a dedicated Amputee Prosthetics Center of Excellence at VA.

Amputations have serious implications for the veteran and his or her family, including medical, physical, social, and psychological. Yet, amputee veterans are treated along with other prosthetic device users with very different needs, who may use PSAS for hearing aids or eyeglasses. Without a Center for Excellence dedicated to amputee prosthetics services and independently led by VA, veterans often choose or are even encouraged to seek care elsewhere, such as at DoD or out in the community. These options to receive amputee prosthetic care outside VA provide a less holistic care experience, are less convenient, and for veterans who must use community care, are often more expensive.

VA's challenges to properly provide prosthetic services for amputees are a result of not only how VA defines "prosthetic" but also the funding structure for PSAS. Currently, the primary purpose of PSAS is to provide logistics and procurement for prosthetics, not clinical care. The size of the staff and budget reflect that VA's prioritization is procurement of prosthetic devices, while using outside sources – such as DoD or the community – to provide the actual care needed. Although a small amount of funding for clinical care is provided for PSAS, this funding is nested under procurement and logistics and is not enough to provide adequate clinical care for amputees, resulting in inadequate resources, including staff and equipment.

The lack of funding for and attention to clinical care often results in long wait times and an inconsistent standard of care, often leading to a perception among veterans that VA is neither

[26] Ardene Nichols et al., *Prosthetic and Sensory Aids Service National Program Office & Strategic Acquisition Center*, U.S. DEP'T OF VET. AFFAIRS, https://thecgp.org/images/2024/05/2024-Spring-CGP-5.5.24-version-2.pdf.
[27] *Prosthetic & Sensory Aids Service (PSAS)*, U.S. DEP'T OF VET. AFFAIRS, https://www.prosthetics.va.gov/psas/index.asp.

knowledgeable nor prepared to meet their needs. WWP's 2022 Annual Warrior Survey revealed that 14.2% of warriors experienced an inability to get prosthetic-related medical care.

VA does not have the ability to correct this funding imbalance between procurement and clinical care on its own. Congress must give VA the funding to build the capacity for in-house amputee prosthetic clinical care for veterans to expand amputee prosthetics at VA from primarily a procurement department into one with force-building capabilities. WWP recommends that Congress provide funding to bolster VA's capacity to hire more prosthetists to provide timely and effective care for amputee prosthetics. We also believe that this funding must be for dedicated clinical care and not stem from a procurement funding stream.

III. **Caregivers**: Prioritize services for caregivers who support veterans with the highest needs, including help with retirement planning.

- **Priority Legislation**: *Veteran Caregiver Reeducation, Reemployment, and Retirement Act* (H.R. 2148, S. 879); *Disabled Veterans Dignity Act of 2025* (S. 3647)

Investing in Home- and Community-Based Care: Investment in home- and community-based care is critical to reducing caregiver burden and supporting veterans with complex needs. Research consistently shows that caregivers experience lower stress and greater sustainability when home-based services are available, reliable, and well-coordinated.[28] The *Sen. Elizabeth Dole 21st Century Veterans Healthcare and Benefits Improvement Act* (P.L. 118-210) included provisions that expanded VA home- and community-based programs, such as Veteran Directed Care and the Homemaker and Home Health Aide Program. The law also codified VA's Home-Based Primary Care and Purchased Skilled Home Care programs, representing an important step forward. As younger veterans with profound injuries continue to age in place, supported by caregivers, the success of these programs will be critical to preserving health, independence, and quality of life for both veterans and their families. WWP stands by to support VA as they implement these provisions.

The *Disabled Veterans Dignity Act of 2025* builds directly on these home- and community-based care efforts by addressing one of the most essential, yet inconsistently supported, medical needs for veterans with spinal cord injuries and disorders. Bowel and bladder care are critical medical services necessary to prevent serious complications and support veterans who depend on others for daily care while living in the community. This legislation would codify VA's existing bowel and bladder care program, ensuring consistent access to clinically appropriate services, individualized assessments based on need, and proper training and reimbursement for those providing care. By clarifying eligibility, standardizing program administration, and ensuring continuity when long-term care needs are established, the bill strengthens VA's ability to support veterans outside institutional settings and preserves dignity, health, and independence for veterans with the most complex needs.

Planning for Caregivers' Long-Term Financial Security: Caregiving responsibilities have lasting financial implications that cannot be ignored. RAND reports that 70 percent of

[28] *See, e.g.*, Arun Ghoshal & Anuja Damani, *Home-Based Care Services*, THE PALGRAVE ENCYCLOPEDIA OF DISABILITY 1–11 (2025), *available at* HTTPS://LINK.SPRINGER.COM/RWE/10.1007/978-3-031-40858-8_535-1.

caregivers – specifically those to Service members and veterans under age 60 – experience difficulty paying their bills, which is nearly twice the rate of non-caregivers.[29] Many caregivers experience work disruptions or are forced to reduce hours to meet caregiving demands, limiting income, career advancement, and retirement savings. Although caregivers collectively provide services valued at more than $119 billion, they often incur significant out-of-pocket expenses and forgo earned income.

Many caregivers enrolled in VA's Program of Comprehensive Assistance for Family Caregivers (PCAFC) face significant barriers to maintaining full-time employment due to the program's intensive caregiving requirements and ongoing eligibility standards, which presume a high level of daily, hands-on support. As a result, many caregivers reduce their work hours or leave the workforce entirely, limiting their ability to earn wages and pay into Social Security in a meaningful way over time. While PCAFC provides a stipend, it does not count as earned income for Social Security purposes and does not contribute toward retirement or disability benefits. Consequently, when the veteran they have been caring for passes away or no longer requires care, these caregivers frequently find themselves without sufficient Social Security credits for retirement, leaving them vulnerable to significant financial insecurity later in life despite years of uncompensated labor supporting a severely disabled veteran.

Legislation such as the *Veteran Caregiver Reeducation, Reemployment, and Retirement Act* reflects growing recognition that caregiving is frequently a long-term role requiring durable economic and workforce supports. This legislation would expand support for PCAFC caregivers of seriously injured veterans, addressing economic hardship by extending healthcare, offering employment assistance (like fee reimbursement for certifications), providing retirement planning, and requiring studies for caregiver retirement savings and VA job opportunities, aiming to help them transition financially after caregiving ends. We support this legislation because strengthening caregiver supports is not only a matter of fairness; it is essential to sustaining the broader system of care on which the nation's most vulnerable veterans depend.

Caregiver Benefits on Appeal: Caregivers with pending appeals before the Board of Veterans' Appeals are currently experiencing significant wait times and the loss of their due-process rights as changing PCAFC eligibility rules and delayed reassessments have left them in a legal uncertainty without clear guidance on how their cases will be adjudicated. Following passage of the *VA MISSION Act*, VA began implementing new PCAFC regulations that made the eligibility standards more difficult to the point that many long-time participants risked losing their benefits. Because of these heightened standards or barriers, thousands of "legacy participants" – those who were enrolled in PCAFC prior to the implementation of new eligibility criteria – were deemed ineligible for the program. VA subsequently paused PCAFC removals due to stakeholder concerns of very unpredictable and inconsistent the PCAFC eligibility rules were depending on the local VAMC or VISN.

On December 6, 2024, VA proposed a final rule that extends eligibility for PCAFC and this extension ensures that legacy participants, legacy applicants, and their caregivers will remain eligible for PCAFC and will not experience any reductions due to a reassessment for three years

[29] Rajeev Ramchand et al., *America's Military and Veteran Caregivers: Hidden Heroes Emerging from the Shadows*, 12 RAND HEALTH QUARTERLY 1, 7 (2024).

through September 30, 2028. However, in the time since, WWP national service officers have observed higher rates of remands for all PCAFC appeals before the Board of Veterans' Appeals with few denials and no grants. As virtually all observed cases have been remanded for further development, affected caregivers have effectively been denied their rights to a timely appeal before the Board – and delaying reassessments and stipend adjustments. In the absence of clear guidance, Veterans Law Judges cannot determine whether caregiver stipend appeals have been rendered moot by the proposed rule by VA.

We encourage Congress and VA to help reach a resolution to this unfortunate situation which builds upon years of stress and uncertainty being felt across the caregiver community after the *VA MISSION Act*.

Brain Health and Traumatic Brain Injury

I. **Prevention, Tracking, and Treatment**: Advance policies to promote brain health, strengthen injury tracking and early intervention, and expand access to evidence-based treatment and recovery options for Service members and veterans.

- **Priority Legislation**: *Blast Overpressure Research and Mitigation Task Force Act* (H.R. 6444)

Coordinating Action on Blast Overpressure: Military service often exposes Service members to blast overpressure, a rapid increase in air pressure generated by explosions or blast waves that exceed normal atmospheric conditions. Repeated or high-intensity exposures are increasingly associated with cumulative neurological effects, including neuroinflammation, cognitive decline, elevated risk of traumatic brain injury, and co-occurring mental health conditions.[30] Those at highest 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. While the DoD has taken important steps to reduce blast exposure during training through increased standoff distances, limits on live-fire events, and protective equipment, these measures largely focus on prevention for active-duty personnel, and do not address the long-term health consequences for Service members and veterans already affected.

The *Blast Overpressure Research and Mitigation Task Force Act* would strengthen coordination between the DoD and VA through a Joint Executive Committee (JEC) task force. By mandating annual reports, cross-agency coordination, and integration of mobile, longitudinal diagnostics, the bill would create the infrastructure needed to translate emerging evidence into standardized screening, targeted mitigation strategies, and benefits adjudication for blast-exposed veterans. Further, the inclusion of Task Force recommendations related to VA claims processing and disability evaluations hold the promise of ensuring that veterans affected by blast

[30] *See, e.g.*, Andrea Diociasi et al., *Distinct Functional MRI Connectivity Patterns and Cortical Volume Variations Associated with Repetitive Blast Exposure in Special Operations Forces Members*, RADIOLOGY (Apr. 2025), *available at* https://pubmed.ncbi.nlm.nih.gov/40167438/; Kyle Bourassa et al., *Traumatic Brain Injury and Accelerated Epigenetic Aging Among Post-9/11 Members*, J. HEAD TRAUMA REHAB. (2025), *availble at* https://pubmed.ncbi.nlm.nih.gov/40828005/.

overpressure injuries are connected to the care and support they have earned through their service.

Assisted Living for Veterans with TBI: While many veterans and families prefer aging in place, home-based care is not safe or feasible for all individuals due to co-occurring behavioral and cognitive challenges, increasing medical complexity, aging caregivers, and limited natural support networks. When aging in place is no longer appropriate, families are often forced to make care decisions in crisis. In the absence of viable alternatives, families face an unacceptable binary choice: remain at home beyond what is safe or appropriate, or enter traditional geriatric nursing facilities that are ill-equipped to meet the clinical, behavioral, rehabilitative, and social needs of younger and mid-life veterans with TBI.

Our current service to nearly 1,000 severely wounded veterans with moderate or severe TBI has shown us that phases of progressive independent living are missing as care options. Currently, 7.25% of our Independence Program participants (average age 45.6) reside in nursing homes/institutions, highlighting the likelihood of an inappropriate placement due to age-generational gap, inability to find an age-suitable facility and/or inability of an institutional or non-institutional caregiving network to provide for the individuals in a safe or effective manner. Traditionally, VA provides clinical services to veterans who suffer the effects of TBI; however, many veterans with TBI may benefit from treatment in an intensive rehabilitation facility to assist with skills allowing for increased independence. Because the facilities are generally residential and the VA does not provide veterans with housing (with some exceptions), accessibility to such programs is limited or requires subsidized payment from other sources to cover the "housing" expense.

The Assisted Living for Veterans with TBI (AL-TBI) pilot program, which ran from 2009 to 2018, provided some of these veterans with placement in private TBI rehabilitation facilities and assumed the living costs that may have otherwise put this treatment beyond their reach. After the program ended, an evaluation by VA concluded that participants had experienced improvements in physical and emotional health, TBI symptoms, and other outcomes. In its place, VA now offers a TBI-Residential Rehabilitation Program, but enrollees must pay for their own room and board, something many veterans cannot afford.

Solutions to remove this financial barrier – and to improve the associated care coordination that can span several systems – are sorely needed. TBI rehabilitation facilities provide a variety of services, primarily therapy in individual and group settings. At the same time, the facilities vary widely in other offerings and lack standardization because individual injuries and the effectiveness of each treatment can vary so significantly.[31] The tools used to measure progress as well as the methods by which therapy is provided or defined may also contain nuance and disparity between facilities.[32] These nuances induce "difficulties [with] outcome analysis related to the blurring of program labels, categories, and definitions" while limited uniform populations make randomized trials and studies nearly impossible.[33] Studies

[31] *See, e.g.*, Tina M. Trudel, et al., *Brain Injury Treatment Models and Challenges for Civilian, Military and Veteran* Populations, 44 J. REHAB. RESEARCH & DEV. 1007 (2007) *available at* https://www.brainline.org/article/brain-injury-treatment-models-and-challenges-civilian-military-and-veteran-populations.
[32] *Id.*
[33] *Id.*

indicate that treatment standardization and standard measurements of progress would assist in formalized rehabilitation programs with improved overall treatment.[34] Further, anecdotal feedback suggests that veterans are most likely to benefit from particular facilities that can accommodate the difficulties associated with behavioral problems in addition to TBI. Such facilities are very limited but are best positioned to support veteran needs.

In sum, the AL-TBI pilot program provided a beneficial service to warriors and caregivers during its tenure but has left a gap to be filled by families, private and other non-VA care, often putting the financial burden on the warrior and/or caregiver. Additional urgency is created by the fact that many of these caregivers are aging beyond their ability to provide the necessary support at home. These challenges continue to highlight the need for durable, well-coordinated, and adequately resourced programs capable of supporting veterans with lifelong injuries, not only for months or years, but over a full lifespan.

II. **Research and Development**: Support sustained congressional funding for evidence-based brain health and traumatic brain injury research to improve operational performance, strengthen force readiness, and reduce long-term brain health issues after service.

- **Priority Legislation**: *Precision Brain Health Research Act* (S. 800); FY27 Department of Defense Appropriations (Defense Health Program)

Commitment to TBI Research: The Congressionally Directed Medical Research Programs (CDMRP) represents a proven and accountable model for investing federal research dollars to achieve high-impact outcomes. Through its unique, coordinated approach, CDMRP has accelerated advances in patient care, driven breakthrough technologies, and delivered tangible results in areas of critical need – particularly with diseases and conditions that have historically received limited research attention. Congress' sustained investment of more than $2.5 billion in the Traumatic Brain Injury and Psychological Health Research Program, led by the Military Health System[35], has resulted in the award of over 297 research studies for nearly 500,000 Service members diagnosed with traumatic brain injury.[36] These efforts have strengthened DoD's ability to prevent, detect, treat, and rehabilitate TBI, while improving psychological health outcomes essential to force readiness and long-term veteran well-being. Continued congressional support for CDMRP is essential to maintain momentum, protect prior investments, and ensure that the DoD can meet its obligations to Service members and their families through evidence-based solutions to TBI and psychological health challenges.

Harnessing Precision Medicine: Despite increased awareness, substantial gaps remain in understanding the long-term effects of repetitive low-level blast exposure and chronic mild TBI. Emerging evidence links these exposures to measurable brain changes, impairments in balance and gait, and increased risk of suicide among veterans. Individuals diagnosed with TBI may continue to suffer from lasting effects that overlap with mental health conditions, substance

[34] *Id.*
[35] Cong. Directed Res. Prog., *Traumatic Brain Injury and Psychological Health Research Program*, U.S. DEP'T OF DEF. (2025), https://cdmrp.health.mil/tbiphrp/pbks/TBIPHRP%20Summary%20Sheet_22July25.pdf.
[36] Cong. Directed Res. Prog., *Traumatic Brain Injury and Psychological Health*, U.S. DEP'T OF DEF. (2025), https://cdmrp.health.mil/tbiphrp/default.

use disorders, and chronic physical symptoms. These complex and interconnected challenges demand a more precise, data-driven approach to care.

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), PTSD, and cognitive decline.

The *Precision Brain Health Research Act* would advance a more systematic and longitudinal approach by directing VA to implement a coordinated 10-year research strategy and establish a structured data-sharing partnership with the DoD. This framework utilizes the promise of precision medicine and would improve tracking of exposure history, support identification of biomarkers associated with brain and mental health conditions, and strengthen VA's ability to deliver earlier, more accurate diagnoses.

Toxic Exposure

I. **Exposure-Related Claims**: Improve VA's presumptive decision-making process to ensure faster, more transparent, and more consistent consideration of new illnesses for inclusion under the *PACT Act*.

- **Priority Legislation**: *K2 Veterans Total Coverage Act of 2025* (H.R. 5915)

Presumptive Decision-Making Process: Wounded Warrior Project strongly supported and relentlessly advocated for the *Sergeant First Class Heath Robinson Honoring Our PACT Act* (P.L. 117-168), and we remain deeply committed to ensuring its promise is fully realized for post-9/11 warriors exposed to environmental hazards. The presumptive decision-making framework established by the *PACT Act* represented a critical shift in how VA evaluates exposure-related conditions, grounding decisions in science and evidence rather than requiring veterans to individually prove causation. This framework is essential not only for today's warriors already impacted by exposure, but also for future generations who may face similar risks in conflicts yet to come. We will continue to work closely with VA, Congress, and veteran service organizations to ensure this system has the capacity, resources, and governance necessary to deliver timely, transparent, and consistent decisions.

At the same time, WWP encourages VA to build on this framework by refining its presumptive decision-making processes to remain responsive as science evolves. In particular, we urge consideration of burn pit–related conditions beyond cancers, including respiratory

illnesses, cardiovascular, neurological, and other health effects that may be linked to exposures not explicitly enumerated in current law. Rather than relying solely on future statutory expansions of eligibility, VA should focus on strengthening its internal decision-making infrastructure to act swiftly on emerging evidence, apply consistent standards, and communicate decisions clearly to veterans. It is essential to ensure that presumptive determinations remain timely, standardized, and credible, and that the system continues to protect veterans from bearing the burden of uncertainty as exposure science advances.

Recognition of K-2 Exposures: A gap in access to care exists for almost 16,000 post-9/11 warriors who served in Karshi-Khanabad (K2) Air Base in southeastern Uzbekistan from 2001 to 2005.[37] These K2 warriors were exposed to hazardous toxins and have reported rare and aggressive cancers that are not currently recognized as presumptive conditions by VA. The *K2 Veterans Total Coverage Act of 2025* would close this gap by granting presumptive service connection for these illnesses. This legislation seeks to shift the burden of proof away from K2 warriors, removing a major barrier that is currently limiting their access to care. WWP urges Congress to swiftly pass the *K2 Veterans Total Coverage Act of 2025* to honor these 16,000 post-9/11 ill warriors and ensure they receive their earned benefits during their deployments to southeastern Uzbekistan.

Research on Missileers: Wounded Warrior Project thanks Congress for the passage of the *Aviator Cancer Examination Study (ACES) Act* (P.L. 119-32), which represents an important step toward better understanding and addressing potential cancer risks associated with military service. One area of growing concern within the veteran community is among Service members who operate and support the nation's intercontinental ballistic missile (ICBM) force, a mission that is central to U.S. national security. The Air Force's network of missile silos spans multiple states, and for years, missileers and their families have raised concerns about health issues they believe may be linked to environmental exposures encountered while serving in these facilities.

In recent years, members of the missile community have come forward reporting higher-than-expected rates of cancer diagnoses, particularly non-Hodgkin's lymphoma. While earlier studies conducted between 2001 and 2005 by the U.S. Air Force School of Aerospace Medicine did not identify a definitive link between missile service and cancer, renewed concerns from affected Service members prompted a reassessment. The DoD-led Missile Community Cancer Study is now underway as a multi-phase effort examining environmental conditions at three ICBM wings and facilities at Vandenberg Space Force Base. This study compares the prevalence of 14 common cancers, including non-Hodgkin's lymphoma, among missile-related career fields relative to the general population. WWP will continue to closely monitor the findings of this work and stands ready to engage on any policy or legislative action informed by its results. Ensuring that potential exposure risks are rigorously examined and transparently addressed is essential to protecting the health of those who serve in these critical national security roles.

[37] Response to Comment for the Department of Veterans Affairs to Assess Exposures and Conditions of Interest for Veterans Who Served at Karshi-Khanabad Air Base, 90 Fed. Reg. 47,909 (Oct. 2, 2025).

II. **Exposure Tracking and Prevention**: Strengthen prevention, monitoring, and response to occupational and environmental hazards by expanding the Individual Longitudinal Exposure Record and improving coordination with VA to ensure seamless exposure tracking across a Service member's career.

Individual Longitudinal Exposure Record (ILER) Expansion: Wounded Warrior Project supports continued development and expansion of the ILER system to ensure comprehensive, lifetime tracking of occupational and environmental exposures, and seamless data sharing between the DoD and VA. ILER aggregates deployment history, locations and events, known hazards, relevant monitoring data, and clinical information into a single, person-centric exposure record that clinicians, benefits adjudicators, and researchers can use to improve care and determinations. By consolidating data from multiple sources and linking individuals to documented exposure events, ILER is designed to improve exposure-informed health care, increase the accuracy and speed of claims processing, reduce the burden of proof on veterans, and support long-term epidemiology and policy.

We encourage Congress and the agencies to keep investing in ILER's functionality, user adoption, and performance measurement so it delivers at scale for today's *PACT Act* workload and for future cohorts. One area of improvement would be to increase transparency and accessibility. The current ILER system may only be used by DoD and VA personnel to track toxics and veteran toxic exposures. In this arrangement, veterans are hindered from developing full disability claims using scientifically vetted data. Bringing ILER to a secure, web-based platform that can be used by veterans to correct or amend their toxic exposure data records to assure accuracy and completeness in the disability claims process would help ensure veterans can access their records in a more seamless and efficient manner. The system could also be enhanced to provide veterans with extensive reference and education material to inform health care decisions and connection to VA health providers.

III. **Cancer Care**: Improve the quality of cancer care for exposed veterans through exposure-informed screening for early detection, more clinical trials, and enhanced care coordination.

- **Priority Legislation**: *VET PFAS Act* (H.R. 3110); *Women Veterans Cancer Care Coordination Act* (H.R. 1860); *Mammography Access for Veterans Act* (S. 3395)

Improve Quality Care for Early Screening and Detection: As toxic exposure research continues to evolve, particularly regarding widespread per- and polyfluoroalkyl substances (PFAS) contamination at hundreds of military installations, the number of veterans (and their families) at elevated cancer risk will continue to grow.[38] Early detection is essential, particularly with post-9/11 veterans requiring cancer screenings at much younger ages than standard screening protocols. Regular monitoring, and proactive identification of high-risk individuals are also critical tools for saving lives. To that end, DoD and VA must have adequate staffing, modernized clinical infrastructure, and specialized training to ensure clinicians can assess risks specific to PFAS, burn pits, and other toxic hazards. Without systemwide capacity, many

[38] Per- and Polyfluoroalkyl Substances (PFAS) Task Force, *Progress Report* (March 2020), U.S. DEP'T OF DEF. (Mar. 2020), https://media.defense.gov/2020/Mar/13/2002264440/-1/-1/1/PFAS_Task_Force_Progress_Report_March_2020.pdf.

veterans may receive delayed diagnoses, or none at all. Every Service member or veteran deserves the highest quality cancer care.

Wounded Warrior Project supports the *VET PFAS Act*, which would establish presumptive conditions and expand access to VA health care for exposed veterans. As research continues to strengthen the association between PFAS exposure and elevated rates of several cancers and chronic conditions, the cancer care system must be prepared to absorb increased caseloads and deliver specialized oncology services that reflect the latest scientific advancements. This includes ensuring VA's precision oncology programs can incorporate exposure data into clinical decision making, and that veterans have timely access to therapies informed by these findings.

Exposure-related cancer care must also be targeted by collaborative care coordination across DoD, VA, and community providers. Veterans navigating exposure-linked cancers often face fragmented care and struggle to access specialists. An integrated model ensures that once an exposed veteran enters the system, they are guided through screening, diagnosis, treatment, clinical trial enrollment and survivorship resources without delays. Additional investment in interoperable health records and case management capacity is essential to achieving this end.

Enhance Care Coordination for Gender Specific Cancer-Related Care: Women veterans continue to experience clear and persistent disparities in cancer prevention, screening, and coordinated care within VA, even as they represent one of the fastest-growing veteran populations. Many VA facilities still lack consistent access to gender-specific cancer services, standardized screening protocols, and reliable follow-up systems. Recognizing the first step in cancer care is screening, past legislative efforts such as the *Dr. Kate Hendricks Thomas SERVICE Act* (P.L. 117-133) have helped in acknowledging that veterans need access to early detection, ensuring VA provides access to early screening for breast cancer for those at an increased risk, including those younger than 40. WWP proudly supported the *SERVICE ACT* and recognizes the importance of the effort, especially as the breast cancer prevalence of veterans using VA health care tripled between 1995 and 2012, reflecting increased utilization of VA care as well as potential increased risk factors for Service members.[39]

While the *Deborah Sampson Act* (P.L. 116-315, Title 5) required VA to formalize their women veteran primary care clinic models and strengthen requirements for primary care health care providers that serve women veterans, there are opportunities for further strengthening for specialty providers within VA and also in the community, especially those who support care such as oncological care. These challenges and issues contribute to delayed detection and poorer outcomes and reflect a VA health care structure historically centered on male veterans, leaving women veterans without the coordinated, evidence-based cancer care they need. The *Women Veterans Cancer Coordination Act* would establish the dedicated oversight and system-wide alignment required to close these gaps, strengthen early detection, and ensure women veterans receive equitable, comprehensive cancer care across all VA facilities.

Coordination for cancer care support was an issue discussed in WWP's 2025 Women Warriors Report. While the majority (77.3%) of women warriors reported that VA was helpful

[39] Yeun-Hee Anna Park et al., *Screening High-Risk Women Veterans for Breast Cancer*, 38 FED. PRACTITIONER S35 (2021), *available at* https://pmc.ncbi.nlm.nih.gov/articles/PMC8223736/pdf/fp-38-5s-s35.pdf.

(extremely helpful, very helpful, or somewhat helpful) in coordinating routine screenings including gynecological screenings & mammogram screenings, there were women warriors (15.5%) who reported that VA was not at all helpful in coordinating those screenings, suggesting there is still work that needs to be done in care coordination, especially as it relates to cancer screening and care. VA has over 500 cancer specialists across the system to provide support, care, and treatment for veterans. There are three VA oncology Systems of Excellence – the Lung Precision Oncology Program (LPOP), the Precision Oncology Program for Cancer of the Prostate (POPCaP), and the Breast and Gynecologic Oncology System of Excellence (BGSoE). The *Women Veterans Cancer Coordination Act* would strengthen the BGSoE by establishing regional coordinators and formalize the reporting processes to ensure national consistency. Additionally, it would update the gynecologic cancers that are covered by the BGSoE, including cervical, ovarian, uterine, vaginal, vulvar, and gestational trophoblastic neoplasia.

While access to care is evolving, it is vital to recognize that not every VA facility has in-house access to mammography units needed to conduct mammography screenings. Under the *Making Advances in Mammography and Medical Options for Veterans Act* or *MAMMO Act* (P.L. 117-135), VA facilities were required to navigate access points for both 2D and 3D Mammograms, providing comprehensive screenings for veterans. Barriers have existed for veterans seeking mammography screenings, including a lack of appropriate equipment at VA facilities or within the Community Care Network, lack of awareness as to when screenings should be accessed, and challenges with getting results and including them in appropriate cancer screening registries. These barriers to accessing mammograms cost time, delay screenings and can impact pursuing escalated care and treatment.

The *Mammography Access for Veterans Act of 2025* builds on the *MAMMO Act* pilot program, which initially focused on expanding mammography access at select VA facilities and testing the feasibility of mobile mammography units. As VA's Office of the Inspector General indicated that the tele-mammography pilot improved access and supported more timely screening for veterans in underserved areas, the program was reported to be beneficial to veterans utilizing mammography services.[40] The 2025 legislation moves beyond the pilot phase by authorizing broader expansion of mammography services across VA, directing the department to increase on-site capacity, improve access in underserved areas, and ensure more consistent availability of breast cancer screening for women veterans nationwide. Provisions should be implemented with urgency and consistency to ensure women veterans receive the preventive care they deserve.

[40] Off. of Insp. Gen., *Comprehensive Healthcare Inspection Program and Care in the Community Report: Mammography Services and Breast Cancer Care*, U.S. DEP'T OF VET. AFFAIRS (2024), https://www.vaoig.gov/sites/default/files/reports/2024-04/vaoig-23-00540-146.pdf.

Economic Empowerment

I. **Veteran Readiness & Employment (VR&E)**: Improve VR&E by expanding access for more service-connected disabled veterans, clarifying eligibility standards for VR&E, increasing transparency in eligibility decisions and available pathways, and strengthening VA staffing and standardization.

- **Priority Legislation**: *Veterans Readiness and Employment Program Integrity Act* (H.R. 3579), *Veterans Readiness and Employment Improvement Act of 2025* (H.R. 980)

Program Value and Workforce Impact: Wounded Warrior Project strongly supports the VR&E program and remains committed to advancing policies that allow the program to operate at its highest potential while expanding access for veterans with service-connected disabilities. VR&E plays a critical role in helping veterans prepare for, secure, and maintain meaningful employment through services such as job training, resume development, employment counseling, and individualized coaching. According to WWP's 2025 Warrior Survey, more than three-quarters (77.4%) of respondents reported using VA or government benefits, with VR&E among the most utilized programs at 21.1 percent. Ensuring VR&E functions effectively is both a veterans' services priority and a sound workforce investment.

Staffing, Wait Times, and Program Integrity: Despite the program's value, WWP continues to hear concerns regarding wait times, counselor workloads, and inconsistent access that limit veterans' ability to receive timely services. Federal law requires VA to maintain a ratio of one VR&E counselor for every 125 participating veterans, yet a recent Government Accountability Office (GAO) report, as well as VA congressional testimony, found that this standard is not being consistently met across VA Regional Offices.[41] Compounding this challenge, VR&E wait times are not uniformly tracked or publicly reported, making it difficult to identify staffing shortages or resource gaps. To improve transparency and accountability, WWP supports the *Veterans Readiness and Employment Program Integrity Act,* which would require VA to collect and report VR&E wait-time data and ensure compliance with statutory counselor-to-veteran ratios.

Eligibility Consistency and Veteran-Friendly Policies: WWP has identified persistent inconsistencies in how VR&E counselors determine eligibility and interpret what constitutes a "severe employment handicap." These inconsistencies often stem from limited standardization and uneven training, resulting in confusion for veterans who may receive conflicting or incorrect information about program access. For many warriors, misunderstandings around eligibility timing and benefit sequencing, particularly regarding Chapter 31 VR&E benefits and education benefits under Title 38, can carry significant long-term consequences. WWP urges reforms that promote clearer eligibility guidance, greater transparency in determinations, and more consistent counselor training to ensure veterans receive accurate and timely information.

[41] *Path of Purpose: Hearing Before the Subcomm. on Economic Opp. of H. Comm. On Vet. Affairs, 119th Cong.* (2025) (statement of M. Devlin, U.S. Dep't of Vet. Affairs) (*available at* https://docs.house.gov/meetings/VR/VR03/20230418/115655/HHRG-118-VR03-Wstate-CampbellT-20230418.pdf).

Eliminating the VR&E Delimiting Date: Current VR&E eligibility rules are also limiting the program's potential for improving the lives of veterans who are seeking to return to work as their disability picture changes. Under current law, veterans who left the military prior to January 1, 2013, must apply for VR&E benefits within 12 years of separation (38 U.S.C. § 3103), which means every post-9/11 veteran who got out prior to this date has now passed that window of eligibility.[42] For many wounded, ill, and injured veterans, this window may have closed just as they reached the point of stability needed to pursue retraining.

Veterans registering for WWP services often do so many years after discharge, and nearly half of veterans responding to our most recent Warrior Survey report chronic physical or mental health conditions that worsen over time. GAO and VA longitudinal data similarly indicate that veterans with TBI, PTSD, chronic pain, and other complex conditions often delay pursuing education or employment services until well beyond the 10-year mark due to extended treatment cycles and fluctuating symptoms.[43] As a result, many veterans become ready for apprenticeships, on the job (OTJ) training, or industry credentials only after their VR&E eligibility has expired.

Eliminating the delimiting eligibility date would ensure veterans can access training when they are medically and functionally prepared to benefit from it, rather than losing eligibility because recovery took longer than the statute anticipates. To bring parity across all generations of service, we believe that the 12-year delimiting date should be removed for all veterans. VA already has the authority to waive the 12-year rule on a case-by-case basis if the veteran is determined to have a "serious employment handicap." However, the standards used to make that determination are not clear and, without specific guidance to follow, a Vocational Rehabilitation Counselor (VRC) is left to make a subjective decision whether to grant the veteran eligibility to the program. Wider and more predictable participation should be the goal.

Aligning VR&E with Total Disability Based on Individual Unemployability (TDIU): Additional opportunities exist to better align VR&E with other disability-related benefits, particularly Total Disability based on Individual Unemployability (TDIU). While TDIU provides essential financial stability for veterans unable to secure gainful employment, some veterans wish to return to work as their health improves. These individuals often face uncertainty about how employment may affect benefits and whether adequate transition support exists. VR&E is uniquely positioned to help veterans with TDIU ratings reenter the workforce safely and gradually, yet clearer referral pathways and eligibility coordination are needed. Improving alignment between TDIU and VR&E would allow veterans to pursue employment with confidence and appropriate support.

For veterans receiving TDIU who wish to explore a return to work to be gainfully employed, WWP supports the development of a clear, supported offramp that prioritizes stability, transparency, and choice. While VA currently provides a 12-month reemployment protection period, during which veterans may attempt to work without immediate loss of TDIU benefits, many warriors report that the process remains confusing, difficult to navigate, and

[42] *See* 38 C.F.R. § 21.41.
[43] *See* Vet. Benefits Admin., *Post-Separation Transition Assistance Program Outcome Study: 2022 Longitudinal Survey Report*, U.S. Dep't of Vet. Affairs (2022); https://benefits.va.gov/TRANSITION/docs/2022-longitudinal-pstap-report.pdf.

inconsistently explained. As a result, veterans often perceive the decision to pursue employment as risky, fearing abrupt changes to compensation or unintended consequences for their families if work attempts are unsuccessful.

An effective TDIU offramp should build on this existing safeguard by pairing it with proactive referral to VR&E, individualized employment planning, and clear, consistent communication about how work activity, income thresholds, and timelines affect benefits. Critically, any transition framework must also ensure that dependents continue to receive health care, education benefits, and other associated supports while a veteran tests a return to work, preventing families from facing sudden disruptions during a good-faith rehabilitation effort. To succeed for high-need veterans, this process must be supported by highly trained VR&E counselors with smaller caseloads, particularly for veterans transitioning off TDIU, so that veterans receive hands-on guidance, accurate information, and coordinated support throughout the reemployment period.

Recovery and employability are not linear, and many veterans need more than one attempt before achieving sustainable employment. Strengthening the existing TDIU transition period with better counseling, clearer pathways, and stronger protections would encourage veterans to pursue rehabilitation and meaningful work without placing themselves or their families at financial risk. A transparent, veteran-centered offramp would align disability compensation more effectively with recovery and reintegration goals while preserving stability for those who need continued support.

II. **Employment**: Create opportunities throughout the federal government to place veterans, including those with significant disabilities, in roles that leverage the skills and experience they developed in the military. Help improve processes at key career transition points, including military separation and improvement from long-term disability.

Expanding Federal Employment for Veterans with Significant Disabilities Through AbilityOne: Wounded Warrior Project supports the AbilityOne Program and its mission to provide employment opportunities for individuals who are blind or have significant disabilities, including many veterans with service-connected injuries. Continued congressional support is essential to protect and strengthen the program's role within the federal procurement system and to ensure it remains a reliable source of stable, meaningful employment for wounded veterans who face barriers to entering the traditional workforce. By centering the experiences of workers with disabilities and advancing policies that promote fair wages, career development, and long-term economic stability, Congress can help ensure AbilityOne as a critical federal pathway to employment for veterans with significant disabilities.

Expanding Use of Nontraditional Pathways: Wounded Warrior Project's Warriors to Work program regularly assists veterans who want nontraditional, skills-based careers. Yet participation in OTJ training and apprenticeships through the GI Bill remains strikingly low. Although most are aware of undergraduate and graduate degree or traditional programs at colleges and universities, many warriors report a lack of awareness of the available nontraditional pathways. Nontraditional pathways include vocational and technical training, apprenticeships and on-the-job training, flight training, correspondence courses, and licensing or

certification programs. Additionally, warriors interested in self-employment may use the GI Bill for entrepreneurship training.

While warriors have several avenues to pursue non-traditional careers, current VA data suggests that existing structures are conducting insufficient outreach as fewer veterans choose these nontraditional opportunities. Across the past five fiscal years (FY2020–FY2024), participation in GI Bill OJT and apprenticeship programs has remained strikingly low, averaging only 1,700–2,300 veterans per year, representing well under one-half of one percent of all GI Bill users in any year.[44] In FY 2024, those figures broke down to approximately 776 apprenticeships and 1,008 OTJ participants under the Post-9/11 GI Bill compared with the 454,179 veterans and Service members using the GI Bill in that fiscal year.[45] These figures point to a persistent gap between employer demand for skills and the pathways most veterans ultimately pursue.

III. **Housing and Homelessness**: Advance an agenda that prevents veteran homelessness, accelerates rapid rehousing, and expands permanent supportive housing so fewer veterans become homeless.

- **Priority Legislation**: *Housing Unhoused Disabled Veterans Act* (H.R. 965, S. 1415)

Housing Access: VA reported that it permanently housed 51,936 veterans in FY 2025, building upon consistent growth in that figure over the last five years – and marking the agency's best annual performance since it began tracking the number of individual veterans housed.[46] Agency initiatives like Getting Veterans Off the Street, community-based efforts like the VA-funded Supportive Services for Veteran Families, and congressionally-backed increases to VA's Grant and Per Diem program have all contributed to substantial progress towards ending veteran homelessness. Now is the time to double-down on efforts that are working.

To that end, WWP is pleased to support the *Housing Unhoused Disabled Veterans Act*. This legislation would codify recent changes to Department of Housing and Urban Development-Veterans Affairs Supportive Housing (HUD-VASH) program regulations that make the program more accessible. In August 2024, HUD announced that it would exclude VA disability income for determining initial eligibility and effectively cleared the way for more veterans – particularly disabled veterans with some of the greatest assistance needs – to access affordable housing.[47] For a small but meaningful percentage of veterans, the amount of VA service-connected benefits received due to the severity of their disabilities results in the veteran being over the low-income limit necessary to use HUD-VASH.

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[44] *See* Vet. Benefits Admin., *Annual Benefits Report Fiscal Year 2024*, U.S. DEP'T OF VET. AFF. 157 (2025), https://www.benefits.va.gov/REPORTS/abr/docs/2024-abr.pdf; Vet. Benefits Admin., *Annual Benefits Report Fiscal Year 2023*, U.S. DEP'T OF VET. AFF. 154 (2024), https://www.benefits.va.gov/REPORTS/abr/docs/2023-abr.pdf; Vet. Benefits Admin., *Annual Benefits Report Fiscal Year 2022*, U.S. DEP'T OF VET. AFF. 154 (2023), https://www.benefits.va.gov/REPORTS/abr/docs/2022-abr.pdf; Vet. Benefits Admin., *Annual Benefits Report Fiscal Year 2021*, U.S. DEP'T OF VET. AFF. 150 (2022), https://www.benefits.va.gov/REPORTS/abr/docs/2021-abr.pdf; Vet. Benefits Admin., *Annual Benefits Report Fiscal Year 2020*, U.S. DEP'T OF VET. AFF. 151 (2021), https://www.benefits.va.gov/REPORTS/abr/docs/2020_ABR.pdf.

[45] *Id.*, U.S. DEP'T OF VET. AFF. (2025) at 157.

[46] Press Release, U.S. Dep't of Vet. Affairs, VA Houses Largest Number of Homeless Veterans in Seven Year (Nov. 2025), https://news.va.gov/press-room/va-houses-largest-number-of-homeless-veterans-in-seven-years/.

[47] Section 8 Housing Choice Vouchers: Revised Implementation of the HUD-Veterans Affairs Supportive Housing Program, 89 Fed. Reg. 65,769 (Aug. 13, 2024).

This legislation was passed by the House of Representatives in February 2025, and by the Senate – as section 5603 of its *National Defense Authorization Act for FY 2026* (S. 2296) – in October 2025. In this context, Congress is poised to take swift action to lock-in a key reform that will continue critical progress towards ending veteran homelessness. Of note, one small difference between the legislation is that H.R. 965 as written allows regulatory flexibility for HUD on the exclusion of "Adjusted Income," which determines how much rent is paid after housing has been acquired. Therefore, we urge both chambers to reconcile the language and pass the *Housing Unhoused Disabled Veterans Act.*

Women Veterans

I. **Gender-Specific Care:** Expand access to gender-specific services at DoD, VA, and community providers.

- **Priority Legislation**: *Improving Menopause Care for Veterans Act* (H.R. 219); *Servicewomen and Women Veterans Menopause Research Act* (H.R. 7596, S. 1320); *Lactation Spaces for Women Veterans Act* (H.R. 1606, S. 778)

Barriers to Care: Today, more than 2.1 million women veterans live in the United States, and VA is experiencing record engagement from this growing population.[48] Between May 2023 and May 2024, more than 53,000 women veterans enrolled in VA health care, marking it the largest single-year enrollment increase on record.[49] Gender-specific care for women encompasses medical, psychological, and social services designed to meet the distinct health needs women face across their lifespan. The growing presence and voice of women within the veteran community continues to expose gaps in health care systems that were not originally designed to address women's specific medical needs, from clinical care to broader VA-provided supports. The 2025 WWP Women Warriors Report shows progress but also makes clear that our current data only scratches the surface. To fully understand and address the challenges women veterans face, comprehensive legislation and more rigorous data collection are essential.

Many women veterans encounter barriers when seeking care, including limited access to specialized providers for gender-specific needs. According to our 2025 Women Warriors Report, women warriors reported being more likely than their male counterparts to prefer providers demonstrating cultural competence, availability of telehealth, care coordination, and patient advocacy. Barriers including extended wait times and poor experiences with providers undermine continuity of care and limit women veterans' ability to fully participate in health care decision-making. Taken together, these challenges highlight the urgent need for care models that recognize and respond to women veterans' unique health journeys.

Menopause Research and Care: To bolster gender-specific care, WWP supports legislative efforts aimed at improving both the quality and coordination of services for women

[48] *Women Veterans Health Care: Facts and Statistics*, U.S. DEP'T OF VET. AFFAIRS, https://www.womenshealth.va.gov/materials-and-resources/facts-and-statistics.asp.
[49] Press Release, U.S. Dep't of Vet. Affairs, More than 50,000 Women Veterans Enrolled in VA Health Care Over Past 365 Days (June 2024), https://news.va.gov/press-room/50k-women-veterans-enrolled-in-va-healthcare-over-past-365-day/.

veterans. The *Improving Menopause Care for Veterans Act* would require the GAO to study and report on the medical services furnished by VA for veterans experiencing perimenopause, genitourinary syndrome of menopause, and menopause stages. The legislation would help ensure a clearer understanding of the menopause-related health services women veterans need as they age. This is especially timely, as VA has acknowledged the average age of women veterans utilizing their health care services is 52 and the average age of WWP's women warrior population is 40 years old.[50]

Research that looks at menopause through the lens of military service is currently limited, resulting in a lack of appropriate supports for women who serve, and especially for those who experience early menopause (menopause that occurs before the age of 42).[51] Strengthening understanding of how military service affects perimenopause, menopause, and post-menopause is essential to improving clinical guidance and care delivery. The *Servicewomen and Women Veterans Menopause Research Act* would require DoD and VA to develop strategic research and understandings of menopause and mid-life women's health, ultimately helping the agencies gather the information needed to better tailor services and close longstanding gaps in support. Research that looks at menopause through the lens of military service is currently limited, resulting in a lack of appropriate supports for women who serve, and especially for those who experience early menopause (menopause that occurs before the age of 42).[52]

VA Medical Facility Improvement: Ensuring that recent women's health reforms translate into meaningful change also requires addressing the physical infrastructure needs that shape veterans' day-to-day experiences in VA facilities. For many new mothers, the absence of clean, private, and accessible lactation spaces creates unnecessary barriers to receiving care and can deter women veterans from attending appointments or fully engaging in care. The *Lactation Spaces for Women Veterans Act* would ensure that VA facilities provide appropriate, dedicated lactation spaces to support new mothers. Ensuring that recent women's health reforms translate into meaningful change also requires addressing the physical infrastructure needs that shape veterans' day-to-day experiences in VA facilities. For many new mothers, the absence of clean, private, and accessible lactation spaces creates unnecessary barriers to receiving care and can deter women veterans from attending appointments or fully engaging in care. This bill would address this gap by requiring all VA medical facilities to establish appropriate lactation rooms that meet established standards for privacy, sanitation, and accessibility. This legislation reinforces the principle that women veterans should not have to choose between attending medical appointments and caring for their families. By modernizing facility requirements, the bill helps ensure that VA's physical environment aligns with the expectations of a health system designed to serve today's women veterans.

We urge the Committees to prioritize access to comprehensive gender-specific care and to support evolving care delivery models that reflect the needs of all veterans. As the population of women veterans continues to grow, sustained congressional commitment to these priorities is essential to building a health care system that fully reflects and responds to their needs.

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[50] U.S. DEP'T OF VET. AFFAIRS, *supra* note 48.

[51] *See generally* Jill Brown et al., *Addressing the Menopause Health Needs of Military Service Members: A Call to Action*, 45 OBSTETRICS & GYNECOLOGY 247 (2022), *available at* https://journals.lww.com/greenjournal/abstract/2025/03000/addressing_the_menopause_health_needs_of_military.2.aspx.

II. **Legislative Implementation**: Ensure laws aimed at modernizing and improving health outcomes for women veterans at VA – such as the *Deborah Sampson Act* and the *MAMMO Act* – are fully implemented.

Realizing the full impact of recent legislation that addressed gaps in women's health and supports requires deliberate, system-level execution across VA program offices, clinical operations, and facility leadership. Statutes such as the *Deborah Sampson Act* (P.L. 116-315, Title 5), the *VA Peer Support Enhancement for MST Survivors Act* (P.L. 117-271), and the *MAMMO Act* established specific mandates intended to expand gender-specific services, standardize care delivery, and address persistent gaps in access and quality. Effective implementation will depend on VA's ability to operationalize these requirements through updated clinical guidance, workforce training, infrastructure investments, and performance monitoring mechanisms that ensure compliance across the enterprise. Ensuring these laws are translated into measurable improvements in service availability and care outcomes is essential to advancing a modernized women's health system within VA.

As well intentioned as these laws are, some provisions have encountered implementation challenges or have not yet realized their intended impact. Within the *Deborah Sampson Act,* several sections remain partially implemented, and others would benefit from additional clarity or reporting to assess outcomes. Section 5107 called for the development of a childcare pilot program, which VA has not fully operationalized. Section 5201 required each VA medical facility to staff at least one full- or part-time primary care provider dedicated for women veteran care. While progress has been reported, the lack of publicly available facility-level compliance data makes it difficult to evaluate the extent of implementation and remaining needs.

Section 104 and 105 addressed environment-of-care standards and facility retrofits. Although public materials suggest that inspections and retrofits are ongoing. A comprehensive, national facility-level tracking mechanism is not publicly available. Sections 106 and 107 focused on the Women Veterans Health Care Mini-Residency Program and a training module for community provider. While the mini-residency program has expanded and a community-provider module has been created, publicly available information on effectiveness – such as completion rates, pre- and post- measures, or outcomes data – remains limited.

Similarly, the *VA Peer Support Enhancement for MST Survivors Act* was designed to strengthen coordination between VBA and VHA and expand peer support staff for veterans filing MST-related claims. To date, this program has not been fully realized, and no alternative, comparable initiatives have been formally established to support MST Claims.

III. **Connection and Recognition of Service**: Strengthen VA outreach to women veterans to improve engagement, increase response rates, and encourage full use of earned benefits.

- **Priority Legislation**: *Servicemembers and Veterans Empowerment and Support Act* (H.R. 2717, S. 1245); *Building Resources and Access for Veterans' Mental Health Engagement (BRAVE) Act* (S. 609)

Tailored Mental Health Outreach: VA's ability to effectively serve women veterans depends heavily on whether those veterans recognize themselves in VA's outreach efforts and feel connected to the benefits and services they have earned. Despite steady growth in the women veteran population, many continue to report that they are unaware of available programs, uncertain about eligibility, or are disengaged from VA systems altogether. These gaps are not solely communication challenges. They represent structural barriers that limit access to health care, mental health support, disability benefits, and recognition of service. Supporting outreach and engagement efforts requires a coordinated, data-driven approach that reflects the diversity of women's military experiences and ensures that messaging resonates across age groups, service eras, and cultural backgrounds.

The *BRAVE Act* directs VA to tailor suicide prevention and mental health outreach to women veterans, refine analytics to include risk factors especially relevant to women in the REACH VET program, and strengthen Vet Center outreach and technology, while also reauthorizing and increasing Staff Sergeant Parker Gordon Fox Suicide Prevention Grants so trusted community partners can reach veterans earlier. Title III focuses specifically on women veterans, requiring VA to assess the effectiveness of women focused messaging and programming and to review retreat and readjustment services, ensuring offerings include women only options where appropriate. Together, these provisions make VA's outreach more visible, relevant, and accessible to women veterans who may face MST, post deployment challenges, or barriers to seeking care, and they improve system capacity to connect veterans of all genders to timely, life-saving resources.

Building a more responsive benefits system for MST claims: VA's screening data show that about 1 in 3 women seen in VA care screen positive for MST, compared to about 1 in 50 men, reflecting a markedly higher rate among women veterans while also confirming that large numbers of men have experienced MST given the military's gender composition. Recent DoD reporting likewise indicates that, in a typical year, tens of thousands of currently serving military Service members experience sexual assault, with roughly similar absolute numbers of women and men affected (about 15,000 women and almost 14,000 men in 2023).[53] MST is not solely a women's issue but does disproportionately impact women by prevalence. By improving clinical pathways, clarifying evidence standards, and reducing the burden on survivors to reconstruct exposure and trauma histories, these proposals would speed fairer decisions for MST-related disability and mental-health claims and deliver benefits more consistently for veterans of all genders.

The *Servicemembers and Veterans Empowerment and Support Act* updates VA policy and practice for MST survivors by modernizing the definition of MST, strengthening MST-related claims development and adjudication, and expanding access to -MST related counseling. Among other provisions, it (1) clarifies MST definitions and directs specialized claims processing and annual accuracy reviews, (2) allows survivors to use non-DoD corroborating evidence and to choose a VA clinician for exams tied to MST claims, and (3) expands eligibility for MST counseling to former Guard and Reserve members. These changes reduce evidentiary barriers,

[53] Konstantin Toropin, *Military Sexual Assaults Have Declined, Marking the First Significant Progress for Prevention Efforts in Years*, MILITARY.COM (May 16, 2024), https://www.military.com/daily-news/2024/05/16/pentagon-reports-drop-sexual-assaults-first-time-nearly-decade.html.

improve survivor- centered adjudication, and help ensure women veterans and other survivors can access trauma- informed- mental health care and fair disability determinations.

IV. **Financial Wellness**: Promote policies to assist with employment, financial obligations, food security, housing stability, and childcare.

Research shows that women face persistent barriers to building wealth over the course of their lives, reflecting the combined effects of caregiving responsibilities, employment disruptions, and lower lifetime earnings.[54] Women hold less wealth than men at the median, driven in large part by periods of reduced labor force participation, lower rates of retirement account ownership, and smaller retirement balances associated with caregiving and family obligations.[55] Studies of unpaid family caregiving consistently document that these responsibilities are more frequently assumed by women and are associated with diminished savings, higher financial strain, and reduced long term economic security.[56]

Available research indicates that women veterans experience many of these same financial pressures, alongside challenges associated with military service and the transition to civilian employment.[57] National analyses show that female veterans report lower overall financial well-being and weaker saving and investing outcomes than male veterans, as well as more adverse employment and income indicators.[58] Research also documents that women comprise a substantial share of military and veteran caregivers, with caregiving responsibilities frequently linked to financial strain, difficulty meeting household expenses, and employment challenges.[59]

Consistent with these findings, the 2025 Women Warriors Report identified significant financial pressures facing women veterans, including persistent employment barriers, rising living costs, and limited access to affordable childcare. Research shows that these conditions are associated with heightened risks of food insecurity and housing instability and with constrained opportunities to save, build assets, or invest in long term financial stability, even among women who are employed.[60] The research base underscores that employment, caregiving responsibilities, food security, and housing stability are closely interconnected factors shaping long term economic outcomes for women veterans.[61]

Taking inspiration from this research, we stand ready to work with Congress to help devise and evaluate programs that support women veterans in building sustained economic

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[54] *See, e.g.*, Jeff Hayes, *How to Improve Women's Retirement Security in 2025*, U.S. DEP'T OF LABOR (Jan. 13, 2025), https://blog.dol.gov/2025/01/13/how-to-improve-womens-retirement-security-in-2025.
[55] *Id.*
[56] *See* Fawn Cothran & Patrice Heinz, *The Economic Effects of Family Caregiving on Women*, TIAA INST. (2022), https://www.tiaa.org/content/dam/tiaa/institute/pdf/insights-report/2022-07/tiaa-institute-nac-the-economic-effects-of-family-caregiving-on-women-wvoee-cothran-july-2022-0.pdf; Richard Johnson et al., *Unpaid Family Care Continues to Suppress Women's Earnings*, URBAN INST. (2023), https://www.urban.org/urban-wire/unpaid-family-care-continues-suppress-womens-earnings.
[57] *See, e.g.*, William Skimmyhorn et al., *The Financial Capability of United States Military Veterans*, FINRA FOUNDATION (2023), https://www.finrafoundation.org/sites/finrafoundation/files/2024-10/research-brief-veterans-financial-capability-11-23.pdf.
[58] *Id.*
[59] Rajeev Ramchand et al., *Hidden Heroes: America's Military Caregivers*, RAND CORP. (2014), https://www.rand.org/pubs/research_reports/RR499.html; *Caregivers and Family Support*, U.S. DEP'T OF VET. AFFAIRS, https://www.hsrd.research.va.gov/research_topics/caregiving.cfm.
[60] *Supra* note 56.
[61] *See* Hayes, *supra* note 54.

stability over time. This includes efforts that strengthen access to meaningful employment, reduce financial strain related to caregiving responsibilities, and support pathways to saving, asset building, and long-term financial security. Collaborative, evidence informed approaches can help ensure that programs intended to support women veterans are responsive to their lived economic realities and promote lasting stability after military service.

Transition Support

I. **Transition Preparation Support**: Promote policies to support warriors while they are still in the military and at or near their transition point to prepare them for the changes they will face when adjusting to civilian life.

- **Priority Legislation**: *Military Financial Literacy Accountability Act* (H.R. 6717)

Life-cycle Model of Practical Financial Education: According to WWP's 2025 Warrior Survey, 67.3% of warriors indicated they did not have enough money to make ends meet at some point in the previous 12 months. Additionally, more than 9 in 10 warriors (92.8%) had outstanding debt other than mortgage debt. As financial insecurity can have significant impacts on quality of life and mental health, these points underscore the importance of ensuring that veterans and Service members are given the training and tools to make smart financial decisions.

To help mitigate against the challenges posed by financial insecurity, WWP is pleased to support the *Military Financial Literacy Accountability Act*. This bill would amend *Financial Literacy Training for the Service Members* (10 U.S.C. § 992) to strengthen oversight and relevancy of financial literacy training for Service members. It requires the DoD to track training completion, identify and address causes of non-compliance, and establish timelines for standardized performance measures. The bill further directs DoD to incorporate Service members' input on what financial topics matter most and how they prefer to receive this information, an essential step not only for their success as Service members but also as citizens managing lifelong financial responsibilities.

As Service members earn on a fixed income based on rank and time in service, they cannot accelerate wealth-building. In this context, practical financial management education throughout their careers is one of the best ways to mitigate financial vulnerability during and after transition from military service.

Aligning Federal Efforts Involved in Military Transition: A challenge transitioning Service members face is how they are presented with different federal programs and connected with employment and training resources at the point of separation. DoD's Transition Assistance Program includes briefings from the Department of Labor (DOL), the Small Business Administration, the Office of Personnel Management (OPM), and VA. While each component provides value, limited coordination and inconsistent handoffs often leave veterans and their families piecing together fragmented information across multiple agencies. Independent reviews by RAND and the GAO have also documented a longstanding college-first emphasis that can eclipse practical navigation into apprenticeships, OJT, and shortcycle credentials. This

imbalance is out of step with today's labor market and with federal placement goals that should leverage the skills veterans already have.

Transition Families – Not Just Service Members: Inclusion of family members in the transition process is a factor in the long-term success of our Service members and their households. Forthcoming legislation such as the *Building Readiness and Integration for Dependents Going to Civilian Environments* (*BRIDGE Act*) recognizes that transition is not an individual task assigned to the Service Member, but a family decision-making process. This legislation would create a pilot program to drive Transition Assistance Program coordination with organizations that provide ongoing resources, training, and neighborhood connection support, including peer-led support groups, resilience workshops, and a digital resource hub focused on emotional wellness, practical life skills, and community reintegration for spouses, children, and caregivers.

For many Service members, transition is the first time in their adult lives they are required to make complex, high-stakes decisions outside of military operations – often prior to their retirement date – with lifelong financial and personal consequences. Ensuring that families are part of the process fosters informed, unified decision-making, strengthens household stability, and reduces the stress that accompanies the move from military to civilian life. As numerous military leaders – to include previous Chief of Staff's of the Army – have often stated, "We recruit Soldiers, but we retain Families," and we must be committed to that principle. Families should be welcomed and invited in the transition process so they can step into their next chapter together – prepared, aligned, and resilient.

A Practical Path Forward: Wounded Warrior Project will continue to advocate for reforms that treat nontraditional pathways as first class outcomes, whether one is separating from the military or reentering the workforce after a long-term disability. Transition curricula and federal placement tools should present apprenticeships, OJT, and industry credentials alongside degree programs, with clear step-by-step navigation, consistent messaging across agencies, and follow-up after separation. Veterans cannot use pathways they do not see, do not understand, or cannot access in time. Aligning information, timing, and support across the DoD, DOL, OPM, and VA will help more warriors move into meaningful federal and private sector roles that honor their service and make full use of their skills.

II. **Health Care**: Support policies that help coordinate efforts across VA, DoD, and the community to ensure that Service members transition seamlessly to civilian life.

- **Priority Legislation**: *Servicemember to Veteran Health Care Connection Act of 2025* (S. 585)

Improving transitions from the Military Health System to the Veterans Health Administration: As Service members transition from active duty to veteran status, those who have relied exclusively on the Military Health System often experience disruptions when entering the VA healthcare system, including gaps in care, incomplete medical record transfers, reassignment to providers unfamiliar with their history, and persistent structural barriers between DoD and VA (such as separate medical record systems and provider credentialing processes).

Appropriate implementation and partnership through new requirements outlined in the *National Defense Authorization Act for FY 2026* (P.L. 119-60 § 731, "Improvements of Availability of Care for Veterans from Facilities and Providers of the Department of Defense") will help establish a seamless framework to improve access and coordination across both systems by promoting earlier and sustained exposure to VA care during a Service member's career, supporting integrated funding through the resource sharing, and requiring alignment on medical record sharing and provider credentialing. Together, these measures will strengthen continuity of care, expand access – particularly in rural and underserved areas – and improve health outcomes for Service members and veterans over the course of their lifetimes.

Health Care Enrollment: The process of transitioning from military service back to civilian life 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 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, VA's Office of Suicide Prevention found that veterans who have recently transitioned to civilian life 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 Service members transitioning to civilian life 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 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.

III. **Benefits Access and Process Improvement**: Support legislation and policies that strengthen the benefits process before, after, and during separation.

- **Priority Legislation**: *Sharri Briley and Eric Edmundson Veterans Benefits Expansion Act* (H.R. 6047)

WWP's Benefits Services program provides VA-accredited professional benefits advocates who can assist warriors and families navigate the VA claims process, ensuring that they receive the benefits they earned in a manner that honors their service. Nearly 8 in 10 warriors responding to our Warrior Survey (78.8%) reported a VA disability rating of 70% or higher, indicating that many are facing health challenges that may create eligibility for other support. Ensuring that benefits are processed and delivered smoothly can have a meaningful impact on the financial security of many warriors, as more than 4 in 6 WWP warriors (67.3%) indicated that at some point in the last 12 months they did not have enough money to make ends meet (i.e., to pay for rent/mortgage, food, utilities, phone, or other basic needs).

The *Sharri Briley and Eric Edmundson Veterans Benefits Expansion Act* represents one of the most meaningful opportunities in decades to strengthen financial security for the nation's most severely disabled veterans. A key provision of this legislation would increase the amount of Special Monthly Compensation (SMC) by $10,000 annually for the most severely disabled veterans – those who depend on regular aid and attendance of another, including for residuals of TBI. SMC is arguably the most important ancillary benefit for veterans with severe, service-connected disabilities. SMC-T in particular, which is provided to veterans with TBI, can help offset caregiver burden and the increasing costs of high-quality care – both of which can keep veterans at home and of institutional living.

Wounded Warrior Project supports this legislation because it reflects the core principle that those who sacrificed the most deserve the strongest safety net. Far too many families shoulder around-the-clock caregiving responsibilities with inadequate financial support, particularly families like the Edmundsons, whose daily lives revolve around complex medical needs following devastating combat injuries. The bill also increases survivor benefits by a total of 1.5 percent over a period of two years for the surviving family members of deceased Service members and veterans, helping surviving spouses like Sharri Briley, who have waited more than 20 years for a meaningful increase. These changes bring long-overdue fairness and dignity to families who have endured the heaviest burdens of war.

Concluding Remarks

Wounded Warrior Project thanks the House and Senate Committees on Veterans' Affairs, their distinguished members, and all who have contributed to a robust discussion of the challenges – and the successes – experienced by veterans across our great nation. As we continue to work together, let us never forget our "why." We are here to bring every warrior fully home –

mind, body, and soul – and reconnect them back to a path of hope and purpose. It is not about coming back; it is about coming *home*, and we simply cannot accomplish this great feat without the help of Congress and the American people. We are thankful for the invitation to submit this statement for record, and we stand by as your partner in meeting the needs of all who served – and all who support them.

Our nation would not be what we are without the brave men and women who have stepped up to defend it. They have done their part, and with great honor and gratitude, it is now time to do ours.

Appendix

WOUNDED WARRIOR PROJECT®

COMMUNITY PARTNERSHIPS

No single organization can meet the care and support needs of all post-9/11 veterans, caregivers and families. By investing in best-in-class organizations, Wounded Warrior Project® (WWP) is helping to reduce duplicative efforts and grow a comprehensive network of support across the military and veteran community. Please refer to this list of current partners as you seek out resources beyond WWP:

Wondering which of our partners might best suit your current needs?

The WWP Resource Center can help! Call 888.WWP.ALUM (997.2586)

Current List Of Partner Organizations (12.1.25)

25-10589355160

WALT PIATT
CHIEF EXECUTIVE OFFICER

★ WOUNDED WARRIOR PROJECT® BIO

Walt Piatt serves as chief executive officer of Wounded Warrior Project® (WWP). He brings 42 years of military experience and leadership to the organization. Piatt oversees day-to-day operations and works with the leadership team to set and implement the organization's strategic vision. He is responsible for ensuring WWP's free programs and services continue to have the greatest possible impact on the warriors, caregivers, and families we serve.

Prior to joining WWP, Piatt served for four years as the Director of the Army Staff. His Army career began with a four-year enlistment in the infantry with the 82nd and 101st Airborne Divisions before attending Lock Haven University. He graduated with a bachelor's degree in biology and joined the Army ROTC program. The Army commissioned him as an officer in 1987.

With more than four decades of dedicated service to our country, Piatt's assignments were comprised of responsibilities from private to three-star general, which included Command of the Joint Multinational Training Command in Germany; Deputy Commanding General, United States Army Europe; and Commanding General 10th Mountain Division (Light) at Fort Drum and in Iraq. His awards and accolades reflect a lifelong career in uniform, including four Army Distinguished Service Medals and five Bronze Stars.

Piatt published two books of poetry from his experience in Afghanistan. He was a pioneer in bringing mindfulness to the military with a goal of helping warriors regulate stress, increase attention, and calmly embrace the demands of military life.

Piatt's education includes the School of Advanced Military Studies and a fellowship with the Institute for the Study of Diplomacy at Georgetown University's Edmund Walsh School of Foreign Service. He holds master's degrees in military history and military science and an honorary doctorate for public service from Lock Haven University.

He is married with two adult children and three grandchildren and resides in Jacksonville, Florida.

STATEMENT OF
TRAGEDY ASSISTANCE PROGRAM FOR SURVIVORS (TAPS)
BEFORE THE
COMMITTEES ON VETERANS' AFFAIRS
UNITED STATES SENATE AND HOUSE OF REPRESENTATIVES

JOINT SENATE AND HOUSE
VETERANS SERVICE ORGANIZATION LEGISLATIVE PRESENTATION

PRESENTED BY
ANITA SULLIVAN
SURVIVING SPOUSE OF CE3 MICHAEL SULLIVAN, U.S. NAVY

MARCH 4, 2026

The Tragedy Assistance Program for Survivors (TAPS) is the national provider of comfort, care, and resources to all those grieving the death of a military or veteran loved one. TAPS was founded in 1994 as a 501(c)(3) nonprofit organization to provide 24/7 care to all military survivors, regardless of a service member's duty status at the time of death, a survivor's relationship to the deceased service member, or the circumstances or geography of a service member's death.

TAPS provides comprehensive support through services and programs that include peer-based emotional support, casework, assistance with education benefits, and community-based grief and trauma resources, all delivered at no cost to military survivors. TAPS offers additional programs, including, but not limited to, the following: the 24/7 National Military Survivor Helpline; national, regional, and community programs to facilitate a healthy grief journey for survivors of all ages; and information and resources provided through the TAPS Institute for Hope and Healing. TAPS extends a significant service to military survivors by facilitating meaningful connections to peer survivors with shared loss experiences.

In 1994, Bonnie Carroll founded TAPS after the death of her husband, Brigadier General Tom Carroll, who was killed along with seven other soldiers in 1992 when their Army National Guard plane crashed in the mountains of Alaska. Since its founding, TAPS has provided care and support to more than 120,000 bereaved military survivors.

In 2025 alone, 9,560 newly bereaved military and veteran survivors connected to TAPS for care and services. This is an average of 26 new survivors coming to TAPS each and every day. Of the survivors seeking our care in 2025, 33 percent were grieving the death of a military loved one to illness, including as a result of exposure to toxins; 29 percent were grieving the death of a military loved one to suicide; and 5 percent were grieving the death of a military loved one to hostile action.

As the leading nonprofit organization offering military grief support, TAPS builds a community of survivors helping survivors heal. TAPS provides connections to a network of peer-based emotional support and critical casework assistance, empowering survivors to grow with their grief. Engaging with TAPS programs and services has inspired many survivors to care for other, more newly bereaved, survivors by working and volunteering for TAPS.

Chairmen Moran and Bost, Ranking Members Blumenthal and Takano, and distinguished members of the Senate and House Committees on Veterans' Affairs, the Tragedy Assistance Program for Survivors (TAPS) is grateful for the opportunity to provide a statement for the record on issues of importance to the 120,000-plus surviving family members of all ages, representing all services, and with losses from all causes who we have been honored to serve.

The mission of TAPS is to provide comfort, care, and resources for all those grieving the death of a military loved one, regardless of the manner or location of death, the duty status at the time of death, the survivor's relationship to the deceased, or the survivor's phase in their grief journey. Part of that commitment includes advocating for improvements in programs and services provided by the U.S. federal government — the Department of Defense (DoD), Department of Veterans Affairs (VA), Department of Education (DoED), Department of Labor (DOL), and Department of Health and Human Services (HHS) — and state and local governments.

TAPS and the VA have mutually benefited from a long-standing, collaborative working relationship. In 2014, TAPS and the VA entered into a Memorandum of Agreement that formalized their partnership with the goal of providing earlier and expedited access to crucial survivor services. In 2023, TAPS and the VA renewed and expanded their formal partnership to better serve our survivor community. TAPS works with military and veteran survivors to identify, refer, and apply for resources available within the VA, including education, burial, benefits and entitlements, grief counseling, and survivor assistance.

TAPS also works collaboratively with the VA and DOD Survivors Forum, which serves as a clearinghouse for information on government and private-sector programs and policies affecting surviving families. Through its quarterly meetings, TAPS shares information on its programs and services as well as fulfills any referrals to support all those grieving the death of a military and veteran loved one.

TAPS President and Founder Bonnie Carroll previously served on the Department of Veterans Affairs Federal Advisory Committee on *Veterans' Families, Caregivers, and Survivors,* where she chaired the Subcommittee on Survivors. The committee advises the Secretary of the VA on matters related to veterans' families, caregivers, and survivors across all generations, relationships, and veteran statuses. Ms. Carroll is also a distinguished recipient of the Presidential Medal of Freedom, the nation's highest civilian honor.

END THE REMARRIAGE PENALTY FOR SURVIVING SPOUSES

TAPS is proud to spearhead this critical legislation and to work alongside the leadership of this committee to advance one of our most urgent legislative priorities — the ***Love Lives On Act of 2025*** **(S.410, H.R.1004)**. This comprehensive bill finally ends a decades-old penalty on surviving spouses by ensuring they do not forfeit their earned benefits if they remarry before the age of 55.

TAPS extends its deep appreciation to Senators Jerry Moran (R-KS) and Raphael Warnock (D-GA) and our 22 original Senate cosponsors, and Representatives Richard Hudson (R-NC-09), Joe Neguse (D-CO-02), Derrick Van Orden (R-WI-03), Kelly Morrison (D-MN-03), Morgan Luttrell (R-TX-08), and Ro Khanna (D-CA-17) for their leadership in introducing this critical legislation, as well as the 54 Senate co-sponsors and 135 House co-sponsors who have demonstrated bipartisan commitment to supporting surviving families by advancing this vital bill in the 119th Congress.

We call on Congress to act now to end these unjust penalties on surviving spouses by:

- Eliminating the arbitrary age-55 requirement that strips surviving spouses of earned benefits upon remarriage.
- Permanently protecting access to both the Survivor Benefit Plan (SBP) and Dependency and Indemnity Compensation (DIC) for surviving spouses who remarry — at any age.
- Restoring TRICARE eligibility to remarried surviving spouses when a subsequent marriage ends due to death, divorce, or annulment.

Current law significantly penalizes surviving spouses if they choose to remarry before the age of 55. Given that most surviving spouses from the post-9/11 era are widowed in their 20s or 30s, we are asking them to wait 20-plus years to move forward in their lives with the financial security earned by their loved ones' service and sacrifice. These spouses are often raising children alone, navigating grief while shouldering the full weight of parenting and financial responsibility. Faced with the devastating loss of benefits that would accompany remarriage, many surviving spouses feel compelled to forgo remarriage altogether, while others are driven to cohabitate rather than legally marry — an outcome that contradicts both family stability and the values we claim to uphold. This policy does not honor sacrifice — it compounds it.

The long-term goal for TAPS is to secure the right for surviving spouses to remarry at any age and retain their benefits. TAPS is leading efforts to pass the ***Love Lives On***

Act of 2025, which is supported by over 50 veteran and military organizations. TAPS spearheaded a letter of support from these partner organizations that has been shared with every member of this committee.

Military spouses are among the most unemployed and underemployed populations in the United States. Due to frequent military moves, the service member's deployment cycle, and expensive child care, military spouses face high barriers to employment and are unable to fully invest in their own careers and retirement. For many families, military retirement pay is treated as the household's retirement pay. These barriers to employment continue when a military spouse becomes a surviving spouse. Many surviving spouses have to put their lives on hold to raise bereaved children. They are reliant on their survivor benefits to help offset the loss of pay from their late spouse and their own lost income as a result of military life.

If a surviving spouse's subsequent marriage ends in death, divorce, or annulment, while most benefits can be restored, TRICARE benefits are not restored. If a surviving spouse was previously eligible for CHAMPVA, that benefit can be restored. TAPS is asking that we provide parity with other federal programs and allow TRICARE to be restored if the subsequent marriage ends.

These restrictions appear to be punitive as they are only imposed on military surviving families, not others who put their lives on the line to protect and defend. For example, in 30 states, including Texas[1], Virginia[2], and Louisiana[3], first responders' survivors may legally remarry in the U.S. and maintain all or partial pensions and benefits.

In certain circumstances, divorcees are granted more respect than surviving spouses. If a service member was married for at least 20 years and served 20 years, their divorced spouse is entitled to a portion of that retirement benefit regardless of whether they remarry or not. Surviving spouses should not be penalized for remarrying when we grant the right to retain benefits to certain divorced spouses.

Additionally, when a surviving spouse remarries before 55, they are legally required to notify the VA to discontinue DIC. The VA states that the processing time for these claims is typically eight to 12 weeks, but unfortunately, this is often not the case. Many surviving spouses experience delays ranging from six to 18 months, with some cases taking up to 42 months of constant effort to terminate their benefits. They often encounter the need to make multiple calls, resend paperwork repeatedly, and are frequently informed that their file hasn't been reviewed, even six months after submission.

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[1] https://www.firehero.org/resources/family-resources/benefits/local/tx/
[2] https://www.firehero.org/resources/family-resources/benefits/local/va/
[3] https://irp-cdn.multiscreensite.com/ac5c0731/files/uploaded/Louisiana.pdf

As these survivors continue to receive payments, they subsequently receive debt letters demanding the immediate repayment of benefits, often with added interest. This places an undue burden and emotional distress on surviving spouses who followed the required procedures. The challenge is exacerbated by the fact that many surviving spouses, often with minor children, are unaware of the specific portions of the payments they are supposed to retain and which portions should cease. Additionally, they may lack the financial resources to repay the VA promptly. This is a waste of VA resources, and allowing our surviving spouses to maintain benefits upon remarriage would eliminate these unnecessary challenges.

According to the VA, there are approximately 530,085 surviving spouses receiving DIC. Less than 35,000 of those surviving spouses are under the age of 55 and could potentially benefit from this legislation. Currently, less than 5 percent of surviving spouses under the age of 55 have chosen to remarry due to these penalties.

The federal government has allowed surviving spouses to maintain benefits upon remarriage over the age of 55 or 57 for decades. There is no specific reason for the age of 55; it is just the age Congress decided they could live with, but it sets the precedent that surviving spouses can and should be able to remarry and retain survivor benefits without waiting 20-plus years. Most choose to cohabitate until age 55, so all this law does is discourage legal marriages and prevent our young surviving children from having a mother or father figure legally in their lives.

With recruiting and retention at an all-time low in the military, every time we do not keep our promises to our military, veterans, and their families, we are discouraging our younger generations from serving. When an 18-year-old enlists in the military, they sign a check for up to and including their life. They also know that if something happens to them, our government will take care of their family. Period. There are no conditions; they are promised that their family will be taken care of for the rest of their lives. The current law breaks that promise. Our military, Members of Congress, and administration frequently remind survivors that the death of their loved one "is a debt that can never be repaid," but ending survivor benefits upon remarriage is saying "that debt is paid in full." Just because a surviving spouse remarries does not mean they stop grieving. A piece of paper will never change that they are a widow or widower; it just means they are also someone else's spouse.

Remarriage should not impact a surviving spouse's ability to pay bills. They should not have to choose between another chance at love, a stable home life for their children, and financial security. They are still the surviving spouse of a fallen service member or veteran, who earned these benefits through their service and sacrifice. Regardless of their marital status, surviving spouses should not be penalized for finding love in the

future. All they are asking for is to choose how they move forward to pick up the broken pieces of their lives.

TAPS appreciates the House and Senate Armed Services Committees including section five (V) of *the* ***Love Lives on Act of 2023***, which expands commissary and exchange benefits to remarried surviving spouses, in *the Fiscal Year 2024 National Defense Authorization Act,* and we appreciate the House and Senate Veterans' Affairs Committees for including sections II and VII in the *Senator Elizabeth Dole 21st Century Veterans Healthcare and Benefits Improvement Act* in December 2024, which expands the Fry Scholarship to remarried spouses and ends the archaic, "Hold oneself out to be married" clause.

The following personal testimonials from surviving spouses help highlight these important issues:

Bonnie Carroll, Surviving Spouse of BG Tom Carroll of Alaska, U.S. Army National Guard

"My name is Bonnie Carroll. I am the President and Founder of the Tragedy Assistance Program for Survivors, known as TAPS, and I am also a surviving spouse. I lost my husband, Brigadier General Tom Carroll, in a military aviation accident. In the quiet aftermath of his death, I stood where millions of military survivors stand. Shocked. Grieving. Trying to understand how life could move forward when everything familiar was gone. From that loss, and from the absence of sustained care for grieving families, TAPS was born.

"On my husband's headstone are three words that have guided my life's work: Love Lives On. They are not a slogan. They are a promise. A promise that love does not end at death, that service does not expire with sacrifice, and that families left behind must never be forgotten.

"For more than 30 years, TAPS has provided 24/7 care, peer support, grief education, and community to all who grieve a military or veteran death, regardless of age, rank, relationship, duty status, or cause of death. Every service is provided at no cost. Because grief does not follow a timetable and love does not disappear when benefits do.

"I strongly support the Love Lives On Act. This legislation addresses a long-standing injustice in federal law that has harmed surviving spouses for generations. Under current policy, many surviving spouses lose critical survivor benefits if they remarry before a certain age, forcing them to choose between financial stability and the human need for love, partnership, and safety.

"This issue is not theoretical for me. It lives in my family. My mother-in-law lost her husband, Major General Thomas P. Carroll, in a military plane crash. Like so many widows of her era, she carried her grief quietly and moved forward with strength and resolve. Years later, she remarried, believing she was choosing companionship after devastating loss. What she did not fully understand was that remarriage would cost her the survivor benefits her husband earned through his service to this nation.

"That second marriage became abusive.

"She stayed far longer than anyone should ever have to stay in danger, not because she lacked courage, but because she lacked options. Without her survivor benefits, she had no financial independence and no safety net. The policy that stripped her benefits did not protect her. It trapped her.

"Eventually, my husband, Tom, helped her leave that marriage. Much later, we learned that she could once again receive her survivor benefits after the marriage ended, and she did regain them. But by then, years had been lost to fear, isolation, and unnecessary suffering.

"No law should ever force a surviving spouse to choose between love and safety, between human connection and survival.

"This is why the Love Lives On Act matters. This legislation ensures that remarriage does not permanently bar a surviving spouse from receiving Dependency and Indemnity Compensation or Survivor Benefit Plan benefits earned through their loved one's service. It recognizes that love does not negate sacrifice, and that survivor benefits are not conditional on remaining alone for life. It restores dignity, choice, and stability to those who have already given so much.

"Most post-9/11 surviving spouses were widowed in their 20s and 30s. Many are raising children alone. They deserve the freedom to rebuild their lives without fear that loving again will come at the cost of their family's security.

"When we say 'love lives on,' we must mean it in policy, not just in sentiment.

"TAPS stands ready to support the implementation of this legislation and to continue walking alongside military survivors for as long as they need us. Honoring the fallen requires caring for the living, not just at the moment of loss, but for the lifetime that follows.

"Thank you for your leadership, your compassion, and your commitment to America's military families. Love lives on when we choose to protect it."

Gina Kincade Piland, Surviving Spouse of Lt Col John Kincade, U.S. Air Force

"On Nov. 21, 2019, my husband of 20 years, Lt Col John (Matt) Kincade, lost his life in a military aviation training mishap at Vance Air Force Base. Through his (our) 20 years of service, I followed him from base to base — Texas to California to Nevada back to California, then Iowa, and finally "home" to Oklahoma — raising our two amazing sons, keeping the home fires burning, and praying he would come home safely.

"The day after my Matt died, I sat down with a representative from Vance AFB and received my benefits briefing. That day, I learned about the benefits I would collect due to Matt's death. I also learned that most of the benefits would never expire — assuming I remained unmarried until the age of 55. I remember thinking that wouldn't be a problem. I couldn't see past the grief and despair of the fresh loss to consider that someday in the future I might meet someone who could make my life — and my sons' lives — beautiful again. And yet, that's exactly where I find myself today.

"In March of 2022, I met Cally, a man who helped me see the beauty of life again. He allowed space for the legacy of my late husband. Cally and I struggled with how to move forward together, knowing the severe financial repercussions we would face upon marrying. Because we are both Christians who are dedicated to having God at the center of our relationship, and because we believe marriage is a holy covenant that we want to model for our combined six children, Cally and I made the choice to accept the financial penalty and were married on Dec. 31, 2023. I am no longer eligible to receive DIC or the SBP that my late husband invested in to provide for our needs.

"For the 20 years my late husband served, our sons have been my priority. Matt and I always had the belief that one parent should be wholly available to our kids at all times, and in the years of deployments, work-ups, and training. I sacrificed my career goals to support him and to raise our two amazing sons. And now, as a result of his death, I find myself at 50 years old starting over again — not just in a relationship, but also in a career.

"In spite of our tremendous loss, under current law, the U.S. government, the Department of Defense, and the Department of Veterans Affairs will be free and clear of any responsibility to the family of the late Lt Col John (Matt) Kincade when our youngest son turns 22."

Marcie Robertson, Surviving Spouse of SFC Forrest Robertson of Kansas, U.S. Army

"I lost my husband in November 2013 when he was killed in action in Afghanistan. At the time, I was 34 years old, and our daughters were 14, 10, and 6 years old. One day, I

had a partner, and the next day, I was the only one to make decisions, discipline, and raise three daughters.

"My husband deployed four times during our marriage, so we both understood his job meant there was a real possibility that he might not come home each time he deployed. Early on, we had a discussion about what would happen if he were to lose his life. He told me where he wanted to be buried, and what to do with the insurance money. He also told me that when I felt ready, he wanted me to move forward with someone new. It was very important to him that I not spend the rest of my life alone. He said this, not realizing that his wish for me would mean the end of the benefits he provided for me.

"He went to war for his country, knowing that if he sacrificed his life, his family would be taken care of. He did not know that meant his widow would have to stay unmarried until she was practically a senior citizen to maintain her benefits.

"I have met a wonderful man who has become a partner to me and a 'bonus dad' to my daughters. He is exactly what my husband would want for the four of us. I dream of the day when I can marry him. I am a Christian and believe that God provided this amazing man to be my husband. I was pulled aside several times by my church leader and told that if I didn't marry him or kick him out of my home, I would lose my ability to volunteer in the church. This ultimately pushed me away from my church and severed important friendships in my support system. I am being forced to make a choice to put aside my religious beliefs to maintain my income.

"Even after all this, he is willing to wait until we are in our late 50s to marry me. I should never have been put in a position to have to ask that of him. Especially when a service member can get divorced, and, if the couple was married for a certain length of time, the spouse will receive as much as half of the service member's retirement. That same spouse can remarry and receive their share of the retirement. It is unbelievable that this is not the same for me.

"It appalls me that my country would ask me to give up my financial independence to get married. We are talking about a small portion of the population of the United States that has sacrificed so much.

"If you are willing to vote 'yes' on a bill to send people to war, you should also hold responsibility for the catastrophic effects of war and serving. It should be a reminder of the cost of war. Continuing to pay these benefits after remarriage is a small price to pay to take care of the families of our fallen. If you are concerned about the cost of supporting survivors, stop asking men and women to give their lives."

Kaanan Mackey Fugler, Surviving Spouse of SSG Matthew Mackey of Louisiana, U.S. Army National Guard

"My first husband, SSG Matthew Mackey, on his last deployment, wrote our children each a 'what if' letter. In those letters, he tells my children that he wants me to find someone to pick up our broken pieces and love them when he is unable. Due to an archaic law, Congress has made our futures all about ways that we can lose our earned benefits. When my spouse died, every hope and dream for OUR future was shattered in a moment.

"Most military widows spent years staying at home to take care of the homefront, while our spouses left for months to a year defending our nation. Our education and job experiences often lacked beyond measures to civilian spouses, due to employment gaps from moving or being unable to afford child care. Those gaps in education and employment will affect our earning potential, whether we remarry or not. That gap is where our death benefits are supposed to come in. We are told to find a new 'normal,' while simultaneously hearing, 'Don't remarry, you will lose everything.' I would have had to wait another 35 years to remarry to be able to keep my survivor benefits that we earned — that is half of my life that the government believes I should be alone.

"Had my deceased husband been a police officer, here in Louisiana, instead of a member of the military, I wouldn't have been in this situation. Their survivors are allowed to keep their benefits and pensions, whether they choose to remarry or not. A piece of paper will never make me less of a military widow. It doesn't take away from the 12 years spent sacrificing my own employment while he served, nor the 12 years after his death spent raising our broken family. I should not have to live in hiding with someone to ensure that the government doesn't take away my earned benefits, because I chose not to wait another 35 years for the government's blessing to be able to remarry and keep them. All we ask for is the freedom to choose how we pick up the pieces of our broken lives, and to be able to move forward without being told we must spend half our lives alone first!"

Kellie Hazlett, Surviving Spouse of Capt Mark Nickles of Colorado, U.S. Marine Corps

"My husband, a United States Marine Corps F-18 pilot, died in a training accident while deployed to Japan in 1997, on my 30th birthday. He is still considered Missing in Action because they were never able to recover his remains. I had to move out of our home in San Diego within six weeks of his death because I could not afford to maintain the payments on our rental without his paycheck, so I moved back home to be a caregiver

to my mother. I could no longer continue my career in the medical field due to the trauma of losing my husband and had to start over.

"Eventually, I met my now husband, Steve, but I hesitated to remarry, as I was dependent on the financial benefits that helped offset my own lost income as a military and surviving spouse. Mark and I never had the chance to start a family, and it was important to me that when Steve and I did, that we were legally married. We now have three beautiful children.

"I was recently diagnosed with a long-term illness, and my treatments are not covered by insurance, as they are viewed as experimental. Restoring my survivor benefits that Mark and I paid into would go a long way in helping offset the very expensive costs of my treatments. As I am 57 years old, I could divorce Steve, reinstate my benefits, and remarry him the next day because of the arbitrary remarriage age of 55. This is something that I have seriously considered, due to the unfair penalty."

Rebecca Morrison Mullaney, Surviving Spouse of CPT Ian Morrison of North Carolina, U.S. Army

"Ian was a West Point graduate and Apache helicopter pilot. We were married at 21. He returned from a deployment to Iraq in 2012 emotionally wounded and in dire need of help. Despite our every effort, the help eluded him, and he died by suicide three months later. At 24, I came home from a night grad school class to find my husband dead in our bedroom. I was left to navigate the hardest days, weeks, and months without my partner — moving from our home, losing my job, burying my beloved husband, managing his affairs, and trying to figure out how to keep living.

"I write this 10 years to the day after Ian's death. I am remarried, running my private trauma therapy practice serving veterans, and, most importantly, a new mom with a son that my husband and I named after Ian. For the past 10 years, I have scraped myself off the floor and worked tirelessly to try and save lives. I could not have done this without Ian's benefits. The small portion of the education benefits I was able to use before remarrying helped me complete another graduate degree, one that would allow me to practice clinically. The monthly stipend allowed me to attend therapy daily and get my own PTSD under control. The health care benefits also granted me peace of mind.

"My journey has been supported and enabled by the man now standing beside me, my husband Brennan, an Army veteran and fellow West Point graduate. The wording of the current law leaves us both insulted. I do not believe that we can accurately assign a monetary value to love or to the life shared between two people. Having fully loved and been married to two men, I can confidently say that both are lifelong commitments. Ian is a part of our daily life; we talk about him and miss him constantly.

"Additionally, proposing that widows wait 10 to 20 years to remarry suggests that we would need to put our lives on hold, lives that, for so many of us, drastically changed at extremely young ages.

"I implore you to shift your lens on this issue. Instead of focusing on what widows could receive, consider what they could DO if we supported them in the way their deceased service member was told we would."

Linda Ambard Rickard, Surviving Spouse of Maj Phil Ambard of Massachusetts, U.S. Air Force

"I became a widow just before my 50th birthday when my husband of 23 years, Major Phil Ambard, was killed in Kabul, Afghanistan, in a mass shooting that left eight airmen and one civilian dead.

"For over two decades, we moved every two to four years. While I had multiple master's degrees and a teaching license, I never progressed beyond probation or provisional status in my jobs because we were never in any one place long enough. I never got too attached to a home, people, or a job because everything was so temporary. When I became a widow, I didn't know where to move. I hadn't lived back home in Idaho since 1979. I was too old to go live with my mom and dad, and too young to live with my children, four of whom were in the military. It took me years to get my feet on the ground.

"I didn't date for many years because I just couldn't. At 57, I met the man who would become my husband. I married him just after my 60th birthday. While I maintain my survivor benefits and survivor social security, due to my age, I had to give up TRICARE even though I now qualify for CHAMPVA. It is ridiculous that younger widows/widowers lose everything with remarriage; there is a big difference with the magic age of 55."

Melissa Blackburn, Surviving Spouse of CW2 Philip A. Johnson Jr. of Alabama, U.S. Army

"I lost my husband, Chief Warrant Officer 2 Philip A. Johnson Jr., when he was killed in action while serving as a medical pilot. His aircraft was shot down by an RPG while transporting wounded service members, and five patients aboard also lost their lives that day. One moment, I was a military wife building a future with the man I loved, and the next, I was a widow learning how to survive a loss I never imagined.

"My husband devoted his life to serving others and believed deeply in the system he served. We talked about the risks of his job, and he trusted that if anything ever happened to him, I would be taken care of by the survivor benefits promised to military

families. Because of that trust, he chose not to carry Servicemembers' Group Life Insurance. He believed his country would honor his sacrifice by caring for his family.

"At age 31, while serving as a staff sergeant in the U.S. Air Force, I remarried while I was in the middle of nursing school. My new husband was younger and still in college, and I was working to build a stable future for our family. We also welcomed a baby because I did not want to miss my chance to have children and build the family we dreamed of. As a Christian, I believe in rebuilding my life with faith, love, and hope after loss.

"Instead of support, I lost my survivor benefits the moment I remarried. I was financially punished for choosing to heal, to love again, and to continue living. I was forced to learn that the benefits my husband believed would protect me were conditional on my remaining a widow. No surviving spouse should ever be placed in a position where they must choose between love and financial security. Our fallen service members went to war believing their families would be cared for. Their widows should not have to pay again for their sacrifice."

Caroline Lawrence, Surviving Spouse of LCpl Kevin O'Neill of Maryland, U.S. Marine Corps

"I lost my husband of 12 years, Kevin O'Neill, on Aug. 1, 2022. My husband was part of the first wave into Iraq, fresh out of high school. Assigned to aviation ordinance, he spent the majority of his military time working with bombs and explosives. It was this exposure that led to Kevin, almost two decades later, developing a rare choroidal melanoma that metastasized to his spinal cord. Kevin lost his ability to walk, then to swallow, then to control his arms, and finally, to breathe. Our daughters were 6 and 8 years old at the time. Between Social Security and DIC, we were able to stay afloat, but Kevin didn't have substantial life insurance, and I never stopped working.

"We discussed when he got sick how important a father is to children, and that if the worst happened to either of us, the other should try to remarry to someone who would make our spouse proud; Tamp Lawrence is that man. I met him even before I knew Kevin, as we were pen pals while he was piloting Blackhawks in 2005 for the Army in Afghanistan.

"In July of 2024, Tamp asked me to be his wife and to help continue to raise Kevin's and my daughters. We then had to decide which of Kevin's final wishes to uphold: to provide for his family, or, his highest priority, ensure his daughters had a father. On June 20, 2025, Tamp and I chose the latter, though it was a choice that I felt unfairly devalued my marriage to Kevin and the promise this country made to his memory."

Tonya Syers, Surviving Spouse of W4 Lowell Syers II of Georgia, U.S. Army

"My husband, Lowell, enlisted in high school via the delayed entry program. We met at Fort Campbell, Kentucky, and married six months later. After multiple moves, he decided to join the National Guard, and we moved to California. He retired after 20.5 years. In May of 2019, we watched my son graduate from the University of Georgia and be commissioned into the U.S. Army Reserve. My husband gave him his first official salute. It was a very exciting moment, but the next day Lowell asked me to take him to the emergency room. Instead of celebrating Jake's graduation, we found out Lowell had stage 4 glioblastoma from exposure to the burn pits while deployed. By the end of July, it took his life.

"Eventually, I met a gentleman named James 'Jay' Matheson. He also retired from the Reserves. We got engaged. I was shocked to learn that remarrying before the age of 55 would cause me to lose my military benefits. Jay's ex-wife was granted half of his Navy retirement. She is free to remarry without any financial loss. Why does the government allow divorcees to keep military pensions but punish military widows? I am not in any way telling the government to rescind ex-wives' court-appointed portions of military pensions. I am only saying that it is morally wrong not to offer military widows the same option to remarry without financial penalty.

"The most pro-family and pro-military decision Congress could make is to change this law! Lowell served over 20 years and never collected one cent in retirement. He died, like most, too early due to military service. We would gladly trade our benefits to have our spouses back. Unfortunately, we do not have that option."

Gabriel Booker, Age 12, Surviving Son of MA1 Corwyn Booker of Virginia, U.S. Navy

"Imagine a world where men and women live happily married together, and we can make that happen with enough effort. Think of it, there are countless men and women out there that cannot get married again and millions of children out there that need a father/mother figure in their lives.

"Unfortunately, now if they get remarried, they will lose all their spouse's earned benefits. So, with passing the Love Lives On Act, we can change countless lives and make a positive difference in the lives of many military families.

"Help us change this law and bring many service members together. Not being able to get married can often prevent couples from feeling secure and legally protected. Many people often suffer from depression or in some cases take their own lives. Preventing that is very important. If my mother wants to get married, I would have to wait 7 years,

until I am 19 years old for my mother to get remarried and my family does not want that to happen.

"So please help me, my family and many others by passing this bill, only then can we say Love Lives On."

IMPROVE DEPENDENCY AND INDEMNITY COMPENSATION FOR SURVIVING SPOUSES

TAPS remains committed to improving Dependency and Indemnity Compensation (DIC) for surviving families and providing equity with all other federal survivor benefits. We continue to work with Congress to:

- Pass the ***Caring for Survivors Act of 2025*** **(S.611, H.R.2055).**
- Pass the ***Sharri Briley and Eric Edmundson Veterans Benefits Expansion Act of 2025*** **(H.R.6047).**
- Increase DIC from 43 percent to 55 percent of the compensation rate paid to a 100 percent disabled veteran, in parity with all other federal survivor programs.
- Reduce the time frame a veteran needs to have a permanent and total (P&T) disability rating from the VA from 10 to five years to assist families who have become caregivers for their disabled veteran, and to allow more survivors to become eligible for critical DIC benefits.

Dependency and Indemnity Compensation (DIC) is a tax-free benefit paid to eligible surviving spouses, dependent children, or dependent parents of service members who die in the line of duty or veterans whose death resulted from a service-related injury or illness.[4] According to the VA, approximately 530,085 surviving spouses receive DIC.

The current monthly DIC rate for eligible surviving spouses is $1,699.36 (Dec. 1, 2025)[5] and has only increased due to Cost-of-Living Adjustments (COLA) since 1993. TAPS is working with Congress to raise DIC from 43 percent to 55 percent of the compensation rate paid to a 100 percent disabled veteran, in parity with all other federal survivor programs; ensure the DIC base rate is increased equally; and protect added monthly amounts, like the eight-year provision and Aid and Attendance.

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[4] https://www.va.gov/family-and-caregiver-benefits/survivor-compensation/dependency-indemnity-compensation/

[5] https://www.va.gov/family-and-caregiver-benefits/survivor-compensation/dependency-indemnity-compensation/survivor-rates/

TAPS supports the ***Sharri Briley and Eric Edmundson Veterans Benefits Expansion Act of 2025*** **(H.R.6047),** introduced by Congressman Tom Barrett (R-MI-07) and Chairman Mike Bost (R-IL-12) and 10 original co-sponsors. This important legislation would increase Special Monthly Compensation (SMC) for our catastrophically disabled veterans by $10,000 annually, and would increase DIC for over 500,000 survivors by 1 percent the first year and 0.5 percent the second year, in addition to the yearly COLA inflation adjustment.

This marks the first time in over 30 years that DIC would be increased beyond COLA. Although this bill would raise the DIC monthly payments only slightly, TAPS greatly appreciates the House Veterans Affairs Committee working to improve DIC and increase the base rate equally for eligible surviving spouses of veterans who died before or after Jan. 1, 1993.

During the House Veterans Affairs Committee markup on Feb. 12, 2026, we were gratified that the bill passed out of committee. TAPS also appreciated the outpouring of support from both majority and minority members for the importance of this program and the need to strengthen DIC further going forward. Increasing DIC, in parity with all other federal survivor programs, is long overdue and imperative to the financial well-being of our families of the fallen.

TAPS and the survivor community have been working to strengthen survivor benefits for many years, especially for military survivors who only receive DIC and Social Security payments. Together, we continue to push for the passage of the bipartisan ***Caring for Survivors Act of 2025*** **(S.611, H.R.2055),** introduced by Ranking Member Richard Blumenthal (D-CT) and Senator John Boozman (R-AR) and Representatives Jahana Hayes (D-CT-5) and Brian Fitzpatrick (R-PA-1).

This important legislation would increase DIC from 43 percent to 55 percent or $454 a month, providing long-overdue parity with other federal survivor programs. It would also reduce the time frame a veteran needs to be rated totally disabled from 10 to five years to assist families who have become caregivers for their disabled veteran, and to allow more survivors to become eligible for DIC benefits.

Unfortunately, the Congressional Budget Office (CBO) score for DIC legislation has increased exponentially after the passage of the ***PACT Act*** **(Public Law 117-168)**. The VA estimated there were potentially 382,000 survivors who may be eligible for PACT-related benefits: 146,000 potential DIC claims based on previously denied deceased veterans' claims and 236,000 potential DIC claims based on previously denied survivors' claims.

During a meeting with the VA, TAPS was informed that because the VA does not track cause of death, the potential 382,000 PACT Act-impacted survivors included all manners of death — those who died of natural causes, age-related conditions, by suicide, or in car accidents — not just those filing claims related to toxic exposure. This helps to explain why, after extensive outreach by the VA and organizations like TAPS, to date, only 44,576 survivors have applied for PACT-related benefits.[6]

TAPS believes the VA's potential survivor numbers have informed CBO scoring of survivor legislation, including the ***Caring for Survivors Act, Sharri Briley and Eric Edmundson Veterans Benefits Expansion Act of 2025,*** and the ***Love Lives On Act,*** almost doubling the cost and making it difficult to find funding with broad support from the veteran, military, and survivor community for these important bills impacting critical DIC benefits.

Increasing DIC benefits for our surviving families remains a top priority for TAPS and The Military Coalition (TMC), which consists of 35 organizations representing more than 5.5 million members of the uniformed services — active, reserve, retired, survivors, veterans, and their families. TAPS currently serves as a TMC Vice President.

The following statements from survivors demonstrate how stringent limitations on critical DIC payments continue to have negative financial and widespread impacts on housing, employment, transportation, food security, and medical and mental health care for surviving families. They also illustrate the long-overdue need to improve these earned survivor benefits:

Jean Gibbs, Surviving Spouse of CW3 David A. Gibbs, U.S. Army

"My husband, Chief Warrant Officer 3 David Gibbs, proudly served our nation for 18 years in both the U.S. Marine Corps and the U.S. Army. He was killed in a helicopter crash in Kosovo in 1999 while serving his country. At the time of David's death, our children were just 10, 8, and 6 months old. Overnight, I became both mother and father, raising them alone while carrying forward David's legacy of service and love.

"Because David's death occurred before 9/11 and before reaching 20 years of service, I do not receive his military retirement. My focus for many years was on raising our children — ensuring they had the stability and opportunities David would have wanted for them. But as a result, I had little ability to plan or save for my own future.

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[6] https://department.va.gov/pactdata/wp-content/uploads/sites/18/2026/01/VA-PACT-Act-Dashboard-Issue54_012326_v9-508.pdf

"Today, surviving spouses like me receive only 43 percent of what a 100 percent disabled veteran would receive, while civilian federal survivors receive 55 percent. The Caring for Survivors Act of 2025 would close that gap, adding about $454 per month in benefits. For me, that isn't just a number — it represents security, dignity, and peace of mind as I grow older after 26 years of sacrifice and perseverance.

"In addition, the Sharri Briley and Eric Edmunson Veterans Benefits Expansion Act of 2025 would provide a much-needed increase to survivor benefits. This would be the first non-cost-of-living increase since 1993, helping surviving families like mine keep pace with today's economic realities. Passing this legislation would be a meaningful step forward, but true parity will only come when survivors receive the full 55 percent that other federal survivor programs provide."

Julie McAdoo, Surviving Spouse of Maj Kevin McAdoo, U.S. Air Force (Ret.)

"My name is Julie McAdoo, and I am the surviving spouse of Major Kevin McAdoo, U.S. Air Force (Ret.). I am also the child of retired USAF Senior Master Sergeant Dennis Nealson, a USAF veteran myself, and now the proud mother of a New Hampshire Air National Guard member. I am asking you to support increasing Dependency and Indemnity Compensation (DIC) from 43 percent to 55 percent of the compensation a veteran would receive if rated 100 percent disabled.

"As a military spouse, I left my own career in the Air Force to support our family, sacrificing years of career advancement, retirement contributions, and Social Security credits. This has left me financially behind my peers who maintained consistent careers. I don't regret choosing to serve my family over fulfilling my career potential, but those lost years created long-term financial consequences that only became significant when Kevin died unexpectedly at the age of 49, leaving me a widow at 44 with two daughters aged 11 and 13.

"Losing Kevin was the most devastating event of our lives. His death upended every plan our family had for the future. We had just relocated for his career to a new state thousands of miles away from family and friends, and purchased the most expensive home we'd ever owned. The month after he died, our household income dropped by 40 percent. We lost all of his income and half of his military retirement, while our expenses — mortgage, insurance, utilities — remained unchanged. In the months that followed, I set aside my career again to care for our grieving children. I left two well-paying jobs over the past five years because they didn't allow the flexibility I needed to help my children recover and thrive after their father's death. That decision further reduced our income by 40 percent, which compounded our financial vulnerability. Like many surviving spouses, I have repeatedly prioritized my family's stability and well-being over financial gain.

"DIC has been a lifeline. Without it, we could not have remained in our home. DIC helps me cover basic needs — utilities, dental care for my daughters, and essential home repairs. However, the current DIC rate, set at only 43 percent of the compensation a veteran would receive if totally disabled, does not adequately reflect the loss of a family's primary earner or the lasting financial impact of military service and sacrifice. I have to defer home maintenance and even my own dental and medical care to meet our family's needs. There are parts of our home we just can't use, like the living room in winter, because we can't afford to fix our fireplace.

"As my children age out of benefits and our support decreases, the inadequacy of the current rate becomes even more pronounced. When my oldest turned 18, we lost $409 per month in DIC alongside her Social Security benefit, even though she still lives at home while attending school. These reductions make it increasingly difficult to maintain stable housing, afford rising utilities, address deferred home maintenance, cover health and dental costs not provided under TRICARE, and support my daughters through college and into adulthood.

"Raising DIC to 55 percent would not be a handout; it would be a correction. Other federal survivor programs — such as those administered by the Department of Justice and the Department of State — provide benefits at 55 percent of the comparable rate. The current disparity undervalues the service and sacrifice of those who gave their lives for our nation and the families who supported them during that service. DIC is not charity, it is an earned benefit, grounded in the promise our nation makes to those who serve and their families."

Nancy Mullen, Surviving Spouse of WO1 Sean Mullen, U.S. Army

"My name is Nancy Mullen, and I am the surviving spouse of WO1 Sean Mullen, who was killed in action (KIA) in 2013. We met when I was 28 and married at 29, and by that time, I already had a college degree, my Certified Public Accountant (CPA) license, and was a couple of years into my career. My brother was active-duty Army, but I have to say, I still had no idea what I signed up for!

"Throughout the next few years, we moved several times — including a short-notice move to Fort Campbell, Kentucky, as my husband transitioned from Army infantry to special forces selection and trained as a medical sergeant. After several moves and four jobs later, I gave up my own defined benefit pension at my initial job and was finally able to just partially vest in the employer match portion of my own 401(k). Getting promotions was difficult, as the topic of 'How long do you think your husband will be here?' would often come up in informal conversations. After all, who would want a partner or accounting leader who may have to resign in a couple of years? Honestly, I hate to say I understand the hesitancy. There is no doubt that being an Army wife

impacted my own retirement and slowed my career trajectory as I moved to support him and his career. But it is what we do, and he was worth every bit of it. I'd do it all again.

"When I lost Sean and learned about the benefits, I was honestly appalled. I had a degree and experience in a stable field and could support myself…but what about others? Even in my situation, I was concerned about my financial well-being after losing the majority of his income and the future military pension he would have received. Sean's teammates were shocked and angry to learn how inadequate the benefits were, as they had always been told — and believed — that our country would take care of their families should they make the ultimate sacrifice.

"There have been several improvements to our benefits since 2013, and I am thankful for those who stood up and championed our cause. But we can and should continue to do better. Raising DIC to 55 percent, bringing it in line with other federal survivor benefits, is the right and equitable thing to do. To continue to let our benefits lag behind those of other federal employees' survivors dishonors not only our fallen and their families, but I truly believe dishonors those currently serving.

"What message does that send to our service members who put their lives on the line and often go months without their families, miss holidays and births, work tirelessly in unsafe conditions in foreign countries, and continuously train in order to be ready to defend all of us? How much is your freedom worth? We are the price of war. We are the price of having a strong and capable military. We can do better."

Michelle Fitz Henry, Surviving Spouse of SCPO Theodore Fitz Henry, U.S. Navy

"I am the surviving spouse of a career service member who died in the line of duty, and I am also a retired public safety officer (PSO). I had only four and a half years on the job as a firefighter/paramedic when my husband died. The survivor benefits I could have provided to my husband, a 21-year career Navy SEAL, far outweigh the survivor benefits I receive.

"It is well past time the gap be addressed. Public safety officers and military service members both face significant risks, but military service is global, constant, and often requires long periods of time away from their families due to multiple deployments. The disparity between what is paid to survivors of PSOs and the families of our nation's fallen sends a bad message to both the service members and the families that love and support them.

"COLA does not keep pace with inflation and hasn't for over 30 years since DIC was last evaluated in 1993. Health care costs, like Medicare premiums, have risen at a faster rate than COLA. The inadequacy of DIC only being corrected for a Consumer

Price Index (CPI)-driven cost-of-living adjustment can force survivors to dip into savings sooner and cut back on spending for things like medications and groceries.

"I appreciate the Sharri Briley and Eric Edmunson Veterans Benefits Expansion Act of 2025, which would modestly increase DIC, but I remain committed to working to increase DIC to 55 percent in line with federal worker survivor programs to help bridge the huge gap between PSO survivor benefits and military survivor benefits. I ask that the service of our military members be recognized and valued as that of our public safety officers and their families. The loss of life in service to our nation should be valued equally, whether that uniform is military or civilian."

Katie Hubbard, Surviving Spouse of CSM James Hubbard Jr., U.S. Army

"Due to my husband's status at the time of his death, the only financial benefit we are eligible for is DIC. Command Sergeant Major (CSM) James W. Hubbard Jr. died May 21, 2009, while in treatment for leukemia caused by the burn pits in Iraq. Having your income cut by more than 60 percent while trying to navigate funeral costs, bills that aren't stopping, and unexpected ambulance and ER charges nearly took me out, too.

"My mental health was not conducive to returning to the workplace quickly after being his caregiver and dealing with the unexpected loss, yet I had to figure out something to make up the income or lose our home too. My future, my best friend, and my normal were gone.

"While a 12 percent increase doesn't seem like much, any widow living paycheck to paycheck can tell you it is. The military is a federal entity, yet its survivors are treated less than. Passing the Caring for Survivors Act would show military widows that their spouses and they are cared for and not forgotten."

Sylvia Pierson, Surviving Spouse of CAPT Brett M. Pierson, U.S. Navy

"When I lost my 58-year-old husband to military service-connected brain cancer in August 2024, I could not have anticipated that it was the first of two blows in a massive one-two punch that irreparably changed my life. Indeed, a mere nine months after I lost the love of my life, my employer announced that they were eliminating my job.

"Those blows to my heart — and my financial security — were no joke. Now, not only would I be navigating life without my husband of 37 years, but I would also be trying to find a job and secure medical benefits as a 59-year-old in a tough job market while trying to live on Dependency and Indemnity Compensation (DIC) that amounts to less than five percent of what my husband and I had been earning. While I'm grateful to have money coming in, relying on an earned benefit that amounts to only 43 percent of

a 100 percent disability rating solidly ranks my income at below the poverty level, places me in a financially precarious situation, and makes me worry about what will happen to me in the future if I ever have to figure out how to pay for costly assisted living.

"When my husband died, he had faith that the survivor benefits he had earned throughout his 30-year career would take care of me. I cannot imagine his heartache and worry if he were to know that not only is DIC paid out at 43 percent — rather than the 55 percent paid out across other federal survivor benefits — but that our life spent serving our nation across 19 moves would render it more difficult for me to find a job. After all, military spouses who have to move every two to three years are never able to fully climb the corporate ladder and attain the financial and retirement security that civilian spouses are able to achieve.

"Aligning DIC to the 55 percent that is standard in the civilian sector would not only achieve much-needed parity but would go a long way toward honoring our military families who sacrifice so much for our nation. This slight increase would also enable our bereaved families to worry just a tiny bit less about their financial security while they also navigate their new lives and figure out how to maintain their security, dignity, and sense of self."

Melissa M. Dunczyk, Surviving Daughter of SP4 James N. Gehrke, U.S. Army

"On Sept. 27, 2024, I stood by mom's side at James A. Haley Veterans Hospital in Tampa, Florida, as we received my father's devastating diagnosis, stage 4 pancreatic cancer. My last conversation with my father, just days before he passed on March 23, 2025, was about a promise: I would personally follow through with Mom's claim for Dependency and Indemnity Compensation (DIC) and, more importantly, continue to advocate for the rightful increase to ensure Mom would be taken care of.

"It pains me that she faces the emotional anguish of this significant loss, along with the financial strain of having her Social Security benefits reduced and her caregiver pay ceasing 90 days after my father's passing. We were fortunate that her DIC application was approved within three weeks, and it was one less thing to worry about.

"The approval reduced my father's benefits to 43 percent. This is 12 percent lower than the 55 percent compensation rate provided for federal survivors. My father was not 'less than' any other federal employee; he was equal. He, like many other Vietnam veterans, was drafted — he was not given a choice but did his service. Raising the DIC rate to 55 percent is not an act of charity, but an act of equality that ensures veteran survivor benefits are finally made equal to those of other federal survivors.

"My mother, like many other seniors and widows, lives on a fixed income. The rising cost of daily life — from essential medications, utilities, groceries, and even supplemental insurance premiums — has made some choose what to pay each month. This modest increase in DIC would alleviate these constant financial stressors, providing a foundation of stability and dignity. It is profoundly unsettling and painful to recognize that there has been virtually no adjustment to the DIC rate since 1993, aside from standard cost-of-living adjustments.

"As a daughter, I made a promise to my dying father. But this fight is larger than that promise. Changes are urgent and needed now for Mom, for Kimberly, for Erin, for Janet, for Sue, and countless others I have met. This increase is about supporting the loved ones left behind, who deserve the financial security and recognition, and who supported their service members from the day they signed on the dotted line. This increase shows the survivor community the respect and dignity they deserve as their loved ones' service was not in vain."

Heather Welker, Surviving Spouse of SSG Mark Welker, Missouri National Guard

"My husband loved this country and gave it 21 years of his life. During those years, he would always tell me, 'It's for our future.' So his career was the priority, which took time away from family. It was supposed to make retirement years easier for us, or so we thought.

"In October of 2022, he was diagnosed with cancer, and the tumor was in a location that had no possibility of surgery because of organs and arteries. It also denied him the ability to continue working, so he was granted disability. I soon had to leave my employment of 18 years to be his caregiver.

"Fast forward to March 5, 2024, that morning my husband died from his service-connected cancer. We were robbed of our golden years together. I have not been able to find employment comparable to what I had before, plus the loss of any income he provided through disability. The increase in DIC to 55 percent of the single disability rate would allow breathing room. I would not be looking for a second job at the age of 54."

Janet Albaugh, Surviving Spouse of SP5 Rick Albaugh, U.S. Army

"There needs to be a change in the way DIC is allowed. It's not the fault of the veteran that they couldn't live until the 10-year rule! My husband did two tours in Vietnam, and he was sprayed with Agent Orange. He had everything wrong with his respiratory system known to man.

"It's just not fair that we don't get any help because our veteran died too soon! Believe me, ALL widows would rather have our husbands still here with us. It's a real hardship to try and hang on to what we fought so hard to build. Is it really fair that we not only lose our husbands, but we lose everything else, too? They fought for our country and did ALL they were asked to do!"

Harry McNally, Surviving Spouse of SGT Shanna Golden, U.S. Army

"Increasing the amount of DIC to levels identical to other federal survivor benefits should have been done decades ago. As it stands, the implication is that the death of a veteran or service member is worth less than the death of other federal employees."

PROVIDE CHAMPVA HEALTH COVERAGE FOR YOUNG ADULTS

TAPS is working with Congress to:

- Pass the ***CHAMPVA Children's Care Protection Act*** **(S.605, H.R.1404)** in the 119th Congress to ensure surviving families with young adults have access to affordable health care and mental health benefits.

The ***Affordable Care Act*** **(ACA),** signed into law in 2010, allows young adults to remain on their parents' health care plans until age 26 without a premium increase. This rule applies to all plans in the individual market and to all employer plans. However, it does not extend to veteran families with young adults under the Civilian Health and Medical Program for the Department of Veterans Affairs (CHAMPVA). Young adults using CHAMPVA are currently no longer eligible for coverage when they turn 18, or 23 if they are a full-time student.

TAPS is actively working to expand CHAMPVA coverage for eligible surviving children up to age 26. We strongly support the reintroduction of the ***CHAMPVA Children's Care Protection Act*** **(S.605, H.R.1404)**. TAPS greatly appreciates Ranking Member Blumenthal (D-CT) and Congresswoman Julia Brownley (D-CA-26) for their leadership on this issue.

This important legislation is endorsed in the 119th Congress by 43 veteran and military organizations and stakeholders, to include TAPS, along with our colleagues in The Military Coalition (TMC), representing 5.5 million members of the uniformed services — active, reserve, retired, survivors, veterans — and their families.

Allowing young adults to remain eligible for medical care under CHAMPVA until their 26th birthday will bring the program in line with private insurance plans and the Department of Defense TRICARE Program. Those eligible would include adult children under the age of 26 of veterans who:

- Died from service-connected disabilities
- Rated permanently and totally disabled for service-connected disabilities
- Were totally disabled from a service-connected disability at the time of their death

Although not under the Veterans' Affairs Committee's purview, TAPS is also working to pass the ***Health Care Fairness for Military Families Act of 2025***, which would allow TRICARE young adults to remain on their parents' policy up to age 26 without a premium increase. This legislation, combined with the ***CHAMPVA Children's Care Protection Act***, will ensure our surviving military and veteran families have affordable access to critical health care and mental health benefits.

Surviving families, who have lost their loved ones as a result of military service, are often at higher risk and in need of behavioral and mental health care. Children of surviving families are highly susceptible to mental health issues and trauma due to multiple deployments, frequent moves, or the loss of a parent. Gaps in health care deprive these young adults of proper mental health services and support systems. CHAMPVA, which offers mental health care support, is essential to the overall well-being of our surviving families.

Unfortunately, young adult survivors who do not pursue a college education, attend part-time, graduate early, or take a gap year lose their CHAMPVA benefits or feel the pressure to attend college full-time to avoid high premiums, all while navigating grief. Many young adult survivors were also impacted by the COVID-19 pandemic and have found it difficult even now to find full-time employment in a challenging job market. These young adults and their families cannot afford expensive out-of-pocket health care costs and should not be uninsured. Surviving families with young adults should be provided the same affordable access to health care and mental health care as civilian families under the protection of the ACA.

TAPS wholeheartedly agrees with Congresswoman Brownley's statement that, *"It is unacceptable that the children of those who sacrificed the most for our country do not have the same health care protections provided to other families under the Affordable Care Act."*

TAPS will continue to work with Members of Congress and fellow VSOs to pass the ***CHAMPVA Children's Care Protection Act***. Surviving families of our nation's veterans deserve nothing less.

The following survivor statements illustrate the importance of expanding CHAMPVA coverage for surviving children up to age 26 in parity with civilian healthcare plans:

Anita Sullivan, Surviving Spouse of CE3 Michael Sullivan, U.S. Navy

"Our oldest son was 15 when his dad died — a sophomore in high school on track to likely play college baseball and begin taking college classes that fall as a high school junior. His dad's suicide death impacted everything and has made for a long journey of healing.

"Drew did enter college that fall, at an exceptional and demanding school. He changed majors and took a semester off to help care for his ill grandmother, as loss changed his priorities, and later was forced to take another semester off for his own recovery after a very severe car accident. He is behind a typical college student plan and will not be ready to provide his own insurance at 23, especially because of his life experiences. If he wasn't a surviving child on CHAMPVA, he would have it until 26, and the unfairness is adding to the loss."

Kaylee Hughes, Surviving Daughter of MAJ Gary G. Hughes, U.S. Army

"I just turned 23 years old, and I am the Gold Star daughter of the late Army Major Gary G. Hughes. My dad passed away Feb. 28, 2018, when I was 16 years old, a junior in high school. Upon my high school graduation, I attended the University of Tennessee at Chattanooga (UTC), where I obtained my bachelor's degree.

"I have had numerous health problems since losing my dad. Mainly a back injury while training in Fort Knox for UTC's Army ROTC program, which ultimately turned into the downfall of that career choice. Afterward, I have had multiple appointments with doctors, nurses, therapists, and surgeons about this ongoing issue that affects me to this day. During these intense years of schooling during the COVID pandemic, I kept good grades and even went to school during the summer months, knowing the importance of keeping health insurance.

"The day I graduated from college, all insurance and benefits halted. I have applied to full-time jobs that contain benefits, but have been consistently turned down after the interview process by someone who has had more time in the field. How am I supposed to get a full-time job with benefits when I don't have experience yet? I then got two part-time jobs in the Williamson County School District to gain some experience in the field, but they offered no medical benefits.

"In February 2024, I had a cyst grow on my lower back, restricting my ability to sit, lie down, and eventually walk. Because I did not have any type of insurance, I limited myself to what treatments I could afford. I went to urgent care three times in the span of three days and was directed to go immediately to the emergency room. Once again crying in excruciating pain and knowing I could not afford to burden my family, I made

my way to Williamson Medical Center in Franklin, Tennessee, and now must pay over $25,000 in medical bills. I just started grad school at Middle Tennessee State University (MTSU) and asked for support from TENCare, but was denied.

"If it were not for my father's coffin being draped with the American flag, I would have been on a parent's insurance until age 26. I am being punished because my father, who served our country for over 20 years, was killed. I have no option but to suffer the consequences our laws have made without keeping dependents like me in mind."

Jessica Byrd, Surviving Spouse of LCpl John Bryd, U.S. Marine Corps

"John was proud to be a Marine, husband, and father. He had plans to serve his entire life and show my son the ways of the Marine Corps. I was pregnant when John was killed in action serving in Operation Iraqi Freedom; we were both 23 years old. As the only parent to Elijah, I was a stay-at-home mom who dedicated my entire life to his schedule and well-being. I am currently in the process of building a career for myself, but am unable to provide for his health care.

"After 20 years of sacrifice and the absence of his father, my son has recently learned that he does not receive the same privilege provided to his peers: to remain under his father's health benefits until age 26. Transitioning into adulthood is hard enough for the average human. But now you have a young man coming of age, realizing how much he missed out on having his father in his life. He is finally using his mental health benefits to explore all of his lifelong emotions of missing his father. We only learned recently that, unlike others his age, he only receives his health care until 23, which leaves him as a full-time college student with no health care.

"My hope and request is that the U.S. government provides the children of the fallen the same transitional time on a parent's health coverage as other United States young adults. Thank you."

Kathleen Paden, Surviving Spouse of William Paden, U.S. Air Force

"My husband passed away at age 35, leaving me with a 6-year-old to raise alone. While I was grateful for receiving DIC and CHAMPVA, I think there could definitely be improvements made. My daughter lost her CHAMPVA coverage for health care the day she turned 23, despite being a full-time college student. If she had traditional health coverage on a policy that I had through an employer, she would have been able to stay on my policy until she turned 26.

"I find it completely unfair that a child of a veteran who died as the result of his military service has fewer options than someone who is on a workplace insurance plan. I tried

to get coverage through my workplace so that she could stay on my policy until age 26, but because I have coverage through CHAMPVA, I could not get coverage through my employer."

Sgt. David Glover, U.S. Army (Ret.)

"On July 9, 2023, my 19-year-old daughter was riding in the backseat of a vehicle when it was struck by a drunk driver. She sustained catastrophic head and spinal injuries that required an emergency back surgery and two facial reconstruction surgeries. She spent 16 days in the hospital, half of that time in an intensive care unit. With her jaws wired shut, she left the hospital having to now plan her recovery process, instead of her upcoming semester at the University of Nevada, Reno (UNR). Cognitive therapy, physical therapy, dental, orthodontics, plastic surgery, and neurology — those are some of her new required courses. But she is a strong young woman with a positive outlook, ready to play the hand she was so unfairly dealt.

"If her only insurance was CHAMPVA, it would be at this point where her coverage would end, as she is no longer a full-time student. Without coverage, at 19, she would face a lifetime of medical debt, a lifetime of debilitating injury, and a lifetime of missed opportunity. Thankfully, she is covered under other insurance and will not have to carry this extreme financial burden; she can focus on healing and returning to her classes at UNR. But what about the families that do not have insurance options? CHAMPVA would fail them.

"Our military families are strong and resilient, facing hardships head-on. While on active duty, we have the full support of the Department of Defense; however, upon leaving active service, we face new challenges and lose some of our health care security. When it comes to health care, we don't ask for more than what the current standards are; we just ask to be equal. It is with a humble heart that I ask this Committee to consider the CHAMPVA Children's Care Protection Act. Thank you."

Amanda Lee Pitzer, Surviving Spouse of CPO Larry Pitzer Jr., U.S. Navy

"As a surviving spouse, my primary responsibility is ensuring my children's well-being, security, and future. However, under the current system, my son faces an unfair gap in coverage simply because he is a military child. Unlike his peers whose parents have private or federal employer-sponsored health plans, his health care coverage will disappear if he chooses to work a trade, take a gap year, or follow a nontraditional path before age 26.

"The Affordable Care Act (ACA) ensures that young adults in civilian families remain covered under their parents' health insurance until they turn 26. Yet, surviving military

children — who have already sacrificed so much — are denied that same protection. This disparity leaves surviving families scrambling to find affordable health care for their children at a time when they should be focused on their education, careers, and personal growth.

"If legislation were passed to extend CHAMPVA coverage to surviving children until age 26, it would provide military children the same stability and security that all other young adults are guaranteed. No child should lose their health coverage simply because they lost a parent in service to this country. Providing this extension is not just a matter of fairness — it is a moral obligation to the families who have already endured the ultimate sacrifice.

"Passing this legislation would ensure that surviving children are not forced into financial hardship just to afford basic medical care. It would give them the freedom to explore their futures without fear — whether that means pursuing higher education, entering a trade, or taking time to determine their path. Military children deserve the same level of care and support as their civilian peers, and this legislation is a crucial step toward honoring that commitment."

TREAT SUICIDE AS A PRESUMPTIVE SERVICE-CONNECTED CAUSE OF DEATH AND PRIORITIZE MENTAL HEALTH AND WELLNESS

In 2026, TAPS will continue to work with Congress to:

- Pass the ***Service-Connected Suicide Compensation Act*** **(H.R.2264).**
- Pass the ***Veterans' Assuring Critical Care Expansions to Support Servicemembers (ACCESS) Act of 2025*** **(S.275, H.R.740).**
- Pass ***The Written Informed Consent Act*** **(S.3314, H.R.4837).**
- Prioritize mental health as essential to the overall wellness and readiness for veterans, service members, families, caregivers, and survivors, and advance collaborative suicide prevention and postvention efforts to help save lives.

In 2025, 29 percent of new surviving families coming to TAPS for services were suicide-loss survivors. While this number has decreased from 32 percent in the previous year, the families of suicide loss face massive struggles when it comes to applying for benefits through the Department of Veterans Affairs (VA). While many illnesses are considered presumptive conditions to prevent families from having to prove that the cause of death is related to service, suicide is not a presumptive condition.

Military service exposes individuals to unique stressors and potential traumas. The presumption of service-connection for veteran suicides would acknowledge that the mental health challenges veterans face are often a direct consequence of their service. On active duty, if a service member dies by suicide, it is often treated as a "line of duty" death, and their eligible dependent family members are awarded various Department of Defense (DoD)-related benefits, such as the Survivor Benefit Plan (SBP) annuity. This policy implicitly recognizes the pressures of military life and the potential for these pressures to contribute to suicide. Extending similar benefits to veterans' families would provide a consistent acknowledgment of service connection that does not end when active duty does.

TAPS strongly supports the ***Service-Connected Suicide Compensation Act* (H.R.2264)** and thanks Representatives Michael Lawler (R-NY-17) and Herbert Conaway (D-NJ-3) for introducing this important bipartisan legislation, which would direct the VA to automatically pay Dependency and Indemnity Compensation (DIC) to a survivor of a veteran with a service-connected mental disorder who dies by suicide.

Offering survivor benefits to families post-suicide death does not incentivize suicide, but rather provides comprehensive lifecycle support for service members and their families to seek and receive help. According to the National Veteran Suicide Prevention Annual Report of 2022, the percentage of veterans enrolled in a VA life insurance policy who died by suicide decreased from 9.1 percent in 2005 to 6.3 percent in 2020. Additionally, according to the DoD Annual Report on Suicide in the Military (CY 2022), evidence suggests that strengthening household financial security and fostering supports that address economic challenges and quality of life issues can reduce suicide risk. Strengthening household financial security and knowing their families will not be financially abandoned may reduce the immense stress some veterans feel about their ability to provide for their loved ones.

The presumption that veteran suicide is service-connected and that survivor benefits should extend to their families is not about incentivizing tragedy; it's about recognizing the full scope of sacrifices made by those who serve. It's about honoring their service, providing for their loved ones, and reflecting a society that takes responsibility for its veterans to the very end, including providing support for the aftermath of the ultimate sacrifice.

The following statements from survivors demonstrate the complicated challenges our suicide-loss surviving families face in applying for VA survivor benefits:

Andrea Schaub, Surviving Spouse of TSgt David Schaub Jr., U.S. Air Force

"The biggest challenge I had after my spouse's suicide was my local VSO telling me that it wasn't worth my time and energy. I had to get his death certificate amended to

include additional circumstances. I had to present additional medical records to the county that originally signed off on his death certificate. I had to submit character letters from his battle buddies, friends, and myself, and obtain a Nexus letter.

"I ended up going to a VSO in a neighboring county that believed my claim was worthy and assisted me with the paperwork claim. My children were 9 and 11 at the time of their father's death, and we did not receive benefits for nearly four years."

Brandy Warfel, Surviving Spouse of Sgt Thomas Warfel, U.S. Marine Corps

"My husband struggled deeply the last six months of his life from PTSD related to his two tours in Iraq. After three failed attempts, the father of my two beautiful children took 90 pills for his depression and was on a vent for a week until I had him removed. March will be five years since his death, and June will be five years of me continuing to fight for his DIC benefits.

"The addition of suicide as a presumptive cause of death would not only allow my children access to their father's rightful benefits, but it would honor him for the pain and trauma his service years inflicted on him and me until his last day."

Lisa Davis Renfro, Surviving Spouse of SPC Clarence Hyder, Tennessee Army National Guard

"My husband was two weeks away from his second deployment when he tried to die by suicide twice. The week before he died, he was seen at the VA in Johnson City, Tennessee. He and I both talked separately with the psychiatrist. I asked that he be committed to the hospital for mental evaluation. The doctor told me to call the police if he showed concerning behaviors. Exactly one week later, my husband died by suicide. It took me almost three years of appeals, letters, and calls to finally get our benefits."

Prioritize Mental Health and Wellness

TAPS has been on the front lines of suicide postvention efforts for more than a decade to support military families grieving deaths by suicide, using gained knowledge to save countless lives through suicide prevention efforts. The TAPS Suicide Postvention team developed a research-informed, best-practice **TAPS Postvention Model™** for suicide-loss survivors, decreasing the risk of additional suicides and promoting critical healing.

TAPS has supported nearly 30,000 individuals whose military and veteran loved ones died by suicide. In 2025, 29 percent of those coming to TAPS for care each day were grieving a death resulting from suicide and a life that included military service. TAPS conducts in-depth interviews with each survivor to reflect on their loved one's life before

suicide. One typical pattern identified among thousands of military suicide survivors is the call for the nation and military community to **prioritize mental health care as an essential element to overall wellness and readiness.**

Above all, mental health care needs to be consistent. TAPS survivors relay that the care their service members or veterans received — marked by uncertainty, confusion, and sudden changes — caused them to lose trust in the process. The bonds formed by veterans and providers at the start of the care cycle are critical. Having to retell their difficult stories time and time again to new providers at each visit can be debilitating. Abruptly changing care teams, especially when a veteran becomes suicidal, only heightens the sense of crisis. Familiarity and predictability are keys to effective mental health care.

Veterans are more likely to seek help from an established provider when they feel a sense of safety and trust. Talking about thoughts of suicide with an established provider — when they are not necessarily intent or have a plan for suicide — should be seen as positive in that the veteran is trusting enough to share some of their deeper struggles, and should not be a reason to transfer them to a new team.

Focusing on retaining providers with active caseloads, streamlining record collection and review, and training all personnel to address suicide risk further upstream in the care experience can alleviate this concern.

In addition, increasing timely access to VA community care providers will help improve mental health care outcomes for our veterans. That is why TAPS greatly appreciates Chairmen Moran and Bost for introducing the ***Veterans' Assuring Critical Care Expansions to Support Servicemembers (ACCESS) Act of 2025*** **(S.275, H.R.740).** This important legislation would establish existing community care access standards as the baseline standard of care for veterans seeking care in the community. It would require the VA to notify veterans of their eligibility for care within two business days of the VA becoming aware that the veteran is seeking care. This bill would also standardize the screening process for veterans to help improve access to mental health programs. We urge Congress to pass this critical legislation within the 119th Congress.

TAPS also strongly supports ***The Written Informed Consent Act*** **(S.3314, H.R.4837),** which will help ensure that clinicians are providing all vital information, including risks and side effects, considering all available evidence-based treatment options to each veteran as a means of minimizing or eliminating the potential risk of suicide. This critical legislation was introduced by Senators Tim Sheehy (R-MT) and Tommy Tuberville (R-AL), and Representatives Gus Bilirakis (R-FL-12), Jack Bergman (R-MI-1), and Keith Self (R-TX-3). Ensuring veterans are aware of the potential side effects of high-risk medications will help save lives, and we urge this bill's swift passage.

TAPS believes that identifying issues related to grief and trauma, which need to be treated separately, is essential to providing consistency of care for veterans. TAPS families grieving a military loved one who died by suicide also cope with symptoms of trauma and complicated grief, putting them at increased risk for suicide, post-traumatic stress, and mental health concerns due to the traumatic nature of their loss. It is imperative that we not wait until a crisis occurs among these survivors or allow the long-term impact of unsupported grief on the youngest survivors lead to lifelong challenges and suffering.

Leading research and TAPS' extensive experience have validated that these risks can be significantly reduced for survivors of all ages with early and relevant social connections that demonstrate respect, offer understanding, and increase their sense of belonging and social connection — especially when paired with customized assistance to meet the challenges of legal, financial, benefits, and care needs.

Knowing how to reduce risk and support survivors, TAPS works closely with agencies and organizations across the country to not only welcome their referred survivors, but to help build their capacity by providing information and training on loss, including suicide loss. Shifting thinking from a crisis response model — which pays attention to mental health only when someone is suffering and suicidal — to treating mental health care as a vital part of overall health and readiness is imperative.

EXPAND TOXIC EXPOSURE PRESUMPTIVE CONDITIONS

TAPS will continue to work with Congress and the Department of Veterans Affairs to:

- Ensure proper implementation of the ***PACT Act*** for veterans and survivors.
- Expand **Toxic Exposure Risk Activities (TERA)** to ensure veterans, families, caregivers, and survivors receive the care and benefits they have earned.
- Strengthen and expand the **Individual Longitudinal Exposure Records (ILER).**
- Pass the ***K2 Veterans Total Coverage Act*** **(H.R.3441).**
- Pass the ***Susan E. Lukas 9/11 Servicemember Fairness Act*** **(H.R.5339).**
- Pass the ***Veterans Exposed to Toxic PFAS Act*** **(H.R.3639).**
- Pass the ***Ensuring Justice for Camp Lejeune Victims Act*** **(S.907, H.R.4145).**
- Pass the ***Justice for ALS Veterans Act of 2025*** **(H.R.1685).**
- Pass the ***Molly R. Loomis Research for Descendants of Toxic Exposed Veterans Research Act*** **(S.2061, H.R.6005).**

As the leading voice for the families of those who died as a result of illnesses connected to toxic exposure and co-chair of the Toxic Exposure in the American Military (TEAM) Coalition, TAPS led efforts to pass the bipartisan ***Sergeant First Class Heath Robinson Honoring Our Promise to Address Comprehensive Toxics (PACT) Act of 2022*** **(Public Law 117-168)**.

The *PACT Act* was signed into law on Aug. 10, 2022, and is the most significant expansion of benefits and services for veterans in more than 30 years. This historic law ensures veterans of multiple generations who were exposed to burn pits, toxins, and airborne hazards while deployed are eligible to apply for immediate, lifelong access to VA health care and benefits for their families, caregivers, and survivors.

The passage of the *PACT Act* is a tremendous victory, but the work does not stop. Each year, more survivors whose loved ones died due to toxic exposure-linked illness connect with TAPS for grief support and help navigating their benefits. Of the survivors seeking our care in 2025, 33 percent were grieving the death of a military loved one due to illness, including toxic exposures.

TAPS remains committed to promoting a better-shared understanding of illnesses that may result from toxins and environmental exposures, occupational exposures, radiation, and per- and polyfluoroalkyl substances (PFAS). TAPS also remains committed to ensuring that impacted service members, veterans, their families, caregivers, and survivors receive critical health care and mental health support, and the benefits they have earned.

TAPS thanks Congress for passing the ***Aviation Cancers Examination Study (ACES) Act*** **(Public Law 119-32)**, which directs the Secretary of Veteran Affairs to oversee a multi-year study — conducted by the National Academies of Sciences, Engineering, and Medicine (NASEM) — on the prevalence and mortality of cancer among individuals who served as active-duty aircrew in the armed forces.

There is an urgency for early diagnosis and intervention, which saves and prolongs the lives of service members and veterans, beloved by family and friends who consider each day together as precious and irreplaceable.

To that end, TAPS urges the use of the **Individual Longitudinal Exposure Records (ILER)** — an electronic database of service members' and veterans' exposures used in collaboration between the Department of Veterans Affairs (VA) and the Department of Defense (DoD) — to identify trends, locations, and potential exposures to proactively reach out to service members and veterans to help save lives. We also request that these records be accessible to service members, veterans, and their families, to help them make better-informed decisions regarding their care.

The DoD's decision to provide active-duty service members with an individual toxic exposure history screen within ILER is an important step forward. However, the TEAM Coalition, which TAPS co-chairs, has identified four remaining changes, each as vital:

- Families of currently serving members of the armed forces will not have ILER access. Their exposures and related consequences will remain unseen and unmeasured.
- None of our nation's 16 million veterans will have ILER access. Many veterans do not know what they were exposed to, and without ILER's vetted data, they cannot develop informed VA disability claims — a due process matter. Veterans sick from perceived service-related exposures are also currently unable to provide relevant information to their health care providers.
- Families of veterans who lived alongside their service member, and in certain cases may have been co-exposed, have no ILER information access.
- DoD and VA health care providers are unable to leverage ILER in diagnoses; this must change. The wall between research and treatment must be deconstructed to facilitate diagnosis and potentially aid individual treatment.

TAPS and the TEAM Coalition have identified an overwhelming need for an ILER 2.0 to expand and strengthen support to toxic-exposed service members, veterans, and their families. Together, we are committed to working with Members of Congress to introduce comprehensive legislation in both the House and Senate.

TAPS and our fellow VSOs continue to work with the VA to identify and expand *PACT Act*-presumptive conditions and locations to the list of toxic exposures, and to advance further toxic exposure-related legislation to address critical health care needs for impacted veterans and their families.

***K2 Veterans Total Coverage Act* of 2025 (H.R.5915)**

TAPS proudly stands with the Stronghold Freedom Foundation (SFF) in support of legislative efforts to address the ongoing health care and benefit needs of the 15,000 impacted Army, Air Force, and Marine Corps personnel who were deployed to Camp Stronghold Freedom, Karshi-Khanabad (K2) Air Base in Uzbekistan between Jan. 1, 2001, and Dec. 31, 2005.

We are grateful to Representatives Stephen Lynch (D-MA-8) and Janelle Bynum (D-OR-5) for introducing the ***K2 Veterans Total Coverage Act of 2025* (H.R.5915),** which would create a presumption of service-connection for all conditions reported from K2 deployments, including but not limited to rare and undiagnosed conditions.

According to declassified DoD documents, K2 veterans were exposed to multiple cancer-causing toxic substances and radiological hazards, to include petrochemicals, depleted uranium, burn pits, and elevated levels of tetrachloroethylene. Many K2 veterans have become ill or have died due to their exposure to toxins.

Natalie White, Surviving Spouse of TSgt Clayton R. White, U.S. Air Force

"My name is Natalie White. I am a military surviving spouse, a K2 Widow, and mother. My extremely intelligent, kind, funny, generous, and loving military husband, Technical Sergeant Clayton R. White never woke up on his 41st birthday– he never met his daughter Piper who was just months away from being held by her loving father. He was dedicated to family, friends, and country, and he would do for others without wanting recognition and acknowledgement.

"He served with honor, valor, and distinction in the United States Air Force for 17.5 years. He answered the call after 9/11 and went to war to defend our country and freedom. He deployed to Karshi-Khanabad (K2) Air Base in Uzbekistan. There, he was repeatedly exposed to toxins that caused his many illnesses and ailments that ultimately cost him his life. He is another casualty of K2, and the loss of his life caused another needless casualty, a fatherless daughter.

"Despite just recently fighting to get the award of DIC, the financial burden of Clayton's prolonged healthcare expenses and ability to work and provide for us in his final few years are still a financial burden. We lost many pregnancies to miscarriage, nearly lost our home, we did lose our healthcare, did lose a two income household, and I became the provider along with being a full time caregiver for Clayton in his final years. Any help, financial and healthcare, we sought from the VA was wrought with roadblocks, dismissal, denials and ignorance.

"As his wife, I was his caregiver and advocate. He IS my hero, soul mate, and the love of my life. I will never be the same, I will continue to grieve the loss of our future, our time, our love. I grieve for the loving and incredible father that he would have been. I will forever grieve for our daughter — her loss of the love and guidance of her father will carry through her lifetime. I will also grieve the heartache and angst suffered by Clayton at the dismissal of our government, military and VA, of the pain, suffering and sacrifice of both Clayton and us, his survivors."

***Susan E. Lukas 9/11 Servicemember Fairness Act* (H.R.5339)**

TAPS greatly appreciates Representatives Suhas Subramanyam (D-VA-10), Don Beyer (D-VA-08), Rob Wittman (R-VA-01), and Bobby Scott (D-VA-03) for introducing the ***Susan E. Lukas 9/11 Servicemember Fairness Act* (H.R.5339)**.

This critical and long-overdue bipartisan legislation would extend the presumption of service-connection for toxic-exposed veterans who reported for duty in the Pentagon between Sep. 11, 2001, and Nov. 19, 2001. Service members who returned to the Pentagon the next day to ensure continuity of service were exposed to an array of toxic substances, including cement dust, glass fibers, asbestos, lead, mold, and other toxicants that are known to cause negative health conditions and outcomes.

Named after our dear friend, Retired Air Force Lieutenant Colonel Susan Lukas, who was in the Pentagon on 9/11 and reported for duty the next day, she now suffers from chronic and persistent health impacts from her exposure. As a former Director of Government Affairs for the Reserve Organization of America (ROA) and a long-time champion for the Reserve Component, Susan continues to exemplify service before self, always standing up for what is right, and TAPS is proud to stand with her.

Lt Col Susan E. Lukas, U.S. Air Force (Ret.)

"As I walked to my office, I could see my footprints in the concourse hallway because the floor was covered in black particulates from where the plane hit the Pentagon. By the time I got to the third floor, I wiped tears from my eyes because they were burning from what was in the air. By the afternoon, I had a terrible headache from where the plane crashed. It was like that as I reported to work each day. My name is Susan Lukas, and I had no idea that my health was being permanently damaged.

"I think people always look at the major effects of toxic exposure, but they don't often think about the day-to-day effects. I accommodate the damage to my throat and lungs with everyday decisions that no one would think about. For example, I buy only non-scented products because scented products burn my lungs and give me headaches. This also happens when I go into some stores or restaurants where there is a strong odor from perfumes or spices used during cooking. When that happens, I turn around and walk out because there is nothing I can do to make things better

"I am not the only one who must deal with these issues. My son and daughter often take on the role of caretaker when I am sick with any type of respiratory illness because the effects are more extreme and last longer than they did before 9/11. Because of this, I have spent thousands of dollars purifying the air in my house so I can breathe. Can you imagine having to wake up every day and think about making it easier to breathe? Unfortunately, that is my reality.

"For myself and all the forgotten veterans who reported to duty in the Pentagon on 9/11 and in the days immediately afterward, I respectfully ask Congress to pass this bill."

***Veterans Exposed to Toxic PFAS Act or VET PFAS Act* (H.R.3639)**

TAPS is grateful to Representatives Michael Lawler (R-NY-17), Josh Riley (D-NY-19), Brian Fitzpatrick (R-PA-1), Rashida Tlaib (D-MI-12), Seth Magaziner (D-RI-2), Suzan K. DelBene (D-WA-1), Ro Khanna (D-CA-17), Judy Chu (D-CA-28), André Carson (D-IN-7), and Brittany Pettersen (D-CO-7) for introducing the ***Veterans Exposed to Toxic PFAS Act or VET PFAS Act* (H.R.3639).**

This vital legislation would extend eligibility for VA care and medical services to veterans and their families, including those in utero, who developed specific conditions after residing at a military installation where they were exposed to perfluoroalkyl and polyfluoroalkyl substances, commonly known as PFAS or "forever chemicals."

Veterans and their families have been exposed to a wide range of toxins at U.S. military bases. The Department of Defense determined that 722 active military installations, Base Realignment and Closure locations, National Guard facilities, and Formerly Used Defense Sites require an assessment of PFAS contamination in both soil and water supplies. According to the VA, PFAS has been linked to serious health issues, such as liver damage, increased risk of kidney and testicular cancer, thyroid disease, fertility issues, pregnancy-induced preeclampsia, and changes in fetal and child development.

TAPS is committed to advocating for veterans and their families who have been impacted by their exposure to these "forever chemicals," and we urge swift passage of the ***VET PFAS Act***.

Candace Wheeler, Spouse of Col Scott Wheeler, U.S. Air Force (Ret.)

"As a young military couple stationed at George Air Force Base in California, from 1987 to 1990, what we didn't know at the time was that, in addition to the inherent risk of military aviation, there was a pervasive threat to the health and safety of all who lived and worked at George AFB.

"Established during World War II, George AFB provided training for aircrews and maintenance personnel and regularly used firefighting foam in fire training exercises. It is estimated that more than 100,000 military and civilian personnel, and their families stationed at George AFB, or living in the surrounding community, were potentially exposed to over 30 toxic substances, to include PFAS, jet fuel, dioxins, benzene, and asbestos.

"During our time at George AFB, military families who lived on base experienced both infertility issues and miscarriages. The daughter of one of our closest friends was born with a congenital birth defect and only lived a year.

"In 1990, George AFB was added to the Environmental Protection Agency's (EPA) Superfund list and was decommissioned in 1992. It has been 34 years since George AFB closed. Since then, the Air Force, EPA, and the California Department of Toxic Control have been working to remove the contaminants from the groundwater and soil, but George AFB remains uninhabited, with cleanup expected to take several decades.

"To this day, we have never officially been notified of our potential exposure, and to my knowledge, that is true for other military families stationed at George AFB. When you consider that George AFB is one of 722 military sites being mitigated for toxic substances, it is important that the process be transparent and that potentially impacted veterans and their families are formally notified, and provided access to VA health care and medical services."

***Ensuring Justice for Camp Lejeune Victims Act of 2025* (S.907, H.R.4145)**

TAPS appreciates Senator Thom Tillis (R-NC) and Ranking Member Richard Blumenthal (D-CT), and Representatives Gregory Murphy (R-NC-3), Deborah Ross (D-NC-2), and Richard Hudson (R-NC-9), along with 20 original co-sponsors, for introducing the ***Ensuring Justice for Camp Lejeune Victims Act of 2025* (S.907, H.R.4145).**

This important bicameral and bipartisan legislation includes technical corrections to the ***Camp Lejeune Justice Act*** to ensure full and swift relief to veterans and their families who were impacted by contaminated water at Camp Lejeune. The bill would permit cases to be heard in any district court in North and South Carolina, provide for jury trials as intended, where victims must only show general causation, and cap attorney fees at 20 percent for settlement and 25 percent for trials.

TAPS strongly supports this critical legislation to ensure Camp Lejeune families exposed to contaminated drinking water receive the justice they deserve.

***Justice for ALS Veterans Act of 2025* (H.R.1685)**

TAPS thanks Representatives Brian Fitzpatrick (R-PA-1) and Chris Pappas (D-NH-1) for introducing the ***Justice for ALS Veterans Act of 2025* (H.R.1685).** TAPS strongly supports this bipartisan legislation, which would extend critical Dependency and Indemnity Compensation (DIC) benefits to surviving spouses of veterans who die from amyotrophic lateral sclerosis (ALS) or Lou Gehrig's disease, regardless of how long the veteran had the disease before their death.

The Department of Veterans Affairs (VA) has included ALS as a presumptive 100 percent service-connected disease since 2008 for veterans who have served in the

military for at least 90 days of continuous active-duty service. Under current law, a veteran must be rated totally disabled for a continuous period of at least eight years immediately preceding their death for their survivors to receive DIC, and a surviving spouse must have been married to the veteran for eight or more years immediately preceding the veteran's death.

Approximately 30,000 people in the United States are currently living with ALS. According to the ALS Association, military veterans are twice as likely to be diagnosed with ALS as civilians, no matter their branch of service or if they served during peacetime or war. Military service members may face a higher risk of developing ALS, from head, neck, or spine injuries, especially traumatic brain injuries (TBI), and from exposure to toxic substances.

A 2025 report from the National Academies of Sciences, Engineering, and Medicine[7] explored the link between various toxic exposures experienced by post-9/11 veterans and neurological conditions, including ALS. The committee ultimately found that there was "a possible risk-conferring relationship between exposure to exhaust or solvents — such as benzene, formaldehyde, and methylene chloride — and ALS."

Veterans are also at greater risk of dying from the disease. The average life expectancy for someone living with ALS is two to five years from the time of diagnosis. Many veterans who contract ALS do not live long enough to secure DIC benefits for their survivors, who often become caregivers to their veteran before their passing.

TAPS strongly supports the ***Justice for ALS Veterans Act of 2025*** and urges its swift passage. Surviving spouses of our nation's veterans, who have died from ALS, should not be kept waiting any longer to receive their veterans' hard-earned benefits.

***Molly R. Loomis Research for Descendants of Toxic Exposed Veterans Research Act of 2025* (S.2061, H.R.6005)**

TAPS is grateful to Ranking Member Blumenthal (D-CT) and Senator Patty Murray (D-WA), and Congresswoman Debbie Dingell (D-MI-6) for introducing the ***Molly R. Loomis Research for Descendants of Toxic Exposed Veterans Act of 2025* (S.2061, H.R.6005).**

Named after Molly Loomis, who was born with spina bifida—a condition linked to her father's service-connected exposure to Agent Orange in Vietnam, this critical legislation will establish an independent, interagency task force to research the diagnosis and treatment of health conditions affecting descendants of veterans from all eras who were exposed to toxic substances.

[7] https://www.nationalacademies.org/projects/HMD-BPH-23-08

TAPS strongly supports this legislation and appreciates Molly sharing her personal testimonial:

Molly Loomis, Surviving Daughter of Lt. Richard Loomis, U.S. Navy

"Three years ago, I learned that the PACT Act qualified my father for toxic exposure while serving in Vietnam. I also learned that the government considers those toxins as the presumptive cause of his cancer, death, and my birth defect: spina bifida. I also just learned that my spinal cord is bound up in scar tissue from the first time it was operated on, and I have two exceptionally rare brain cysts, one of which is growing. This is not normal.

"Military service has always carried risk. But it is entirely different to expect recruits to risk harming not only themselves, but future generations — and be denied acknowledgement or support.

"My story is not unique. Military families across different eras of engagement report the same pattern: healthy children born before exposure. Premature births, rare diseases, infertility, and devastating birth defects in kids born after. This did not stop with Vietnam. Gulf War families, and others, are living out the same pattern.

"Current VA research addresses one era of toxic exposure. Mounting scientific evidence, including peer-reviewed studies and advances in genetics, contradicts these findings. Serious investigation and research guided by a clear timeline, goals informed by those impacted, and independent oversight is warranted. The ***Molly R. Loomis Research for Descendants of Toxic Exposed Veterans Act of 2025*** *does just that.*

"The true cost of war must include its impact on descendants. Supporting S. 2061 is a crucial step in the right direction."

ENSURE THE DEPARTMENT OF VETERANS AFFAIRS COLLECTS CAUSE OF DEATH DATA

TAPS is working with Congress to:

- Pass the ***Justice for America's Veterans and Survivors Act*** **(S.3042, H.R.3627)** in the 119th Congress.

While the Department of Veterans Affairs (VA) does a fantastic job of tracking major data categories for surviving families, the one major piece of information that the VA does not currently track is the "cause of death" of the veteran. While the VA currently supports 530,085 surviving spouses, they cannot tell you what percentage are suicide, or illness, or combat-related, or training accident-related deaths. This information would be crucial to

ensuring that the VA and other organizations are providing the necessary care and programs those families need.

During a meeting with the VA last year, we were informed that because the VA does not track cause of death, the potential 382,000 PACT Act-impacted survivors includes all manners of death, including those who died of natural causes, age-related conditions, by suicide, or in car accidents, not just those filing claims related to toxic exposure. This helps to explain why, after extensive outreach by the VA and organizations like TAPS, to date, only 44,576 survivors have applied for PACT-related benefits. Unfortunately, the potential survivor numbers have also informed the Congressional Budget Office's (CBO) scoring of current survivor legislation, such as the *Love Lives On Act* and *Caring for Survivors Act*, almost doubling the cost and creating exorbitant scores, making it difficult to find funding.

This type of data is critical to tailoring programming for surviving families and researching suicide prevention, toxic exposures, and illnesses that have led to the tragic deaths of many veterans. The Department of Defense has been doing this for many years, so it is logical to presume the VA can and should do the same.

TAPS thanks the House of Representatives for passing this critical legislation last year, and looks forward to seeing Senate passage this year.

CREATE ONE GI BILL FOR ALL

TAPS requests Congress:

- Pass the ***Gold Star Family Education Parity Act*** **(H.R.2720)** to sunset Chapter 35 and expand the Fry Scholarship to families not previously eligible, non-active-duty survivors, pre-9/11 survivors, and families of 100 percent disabled.

Survivors' and Dependents' Educational Assistance, or Chapter 35, is an outdated education benefit created by the ***War Orphans' Educational Assistance Act of 1956*** (Public Law 634, 84th Congress), and it has not had many improvements since then. The Forever GI Bill increased education benefits by $200 per month; however, that remains nearly half of the amount paid by the Montgomery GI Bill, and far less than the Post-9/11 GI Bill and Fry Scholarship. With the current rate of only $1,536 per month, Chapter 35 benefits barely make a dent in the cost of an education in today's economy.

TAPS thanks Representative Tim Kennedy for introducing the ***Gold Star Family Education Parity Act*** **(H.R. 2720),** which would terminate Chapter 35 benefits on Aug. 1, 2029, and entitle all eligible recipients to educational assistance under Chapter 33.

TAPS has recommended for years sunsetting Chapter 35 and moving all qualified recipients to Chapter 33, even if it is on a lower scale, such as 80 percent as opposed to

100 percent of the benefit. Benefits under the Survivors' and Dependents' Educational Assistance (DEA) program are significantly lower than those under the Post-9/11 GI Bill, Fry Scholarship, and Montgomery GI Bill.

Those using DEA are dependents of a 100 percent disabled veteran, those who died of a service-connected death, and those who died before 9/11, all of which are populations that traditionally receive fewer benefits than their active-duty, post-9/11 counterparts.

While the VA has made major improvements with the Digital GI Bill toward automation for Chapter 33 benefits, they are still utilizing COBOL to process most Chapter 35 claims. COBOL is a program from 1959 and is not widely utilized anymore. The VA has not upgraded this system, which causes more processing errors and delays than other GI Bill programs.

VA Secretary Collins has consistently stated that one of his goals at the Department of Veterans Affairs is to simplify processes and streamline programs. This critical legislation would do exactly that by ensuring one benefit is in place for all surviving spouses and children, and alleviating confusion on the survivors' part. It would also allow the VA to automate these claims to reduce the backlog and ensure consistent Certificates of Eligibility and payment of benefits.

By aligning the benefits for survivors equitably, we acknowledge the profound sacrifices made by these families and affirm our nation's commitment to supporting them. Consolidating educational benefits under the Fry Scholarship simplifies the process for beneficiaries and the Department of Veterans Affairs, reducing confusion and administrative overhead. The following personal testimonials from surviving families help highlight these education benefit issues:

Malia Fry, Surviving Spouse of GySgt John David Fry, U.S. Marine Corps

"It has been my honor to watch the Fry Scholarship touch so many people's lives as the years have passed. As the children and spouses of fallen service members graduate, it is amazing to see all the wonderful things they are accomplishing. It is so sad that some children whose parents served our country honorably may not have the same opportunity just because of the date they died.

"When I first approached Congressman Chet Edwards about the need for expanding VA education benefits for children of fallen service members, we wanted to help these children achieve their goals, their dreams. It never crossed my mind that there would be members of the military whose children would not be allowed to use these benefits because their parent happened to die a few days before 9/11 or months after they were medically retired.

"We must consider the cancer survivors and other wounded veterans who died after leaving service. These service members served honorably, and, in many cases, were exposed to things that caused their illnesses or were wounded while on duty. These children are being penalized because their fathers and mothers were forced to leave military service.

"If a service member serves honorably and is willing to give their lives, then we as a country need to care for their children. These children should have the ability to go to college without justifying their parents' service."

Kristy Oman-Gilbert, Surviving Spouse of SPC Keith Gilbert, U.S. Army

"We lost my husband at the age of 35 to a service-connected suicide. Before he was medically discharged, he could not transfer his GI Bill to our son, as he did not meet the continuing service requirements. With his death being after active duty, we do not currently qualify for the Fry Scholarship, and we cannot take out Parents Plus Loans in his name to be dismissed due to his service-connected disability. This leaves the financial burden of paying for college on my son and me.

"My husband's death was confirmed to be service-connected, but we will struggle to put my son through school without help from private organizations. Extending the Fry Scholarship to ALL surviving spouses and children would show that the country recognizes the sacrifice of those remaining, no matter when the death occurred. The timing of my husband's death should not negate the opportunity for my son to have the best future possible."

Ursula Palmer, Surviving Spouse of SFC Collin Bowen, U.S. Army National Guard

"I have two children. My daughter lost her father in Afghanistan when she was just 3 years old. Having Chapter 35 and the Fry Scholarship has given me peace of mind and the reassurance that her dad's sacrifice was not in vain.

"Then I found love again. He was also a service member. We had a son. My new husband also served in Afghanistan, came back sick with some type of virus, and was in and out of hospitals for months. He even had a surgery to remove what they thought was cancer, but once he was on the operating table, they didn't find anything. Doctors never determined the root of the virus, and even though he slowly recovered, the long-term side effects stayed, including PTSD and TBI. He never went back to being the same healthy and strong man he once was. He retired after 30 years of service with a disability rating of 100 percent.

"The only difference between my first and second husbands is that the first died of his visible injuries. My second husband lives with the side effects of his disease and invisible wounds. Why would our country find his service and its life-changing repercussions less worthy of benefits for his child just because he didn't die?"

Renee Monczynski, Surviving Spouse of PO2 Matthew Monczynski, U.S. Navy

"The difference for my daughter between Chapter 35 and Fry for the next two years is the constant worry of how we are going to pay for each semester — waiting to see if she has enough scholarships to cover all expenses and scrambling for loans to cover the rest. Every time we fill out an application, we are reminded that the Navy and our country don't care about Matt's sacrifice because it was in June 2001. He died on the wrong day for our country to care. That care is reserved for those who served and died after 9/11.

"We were dual-active. We were both willing and did serve our country. But according to a document his sacrifice is not worth a college education for our daughter. Nor is my 70 percent VA-rated disability. So I'm not broken enough, and he died on the wrong day for anyone to care about our sacrifices."

GUARD VA BENEFITS ACT (H.R.1732)

TAPS will continue to work with Congress to:

- Pass the ***GUARD VA Benefits Act*** **(H.R.1732),** which would reinstate criminal penalties for unaccredited individuals who charge fees and compensation for assisting veterans and survivors with filing a Department of Veterans Affairs (VA) benefits claim.

This enforcement mechanism was previously removed in 2006, leaving the VA Office of the General Counsel (OGC) constrained in its oversight over groups that operate outside of accreditation. Currently, the OGC can only apply administrative penalties to accredited individuals and refer matters relating to nonaccredited individuals to federal or state enforcement agencies. By reinstating criminal penalties, OGC will be able to exercise jurisdiction over unaccredited individuals and hold them accountable for predatory behavior.

Since the passage of the PACT Act, the VA and numerous VSOs have noticed an influx of advertisements and solicitations from predatory claims consultants. With nearly 40,000 additional survivors with completed PACT Act-related claims, increased regulatory oversight is crucial to ensuring that these survivors receive adequate care and representation throughout the VA benefits claim process.

Historically, surviving spouses have had a large target on their backs from predatory actors, and claim sharks are no different. TAPS wants to ensure that surviving spouses applying for benefits from the VA are not taken advantage of by predatory actors when there are so many free and low-cost options available.

Although veterans are considered a vulnerable population to predatory actors, we believe that surviving spouses are as well. When a disabled veteran dies, surviving spouses lose more than half of their financial benefits and are provided limited support in figuring out how to file for benefits as a surviving spouse. If you call the VA they will give you the form number for DIC or tell you to contact a VSO for assistance in filing a claim. If you Google how to "file a DIC claim as a widow", the first response takes you to the VA's website. Seven of the next nine results are paid sponsorships and claim sharks. The 10th response takes you to the Disabled American Veterans — the first true VSO result available.

We fully acknowledge that there are changes that need to be made to accreditation to allow reputable actors into the space. TAPS is not an accredited VSO because the rules stipulate that you must help the veteran community as a whole. Since our mission is solely focused on surviving families, we are not the best equipped to serve veterans, but we are well-equipped to serve survivors.

In 2025 alone, our TAPS Casework team assisted almost 2,000 survivors on benefit claims. We would welcome the opportunity to be accredited to help make the process easier for surviving families, but **have never and would never charge for our services.**

TAPS strongly supports the ***GUARD VA Benefits Act*** **(H.R.1732)** and thanks Representatives Chris Pappas (D-NH-1) and Brian Fitzpatrick (R-PA-1) and 52 original co-sponsors. This important legislation will help deter predatory behavior and ensure that veterans and survivors receive their full earned benefits at no additional cost.

CONCLUSION

TAPS thanks the leadership of the Senate and House Committee on Veterans' Affairs, their distinguished members, and professional staff for holding this Joint Session of Congress to hear the legislative priorities of veteran and military service organizations. TAPS is honored to testify on behalf of the thousands of surviving military and veteran families we serve.

Anita Sullivan is the widow of Navy Petty Officer 3rd Class Michael Sullivan, lost to service-connected suicide in 2019 after a long battle with mental and physical illnesses. She is raising their three busy children in North Florida while working full-time, volunteering as a peer mentor with TAPS, and passionately advocating for surviving families. She shares her (messy) story to help heal and connect, because others have done the same for her along the way.

TESTIMONY OF THE

NATIONAL GUARD ASSOCIATION OF THE UNITED STATES

Senate Committee on Veterans' Affairs

House Committee on Veterans' Affairs

Joint Hearing on Legislative Presentations

March 4, 2026

Chairman Moran, Ranking Member Blumenthal, Chairman Bost, Ranking Member Takano and other distinguished members of the Senate and House Committees:

Introduction:

On behalf of the almost 45,000 members of the National Guard Association of the United States and the nearly 450,000 Soldiers and Airmen of the National Guard, we are grateful for this opportunity to discuss current concerns and interests. We appreciate the Committees' longstanding, bipartisan support for veterans and service members and for recognizing the vital role of the National Guard. We must ensure those who serve are treated with fairness, consistency, and respect.

Over the past two decades, the role of the National Guard has expanded dramatically. Once viewed primarily as a strategic reserve, the Guard is now an operational force, routinely employed across the full spectrum of missions. Guard members deploy globally in support of combatant commands, strengthen alliances through security cooperation, conduct cyber operations, and provide critical capabilities to the Total Force. At the same time, they remain the nation's first

military responder – protecting communities during natural disasters, supporting civil authorities, securing critical infrastructure, and responding to emerging domestic threats.

These increased responsibilities have come with sustained operational tempo and growing demands on Guardsmen, their families, and employers. As the Guard's mission set has expanded, it has become increasingly important that policies governing service, benefits, and veteran outcomes keep pace with the realities of how the National Guard is used today.

Today, I would like to focus on three priorities that directly affect our members both in service and after they transition into veteran status: Duty Status Reform, remaining gaps in GI Bill parity, and the development of a Reserve Component–specific track within the Transition Assistance Program (TAP).

Duty Status Reform

As of this week, more than 40,000 National Guard members are on orders, serving both here at home and abroad. In the aftermath of recent natural disasters, thousands of Guardsmen from across multiple states were activated to support lifesaving response and recovery missions. In many of these missions, National Guard members serve shoulder-to-shoulder with Active Component forces, performing the same duties, under the same conditions, and facing the same risks. Yet too often, they do so under duty statuses that provide significantly less pay and benefit protections.

This disparity is not accidental. It is the result of a complex and outdated patchwork of more than 30 distinct duty statuses, many of which were created for a different era. In practice, this system allows orders to be structured in ways that deny Guardsmen access to housing allowances, medical coverage, and education benefits—particularly when missions are

intentionally kept below 30 days. The result is a system where service is equal, but compensation and benefits are not.

For over a decade, Congress and the Department of Defense have recognized this problem. The FY2016 National Defense Authorization Act directed the Department to submit a Duty Status Reform legislative proposal. Since then, multiple iterations have been developed but have not advanced, largely due to interagency concerns about benefit alignment. While studies and discussions have continued, the operational reality has only intensified.

Duty Status Reform is not about expanding benefits indiscriminately. It is about aligning duty status authorities with how the National Guard is actually used today. It is about ensuring that Guardsmen receive fair treatment when they are mobilized to meet federal and state requirements, and about removing barriers that undermine morale, retention, and readiness.

From a readiness perspective, this matters deeply. Guardsmen who repeatedly accept missions without predictable pay and benefits face financial strain on their families and employers. Over time, that strain erodes retention—particularly in high-demand fields such as cyber, aviation, medical, and logistics. Readiness is not just equipment and training; it is people willing and able to answer the call.

Duty Status Reform would also have a positive downstream effect on veteran outcomes. Consistent access to benefits such as healthcare and education strengthens transition outcomes and ensures that Guard veterans are not disadvantaged by administrative distinctions unrelated to their service. The National Guard has proven, time and again, that it is indispensable to the nation's security. It is time for policy to catch up with practice.

The Duty Status Reform Act has support from both the Department of War and Department of Veterans affairs. We ask your support for H.R.6976 and for the introduction of a companion bill in the Senate.

GI Bill Parity

The Post-9/11 GI Bill is one of the most powerful recruitment, retention, and transition tools our nation has ever created. It reflects a simple principle—that those who serve earn the opportunity to pursue education and build a successful civilian future. However, for members of the National Guard and Reserve, eligibility has not kept pace with the way they are employed today.

Again, Guard and Reserve members routinely serve alongside Active Component forces, often under identical conditions and performing the same duties. Yet many periods of service still do not qualify for Post-9/11 GI Bill credit, particularly when members serve under certain Title 32 authorities or short-duration orders that fall outside qualifying thresholds.

This creates a disparity that is increasingly difficult to justify. Service is service. When a Guardsman leaves their civilian job, separates from family, and answers the nation's call under federal authority, the benefit earned should reflect that sacrifice—regardless of the duty status under which the mission was funded. This is not about expanding benefits beyond what has been earned. It is about ensuring that credit accrues fairly and consistently when members are performing federal missions.

It is also about strengthening the force. Education benefits remain one of the top incentives for recruiting and retaining high-quality talent, particularly in high-demand career fields such as

cyber, medical, engineering, and aviation. When Guard members perceive their service does not earn equivalent educational opportunity, it can undermine morale and long-term retention.

Parity also has significant implications for veteran outcomes. The transition from uniformed service to civilian life is one of the most consequential periods in a service member's career. Education benefits provide a bridge – enabling economic mobility, family stability, and long-term financial security. Ensuring equitable access to those benefits for Reserve Component members strengthens not only individual veterans, but the communities to which they return.

The Guard and Reserve GI Bill Parity Act takes an important step to expand qualifying service. We are grateful to Chairman Moran, Ranking Member Blumenthal, and Congressmen Takano, Levin, and Kelly for leading this effort. We appreciate the Committees' attention to this inequity and ask for swift passage of S.649 and H.R.1423.

Reserve Component Track for the Transition Assistance Program

Lastly, NGAUS would like to address the importance of congressional oversight in the development of a Reserve Component–specific track within the Transition Assistance Program, or TAP.

The Transition Assistance Program has long served as a cornerstone for preparing service members for life after uniformed service. It provides critical instruction in employment readiness, financial planning, benefits awareness, and educational opportunities. For many Active Component members, TAP represents a structured and predictable process tied to a defined separation date.

For members of the National Guard and Reserve, however, transition is often fundamentally different. Most Guard members do not separate from military service at the same time they transition from active duty orders. Instead, they move from a period of mobilization back to part-time service in their home state while simultaneously reintegrating into civilian employment and family life. This dual-status reality presents unique challenges that the traditional TAP model was not designed to address.

Guardsmen frequently return home within days of demobilization, often to employers who expect them back immediately. Many do not receive tailored counseling that reflects their continued military affiliation, the nuances of Reserve retirement, TRICARE eligibility changes, or how fragmented qualifying service affects benefits such as the GI Bill. As a result, critical information can be missed during a narrow and high-tempo reintegration window.

Congress recognized this gap in the FY25 NDAA and directed the Department of Defense to develop a Reserve Component–specific track within TAP. We commend that action. However, continued oversight is essential to ensure that this requirement is fully implemented in a manner that meaningfully serves Guard and Reserve members.

A Reserve Component track should address several key distinctions: reintegration to civilian employment under USERRA protections; understanding of non-regular retirement calculations; continued service obligations; access to VA healthcare and disability claims processes; and the cumulative impact of multiple mobilizations over a career. It should also provide flexibility in delivery – leveraging virtual platforms and extended timelines to accommodate members who transition from federal orders but remain in uniform.

Without deliberate oversight, there is a risk that a Reserve Component track becomes a repackaged version of the Active model rather than a truly tailored program. The Guard's operational tempo over the past two decades has produced a generation of Reserve Component veterans whose service patterns differ significantly from their Active counterparts. Policy and program design must reflect that reality.

NGAUS respectfully requests an update from the Department on the status, implementation timeline, and evaluation metrics for the Reserve Component TAP track. We stand ready to assist in ensuring it meets the needs of today's operational Guard.

Conclusion

In closing, NGAUS thanks the Committees for their continued leadership and commitment to those who serve. Duty Status Reform, GI Bill parity, and improved transition assistance are not abstract policy concepts; they are tangible issues that affect readiness, retention, and the long-term well-being of National Guard members and veterans.

The National Guard stands ready to meet the nation's needs—whether responding to natural disasters, defending the homeland, or supporting overseas operations. In return, our service members ask only for fairness, clarity, and recognition of their service.

We look forward to working with Congress, the Department of Defense, and the Department of Veterans Affairs to address these issues and to ensure that National Guard service is treated with the equity and respect it deserves.

Thank you for the opportunity to testify, and we welcome your questions.

Major General Francis M. McGinn (Ret.)

NGAUS

NGAUS President

president@ngaus.org 202-408-5894

Retired Major General Francis M. McGinn assumed the duties of president of the National Guard Association of United States on Jan. 2, 2024.

General McGinn serves as chief executive officer of NGAUS. He is responsible for the association's day-to-day operations in Washington, D.C., and a staff of 28 employees. He also oversees the National Guard Educational Foundation, which maintains the National Guard Memorial Museum, and the NGAUS Insurance Trust.

His principal duties include providing the Guard with unified representation before Congress and a variety of other functions to support a nationwide membership of more than 45,000 current and former National Guard officers across 54 states, territories, and the District of Columbia.

He was elected NGAUS president by the association's board of directors in November 2023. He had previously served on the board for 15 consecutive years.

General McGinn has four decades in uniform, all of it as a traditional, part-time member of the Massachusetts Army National Guard. For much of the time, he juggled his military duties with the demands of full-time positions in civilian law enforcement. This includes 30 years in the Massachusetts State Police and two years as commander of the Metropolitan Washington Airports Authority Police Department's Ronald Reagan Washington National Airport.

He began his military career in 1981 as an enlisted Soldier, earning his commission as second lieutenant through the Massachusetts State Officer Candidate School in 1984. His final assignment was as mobilization assistant to the director of the Defense Intelligence Agency in Washington, D.C. He retired in 2021.

Other career highlights include serving as Deputy Commander-Army National Guard at the U.S. Army Cyber Center of Excellence at Fort Gordon, Georgia, and Assistant Division Commander-Support of the 42nd Infantry Division. He deployed to Iraq with the 42nd Infantry Division from 2004 to 2005, serving as garrison commander of Forward Operating Base Speicher in Tikrit, Iraq.

General McGinn holds a bachelor's degree in criminal justice from the University of Massachusetts-Boston, a master's degree in criminal justice from Anna Maria College, and a master's degree in strategic studies from the U.S. Army War College. He has completed numerous schools as part of his military education, including the General and Flag Officer Homeland Security Executive Seminar at Harvard University, and the National Security Studies Management Course at Syracuse University.

The general holds several military decorations, including the Defense Superior Service Medal, the Legion of Merit (with one Bronze Oak Leaf cluster), the Bronze Star Medal, the Meritorious Service Medal (with four Bronze Oak Leaf clusters), and several Massachusetts National Guard awards.

VERBAL TESTIMONY
OF
MR. JAMES WHALEY
CHIEF EXECUTIVE OFFICER
MISSION ROLL CALL
MARCH 4, 2026

FOR THE
JOINT HOUSE AND SENATE VETERANS' AFFAIRS COMMITTEES
VETERAN SERVICE ORGANIZATION HEARING
US HOUSE OF REPRESENTATIVES AND US SENATE
ON
2026 LEGISLATIVE PRIORITIES

Chairmen Bost and Moran, Ranking Members Takano and Blumenthal, and distinguished Members of both Committees, thank you for the opportunity to testify today.

My name is Jim Whaley. I am the CEO of Mission Roll Call. We represent veterans by doing one thing consistently: listening. We survey veterans, their families, and caregivers nationwide, and we bring that data directly to policymakers, so decisions are grounded in lived experience.

Our 2026 priorities come straight from those surveys. Veterans told us four issues should guide the work ahead: access to quality healthcare, support for service-connected injuries, suicide prevention, and housing stability.

For veterans, these priorities are connected. When access falters, injuries worsen. When injuries go untreated, mental health risk increases. Without stable housing, even effective care becomes difficult to sustain.

First, access to quality healthcare, both VA and non-VA.

Veterans define access by timing, distance, and follow-through.

In May 2025, Mission Roll Call surveyed more than 1,200 respondents in all 50 states on the ACCESS Act. Sixty-seven percent said the legislation would improve healthcare outcomes overall. Among rural veterans, seventy-one percent said it would improve timely access. Mental health access is central to this discussion. Sixty percent of veterans told us they are comfortable receiving mental health care from a non-VA provider. Seventy-nine percent said allowing veterans to access mental health or substance use care in the community without a VA referral would improve access.

Veterans are not voting against the VA. Many report positive experiences. But they are asking for options that reduce delays, shorten travel burdens, and help them get care before a problem becomes a crisis.

Second, support for service-connected injuries and conditions, including traumatic brain injury.

When veterans speak about injuries, they speak about function. Work. Sleep. Family stability. Cognitive clarity.

In our 2025 TBI survey of more than 2,400 veterans, family members, and caregivers, fourteen percent reported a TBI diagnosis in their household. Among those seeking TBI-related care, more than seventy percent said accessing appropriate treatment is somewhat or very difficult. Distance, wait times, and fragmented care remain consistent barriers.

Mild to moderate TBI is where we see the greatest gap. Symptoms persist, but care pathways are often unclear and coordination between VA and non-VA providers remains inconsistent.

This is the space the BEACON Act seeks to address. The legislation creates a structured, evidence-based framework to evaluate innovative neurorehabilitation approaches for veterans with chronic mild-to-moderate TBI, with rigorous outcome measurement and independent evaluation. Veterans are not asking for lower standards. They are asking the VA to test promising therapies responsibly, publish results transparently, and expand access when evidence supports it.

This urgency is reinforced by the VA's 2025 suicide report, which shows the suicide rate among recent VHA users with a TBI diagnosis was nearly 94 percent higher than among those without a TBI. Early intervention in TBI care is not separate from suicide prevention. It is part of it.

Third, veteran suicide prevention.

Veterans tell us the current trajectory is unacceptable.

In July 2025, Mission Roll Call surveyed more than 2,100 veterans, family members, and caregivers nationwide. Sixty-seven percent of veteran respondents said they have struggled with suicidal thoughts or mental health challenges themselves, or know someone who has. Nearly one third described access to mental health care as difficult or very difficult.

Veterans also told us the barriers are not only clinical. They pointed to isolation, stigma, and loss of purpose as early warning signs.

From this feedback, a consistent theme emerged. Veterans want support that begins earlier. Many describe peer connection, meaningful work, and structured community engagement as stabilizing forces long before crisis intervention is required.

We have come to describe this as working "Left of Clinical." Not instead of care, but before crisis. Earlier engagement. More on-ramps to stability. Fewer veterans reaching a breaking point before help arrives.

Fourth, housing stability.

Housing is foundational. Without stability at home, treatment adherence, employment, recovery, and family life suffer. Veterans consistently rank housing access and homelessness prevention among their top priorities because instability magnifies every other challenge.

Across all of our surveys, veterans are asking Congress to do a few consistent things: expand access where delays persist, strengthen community care pathways, treat TBI and chronic conditions as long-horizon rehabilitation challenges, invest in earlier suicide prevention strategies, and protect housing stability as a core element of veteran wellness.

None of these priorities replace the VA. They strengthen it by recognizing that veteran wellness is built upstream, long before prescription drugs, an emergency room, or an inpatient bed is involved.

Veterans are speaking clearly. We are listening. Mission Roll Call is here to ensure their voices remain central to the work of these Committees.

Thank you. I look forward to your questions.

MISSION ROLL CALL

Jim Whaley – CEO, Mission Roll Call

Jim Whaley serves as the CEO of Mission Roll Call, a non-partisan movement dedicated to amplifying the voices of veterans, their families, and supporters through polling, outreach, and advocacy. Under his leadership, Mission Roll Call gathers and delivers unfiltered, apolitical perspectives from across the veteran community, ensuring their concerns and ideas are heard at the highest levels of policy-making.

In his role, Jim provides strategic and operational leadership, working closely with the Board of Directors and a high-performing team to shape legislation and policies affecting military and veteran communities. He is dedicated to expanding Mission Roll Call into a household name and advocating tirelessly for positive change.

Before joining Mission Roll Call, Jim founded Sonnet Public Relations, an organization dedicated to helping brands drive social impact by telling authentic, purpose-driven stories.

Jim's career reflects an unwavering commitment to service and leadership. As President of the USO Southeast Region, he oversaw operations and fundraising across ten states, home to over 35% of the nation's active military force and National Guard. He also served as Vice President of Global Corporate Communications and Government Affairs for Sealed Air Corporation, where he led global branding, reputation-building, and communications efforts.

Earlier, Jim was the Senior Vice President of Communications and Marketing for Siemens Corporation, where he managed corporate communications, marketing, and corporate responsibility across North America, while also serving as Chairman of the Siemens Foundation. His career in communications began at the United States Military Academy at West Point, where he directed communications during the institution's bicentennial celebration, demonstrating his ability to lead on a national stage.

A graduate of Lock Haven University with a BA in Communications, Jim also holds an MBA from Embry-Riddle Aeronautical University. A retired Master Army Aviator and U.S. Army Helicopter Instructor Pilot, Jim served over 20 years in the U.S. Army, earning prestigious honors, including the Legion of Merit, Air Assault Badge, and Humanitarian Service Medal.

Beyond his professional roles, Jim continues to give back through board positions with Veterans Bridge Home and the Red Cross of the Carolinas.

PO Box 1373
Clover, SC 29710

missionrollcall.org
info@missionrollcall.org

Statements for the Record

OFFICIAL STATEMENT OF THE AIR FORCE SERGEANTS ASSOCIATION

FOR THE U.S. SENATE AND HOUSE COMMITTEES ON VETERANS' AFFAIRS

ON AFSA's 119th CONGRESS VETERAN'S POLICY PRIORITIES

March 4, 2026

✦ AFSA IS QUALITY OF LIFE ✦

THROUGH ADVOCACY AND EDUCATION FOR THE IMPROVED QUALITY-OF-LIFE AND ECONOMIC FAIRNESS

TO SUPPORT THE WELL-BEING OF MILITARY SERVICE MEMBERS AND THEIR FAMILIES | ONE POWERFUL FORCE UNITED TOGETHER

DISCLOSURE OF FEDERAL GRANTS OR CONTRACTS

The Air Force Sergeants Association (AFSA) does not currently receive, nor has the Association ever received, any federal money for grants.

Introduction

Chairman Bost, Chairman Moran, Ranking Member Takano, Ranking Member Blumenthal, and distinguished members of the Committees on Veterans' Affairs,

On behalf of the Air Force Sergeants Association (AFSA) and 75,000 service members, veterans, and their families we represent, I thank you for the opportunity to address the critical policy priorities facing our nation's veterans. The men and women who have served in uniform have made tremendous sacrifices in defense of our freedoms, and it is our collective responsibility to ensure that they receive the care, benefits, and support they have rightfully earned.

Veterans across the country continue to face serious challenges, from an ongoing mental health crisis to gaps in healthcare access, education benefits, and financial security. Despite bipartisan progress in recent years, issues such as veteran suicide, barriers to alternative treatments like Hyperbaric Oxygen Therapy (HBOT), disparities in Guard and Reserve benefits, the continued exploitation of veterans by predatory claims agents, and inadequate support for caregivers and survivors demand immediate attention. Furthermore, we must stand firm in protecting veterans' disability and retirement pay from budgetary reductions that threaten their financial well-being.

The solutions we advocate today are not partisan, they are about honoring the commitment our nation made to those who served. It is imperative that we work together, across party lines, to enact policies that will have a lasting impact on the lives of our veterans. The passage of the Senator Elizabeth Dole 21st Century Veterans Healthcare and Benefits Improvement Act is a testament to what can be accomplished when we put politics aside and prioritize those who have sacrificed for our country.

AFSA remains dedicated to advocating for common-sense policies that improve the quality of life for our veterans and their families. We urge you to take bold, bipartisan action to address these critical issues and uphold the sacred promise we have made to those who have defended our nation.

Thank you for your time and commitment to our veterans. I look forward to working with you to turn these priorities into meaningful legislation.

Chief Executive: Keith A. Reed, 301-899-3500 x270

Legislative Policy Advisor: Jon Nutman, 301-899-3500 x227

Executive Summary

Ending Veteran Suicide & Improving Mental Health Support (page 5)

Veteran suicide remains a national crisis, with an average of 17.6 veterans dying by suicide each day. Addressing this requires a comprehensive strategy, including increased VA staffing, expanded telehealth services, and preserving access to in-person mental health care. While telehealth has proven effective in reaching veterans in rural and underserved areas, it must complement and not replace the critical support provided by VA mental health professionals.

Written Informed Consent for Black Box Medications (page 7)

Many veterans prescribed psychiatric medications with black box warnings are not fully informed of the risks. The VA must require written informed consent to ensure transparency, patient autonomy, and informed decision-making regarding high-risk medications.

Expanding Access to Hyperbaric Oxygen Therapy (HBOT) (page 8)

Veterans with PTSD and Traumatic Brain Injuries (TBI) deserve access to Hyperbaric Oxygen Therapy (HBOT) as a treatment option. Studies indicate that HBOT can significantly reduce PTSD symptoms and improve cognitive function in veterans with TBIs. The VA should implement pilot programs to evaluate HBOT's effectiveness as a covered treatment.

Supporting the Student Veteran Benefit Restoration Act (page 10)

The Student Veteran Benefit Restoration Act ensures that veterans who lose educational benefits due to school closures or fraud can have their benefits reinstated. Veterans should not suffer financial losses due to circumstances beyond their control.

Supporting Guard and Reserve GI Bill Parity Act (page 11)

National Guard and Reserve members serve alongside active-duty counterparts yet receive fewer education benefits. The Guard and Reserve GI Bill Parity Act seeks to correct this disparity by ensuring all service days count toward Post-9/11 GI Bill eligibility.

Ending the "Wounded Veteran Tax" — The Major Richard Star Act (page 11)

Combat-injured veterans who are medically retired before completing 20 years of service face an unjust dollar-for-dollar offset that reduces their earned retirement pay. The Major Richard Star Act (H.R. 2102/S. 1032) would allow these 52,000 veterans to receive both their earned retirement pay and VA disability compensation concurrently, ending a "wounded veteran tax" that breaks faith with those who sacrificed most.

Supporting Veterans' Caregivers (page 12)

The millions of family members who provide daily, uncompensated care to veterans are the backbone of our veterans' care system. Yet caregivers frequently sacrifice their own financial security and career advancement with little support. AFSA supports the Veteran Caregiver Reeducation, Reemployment, and Retirement Act and calls for comprehensive reforms to ensure caregivers are not left behind when their caregiving role ends.

Protecting Survivor Benefits (page 13)

Surviving spouses of fallen service members should not face financial penalties for rebuilding their lives. AFSA supports elimination of the remarriage age restriction for Dependency and Indemnity Compensation (DIC) recipients and modernizing DIC rates to reflect the true cost of sacrifice. No surviving spouse should be forced to choose between financial security and honoring their loved one's wishes.

Protecting Veterans' Disability and Retirement Pay (page 14)

Veterans' disability and retirement pay must be safeguarded. We echo VA Secretary Doug Collins in opposing any legislative efforts to reduce veterans' benefits to balance the federal budget. Cutting these benefits undermines national trust and deters future enlistments.

Protecting the VA as an Institution (page 15)

The Department of Veterans Affairs exists to fulfill a sacred obligation to those who served. AFSA opposes any effort to dismantle or privatize the VA in ways that would erode the specialized, veteran-centric care it provides. Reforms must modernize and strengthen the VA, not hollow it out.

Thank You For Passing The Senator Elizabeth Dole 21st Century Veterans Healthcare and Benefits Improvement Act

Chairman Bost, Chairman Moran, Ranking Member Takano, Ranking Member Blumenthal, and distinguished members of the committees, on behalf of veterans, service members, and their families, I extend my deepest gratitude for the passage of the Senator Elizabeth Dole 21st Century Veterans Healthcare and Benefits Improvement Act. This legislation represents a crucial step forward in ensuring that those who have served our nation receive the high-quality care and support they deserve.

Your commitment to common-sense solutions is evident in the Act's provisions, which focus on streamlining access to care, improving educational outreach for veterans regarding their healthcare options, and ensuring that resources are utilized efficiently. By prioritizing education and transparency, you have empowered veterans to make informed decisions about their well-being.

Furthermore, the bipartisan collaboration that led to the success of this legislation is commendable. In a time when unity is more important than ever, your ability to work across party lines to address the needs of our nation's heroes is an example of true leadership.

This Act will undoubtedly make a lasting impact, providing veterans with better healthcare, increased support, and a system that truly honors their service. Thank you for your dedication and continued efforts to improve the lives of those who have given so much to our country.

Ending Veteran Suicide & Improving Mental Health Support

The Growing Mental Health Crisis

- 17.6 veterans die by suicide each day
- 61% of VHA facilities have a "severe shortage" in Psychologists[1]
- Many VA facilities remain understaffed, causing long wait times
- Access to mental health services is critical for reducing veteran suicide

The Urgent Need for More VA Mental Health Professionals

The United States has a duty to provide adequate care for its veterans, yet a severe shortage of mental health professionals within the Department of Veterans Affairs (VA) has led to devastating consequences. With increasing rates of PTSD, depression, and suicide among veterans, the VA's current staffing levels are simply insufficient to meet the growing demand for psychiatric care. Addressing this shortfall is not just a matter of policy—it is a moral imperative.

The Growing Mental Health Crisis Among Veterans

Veterans face unique psychological challenges due to their military experiences, including exposure to combat, traumatic brain injuries, and military sexual trauma. According to the Department of Veterans Affairs, approximately 17 veterans die by suicide every day[2]. The demand for mental health services has surged, yet many VA facilities remain understaffed, leading to long wait times and inadequate care. For example, a ProPublica investigation revealed that some VA clinics lack full-time psychiatrists, forcing veterans into virtual consultations or long delays, with tragic outcomes.

The Consequences of Understaffing

When veterans cannot access timely mental health care, they are at higher risk for crisis situations, substance abuse, and homelessness. Many veterans, already struggling with the stigma surrounding mental health, may give up on seeking treatment altogether if faced with systemic barriers. Without enough professionals to provide regular counseling, crisis intervention, and medication management, the VA is failing those who have sacrificed for their country.

Investing in Solutions

To address this crisis, Congress must prioritize funding to recruit and retain mental health professionals within the VA system. Incentives such as student loan forgiveness, competitive salaries, and streamlined hiring processes can attract more qualified psychiatrists, psychologists, and social workers. Additionally, increasing partnerships with community-based providers can help bridge the gap while VA staffing levels are improved.

A Moral and Practical Obligation

Ensuring access to quality mental health care for veterans is not just a governmental responsibility, it is a national one. These men and women have put their lives on the line for their country; they should not have to fight another battle to receive the care they deserve. Expanding the VA's mental health workforce is not only the right thing to do, it is an essential step in preventing further loss of life and improving the well-being of those who have served.

The Role of Telehealth

Telehealth provides vital access to veterans in rural areas, and is a greatly important healthcare tool. However, it is not a replacement to vital in-person care. We know that direct interaction with mental health professionals significantly improves long-term treatment outcomes.

Policy Recommendations:

1. Increase VA mental health staffing.
2. Expand telehealth services, but retain in-person options.

3. Fund alternative mental health treatments, including service dogs, peer-support networks, and alternative therapies.

Sources:

[1] "OIG Determination of Veterans Health Administration's Severe Occupational Staffing Shortages Fiscal Year 2024" Figure 3, Page 9.
https://www.vaoig.gov/sites/default/files/reports/2024-08/vaoig-24-00803-222.pdf

[2] 2024 National Veteran Suicide Prevention Annual Report, Dept. of Veteran Affairs.
https://www.gao.gov/products/gao-22-105326

Written Informed Consent for Black Box Medications

Understanding Our Medications

- Many psychiatric medications prescribed to veterans carry FDA black box warnings.
- Without written informed consent, veterans may not understand risks such as suicidal ideation or withdrawal effects.
- A ProPublica investigation found that many veterans lack adequate counseling on medication risks.
- In AFSA's internal surveys we found a shocking amount of Veterans who were uninformed about their medications' side effects and withdrawal symptoms.

The Need for Written Informed Consent for Black Box Medications in VA Mental Health Care

Veterans seeking mental health care through the Department of Veterans Affairs (VA) often rely on prescription medications to manage conditions such as PTSD, depression, and anxiety. However, many of these medications carry black box warnings which is the highest level of caution issued by the FDA. Due to serious potential side effects, including suicidal ideation and severe withdrawal symptoms. Despite these risks, veterans are often prescribed these powerful medications without thorough, written informed consent. To ensure patient safety and autonomy, the VA must implement a policy requiring written informed consent before prescribing black box medications.

The Dangers of Inadequate Consent

As highlighted in the ProPublica investigation[1], gaps in VA mental health services have already led to tragic consequences for veterans. When psychiatric care is inconsistent or understaffed, veterans may not receive adequate counseling on the risks associated with their prescribed medications. Without clear, documented consent, they may be unaware of dangerous side effects, withdrawal risks, or alternative treatment options, leading to unintended harm.

The Importance of Written Informed Consent

Currently, informed consent for psychiatric medications is often verbal and informal, leaving room for miscommunication or lack of awareness. A standardized written consent process would:

4. **Ensure Transparency:** Veterans would receive clear, detailed information about the risks and benefits of black box medications before agreeing to take them.
5. **Promote Patient Autonomy:** Providing written consent empowers veterans to make informed decisions about their treatment.
6. **Enhance Accountability:** A documented process ensures that healthcare providers are fully informing patients of potential risks, reducing the likelihood of legal and ethical issues.
7. **Encourage Alternative Treatments:** Veterans should be made aware of therapy, non-drug interventions, and other options that may be preferable to high-risk medications.

Policy Recommendations:

8. Implement standardized written informed consent for all black box medications.
9. Ensure providers discuss risks and alternatives before prescription.
10. Improve follow-up protocols for veterans prescribed these medications.

Sources:

[1] Three Days of Tragedy: How a VA Clinic's Inability to Help Veterans in Crisis Destroyed Two Families by Kathleen McGrory and Neil Bedi, ProPublica. https://www.propublica.org/article/when-veterans-cant-access-the-psychiatric-care-they-need

Expanding Access to Hyperbaric Oxygen Therapy (HBOT)

Why HBOT?

- HBOT has shown promise in treating PTSD and TBI.
- Clinical studies report a significant reduction in PTSD symptoms among veterans receiving HBOT.
- Despite its potential, HBOT is not widely covered by the VA.

VA Pilot Program on HBOT for TBI & PTSD

The Department of Veterans Affairs (VA) has a responsibility to provide cutting-edge, effective treatments for veterans suffering from Traumatic Brain Injury (TBI) and Post-Traumatic Stress Disorder (PTSD). As traditional treatments, such as medication and psychotherapy, have shown limited success for many veterans, the VA must explore alternative, science-backed options. One such promising intervention is Hyperbaric Oxygen Therapy (HBOT), a well-documented therapy that enhances healing by delivering high levels of oxygen in a pressurized chamber. Given the emerging evidence supporting HBOT's effectiveness in treating neurological injuries, the VA

should launch a pilot program to evaluate its potential in improving the quality of life for veterans with TBI and PTSD.

HBOT Has Shown Promising Results in Treating Brain Injuries

While traditionally used for conditions like wound healing and decompression sickness, HBOT has gained traction in the medical community for its neuroregenerative properties. Studies have demonstrated that HBOT increases oxygen delivery to damaged brain tissue, reduces inflammation, and promotes neuroplasticity, all of which are critical for treating TBI and PTSD.

- Research in *The Journal of Clinical Psychiatry* showed improved brain function, reduced PTSD symptoms, and lower depression rates among participants who underwent HBOT.[1]
- The Israel Defense Forces (IDF) have successfully incorporated HBOT in their treatment protocols for soldiers with brain injuries, yielding positive long-term outcomes.[2]

Many Veterans Are Not Responding to Traditional Treatments

- Antidepressants and anti-anxiety medications are often prescribed but can come with severe side effects, dependency risks, and limited long-term success.
- Cognitive Behavioral Therapy (CBT) and Prolonged Exposure Therapy can be beneficial but require long-term commitment and often fail for veterans with severe PTSD.
- Suicide rates among veterans remain alarmingly high, with an estimated 17–22 veteran suicides per day, highlighting the urgent need for alternative, innovative therapies.

Policy Recommendations:

11. Establish VA pilot programs to study HBOT's effectiveness.
12. Expand coverage options for veterans with PTSD and TBI.
13. Increase research funding to validate HBOT as a viable treatment.

Sources:

[1] Doenyas-Barak, K., et al. (2024). Hyperbaric Oxygen Therapy for Veterans With Combat-Associated Posttraumatic Stress Disorder: A Randomized, Sham-Controlled Clinical Trial. The Journal of Clinical Psychiatry, 85(4). https://doi.org/10.4088/JCP.24m15464

[2] A promising new treatment for PTSD, by Seth Doane, 2024, CBS. https://www.cbsnews.com/news/promising-treatment-for-ptsd-hyperbaric-oxygen-therapy/

Supporting the Student Veteran Benefit Restoration Act

- Veterans lose education benefits when schools close or engage in fraudulent practices.
- The Student Veteran Benefit Restoration Act (H.R. 1391) ensures that education benefits are reinstated in these cases.

The Case for the Student Benefit Restoration Act

The Student Benefit Restoration Act is a critical piece of legislation that seeks to correct a longstanding injustice affecting student veterans. By restoring access to vital benefits, this bill ensures that veterans can pursue their education without unnecessary bureaucratic hurdles. With bipartisan support and the backing of numerous veteran advocacy groups, the act represents a crucial step toward fulfilling the nation's commitment to those who have served.

Background and Need for Reform

Under current policies, student veterans who experience disruptions in their education may lose access to key benefits under the GI Bill. These disruptions can include school closures, program disqualifications, or unforeseen personal circumstances. The Student Benefit Restoration Act aims to address these issues by reinstating benefits for veterans affected by such setbacks. According to a GAO report, thousands of Veterans can lose their benefits in the blink of an eye when an educational institution abruptly closes. Many of these veterans were left without recourse, forcing them to either abandon their education or shoulder additional financial burdens. This legislation would reinstate benefits for affected individuals, ensuring they are not penalized for circumstances beyond their control.

Policy Recommendations:

14. Guarantee full benefit restoration for impacted veterans.
15. Strengthen oversight on educational institutions.
16. Provide financial protections against fraudulent institutions.
17. Fund more studies that focus on the transition from military to civilian life.

Sources:

[1] POST-9/11 GI BILL Veterans Affected by School Closures.
https://www.gao.gov/assets/gao-19-553t.pdf

Guard and Reserve GI Bill Parity Act

- National Guard and Reserve members face unequal access to GI Bill benefits.
- Many service days do not count toward education benefits eligibility.

The Case for the Guard and Reserve GI Bill Parity Act

The Post-9/11 GI Bill has provided invaluable educational benefits to service members, helping them transition successfully into civilian life. However, National Guard and Reserve members face significant disparities in access to these benefits compared to their active-duty counterparts, despite playing a crucial role in national defense. The Guard and Reserve GI Bill Parity Act is essential to ensuring that all service members receive fair and equitable educational benefits.

Why Parity is Necessary

18. **Equal Service, Equal Benefits:** National Guard and Reserve members are integral to military operations, often serving alongside active-duty troops. They should not be penalized with fewer education benefits for the same commitment.
19. **Retention and Readiness:** Providing equal GI Bill benefits will improve recruitment and retention, ensuring that the Guard and Reserve remain a strong, capable force.
20. **Economic and Workforce Development:** Ensuring educational benefits for all service members supports career advancement, workforce development, and economic stability for veterans and their families.
21. **Fair Recognition of Service:** Many National Guard members have served multiple deployments but still do not qualify for full GI Bill benefits. This is an oversight that must be corrected to honor their contributions appropriately.

Policy Recommendations:

22. Ensure all service days count toward GI Bill eligibility.
23. Align Guard and Reserve benefits with active-duty standards.

Ending the "Wounded Veteran Tax" — The Major Richard Star Act

AFSA's Stance:

- Combat-injured veterans who are medically retired before 20 years face an unjust dollar-for-dollar offset between retirement pay and VA disability compensation.
- More than 52,000 combat-injured veterans are affected by this inequity.
- The Major Richard Star Act (H.R. 2102/S. 1032) would end this penalty and restore earned benefits.

Combat-injured service members who are medically retired before completing 20 years of service face a unique and unjust penalty: a dollar-for-dollar offset that reduces their

earned retirement pay by the amount of VA disability compensation they receive. These are not duplicative payments — the Department of Defense is responsible for retirement pay, and the VA is responsible for disability compensation. They are different payments for different purposes.

While Congress has partially addressed this inequity through Combat-Related Special Compensation (CRSC), more than 52,000 combat-injured veterans remain excluded from full concurrent receipt. Nearly 28,000 of these veterans have 10 or more years of service yet are denied the same benefits afforded to longevity retirees despite injuries sustained in direct defense of our nation.

This policy penalizes those forced out of service due to wounds incurred in defense of the nation and undermines trust in the military compensation system. As an organization representing those who served in uniform, AFSA finds this inequity unconscionable. The men and women who gave the most — those whose injuries ended their careers prematurely — should not be forced to forfeit retirement pay they rightfully earned.

The Major Richard Star Act (H.R. 2102/S. 1032) has garnered overwhelming bipartisan support, with more than 315 House and 77 Senate cosponsors. That represents three-quarters of Congress, and AFSA urges the committees to ensure this bill is brought to the floor without further delay.

Policy Recommendations:

24. Enact the Major Richard Star Act (H.R. 2102/S. 1032) to allow combat-injured medical retirees to receive both retirement pay and VA disability compensation concurrently.
25. End the practice of penalizing veterans whose injuries forced them out of service before reaching the 20-year longevity threshold.

Sources:

[1] Major Richard Star Act, H.R. 2102/S. 1032, 119th Congress. https://www.congress.gov/bill/119th-congress/house-bill/2102/text

Supporting Veterans' Caregivers

AFSA's Stance:

- There are an estimated 14.3 million military and veteran caregivers in the United States.
- Caregivers frequently sacrifice their own financial security, career advancement, and well-being.
- The Veteran Caregiver Reeducation, Reemployment, and Retirement Act (H.R. 2148/S. 879) would help address these gaps.

Family caregivers are an indispensable, yet often overlooked, component of our veterans' care system. Millions of military and veteran caregivers provide daily,

uncompensated care to veterans who are aging, disabled, or managing complex service-connected injuries and illnesses. These caregivers enable veterans to remain in their homes, reduce avoidable institutional care, and help stabilize already strained VA and community healthcare resources.

Yet despite their critical role, caregivers frequently are forced to sacrifice their own financial security, career advancement, physical health, and emotional well-being. According to a 2024 RAND report, approximately one-third of military and veteran caregivers believed they needed mental health care but did not receive it — primarily because they lacked the time. Individuals reported spending an average of $8,583 out of pocket annually on delivering care and forgoing more than $4,000 in annual income.[1]

The VA provides clinical support and a monthly stipend for roughly 67,000 caregivers enrolled in its Program of Comprehensive Assistance for Family Caregivers (PCAFC). However, that stipend is classified as unearned income, meaning caregivers are unable to build Social Security credits, retirement savings, or other long-term financial protections during years of full-time caregiving. When caregiving ends — whether due to a veteran's recovery, loss of eligibility, or death — many caregivers emerge financially insecure and disconnected from the workforce.

AFSA strongly supports passage of the Veteran Caregiver Reeducation, Reemployment, and Retirement Act (H.R. 2148/S. 879). This bipartisan legislation would reimburse caregivers for licensure fees, provide employment assistance for workforce reentry, and study the feasibility of caregiver-specific retirement planning support. Caregivers serve our veterans with unwavering dedication; they should not have to rebuild their own lives alone once that service ends.

Policy Recommendations:

26. Enact the Veteran Caregiver Reeducation, Reemployment, and Retirement Act (H.R. 2148/S. 879).
27. Publish and implement revised PCAFC regulations with a clear, transparent implementation timeline.
28. Provide retirement planning services and study the feasibility of a caregiver-specific retirement plan.

Sources:

[1] RAND Report, Sept. 24, 2024: America's Military and Veteran Caregivers: Hidden Heroes Emerging from the Shadows.
https://www.rand.org/pubs/research_reports/RRA3212-1.html

Protecting Survivor Benefits

AFSA's Stance:

- Dependency and Indemnity Compensation (DIC) rates have not kept pace with inflation or the true cost of loss.
- The remarriage age restriction penalizes surviving spouses for rebuilding their lives.
- The Love Lives On Act (H.R. 1004/S. 410) and the Caring for Survivors Act (H.R. 2055/S. 611) would address these longstanding inequities.

Servicemembers are asked to accept extraordinary risks in defense of our nation. They do so with the belief that if the unthinkable happens, their sacrifice will secure lifelong financial protection for their families. That promise must be kept — fully and without hidden conditions.

Under current law, surviving spouses who remarry before the age of 55 lose eligibility for Dependency and Indemnity Compensation (DIC). This policy financially penalizes survivors for rebuilding their lives, creating a government-designed incentive to remain single. AFSA joins the call to eliminate this remarriage age restriction entirely. A service member's sacrifice earns benefits for their family; those benefits should not come with an expiration date tied to the survivor's personal choices.

Furthermore, DIC rates have declined in real purchasing power over time. The baseline DIC benefit established in 1993 has lost more than half its buying power due to inflation, leaving many surviving spouses with inadequate financial support despite COLA adjustments. Survivors of federal civil service retirees receive up to 55% of the retiree's benefits — veterans' surviving spouses deserve no less.

AFSA supports the Love Lives On Act (H.R. 1004/S. 410), which would eliminate the remarriage age restriction, and the Caring for Survivors Act (H.R. 2055/S. 611), which would modernize DIC by setting it at 55% of the compensation for a 100% service-disabled veteran — matching the benchmark used for the Survivor Benefit Plan.

Policy Recommendations:

29. Enact the Love Lives On Act (H.R. 1004/S. 410) to eliminate the DIC remarriage age penalty.
30. Enact the Caring for Survivors Act (H.R. 2055/S. 611) to modernize DIC rates.
31. Index DIC to inflation to ensure fair and meaningful support for surviving families into the future.

Sources:

[1] Love Lives On Act, H.R. 1004/S. 410, 119th Congress.
https://www.congress.gov/bill/119th-congress/house-bill/1004/text

[2] Caring for Survivors Act, H.R. 2055/S. 611, 119th Congress.
https://www.congress.gov/bill/119th-congress/house-bill/2055/text

Protecting Veterans' Disability and Retirement Pay

AFSA's Stance:

- Disability and retirement pay are essential for veterans' financial security.
- Proposals to reduce these benefits must be firmly opposed.

We urge you to oppose any changes that would reduce veterans' disability compensation or military retirement pay—including any proposals that would limit or roll back concurrent receipt of both.

Veterans have served with unwavering dedication, often at great personal cost. Many depend on these benefits for financial stability, healthcare, and housing. Cutting them would break our nation's commitment, erode trust, and harm recruitment and retention efforts.

While fiscal responsibility is important, it should never come at the expense of those who have already sacrificed so much. Echoing VA Secretary Doug Collins, we must not balance the budget on the backs of our veterans. AFSA also strongly opposes any efforts to tax VA disability compensation or count it as income for other federal program eligibility. Veterans with service-connected disabilities should not face new financial burdens on benefits meant to offset the lifelong impacts of their injuries.

Policy Recommendations:

32. Maintain full disability and retirement benefits.
33. Oppose any budget cuts targeting veterans.
34. Oppose any proposal to tax VA disability compensation or apply it as countable income for other federal benefit programs.

Protecting the VA as an Institution

AFSA's Stance:

- The VA exists to fulfill a sacred obligation to those who served — it must be reformed and strengthened, not dismantled.
- Private healthcare systems are not designed around military service and cannot replicate the specialized care the VA provides.
- Efforts to dismantle or significantly privatize the VA threaten the long-term well-being of veterans.

The Department of Veterans Affairs was not created by accident or convenience. It was built out of necessity and obligation. After each major conflict in American history, our nation confronted the same question: How will we keep our promise to those who bore the cost of war? The VA emerged as the answer — a comprehensive system designed to provide healthcare, disability compensation, education benefits, housing support, and dignified burial services to a population defined not by income, age, or geography, but by service and sacrifice.

AFSA acknowledges that the VA faces real challenges: long wait times, aging infrastructure, and administrative inefficiencies are legitimate concerns that demand serious reform. However, acknowledging flaws is not the same as abandoning the mission. Calls to dismantle or significantly privatize the VA are often framed as pragmatic solutions offering veterans "choice." In practice, they risk hollowing out the only healthcare system in the country that is purpose-built for veterans.

Private healthcare systems are not designed around military service. They do not specialize in combat trauma, polytrauma rehabilitation, or the lifelong consequences of military exposures. And they are not accountable to veterans in the same way a public institution is. Once dismantling begins, it is rarely reversible. As resources, talent, and expertise are redirected away, the VA's ability to function deteriorates — creating a self-fulfilling prophecy in which weakened performance is used to justify further erosion.

Preserving the VA means reforming it with seriousness and resolve. It means modernizing facilities, investing in digital health infrastructure, streamlining claims processing, and holding leadership accountable for performance. It means expanding mental health capacity, strengthening rural access, and ensuring care keeps pace with evolving medical science. Most importantly, it means recognizing that the VA is not simply a healthcare provider — it is a covenant with those who have used and earned its services.

Policy Recommendations:

35. Oppose any legislation or executive action that would dismantle or significantly privatize the VA in ways that erode its core, veteran-centric mission.
36. Ensure sustained, predictable funding to modernize VA facilities, workforce, and digital infrastructure.
37. Hold VA leadership accountable for wait times, care quality, and accessibility for all veterans, including those in rural and underserved communities.

Conclusion

The well-being of our veterans is not a partisan issue, it is a national obligation. The policies outlined in this statement reflect a commitment to ensuring that those who have served our country receive the care, resources, and opportunities they deserve. From addressing the urgent mental health crisis and expanding access to innovative treatments like Hyperbaric Oxygen Therapy, to ending the wounded veteran tax, supporting caregivers and survivors, safeguarding educational benefits, and protecting veterans' disability and retirement pay — these priorities require unified action.

As members of Congress, you have the power to make a lasting impact. By working together, you can uphold the promises made to our service members and their families. Through bipartisan collaboration, we can enact policies that provide veterans with the support they need to transition successfully into civilian life, pursue their goals, and maintain their quality of life.

The Air Force Sergeants Association stands ready to work with you to advance these critical initiatives. Let us honor our veterans not just with words, but with decisive action. Together, we can ensure that those who have sacrificed so much for our freedoms receive the dignity, care, and benefits they have rightfully earned.

Written Statement for the Record of
Jerusha S. Hancock, Esq., Chief of Legal Operations[1]
Berry Law[2]

Submitted for the Joint Legislative Sessions on Veterans' Legislative Priorities

before the U.S. Senate and U.S. House of Representatives,
Committees on Veterans' Affairs

March 2026

Chairmen Moran and Bost, Ranking Members Blumenthal and Takano, and distinguished Members of the Committees,

My name is Jerusha Hancock, and I am the Chief of Legal Operations with Berry Law. I am honored to submit this statement to contribute to the Committees' consideration of legislation affecting veterans' disability claims adjudication, as well as the integrity, transparency, and accountability of the VA benefits system.

Berry Law represents veterans nationwide in VA disability claims, including complex cases involving chronic pain, neurological conditions, mental health disorders, and service-connected toxic exposures. Through this work, our firm has gained extensive firsthand experience with how VA health care delivery, clinical documentation, and administrative policy impact veterans' ability to establish service connection and obtain accurate disability ratings.

Our attorneys and staff regularly interpret and apply VA statutes, regulations, and claims guidance, providing practical insight into how legislative and policy changes operate in practice, both in the delivery of care and in the evidentiary record used to adjudicate claims. This claims-focused perspective allows Berry Law to evaluate proposed legislation not only as a matter of policy, but also in terms of its tangible effects on veterans navigating the VA system.

Our perspective complements the indispensable work of Veterans Service Organizations by providing formal legal expertise, appellate advocacy, and an integrated understanding of how medical evidence, access to care, and benefits adjudication intersect. Because veterans' health

[1] Biography available at: www.ptsdlawyers.com/veterans-lawyers/jerusha-hancock.
[2] Berry Law is a midwestern law firm established in 1965 that handles personal injury litigation and veterans' disability appeals, providing legal counsel to injured civilians and veterans nationwide with an emphasis on securing VA benefits and compensation entitlements. For more information, visit www.ptsdlawyers.com.

outcomes, access to care, and disability compensation are deeply interconnected, improvements to VA claims processes directly reinforce the Subcommittee's mission of ensuring timely, high-quality support for those who have served.

My testimony today highlights five priority areas where targeted reforms can ensure veterans receive timely, accurate, and equitable benefits, while modernizing VA operations to reflect contemporary clinical science, economic realities, and technological advancements. These priorities are interrelated: each addresses systemic weaknesses that compound over time, and together they offer a roadmap for improving outcomes for veterans, reducing preventable appeals, and strengthening confidence in the claims process.

1. **Restoring Accountability for Delayed and Erroneous Claims**
   Veterans should never be forced to endure years of uncertainty or lost benefits due to preventable administrative errors. Strengthening oversight, clarifying regulatory requirements, and creating mechanisms for timely review are essential to restoring trust in the system.

2. **Expanding Equity in Service-Connected Compensation**
   The current claims framework must reflect both contemporary clinical understanding and the diverse experiences of modern veterans. This includes recognizing trauma-related conditions, accurately adjudicating PTSD and related disorders, and ensuring that mental health claims are adjudicated in alignment with the latest research and evidence-based standards.

3. **Modernizing Mental Health Standards**
   Veterans seeking benefits for trauma-related conditions deserve a claims process grounded in contemporary psychiatric research. Updating stressor corroboration standards, expanding recognition of clinically validated trauma markers, and establishing systemic reforms will reduce preventable denials and remands while promoting equitable treatment.

4. **Promoting Economic Fairness Through Back Pay Reform**
   Delayed benefits are not merely administrative inconveniences, they have long-term consequences for financial stability, health, and retirement security. Reforming the backpay system to account for the economic opportunity lost during decades of delayed compensation will ensure that veterans are truly made whole, reflecting the realities of lifetime financial planning.

5. **Implementing Responsible, Transparent, and Accountable AI**
   Artificial intelligence holds great promise to improve claims accuracy, reduce errors, and standardize medical examinations. At the same time, AI introduces

unique challenges regarding privacy, oversight, and fairness. Careful, structured integration of AI as a decision-support tool, guided by human judgment, rigorous oversight, and transparent safeguards, will enable modernization without compromising veterans' rights or trust.

Across all five priorities, several consistent themes emerge: veteran-centered outcomes, evidence-based decision-making, and accountability for both administrative and technological processes. These reforms are not only morally imperative, but they are also operationally sound. They enhance efficiency, reduce avoidable appeals, and promote fairness, ensuring that veterans receive benefits that accurately reflect the service-connected impact of their conditions.

To provide clarity and assist Congress in evaluating these reforms, a comprehensive table of recommendations is included following this introduction. This table summarizes the priority areas, the systemic challenges they address, and the concrete actions we recommend for the VA and Congress to implement. In the testimony that follows, I will provide a detailed analysis of each priority, including both the challenges currently facing veterans and the concrete legislative and administrative steps that can improve outcomes across the country.

	Recommendation	**Intended Outcome / Purpose**
Priority No. 1: Timely & Accurate Claims Decisions (p. 5)	Implement standardized quality control procedures and training for adjudicators.	Reduce errors, remands, and prevent unnecessary delays in claims processing.
	Improve transparency and clarity in decision letters.	Ensure veterans understand decisions and avoid preventable appeals.
	Strengthen oversight and reporting mechanisms for front-end accuracy.	Promote accountability and consistent adjudication across the VA system.
Priority No. 2: Duty to Assist and Higher-Level Review Reforms (p. 13)	Clarify that duty-to-assist errors should only benefit claimants, not trigger redevelopment of previously granted service connection.	Preserve statutory intent and protect veterans' established benefits.
	Require enhanced notice when duty-to-assist errors could affect existing service connection.	Ensure veterans are aware of potential consequences and can respond before adverse actions.
	Align higher-level review practices with pro-claimant principles in 38 U.S.C. § 5103A and AMA.	Restore fairness, consistency, and confidence in the appeals system.

	Recommendation	Intended Outcome / Purpose
Priority No. 3: Modernizing Mental Health Standards (p. 22)	Clarify and expand stressor corroboration criteria for PTSD claims.	Reduce preventable remands and denials; reflect contemporary understanding of trauma.
	Recognize scientifically validated behavioral, cognitive, and physiological trauma markers across mental health conditions.	Ensure equitable adjudication for all trauma-related disorders.
	Establish a scientific task force to review evidentiary standards and recommend regulatory updates.	Align VA adjudication with contemporary clinical research and best practices.
Priority No. 4: Economic Fairness and Back Pay Reform (p. 25)	Calculate back pay using current COLA-adjusted rates for cases involving VA error.	Compensate veterans for lost opportunity, build equity, and make them financially whole.
	Alternatively, calculate back pay using historical rates plus interest.	Provide partial remedy for lost financial stability where full COLA-adjusted approach is not feasible.
	Limit reform to cases of VA error, excluding delays caused by the veteran, with phased implementation.	Manage fiscal impact while targeting relief to those harmed by VA mistakes.
Priority No. 5: Responsible AI Integration (p. 30)	Use AI to calculate effective dates for service connection and increased evaluations, with human review of all outputs.	Reduce effective date errors, improve retroactive compensation accuracy, and prevent unnecessary appeals.
	Maintain human oversight and establish training, probation, and audit programs for AI-assisted workflows.	Preserve fairness, accountability, and legal compliance in claims adjudication.
	Ensure transparency and veteran choice, including opt-out options for AI-assisted processes.	Uphold veterans' rights, maintain trust, and provide informed participation.
	Implement robust data protection, cybersecurity, retention policies, and feedback mechanisms for AI workflows.	Protect PII, PHI, and sensitive veteran data; mitigate security and privacy risks.
	Use AI to pre-screen medical examination reports for completeness, rationale, and regulatory compliance.	Reduce remands, improve examination quality, and increase efficiency without replacing medical judgment.

PRIORITY No. 1: IMPROVING TIMELINESS

Preventing early errors and reducing remand cycles.

The most effective way to reduce backlog in the VA disability claims system is to ensure accuracy and completeness at the earliest stages of adjudication. Systemic delays are less often caused by legal ambiguity and more frequently by recurring procedural errors, inconsistent evidence development, redundant nexus examinations, and avoidable remand cycles. Even under the *Veterans Appeals Improvement and Modernization Act of 2017* (AMA),[3] many Veterans continue to wait years for final resolution of their claims. These delays impose not only financial and emotional burdens on Veterans but also substantial operational costs on the VA, further straining adjudicative resources. Veterans who rely on disability compensation to cover basic living expenses may face months of hardship when claims are prolonged by preventable errors.

Frequent contributors to delay include repeated remands, incomplete evidence collection, inconsistent examination quality, and unclear reasoning in decision letters. These inefficiencies cascade throughout the system: a single early-stage error can multiply into multiple supplemental claims, Higher-Level Review (HLR) requests, and Board of Veterans' Appeals (Board) remands, significantly extending total adjudication time.

The existing statutory and regulatory framework already provides sufficient authority to address these challenges. The central opportunity lies not in structural overhaul, but in disciplined execution: proactive error prevention, standardized operational practices, and consistent application of procedural requirements. By prioritizing early-stage accuracy, ensuring thorough and consistent evidence development, and maintaining transparency in decision-making, the VA can reduce unnecessary remands, shorten claim lifecycles, and deliver timely, reliable, and Veteran-centered decisions.

A. Root Causes of Delay

Even though the AMA established a multi-lane review system, including supplemental claims, Higher-Level Review (HLR), and direct Board appeals, bottlenecks persist across the VA disability claims process. Delays are particularly pronounced in cases requiring additional evidence development or when technical deficiencies in initial decisions trigger mandatory remands. Several recurring factors contribute to prolonged claim lifecycles, each compounding downstream workloads for Regional Offices and the Board.

A principal source of delay is repeated and incomplete evidence development. Under 38 U.S.C. § 5103A and 38 C.F.R. § 3.159, the VA has a statutory duty to assist claimants in obtaining relevant evidence, including federal and private medical records, and to provide medical examinations when necessary. In practice, however, evidentiary gaps remain common. Missing or incomplete records, inadequate medical opinions, and failure to properly consider competent lay

[3] Pub. L. No. 115-55.

evidence often necessitate supplemental development or Board remands, creating cycles of inefficiency.

Key contributors to delays include:

- Inadequate Examinations: Medical opinions that lack sufficient rationale, fail to address aggravation,[4] or omit consideration of competent lay evidence frequently trigger repeated development cycles. When examiners do not fully analyze all facets of a claimed condition, subsequent reviewers must request additional examinations or clarifying opinions, which lengthens adjudication timelines.
- Failure to Address All Theories of Entitlement: Initial decisions that overlook secondary service connection,[5] aggravation, and other reasonably raised theories of entitlement force Veterans to submit supplemental claims or appeal to the Board. These preventable gaps propagate through every stage of the process, multiplying workload and delaying final resolution.
- Insufficient "Reasons or Bases":[6] Decisions that do not clearly explain how evidence was weighed or why certain findings were made fail to meet the requirements of 38 U.S.C. § 7104(d)(1) and 38 C.F.R. § 3.103(a). Without clear reasoning, remands become the primary corrective mechanism, compounding inefficiency and contributing to a cycle of repeated review.

Judicial precedent reinforces the need for thorough, well-reasoned decision-making. In *Barr v. Nicholson*, 21 Vet. App. 303 (2007), the Court held that once VA provides an examination, it must be adequate. In *Stefl v. Nicholson*, 21 Vet. App. 120 (2007), the Court emphasized that medical opinions must contain sufficient rationale to permit informed Board review. Similarly, *Robinson v. Peake*, 21 Vet. App. 545 (2008), requires VA to address all theories of entitlement reasonably raised by the record. Consistent adherence to these standards is essential to prevent avoidable remands and improve system-wide efficiency.

B. The Remand Ripple Effect: How Backlogs Multiply

Remands extend the lifecycle of claims because the Board is legally obligated to correct deficiencies under 38 U.S.C. §§ 5103A(f)(2) and 7104(a). While remands play an important role

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[4] "Aggravation theory" refers to compensation for the degree to which a non-service-connected disability is permanently worsened beyond its natural progression by a service-connected condition. 38 C.F.R. § 3.310(b); see also *Allen v. Brown*, 7 Vet. App. 439 (1995).

[5] "Secondary service connection" refers to a disability that is proximately due to or the result of an already service-connected condition. 38 C.F.R. § 3.310(a).

[6] "Reasons or bases" refers to the statutory and regulatory requirement that the VA provide a clear written explanation of the factual findings, legal standards applied, and rationale supporting its decision, sufficient to permit the claimant to understand the precise basis for the decision and to facilitate meaningful judicial review.

in safeguarding due process and reinforcing the VA's duty to assist, repeated remand cycles can significantly prolong overall processing times. Claims that could be resolved in months may instead take years, as files are redeveloped, additional examinations are scheduled, and new decisions are issued.

These delays create cascading administrative burdens throughout the system. Each remand can trigger supplemental evidence development, additional medical examinations, HLR, and repeated Board evaluations. Many of these remands result not from substantive disagreement over entitlement but from predictable, correctable deficiencies, such as incomplete evidence collection, insufficient rationale in medical opinions, or failure to address all reasonably raised theories of entitlement.

Data consistently demonstrate that remanded claims take substantially longer to reach final disposition than non-remanded claims.[7] Our firm's experience confirms that a large portion of remands stem from recurring errors that could have been corrected at the initial adjudicatory stage. This pattern highlights a fundamental principle: improving accuracy early in the claims process is not merely advantageous, it is essential to reducing systemic delays.

By prioritizing thorough development, complete evidence collection, and clear, well-supported reasoning at the outset, the VA can prevent errors from cascading through subsequent stages, shorten claim lifecycles, and alleviate both administrative workload and Veteran hardship. Early-stage diligence is the most effective safeguard against the compounding delays caused by repetitive remands.

C. Preventing Early-Stage Errors

A substantial portion of systemic delay originates at the initial claim and HLR stages. These errors are rarely novel or legally complex; they are recurring and identifiable. When they occur early, mistakes cascade through the system, driving supplemental claims, HLR requests, and ultimately Board remands. Addressing these issues at the outset materially reduces the number of cases that advance unnecessarily and shortens claim lifecycles.

Get It Right the First Time

Initial rating decisions are governed by the duty to assist under 38 U.S.C. § 5103A and 38 C.F.R. § 3.159. This duty encompasses:

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[7] *See* Department of Veterans Affairs, Board of Veterans' Appeals. (2024). *Chairman's annual report: Fiscal year 2023* (p. 43) (Average Remand Time Factor of 331 days, representing the additional time remanded cases spend in development before final resolution compared with non-remanded cases). U.S. Department of Veterans Affairs. Available at: www.department.va.gov/board-of-veterans-appeals/wp-content/uploads/sites/19/2025/04/2023_bva2023ar.pdf. Last accessed: Feb 28, 2026.

- Comprehensive Evidence Collection: Ensuring that all relevant service and medical records, both federal and private, are obtained before a decision is issued.
- Adequate Medical Examinations: Providing needed examinations that thoroughly address both primary and secondary service connections, including aggravation analyses, and that incorporate all competent lay evidence.
- Clear and Defensible Decisions: Issuing rating decisions with well-articulated reasons-and-bases that demonstrate how evidence was weighed and why certain findings were made.

Failure to address all reasonably raised theories of entitlement propagates errors through every subsequent stage of review, generating downstream workload and unnecessary delays.

Common Early Errors

Under the AMA, remand is required, not discretionary, for pre-decisional duty-to-assist errors.[8] Our firm has found that these patterns, often detectable before a decision is finalized, include:

- Incomplete Medical Opinions: Examinations or opinions that omit aggravation analysis under 38 C.F.R. § 3.310(b) or fail to connect the condition to service.
- Insufficient Consideration of Lay Evidence: Examinations or decisions that ignore credible statements from Veterans or other competent lay sources.
- Factual Deficiencies: Opinions based on incomplete or inaccurate factual histories that fail to reflect the totality of the record.
- Evidence Gaps: Failure to obtain or review all relevant federal or private treatment records.
- Neglected Entitlement Theories: Decisions that do not explicitly address all reasonably raised claims, including secondary service connection, aggravation, or alternative bases of entitlement.

When left uncorrected, these errors generate years of avoidable supplemental claims, HLR requests, and Board remands, compounding delays and administrative burden.

[8] 38 U.S.C. § 5103A(f)(2); 38 C.F.R. § 20.802(a).

Making Higher-Level Review Meaningful

HLR is designed to provide *de novo*[9] review by a more experienced adjudicator, offering an opportunity to correct early-stage errors before a case reaches the Board. Its effectiveness depends on active, rigorous evaluation:

- Proactive Error Correction: When HLR officers thoroughly reassess examination adequacy, duty-to-assist compliance, and coverage of all entitlement theories, many appeals can be resolved without further escalation.
- Avoiding Mere Confirmation: If HLR primarily serves to confirm initial decisions, early errors persist, compounding workload, delaying resolution, and undermining Veterans' confidence in the VA process.

In many instances, appeals arise not just from disagreement with the outcome, but from a lack of clarity in the rationale. Decisions that clearly articulate their analytical pathway are more defensible and reduce avoidable appellate review. Transparent reasons-and-bases reinforce trust in the system, clarify evidentiary gaps, narrow disagreements, and minimize unnecessary supplemental filings, benefiting both veterans and the VA.

D. Strengthening HLR Conferences

Because HLR is conducted *de novo* and does not permit submission of new evidence, HLR conferences were established under the AMA to allow claimants to clarify the existing record, address issues potentially overlooked in the initial rating decision, and resolve disputes before cases proceed through adjudication. These conferences provide a critical early-stage intervention, fostering direct engagement with adjudicators and enhancing transparency in evidentiary evaluation.

Veterans consistently report that substantive HLR conferences improve their understanding of the claims process and increase confidence in adjudication outcomes. When conducted properly, they allow minor procedural or evidentiary issues to be corrected before cases escalate to formal remands and ensure that all reasonably raised theories of entitlement are considered. This potential, however, is realized only when conferences are substantive rather than perfunctory.

Despite this promise, current HLR practices vary widely, undermining system efficiency. Across Regional Offices, procedures for scheduling and rescheduling conferences are inconsistent, resulting in missed or delayed appointments. Adjudicator interpretation of medical evidence differs across offices, producing uneven outcomes. In some locations, conferences primarily confirm the

[9] "*De novo* review" refers to review conducted without deference to the prior decision-maker's factual findings or legal conclusions. In the context of HLR, it means that a qualified VA reviewer examines the claim anew, considering the evidence of record at the time of the review, without deference to the prior decision, but does not allow submission of new evidence. 38 C.F.R. § 3.2600; 38 U.S.C. § 5104B(c).

initial decision rather than critically reviewing evidence, adequacy and reasoning. As a result, avoidable errors persist into the Board stage, generating remands and extending final resolutions by months or even years. This inconsistency increases workload and erodes veterans' confidence in timely, fair adjudication.

HLR conferences have the potential to serve as a critical safeguard against early-stage errors in VA disability claims. Fully realizing this potential requires consistent, standardized procedures, comprehensive training, and data-informed oversight. When HLR functions as intended, identifying errors early, correcting deficiencies, and clarifying evidentiary issues, the VA system benefits from improved timeliness, reduced remand rates, and more reliable decisions. For veterans, a strengthened HLR process translates into faster, more accurate determinations and greater confidence that their claims are evaluated thoroughly, fairly, and transparently.

E. Reducing Remand Cycles

Repeated remands between the Board and Regional Offices are a major cause of delays in the disability claims process. While remands are sometimes necessary to ensure compliance with statutory and regulatory obligations, their frequency and persistence reveal systemic weaknesses. Each remand can add months or even years to claim resolution, creating financial, health, and emotional burdens for Veterans while consuming substantial administrative resources.

Many remands do not arise from genuine disagreements over entitlement but from correctable procedural errors. Common drivers include incomplete evidence development, inadequate medical examinations, and insufficient reasoning in decisions.[10] Across all claim types, these recurring procedural deficiencies compound over time, producing cyclical remand patterns that significantly extend claim lifecycles.

The impact on timeliness is profound. These triggers are identifiable, predictable, and, most importantly, preventable. By addressing them systematically, VA can improve efficiency, reduce processing time, and preserve claimant protections without altering entitlement standards. Prioritizing accuracy and thoroughness at the earliest stages, through comprehensive evidence collection, well-supported medical examinations, and clear, defensible decision-making, can substantially reduce avoidable remands. Early-stage diligence prevents errors from multiplying throughout the system, shortens claim lifecycles, conserves resources, and delivers timely, reliable outcomes for Veterans.

F. Leveraging Presumptive Secondary Conditions

Many secondary service connection claims require repeated nexus opinions, even when the relationship to a primary service-connected condition is well-established. Certain secondary conditions have well-documented associations with primary service-connected disabilities.

[10] As an example, in mental health claims, particularly posttraumatic stress disorder (PTSD), remands frequently occur due to incomplete verification of claimed stressors under 38 C.F.R. §§ 3.304(f) and 3.307.

Frequently encountered examples include radiculopathy resulting from degenerative spine disease, peripheral neuropathy secondary to orthopedic conditions, chronic migraines following traumatic brain injury, and depressive or anxiety disorders associated with chronic pain. Despite the medical consensus supporting these relationships, current procedures often require duplicative nexus development, contributing to delays and unnecessary administrative burden.

Implementing narrowly tailored presumptive frameworks for medically established secondary conditions could streamline adjudication and reduce redundant development. This approach builds on statutory precedent, such as chronic disease presumptions under 38 U.S.C. § 1112 and toxic exposure presumptions under the *Honoring our PACT Act of 2022*,[11] which recognize patterns of causation supported by clinical and epidemiological evidence.

Key safeguards for any presumptive framework would include:

- Limiting recognition to medically supported conditions: Ensuring only conditions with strong, consistent evidence are covered.
- Requiring a clear diagnosis of the primary disability: Establishing the service-connected condition before applying the presumption.
- Allowing rebuttal evidence: Maintaining accuracy by permitting evidence that demonstrates an alternative cause.
- Grounding presumptions in clinical and epidemiological consensus: Using established medical science to ensure reliability and fairness.

By adopting such frameworks, adjudicators can focus on evaluating proper rating criteria, severity, functional loss, and occupational impact, rather than repeatedly confirming causation that is rarely in genuine dispute. This targeted approach reduces procedural delays, prevents avoidable remands, and allows VA resources to be allocated to more complex or contested claims, ultimately improving timeliness and efficiency for Veterans

G. Optimizing Examination Scheduling and Communication

Missed Compensation and Pension (C&P) examinations are one of the most preventable sources of delay in the VA disability system. These examinations are essential to accurate adjudication, yet breakdowns in scheduling and communication frequently result in missed appointments. We have found that, often, these issues arise from systemic operational challenges (e.g., short notice, outdated contact information, unclear instructions, or inconsistent outreach) rather than from any lack of participation by the Veteran. Missed examinations can lead to incomplete records, denials, and appeals, creating cascading delays that again extend claim timelines and consume substantial administrative resources.

[11] Pub. L. 117-168.

Operational failures contributing to missed exams include last-minute scheduling changes, communications from unfamiliar phone numbers being filtered as spam, lost postal notices, and unclear instructions regarding appointment location, importance, or virtual platforms. Reliance on a single communication channel without confirmation further exacerbates these challenges. While VA regulations[12] provide guidance for timely notifications and documentation, implementation varies widely across contractors and facilities, leaving room for confusion and preventable missed appointments.

To address these challenges, VA should standardize and streamline communication and scheduling practices. Multi-channel notifications with minimum notice periods, documented outreach attempts, confirmation of receipt, and centralized access to scheduling portals, such as VA.gov and My HealtheVet, can ensure Veterans receive clear, timely information. Instructions should clearly explain how to report barriers or request rescheduling. By implementing these operational improvements, VA can reduce preventable missed examinations, minimize downstream appeals and remands, conserve resources, and deliver more timely, reliable outcomes for Veterans.

H. Toward Faster, More Accurate Decisions

Delays in VA disability claims arise primarily from recurring, preventable process deficiencies rather than substantive entitlement disputes. Early-stage errors, incomplete evidence, unclear reasoning, inconsistent HLR practices, repetitive nexus analyses, and missed examinations all contribute to cascading remands.

Addressing these issues through standardized procedures, quality control measures, competency-based training, and data-informed oversight allows VA to exercise its existing statutory authority effectively, reduce unnecessary remands, and improve timeliness. Prioritizing early accuracy, consistency, and proactive error correction strengthens the system, conserves resources, and ensures Veterans receive fair, timely, and reliable access to benefits.

To translate these insights into actionable improvements, the following targeted measures, directed by Congress, can help VA strengthen early-stage accuracy, reduce preventable remands, and ensure timely, Veteran-centered decisions:

- Front-Loaded Quality Assurance: Implement pre-decision quality reviews at Regional Offices to verify evidence completeness, adequacy of medical examinations, and consideration of all reasonably raised entitlement theories. Require certification with each rating decision that statutory and regulatory standards are met.
- Standardization and Checklists: Use standardized adjudication checklists to ensure direct, secondary, and aggravated claims are properly addressed.

[12] *See* 38 C.F.R. § 3.655 and 38 C.F.R. § 3.160(f), and VHA Directive 1500 series.

Standardize reasons-and-bases requirements to reduce remands caused by insufficient explanations.

- HLR Strengthening: Transform Higher-Level Review into an active error-correction mechanism by:
    - Standardizing HLR conference procedures.
    - Providing comprehensive competency-based training for adjudicators.
    - Aligning performance metrics with error identification and correction rather than throughput alone.

- Training and Performance Oversight: Implement recurring, competency-based training for adjudicators and examiners focused on aggravation, adequate rationale, and evaluation of competent lay evidence. Track remand root causes by claim type, adjudicator, and Regional Office to enable targeted improvements.
- Presumptive Secondary Conditions: Adopt narrowly tailored presumptive frameworks for medically well-established secondary conditions, with safeguards for rebuttal evidence, ensuring focus is on rating criteria rather than repetitive causation analysis.
- Examination Scheduling and Communication: Standardize multi-channel appointment notifications, ensure minimum notice periods, document outreach attempts, centralize scheduling access via VA secure portals, and clarify instructions for reporting barriers or requesting rescheduling.
- Data Transparency and Continuous Improvement: Collect and publish standardized data on primary remand drivers, recurring error trends, and corrective actions to support oversight, data-driven decision-making, and continuous quality improvement.

PRIORITY No. 2: STANDARDIZED ADJUDICATION

Ensuring consistent, high-quality, and transparent adjudication nationwide.

Veterans rely on the VA to adjudicate claims for disability benefits in a fair, timely, and consistent manner. For veterans with similar claims, outcomes should be predictable, consistent, and reflective of statutory and regulatory standards, regardless of which Regional Office or adjudicator handles the case. Consistency is a fundamental component of fairness in the veterans' benefits system, and its absence has profound consequences. When similar claims yield divergent results, veterans lose confidence in the system, appeals increase, and administrative resources are

consumed unnecessarily. Addressing adjudication variability is therefore essential both to restore trust and to improve efficiency across the VA system.

A. Systemic Variability in Adjudication

Despite clear statutory and regulatory guidance, including 38 U.S.C. § 1155 (governing disability evaluations), 38 U.S.C. § 5107(b) (the evidentiary standard for service connection), and the Schedule for Rating Disabilities at 38 C.F.R. Part 4, outcomes in VA claims remain inconsistent. The U.S. Court of Appeals for Veterans Claims has repeatedly affirmed that when evidence is in "approximate balance," the benefit of the doubt is to be resolved in favor of the veteran.[13] Yet, in practice, identical or nearly identical claims are often adjudicated differently depending on the RO, the assigned Rating Service Representative, or the contract examiner used.[14]

Variability manifests not only in outcomes but also in the quality of reasoning and analysis. Cases are routinely remanded by the Board of Veterans' Appeals for errors that could have been avoided with thorough front-end adjudication. These remands often involve the failure to consider all reasonably raised theories of entitlement, inadequate or legally insufficient medical examinations, or unclear reasoning in the decision letters.[15] Such disparities impose real costs on veterans, forcing them to navigate complex appeals over matters that should have been decided correctly the first time. For the VA, inconsistent adjudication results in repeated workloads, inefficiencies, and prolonged resolution of claims.

Further, the increased reliance on contract medical examiners to meet timeliness metrics has created a new source of variability. While contracting allows the VA to scale operations quickly, oversight mechanisms have not consistently ensured that contract examinations meet legal and medical standards. This has led to recurring deficiencies, including incomplete review of prior records, inaccurate factual assumptions, and superficial or conclusory opinions. Examiners sometimes misunderstand or misapply legal standards for service connection, apply inappropriate probability thresholds, or fail to perform required analyses for secondary service connection or aggravation. In effect, these inconsistencies produce a system in which veterans with equivalent service histories and medical evidence may receive widely differing outcomes.

The human impact of this variability cannot be overstated. Veterans are left confused, frustrated, and distrustful of a system intended to support them. They may endure unnecessary delays in receiving earned benefits, file repetitive appeals, and expend personal time and resources

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[13] *Gilbert v. Derwinski*, 1 Vet. App. 49 (1990).

[14] Oversight bodies have repeatedly found that error rates, remand rates, and medical examination deficiencies vary significantly by location and adjudicator, undermining confidence in the system and creating inequitable treatment for similarly situated veterans. U.S. Gov't Accountability Office (GAO), *VA Disability Benefits: Improved Quality Assurance and Oversight Needed* (GAO-18-352) (2018); VA Office of Inspector General (OIG), *Review of VBA's Oversight of Contract Medical Examinations* (Report No. 19-XXXX) (2020).

[15] *See, generally,* Board of Veterans' Appeals Annual Reports, available at www.department.va.gov/board-of-veterans-appeals/annual-reports-to-congress. Last accessed Feb. 25, 2026.

to correct errors that were preventable. In some cases, these discrepancies discourage veterans from using streamlined appeals processes, such as higher-level review, because they fear additional scrutiny or unintended consequences on already granted benefits. The resulting bottlenecks further strain the system and diminish the efficiency gains that reforms such as the Appeals Modernization Act (AMA) were designed to achieve.

B. Adequacy and Consistency of Medical Examinations

Medical examinations are a cornerstone of accurate adjudication, as they form the evidentiary basis for determining the nature, severity, and service connection of a disability. Under 38 U.S.C. § 5103A, the VA has a statutory duty to provide adequate examinations when necessary to decide a claim. For an examination to be adequate, it must be based on a complete review of the veteran's claims file, include a detailed description of the disability, and provide a clear, reasoned medical opinion that allows adjudicators to make informed decisions.[16] Examiners must avoid substituting their judgment for the adjudicator's and must not resolve legal questions, instead providing medical expertise to support adjudication.[17]

Despite these standards, recurring deficiencies plague medical examinations, both from contract examiners and VA staff. Common problems include incomplete review of prior medical history, reliance on inaccurate factual assumptions, insufficient reasoning in medical opinions, and failure to address legally mandated elements such as aggravation, secondary service connection, or the relevance of lay evidence.[18] Secondary conditions, in particular, are prone to inconsistency, as examiners frequently fail to analyze causal chains comprehensively or document intermediate steps,[19] such as the role of obesity in exacerbating a service-connected condition.[20]

The consequences of inadequate or inconsistent examinations are significant. They lead to unnecessary remands, repetitive development requests, and delays that can last months or years. Veterans who have already experienced prolonged waits for determinations may face additional barriers in demonstrating entitlement to benefits. In practice, inadequate examinations can also compromise decision-making at later stages, including HLR or Board review, because subsequent adjudicators are forced to resolve uncertainties caused by incomplete or legally deficient medical documentation.

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[16] *Barr v. Nicholson*, 21 Vet. App. 303 (2007); *Nieves-Rodriguez v. Peake*, 22 Vet. App. 295 (2008).
[17] *Delrio v. Wilkie*, 32 Vet. App. 232 (2019).
[18] VA OIG, *Contracted Disability Examination Program Review* (multiple reports). *See also* GAO-18-352.
[19] National Academies of Sciences, Engineering, and Medicine. (2007). *A 21st century system for evaluating veterans for disability benefits*. National Academies Press. Available at www.nationalacademies.org/read/11885. Last accessed on Feb. 25, 2026. (Noting that C&P exam deficiencies, including incomplete exams and inadequate medical opinions, constituted a large proportion of remand reasons, demonstrating longstanding challenges in exam quality).
[20] *Walsh v. Wilkie*, 32 Vet. App. 300 (2020).

C. Transparency and Accountability in Adjudication

Veterans currently have limited visibility into the performance of adjudicators or medical examiners. While internal quality review mechanisms exist, there is no publicly accessible system tracking patterns of inadequate performance, corrective measures, or repeat deficiencies.[21] When flawed examinations or decisions lead to denials, veterans are forced into appeals to correct systemic errors. This shifts the burden onto the claimant, creating inequities and undermining trust in the system.

The lack of transparency also impedes broader accountability. Without clear reporting on examiners' performance, recurring deficiencies persist uncorrected, and systemic trends remain difficult to address proactively. This opacity affects both veterans and the VA, as it increases appeals, delays benefits, and consumes administrative resources that could otherwise be directed toward complex or novel cases.

D. Clear Decision Letters

Clear, comprehensible decision letters are essential to due process, administrative fairness, and veteran trust. Veterans must be able to understand what has been decided, why, and what options are available for review or appeal. The statutory framework under 38 U.S.C. § 5104 is designed to provide notice of issues adjudicated, evidence considered, favorable findings, reasons for denials, and instructions for review.

Unfortunately, in practice, decision letters frequently fall short of this statutory mandate. They frequently contain dense regulatory citations, technical language, and poorly organized reasoning that is inaccessible to most veterans. This lack of clarity makes it difficult to determine whether an appeal is worthwhile or how to strengthen their case.

The VA's February 2024 *Periodic Progress Report on Appeals* shows that only 25% of veterans requested a review of their initial claims' decisions.[22] It is deeply troubling and likely reflects the confusing and opaque nature of decision letters rather than satisfaction with outcomes. In fiscal year 2025, the VA processed over one million claims, granting more than 60% and denying roughly 40%.[23] Even among granted claims, veterans may have legitimate grounds to appeal

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[21] For additional information, please see my colleague, Stephanie Costello's, statement for the record submitted for the January 14, 2026, oversight hearing "Reevaluating the Rating Schedule: Examining VA's Efforts to Modernize Disability Benefits." Available at: https://docs.house.gov/meetings/VR/VR09/20260114/118820/HHRG-119-VR09-20260114-SD002.pdf.

[22] U.S. Department of Veterans Affairs. (2024). Periodic Progress Report on Appeals. Accessed on February 23, 2025, at https://benefits.va.gov/REPORTS/AMA/CMR/2024/appeals-report-cmr-202402.pdf.

[23] VA News. (February 25, 2025). VA processes one million disability claims faster than ever before. Accessed on February 24, 2026, at https://news.va.gov/press-room/va-processes-one-million-disability-claims-faster-than-ever-before/#:~:text=Despite%20receiving%2015.6%25%20more%20claims,to%20Veterans%20and%20VA%20beneficiaries.%E2%80%9D&text=Veterans%20with%20questions%20about%20their,documents%20can%20be%20submitted%20online.

aspects such as assigned disability ratings, effective dates, or other components that materially affect their benefits.

When three-quarters of veterans do not seek any form of review, we must ask why. Are they truly satisfied?

Experience suggests otherwise: many veterans contact our firm not because they want to appeal, but because they cannot comprehend their decision letters or the options. The low appeal rate may reflect confusion, frustration, or resignation, leaving meritorious claims unreviewed.

Unclear decision letters have cascading effects. Veterans may not realize that an adverse decision was rendered, miss appeal deadlines, or file unnecessary appeals for already favorable decisions. They may also contact Veterans Service Organizations, private attorneys, or VA call centers for clarification, diverting time and resources from substantive assistance. Systemic inefficiencies arise when follow-up adjudicators cannot easily interpret prior decisions, potentially re-litigating previously resolved issues or overlooking favorable findings.

Decision letters must be written for the veteran, not as internal administrative documents. Key elements must include:

- Explicit favorable findings with clear ratings and effective dates;
- Clear adverse findings explaining why claims were denied and what additional evidence could support a successful claim;
- Transparent discussion of how evidence was weighed and conclusions reached;
- Complete plain-language instructions on appeal rights and deadlines; and
- Identification of unresolved issues to prevent duplicative filings.

E. Duty-to-Assist and Post-Service-Connection Safeguards

As previously mentioned, under 38 U.S.C. § 5103A, the VA has a statutory duty to assist claimants in developing their claims.[24] Congress explicitly clarified that these responsibilities "shall not be construed as precluding the Secretary [of Veterans Affairs] from providing such other assistance [. . .] as the Secretary considers appropriate."[25]

In practice, when a higher-level adjudicator identifies a duty-to-assist error during review but cannot grant the maximum benefit, the claim must be returned for correction and

[24] 38 U.S.C. § 5103A. *See also* 38 C.F.R. §§ 3.156, 3.159.
[25] *See* 38 U.S.C. § 5103A(f).

readjudication.[26] The duty to assist exists solely to benefit the claimant and is grounded in the pro-veteran canon of statutory interpretation.[27] It is not intended as a mechanism to re-litigate or reduce already established service connections.

Despite this, HLR processes frequently use identified duty-to-assist errors to redevelop or readjudicate service-connected conditions. This practice undermines the statutory safeguards that Congress intended, discourages veterans from using streamlined appeal processes, and increases workloads for the Board.[28]

Current notice practices are generic, and thus inadequate. Veterans are often informed generically that a duty-to-assist error was identified and that additional development will occur, without being told that their previously granted service connections may be at risk. Typical language includes:

> *We failed to get an examination(s) and/or medical opinion(s). We will develop for adequate VA examination(s) and/or medical opinion(s).*

Internal VA memos that outline the intent to redevelop or readjudicate service connection are not provided to the veteran and require Freedom of Information Act (FOIA) or Privacy Act requests to access,[29] a process that can take months, or even years.

Adequate notice should include:

- A clear explanation of the error and why additional development is necessary;
- An opportunity to respond before development occurs; and
- Disclosure of potential consequences, including possible reduction or severance of benefits.

VA's reporting illustrates the scale of potential impact:

- As of February 23, 2025, 574,246 claims were pending, including those requiring development and decision by the Veterans Benefits Administration (VBA).[30]

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[26] *See* 38 C.F.R. § 3.2601(g) *See also Hodge v. West*, 155 F.3d 1356, 1362 (1998) ("This court and the Supreme Court both have long recognized that the character of the veterans' benefits statutes is strongly and uniquely pro-claimant.").
[27] *Gilbert v. Derwinski*, 1 Vet. App. 49.
[28] Board of Veterans' Appeals. Decision wait times. Accessed on February 23, 2026, at https://department.va.gov/board-of-veterans-appeals/decision-wait-times.
[29] Accredited representatives have a right to remote, read-only access to Veterans Benefits Management System (VBMS) file under 38 C.F.R. §§ 1.600(b)(1) and 1.601(a)(2).
[30] U.S. Department of Veterans Affairs. Veterans Benefits Administration Reports – Detailed Claims Data. Accessed on February 23, 2026, at https://www.benefits.va.gov/reports/detailed_claims_data.asp.

- Approximately 25% of Veterans requested a review of their initial decisions; 85% filed a supplemental claim or HLR request, and 15% appealed to the Board." [31,32]
- In January 2026, 141,872 HLR requests were pending.[33]
- Since AMA's inception, VA metrics report 631,535 duty-to-assist errors related to inadequate examinations and medical opinions.[34]

Current reporting does not indicate how many of these errors led to redevelopment of service connection, nor how many resulted in reduction or severance of benefits. This lack of transparency raises due process concerns and prevents meaningful Congressional oversight.

Veterans should receive clear, advance notice whenever a duty-to-assist error may adversely affect established service connection, similar to the protections in 38 C.F.R. § 3.105(d) for proposed severance.

A statutory amendment to 38 U.S.C. § 5104B(c) could codify this right:

> (c) Decision.—Notice of a higher-level review decision under this section shall be provided to the claimant (and any representative of such claimant) and shall include a general statement—
>
> (1) reflecting whether evidence was not considered pursuant to subsection (d); ~~**and**~~
>
> (2) noting the options available to the claimant to have the evidence described in paragraph (1), if any, considered by the Department-; and
>
> **(3) if the higher-level adjudicator determines that the prior grant of service connection was based on error of law or fact, or that the evidence of record does not support continued entitlement, clearly notifying the claimant that such determination is unfavorable and providing an opportunity to submit evidence or argument before readjudication.**

This amendment would ensure that veterans are fully informed of the practical consequences of a duty-to-assist determination and have a meaningful opportunity to respond before benefits are disturbed. Clarifying that duty-to-assist errors may only be corrected in ways that benefit the

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[31] The VA is statutorily required to submit a biannual report to the appropriate committees of Congress and the Comptroller General on the implementation of the new appeals system. Pub. L. No. 115-55 Section 3(d).
[32] U.S. Department of Veterans Affairs. (2024). Periodic Progress Report on Appeals. Accessed on February 23, 2026, at https://benefits.va.gov/REPORTS/AMA/CMR/2024/appeals-report-cmr-202402.pdf.
[33] U.S. Department of Veterans Affairs. January 2026 AMA Metrics Report. Accessed on February 23, 2026, at https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.benefits.va.gov%2FREPORTS%2FAMA%2Fama-2026%2Fama-01312026.xlsx&wdOrigin=BROWSELINK (*See* AMA Timeliness Appendix).
[34] U.S. Department of Veterans Affairs. January 2026 AMA Metrics Report. Accessed on February 23, 2026, at https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.benefits.va.gov%2FREPORTS%2FAMA%2Fama-2026%2Fama-01312026.xlsx&wdOrigin=BROWSELINK (*See* Part 1(T-V)).

claimant and requiring explicit notice when existing benefits may be affected, would restore the pro-claimant structure Congress intended and reinforce trust in the appeals system.

F. Ensuring Front-End Accuracy and System-Wide Reform

Timeliness in the VA benefits system is inseparable from accuracy. Inconsistent adjudication, inadequate medical examinations, unclear decision letters, and misuse of the duty-to-assist collectively generate avoidable appeals, remands, and administrative rework. To achieve fair, timely, and reliable outcomes, the VA must prioritize front-end accuracy: decisions must be accurate, legally sound, and clearly communicated from the outset. Front-end diligence ensures that veterans receive benefits sooner, appeals decline, and the VA can allocate resources efficiently to complex or contested claims rather than re-litigating preventable errors.

In addition to the statutory amendment suggested above, Congress should direct the VA to implement the following reforms to ensure consistent, high-quality, and transparent adjudication nationwide:

- Cross-Office Calibration and Training
    - Mandatory, recurring legal and procedural training for Rating Service Representatives and Decision Review Officers, focusing on high-error areas;
    - National calibration sessions to harmonize interpretation of rating criteria; and
    - Targeted intervention plans for offices with persistent outlier error rates.
- Standardized and Legally Adequate Medical Examinations
    - Develop standardized examination protocols and templates aligned with statutory and regulatory standards;
    - Conduct regular review and revision of 38 C.F.R. Part 4;
    - Implement enhanced quality review of examinations before rating decisions are issued;
    - Establish clear communication channels between adjudicators and examiners; and
    - Provide competency-based training emphasizing legal standards, aggravation, secondary service connection, and consideration of competent lay evidence.

- Clear and Comprehensible Decision Letters
  - Use standardized templates in plain language;[35]
  - Clearly identify favorable and adverse findings;
  - Provide transparent analysis of evidence and reasoning;
  - Include comprehensive, plain-language instructions on appeal rights and deadlines;
  - Identify unresolved issues to prevent duplicative filings; and
  - Establish quality assurance processes to monitor clarity and provide iterative training.
- Duty-to-Assist Safeguards
  - Limit the use of duty-to-assist errors to the issues raised by the claimant and to outcomes favorable to the veteran;
  - Require explicit notice when errors may trigger redevelopment or readjudication of established service connections;
  - Amend 38 U.S.C. § 5104B(c) to codify these notice requirements; and
  - Track and publicly report the use of duty-to-assist errors in redevelopment and readjudication.
- Front-End Accuracy and Oversight
  - Embed accuracy-first principles at every stage of claims processing;
  - Conduct regular audits, national calibration, and transparent reporting of performance metrics; and
  - Ensure early-stage diligence reduces downstream remands, appeals, and rework.

By implementing these reforms, Congress can ensure that veterans receive fair, consistent, and timely benefits, reduce preventable delays, and restore confidence in the VA disability claims system. Standardization, transparency, and front-end accuracy are the foundation of a functional and trustworthy system that fulfills both statutory mandates and the promises made to those who have served.

[35] *See* www.opm.gov/information-management/plain-language.

PRIORITY No. 3: MODERNIZING MENTAL HEALTH STANDARDS

Adjudicating claims consistent with contemporary science and equitable standards.

Veterans seeking benefits for trauma-related conditions deserve a claims process that reflects both the realities of military service and the latest clinical understanding of mental health. Posttraumatic stress disorder (PTSD) and other trauma-related disorders are among the most frequently appealed claims in the VA system.

Inconsistent application of stressor corroboration standards, insufficient recognition of behavioral, cognitive, and physiological markers, and reliance on outdated evidentiary frameworks contribute to preventable denials, remands, and delays in benefits. Veterans whose conditions arise from combat, military sexual trauma (MST), repeated exposure to hazardous conditions, or secondary trauma are frequently subjected to adjudicative processes that do not fully capture the realities of their service or symptom presentation. As a result, delays in service connection, repeated appeals, and inconsistent outcomes undermine both the efficiency and the fairness of the system.

Applying the core principle of evidence-aligned and equitable adjudication requires revisiting regulatory criteria, expanding scientifically grounded marker recognition, and instituting systemic reforms to ensure uniform, accurate, and timely resolution of mental health claims.

A. Clarifying Stressor Corroboration to Reduce PTSD Remands

PTSD claims are adjudicated under 38 C.F.R. § 3.304(f), which establishes three foundational elements:[36]

- A diagnosis in accordance with the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) and 38 C.F.R. § 4.125(a);
- Credible supporting evidence that the claimed in-service stressor occurred; and
- A medical nexus linking current symptoms to the stressor.

Despite the clarity of these statutory provisions, remands for PTSD service connection dominate the Board's docket.[37] One of the primary drivers is inconsistent application of stressor corroboration standards. Veterans may be denied benefits despite credible supporting evidence of trauma, including behavioral indicators, contemporaneous treatment records, and lay statements

[36] These requirements derive from the Secretary's statutory authority under 38 U.S.C. § 501(a) and the consideration of service circumstances under 38 U.S.C. § 1154(a).

[37] Between 2024–2025, more than 300 Board of Veterans' Appeals decisions were remanded for PTSD service connection *See* U.S. Department of Veterans Affairs, Board of Veterans' Appeals. (n.d.). *BVA decision docket reports*. Available at: www.va.gov/board-of-veterans-appeals/search. Last accessed: Feb 26, 2026.

from the veteran or others with direct knowledge of the stressor. This problem is particularly acute in cases involving MST, non-combat trauma, or repeated exposure to hazardous environments where documentation may not perfectly align with regulatory expectations.

Current distinctions in stressor categories (e.g., combat, fear of hostile military activity, captivity, in-service assault, or PTSD diagnosis during service) do not always reflect the complexities of modern military service. Policymakers should consider clarifying and expanding stressor corroboration criteria to incorporate clinically validated indicators of trauma, including behavioral changes, treatment history, comorbid mental health conditions, and credible lay evidence. Doing so would reduce unnecessary remands, decrease appeals, and ensure a more equitable application of the law.

Enhanced adjudicator training, quality review audits, and performance metrics tied to remand rates would support the consistent application of stressor corroboration standards.[38] Implementing these measures would help ensure that veterans' claims are evaluated based on their actual service experiences and symptomatology rather than procedural technicalities.

B. Expanding Recognition of Trauma Markers Across Mental Health Conditions

Trauma-related conditions extend beyond PTSD and often present overlapping behavioral, cognitive, and physiological markers. Symptoms can include intrusive recollections, hyperarousal, avoidance behaviors, negative alterations in cognition and mood, sleep disturbances, irritability, substance use disorders, and functional impairments in social or occupational contexts. Comorbid conditions, such as depression, neurocognitive disorders, or autoimmune and metabolic disorders, may also emerge as trauma markers, further complicating diagnosis and evaluation.[39]

Current VA adjudication frameworks inconsistently recognize these scientifically validated markers. Veterans presenting clinically significant trauma symptoms may face denials or remands simply because their experiences fall outside narrowly defined stressor categories, despite clear evidence of a nexus and functional impairment. Indirect or secondary trauma exposure, such as repeated exposure to accounts of combat or atrocities, may also produce clinically significant PTSD symptoms[40] but is frequently undervalued in claims evaluation.

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[38] Veterans are often denied benefits for failing to meet a single one of the five criteria, such as not having experienced direct combat or a traumatic incident, even when they served under constant anxiety due to threatened violence. *See* Department of Homeland Security. (n.d.). *Living with threats of violence* (FOH 508). https://www.dhs.gov/living-with-threats-of-violence. Last accessed: Feb. 26, 2026. *See also* Magellan Healthcare. (2019, May). *Living with threats of violence*. https://www.magellanhealth.com/documents/2019/05/living-with-threats-of-violence.pdf. Last accessed: Feb 26, 2026.

[39] Department of Veterans Affairs, National Center for PTSD, Co-Occurring Conditions - PTSD: National Center for PTSD. See also Merck Manual Professional Edition.

[40] PTSDUK, Secondary Trauma Explained, Secondary Trauma – PTSD UK. See also, generally, Vukčević Marković M, Živanović M. Coping with Secondary Traumatic Stress. Int J Environ Res Public Health. 2022 Oct 8;19(19):12881. doi: 10.3390/ijerph191912881. Coping with Secondary Traumatic Stress - PMC.

The adoption of evidence-based standards that explicitly incorporate behavioral, cognitive, and physiological markers in service connection determinations for trauma-related conditions are necessary. Regulatory guidance should clarify how these markers, when supported by competent medical opinion, can satisfy corroboration requirements. Standardized examiner templates, adjudicator guidance, and quality oversight would promote uniform evaluation, reduce examiner- and adjudicator-dependent variability, and increase equitable access to benefits.

C. Aligning Policy with Modern Research to Ensure Equitable, Evidence-Based Adjudication

To provide timely, fair, and clinically accurate adjudication for veterans with trauma-related mental health conditions, Congress should authorize the establishment of a formal scientific task force.[41] This panel should include psychiatrists, clinical psychologists, adjudication specialists, and Veteran Service Organization representatives. Its mandate should include:

- Evaluating whether current evidentiary standards across mental health diagnoses remain consistent with contemporary clinical research;
- Assessing whether stressor and trauma marker requirements reflect the realities of military service and modern psychiatric knowledge;
- Reviewing examiner and adjudicator training materials to ensure alignment with updated evidence;
- Recommending enhancements to quality assurance, oversight, and performance evaluation metrics to reduce preventable remands.

The task force should also examine indirect and secondary trauma exposure, considering the peer-reviewed clinical literature demonstrating that trauma can occur through vicarious experiences or cumulative stress. Task force findings should inform revisions to 38 C.F.R. § 3.304(f), regulatory guidance, training curricula, and adjudication templates. Transparent reporting to Congress would ensure accountability and allow for ongoing monitoring of the implementation and impact of reforms.

In addition to establishing a task force, Congress should also enact the following reforms to modernize mental health standards in the VA disability system:

[41] There is precedent for Congress or the Secretary to establish formal task forces or advisory panels to review and recommend updates to VA regulations and policies, particularly on clinically and scientifically complex issues. Examples include the VA Mental Health Task Force convened to evaluate veterans' access to mental health care and the National Academies of Sciences panels on PTSD and traumatic brain injury, which informed VA clinical and compensation policies.

- Clarify Stressor Corroboration Standards: Expand and modernize § 3.304(f) to include validated behavioral, cognitive, and physiological markers, and update adjudicator guidance to ensure consistent application.
- Expand Recognition of Trauma Markers: Include indirect trauma, repeated exposure to stressors, and clinically validated comorbidities in PTSD and trauma-related condition evaluations.
- Standardize Examiner Templates and Adjudicator Guidance: Ensure consistent documentation and evaluation across all trauma-related claims to reduce variability and remands.
- Enhance Training and Quality Oversight: Provide competency-based training on updated trauma standards, conduct regular audits, and implement performance metrics tied to remand rates for PTSD and trauma-related claims.
- Transparent Reporting and Accountability: Require public reporting on remand rates, decision outcomes, and implementation of task force recommendations to ensure accountability, continuous improvement, and equitable treatment of veterans.

By grounding mental health adjudication in contemporary science and equitable principles, the VA can reduce preventable denials and remands, increase system efficiency, and maintain both statutory and clinical integrity. Veterans with PTSD and other trauma-related disorders would receive benefits that accurately reflect the service-connected impact of their conditions, improving confidence in the system and supporting timely access to care and compensation.

PRIORITY No 4: ECONOMIC FAIRNESS

Where errors delay benefits, veterans should be restored
as closely as possible to the position they would have held absent that error.

When a Veteran is awarded a grant of service connection due to an administrative error or other deficiency on the part of the VA, current law provides for back pay. This back pay is calculated using historical compensation rates for each year that a Veteran was improperly denied benefits. On the surface, this approach may seem equitable. In practice, however, it fails to account for the real-world economic consequences of delayed benefits. Compensation received on time enables Veterans to build stability, equity, and long-term financial security.

Veterans whose claims are denied due to clear and unmistakable errors (CUE),[42] misapplied rating criteria, or other systemic administrative deficiencies, on the other hand, often experience compounded harm that extends far beyond their lost monthly compensation. These harms accumulate in the form of lost opportunities, diminished wealth accumulation, disrupted life planning, and stress-related health consequences. This section examines the economic and human impact of delayed benefits, compares potential policy solutions, and identifies actionable steps to restore true fairness for Veterans.

A. The Real-World Impact of Timely Compensation

Consider the following illustrative scenario comparing two veterans who are both entitled to a 70% disability rating effective in 1990.

Veteran A (PBA) receives the rating in a timely manner and begins receiving monthly compensation of $710. Adjusted annually for cost-of-living increases, this amount grows to $1,815 per month by 2026, resulting in approximately $486,000 in cumulative compensation over 36 years. The timely payments provide more than just nominal financial benefits: they enable PBA to qualify for a VA home loan in the mid-1990s and build equity over decades, pursue vocational training and stable employment that supplements disability compensation, contribute consistently to retirement savings, and enjoy the reduced stress and improved health outcomes associated with long-term financial stability.

By contrast, Veteran B (RBK) is wrongfully denied the 70% rating in 1990 due to an administrative mistake and does not receive the award until filing a successful CUE motion in 2026. While RBK ultimately receives the same total nominal compensation (approximately $486,000 in back pay) the delayed award dramatically alters long-term outcomes. RBK is unable to purchase a home and instead pays roughly $432,000 in rent over the same period without building equity, misses opportunities for vocational training and career advancement tied to financial stability, accumulates minimal retirement savings, and experiences heightened stress with likely negative impacts on health and service-connected conditions.

The table below illustrates how the timing of disability awards, timely versus delayed, can profoundly shape not only cumulative compensation but also veterans' long-term financial security, home ownership, retirement savings, and overall quality of life.

[42] A "clear and unmistakable error" (CUE) is a final VA decision that is undebatably wrong based on the evidence of record at the time it was issued, such that the error would have manifestly changed the outcome if it had not been made. *See* 38 C.F.R. § 3.105(a); 38 U.S.C. § 5109A; and *Fugo v. Brown*, 6 Vet. App. 40, 43 (1993) (describing CUE as an error that is "undebatable" and "undeniable" in the record). CUE claims may be raised at any time to correct these types of errors in previously adjudicated benefits decisions.

Metric	Veteran PBA (Timely)	Veteran RBK (Delayed)	Opportunity Cost
Total Compensation Received	$486,000	$486,000	$0
Home Equity	$240,000	$0	$240,000
Retirement Savings	Accumulated	Minimal	$84,000 [43]
Financial Stress & Health Benefits	Improved	Declined	(not quantifiable)
Total Estimated Value	**$810,000+**	**$486,000**	**~$324,000**

The opportunity cost gap between Veteran A and Veteran B is approximately $324,000, reflecting lost home equity, foregone retirement contributions, and the financial value of stability-related health benefits.

This scenario is not a hypothetical problem. We see this pattern repeatedly in practice, and it demonstrates that timely disability awards provide far more than financial compensation. They enable long-term economic security, access to home ownership, retirement savings, career opportunities, and health benefits that are effectively denied to veterans whose claims are delayed, even when back pay is eventually granted.

Empirical research reinforces these observations. One study found that timely disability compensation significantly shapes veterans' labor force participation, educational attainment, and long-term economic outcomes. [44] More recent research demonstrates that veterans experiencing financial instability are three times more likely to report suicidal ideation and are at heightened risk of relying on predatory financial services, compounding financial trauma over time. [45] Specifically, veterans who reported difficulty covering basic needs were three times more likely to endorse suicidal ideation one year later compared with veterans who could meet their basic needs (22% vs. 7%). The study also found that financial strain is associated with increased use of predatory financial tools, including "buy now, pay later" services, unpaid credit card balances, and overdraft fees. These patterns create additional financial burdens that accumulate over time, further undermining the ability of veterans like RBK to achieve long-term financial stability and security.

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[43] This is an approximate, conservative estimate based on decades of foregone contributions.

[44] Coile, C., Duggan, M., & Guo, A. (2015). Veterans' labor force participation: What role does the VA's disability compensation program play? *American Economic Review, 105*(5), 131–136. https://doi.org/10.1257/aer.p2015104.

[45] Elbogen, E. B., Serrano, B. N., & Huang, J. (2024). *Financial well-being of U.S. military veterans and health impact: Results from the Survey of Household Economics and Decisionmaking*. *Medical Care, 62*(12 Suppl 1), S91–S97. https://doi.org/10.1097/MLR.0000000000002077,

B. Policy Options for Addressing Economic Harm

Two primary approaches could mitigate these harms and provide Veterans with compensation that better reflects the economic impact of delayed benefits.

(1) *Option 1: Back Pay Using Current COLA-Adjusted Rates*

This approach calculates all back pay using the current year's compensation rate for the entire back pay period. For example, RBK's 36-year award would be recalculated at the 2026 rate of $1,815/month:[46]

36 years x 12 months/year x $1,815 = $783,720

This method recognizes that:

- COLA adjustments already account for inflation, cost-of-living increases, and the economic value of benefits in the current year.
- Veterans denied benefits in earlier decades lost opportunities to invest in housing, education, retirement, and other wealth-building activities.
- Administering this calculation is straightforward, requiring a single rate application.

Benefits of this approach include restoring Veterans to the position they would have held absent administrative error, promoting equity, and providing accountability for systemic failures within the VA.

(2) *Option 2: Historical Rates Plus Interest*

Alternatively, back pay could be calculated using historical rates with interest applied from the date each payment should have been issued. Using standard Treasury bill[47] or federal benchmark rates,[48] Veteran B's award could increase to approximately $655,000–$680,000.

This method provides a partial correction for the time value of money, aligning with practices in federal tax refunds[49] and the Federal Tort Claims Act.[50] While more faithful to historical nominal values, this option has several drawbacks:

- Administrative complexity due to multi-year interest calculations.

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[46] *See* www.va.gov/disability/compensation-rates/veteran-rates.
[47] *See* www.home.treasury.gov/resource-center/data-chart-center/interest-rates/TextView?type=daily_treasury_bill_rates.
[48] *See* www.treasurydirect.gov/govt/rates/rates.htm.
[49] 26 U.S.C. § 6611.
[50] 28 U.S.C. § 1961.

- Interest may not capture opportunity costs associated with homeownership, education, or retirement accumulation.
- Fails to fully account for health and social impacts of long-term financial insecurity.

While Option 2 represents an improvement over the current system, it does not fully restore veterans to the financial position they would have enjoyed had benefits been awarded on time. In contrast, Option 1, with COLA-adjusted rates, provides the most equitable and administratively efficient solution, ensuring that veterans receive compensation that reflects both the passage of time and the impact of inflation.

- Equity: Current rates reflect the purchasing power and opportunity value Congress has determined necessary for Veterans' compensation in today's economy.
- Administrative Simplicity: Requires only one calculation rather than interest compounding over decades.
- Accountability: Incentivizes prompt correction of VA errors and systemic improvements, as delayed resolution results in higher backpay awards.
- Realistic Restoration: Provides financial restoration beyond nominal compensation, accounting for lost wealth-building and opportunity costs.

As mentioned above, research consistently shows that delayed compensation has broad and enduring consequences.[51] Veterans denied benefits during critical transition years from military to civilian life experience financial instability that affects housing, career development, retirement security, and health. Calculating back pay at current COLA-adjusted rates addresses these harms more comprehensively than simple historical rate payments or interest-only models.

To manage fiscal and policy concerns, this reform could include reasonable limitations:

- Apply only to cases where VA error is established (CUE, duty to assist violations, rating schedule misapplication).
- Exclude delays attributable to Veterans (e.g., failure to respond to development requests or late-filed appeals).
- Phase implementation to manage budgetary impact and allow smooth integration into existing VA systems.

Under the current back-pay system, administrative errors are treated as cost-neutral, forcing veterans to absorb the full opportunity cost of delayed benefits. Timely, economically fair

[51] *Supra* Note 43.

compensation is not just a matter of dollars: it restores Veterans' ability to plan their lives, maintain stability and health, and pursue opportunities that VA errors should never have denied.

PRIORITY No. 5: IMPLEMENTING RESPONSIBLE, TRANSPARENT, AND ACCOUNTABLE USE OF ARTIFICIAL INTELLIGENCE

The VA has begun integrating artificial intelligence (AI) into claims processing to improve timeliness, accuracy, and operational efficiency. AI holds significant potential to standardize processes, detect errors, and accelerate decision-making across the claims' lifecycle. For instance, AI can analyze claims histories to identify missing forms, flag inconsistencies in medical examinations, or detect patterns indicative of continuous pursuit of benefits. When implemented thoughtfully, AI has the potential to reduce preventable appeals and remands, delivering faster and more reliable outcomes for veterans.

However, AI also introduces complex challenges, particularly around human oversight, privacy, data security, and procedural fairness. Generative models may produce outputs that appear plausible but are legally or clinically inaccurate, a phenomenon known as "hallucination." Without structured oversight, such errors can compound existing systemic deficiencies, inadvertently delaying benefits or generating inequities. Consequently, the VA must carefully balance efficiency gains with rigorous safeguards to ensure that technology serves veterans rather than creating new risks.

A. Eliminating Effective Date Errors Through Intelligent Claims Timeline Analysis

One of the most frequent sources of preventable appeals is errors in assigning effective dates for service-connected conditions or claims for increased evaluation. Veterans often pursue claims over months or years, and retroactive awards are sometimes misdated to the most recent appeal, supplemental claim, or examination rather than to the initial claim or intent-to-file (ITF) date. These errors can result in significant financial loss and administrative burden.

For example, a veteran-client (FSK) filed for service connection for sleep apnea in August 2024 using VA Form 526EZ. The claim was initially denied in February 2025, appealed in June 2025, and granted in September 2025. The VA initially assigned an effective date to the appeal submission in June 2025, ten months later than the original claim. FSK was forced to submit an additional appeal, compiling a timeline of prior submissions, before the VA corrected the effective date in February 2026. This delay caused lost retroactive compensation, added administrative burdens for the veteran, and increased workload for the VA.

AI, particularly generative AI,[52] can support adjudicators by analyzing a claim's full history, identifying continuous pursuit, and constructing accurate timelines. For example, AI could

[52] Generative AI systems are designed to produce new content by learning patterns from large datasets. Unlike traditional AI models, which primarily classify or predict information, generative AI uses advanced machine learning

automatically detect prior submissions mentioning "migraine" or "headache" to assign the correct effective date for a claim. While AI can automate these complex processes, human adjudicator verification remains essential to prevent misinterpretation or erroneous assignments.[53]

B. Preserving Human Judgment: Oversight, Accountability, and Ethical Guardrails

AI tools are best utilized as decision-support mechanisms and must not replace human adjudication. While AI excels at analyzing large datasets and identifying patterns, it cannot interpret regulatory requirements, evaluate evidence credibility, or assess individual circumstances. Human oversight is ethically and operationally essential.

The VA's principles for responsible data use, codified under 38 C.F.R. § 0.605, emphasize equity, transparency, meaningful choice, secure handling of personally identifiable and health information (PII/PHI), and accountability. Generative AI systems cannot independently ensure compliance with these principles. They may hallucinate, misinterpret evidence, or produce outputs that lack transparency regarding their reasoning.[54] Frontline staff face the dual challenge of leveraging AI for efficiency while maintaining full responsibility for accuracy. Without structured guardrails, reliance on AI could amplify errors and risk disclosure of sensitive information.[55]

Human oversight must also extend to processing timelines and appeal lanes. Reports indicate rating decisions sometimes issued within a single day of submission, raising concerns that claims may be finalized before evidence is fully reviewed. Establishing structured oversight is therefore critical to uphold veterans' rights and ensure fair, accurate outcomes.

C. Safeguarding Veteran Data in the Age of Generative AI

Protecting veterans' PII and PHI is paramount. Veterans' information (e.g., medical histories, mental health disclosures, and service treatment records) carries privacy and national security implications. Many veterans served in sensitive or classified roles, and a breach could

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techniques to create outputs based on user instructions or prompts. *Guidance for Generative AI use at VA, VA Artificial Intelligence (2026)*, See: https://department.va.gov/ai/guidance-for-generative-ai-use-at-va/ (last visited Feb 20, 2026).

[53] Note: Industry leaders continue to impress that it is essential for employees to review the AI's output for accuracy before relying on it. *Id.*

[54] U.S. Department of Veterans Affairs. (n.d.). Guidance for generative AI use at VA. Retrieved February 24, 2026, from https://department.va.gov/ai/guidance-for-generative-ai-use-at-va/#tips-for-assessing-when-to-use-generative-ai-technologies.

[55] Without structured guardrails, employees may rely too heavily on AI, increasing the risk of errors and potential disclosure of sensitive veteran information. Past errors by human adjudicators alone have cost millions; introducing AI without proper oversight risks compounding these mistakes. The American Legion. (2024, August). VA worker errors when reviewing claims for full disability cost $100M, auditors say. https://www.legion.org/information-center/news/veterans-benefits/2024/august/va-worker-errors-when-reviewing-claims-for-full-disability-cost-100m-auditors-say.

pose operational risks.[56] Moreover, the history of stigma and adverse professional consequences associated with mental health treatment further emphasizes the need for robust privacy protections.[57] Without strong privacy protections, veterans may withhold information essential to accurate adjudication and appropriate care.

The integration of generative AI introduces unique risks. Unlike traditional systems, these models may store, synthesize, or analyze data in ways that are not fully transparent or auditable, raising the possibility of inadvertent exposure. The VA Office of Inspector General (OIG) reported in 2026 that the Veterans Health Administration (VHA) lacked formal mechanisms to identify, track, and mitigate AI-related risks, warning that without structured feedback loops and oversight, ensuring meaningful patient protection is impossible.[58]

Federal privacy standards, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA),[59] codify the veterans' rights to confidentiality and privacy in healthcare settings.[60] These statutory protections reflect a broader ethical principle central to VA operations: veteran data must be used solely to advance veteran's interests. Any modernization effort, particularly involving AI, must reinforce, not dilute, this foundational commitment.

Key safeguards should include:

- Data Retention and Cybersecurity: Strong access controls, retention policies, and regular audits must be implemented to protect sensitive information. AI risk frameworks, such as the "MIT AI Risk Repository,"[61] provide models for assessing vulnerabilities and establishing mitigation strategies.

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[56] Steidl, R. (Speaker). (2025, September). The intersection of artificial intelligence and cybersecurity [Video]. American Bar Association Cybersecurity Legal Task Force. https://www.americanbar.org/groups/cybersecurity/videos/intersection-artificial-intelligence-cybersecurity/.

[57] *See* Tanielian, T., & Jaycox, L. H. (Eds.). (2008). *Invisible wounds of war: Psychological and cognitive injuries, their consequences, and services to assist recovery* (Center for Military Health Policy Research). RAND Corporation. https://www.rand.org/pubs/monographs/MG720.htm (reviews psychological injuries affecting veterans and service members, including barriers to care such as stigma and its impacts on treatment-seeking). *See also* Piro, L., & Huo, H., et al. (2023). *Racial and ethnic differences among active-duty service members in use of mental health care and perceived mental health stigma: Results from the 2018 Health Related Behaviors Survey. Preventing Chronic Disease*, 20, Article E85. https://doi.org/10.5888/pcd20.220419. (A CDC-published analysis of the 2018 Department of Defense (DoD) Health Related Behaviors Survey found that perceived mental health stigma was reported by about one-third of active-duty service members and acted as a barrier to mental health care use.).

[58] U.S. Department of Veterans Affairs Office of Inspector General. (2026, January 15). *Review of VHA's use of generative artificial intelligence* (Report No. 26-00182-42). https://www.vaoig.gov/reports/preliminary-result-advisory-memorandum/review-vhas-use-generative-artificial-intelligence. Last accessed: Feb 26, 2026.

[59] Pub. L. No. 104-191, 110 Stat. 1936.

[60] U.S. Department of Health and Human Services. (n.d.). Summary of the HIPAA Privacy Rule. HHS.gov. Retrieved February 24, 2026, from https://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/index.html.

[61] Available at: www.airisk.mit.edu.

- Veteran Choice and Transparency: Veterans must receive clear notification about AI use, including data scope, retention timelines, and potential impacts. Opt-out mechanisms should allow veterans to decline AI-assisted review without penalty. For example, integrating these safeguards into the Fully Developed Claims process while allowing optional AI review for Standard Claims ensures meaningful choice.

D. Standardizing Medical Examination Quality Through AI-Assisted Review

Inadequate or inconsistent medical examinations remain a leading cause of remands. Examiners often omit required elements or provide insufficient rationale, delaying final decisions and imposing hardship on veterans. Repeated examinations may require veterans to travel long distances, take leave from work, or arrange childcare.[62]

AI can serve as a pre-decisional quality assurance tool. For example, it can scan Disability Benefits Questionnaires (DBQs) to flag:

- Secondary service connection opinions: Ensuring both causation and aggravation are addressed.[63]
- Functional loss and flare-ups in musculoskeletal claims: Identifying missing discussion of limitations due to repetitive use or pain.[64]
- Improper reliance on absence of in-service documentation: Detecting when examiners incorrectly assume a negative nexus.[65]

This pre-screening reduces remands, avoids unnecessary repeat examinations, and supports both adjudicator efficiency and veteran convenience. AI reinforces quality standards without replacing medical judgment.

E. Ensuring Technology Serves Veterans, Not the Other Way Around

AI integration is valuable only if it supports veterans, rather than replacing essential human judgment. Decision-making authority must remain with trained adjudicators and examiners, who review, contextualize, and validate all AI outputs. Congress and the VA must establish statutory guardrails ensuring transparency, accountability, and enforceable privacy protections. AI adoption should be guided by trust, accuracy, and fairness rather than expediency alone.

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[62] Within the firm, veteran-clients regularly report second in-person examinations lasting fewer than ten minutes. These brief evaluations often require veterans to take time off work, arrange transportation, and disrupt personal schedules, yet they rarely provide substantive new information, raising questions about administrative efficiency and the proportionality of such procedures.

[63] *See Atencio v. O'Rourke*, 30 Vet. App. 74 (2018); *El-Amin v. Shinseki*, 26 Vet. App. 136, 140 (2013).

[64] *See* M21, V.iii.1.A.1.b-m; *Deluca v. Brown,* 8 Vet. App. 202 (1995); *Schafrath v. Derwinski*, 1 Vet. App. 589, 593 (1991); 38 C.F.R. § 4.2 (2023).

[65] *See Buchanon v. Nicholson*, 451 F.3d 1331 (Fed. Cir. 2006); *Dalton v. Nicholson*, 21 Vet. App. 23 (2007).

To maximize AI benefits while preserving fairness, privacy, and accuracy, the following measures should be implemented:

- Effective Date Assignment: Authorize AI to identify earliest continuous pursuit dates; require adjudicator verification; monitor accuracy and equity.
- Human Oversight & Training: Probationary training period (≥6 months); dedicated audit teams; periodic staff competency exams tied to AI access.
- Transparency & Veteran Choice: Clear AI-use notification; opt-out options; publicly accessible reporting of AI-assisted claim metrics.
- Data Protection & Security: Strong cybersecurity protocols; controlled access; retention policies; regular audits; HIPAA compliance; feedback loops for risk mitigation.
- Medical Examination Quality: Pre-screen DBQs and reports for legal sufficiency and completeness; flag recurring deficiencies (secondary service connection, functional loss, improper reliance on service treatment records).

AI offers transformative potential for the VA claims process, improving efficiency, reducing errors, and standardizing medical examinations. However, it also introduces risks to fairness, privacy, and accountability. By implementing robust oversight, clear statutory guardrails, rigorous training, and transparent veteran choice mechanisms, AI can serve as a tool that strengthens the claims system rather than undermining it.

When deployed responsibly, AI will reduce preventable appeals, ensure accurate effective dates, standardize examination quality, and safeguard sensitive data, while fully preserving human judgment. These measures align with the VA's mission to deliver timely, equitable, and accurate benefits to veterans, ensuring that technological advancement enhances, not replaces, the department's commitment to those who have served.

* * *

I would like to express our sincere appreciation to the Committees for their careful consideration of these legislative priorities and proposals, each of which addresses critical aspects of veterans' benefits, service-related health conditions, and administrative processes. Collectively, the measures aim to improve fairness, transparency, efficiency, and access to benefits across a wide spectrum: from disability compensation and toxic exposure presumptions to burial allowances, appeals reporting, and the integrity of VA claims administration.

We strongly support the intent of many existing initiatives to remove arbitrary barriers, clarify eligibility criteria, enhance oversight, and standardize processes in ways that directly benefit veterans and their families. At the same time, we encourage the Committee to consider targeted refinements to ensure consistent implementation, retroactive applicability where

appropriate, clear guidance for VA adjudicators, and safeguards that protect veterans from unintended consequences. Attention to timelines, reporting standards, and stakeholder engagement will help translate legislative intent into meaningful, real-world outcomes for those who have served.

Berry Law stands ready to provide further clarification, technical assistance, or expertise to the Committees on these and other legislative matters affecting veterans' health care, research, and disability compensation. Please contact my colleague, Andy Blevins, Senior Counsel, at andy.blevins@berrylaw.com, if we may be of service.

Respectfully Submitted,

Jerusha S. Hancock

HIRE HEROES USA

STATEMENT OF ROSS DICKMAN
CHIEF EXECUTIVE OFFICER, HIRE HEROES USA

SUBMITTED FOR THE RECORD TO THE

HOUSE AND SENATE VETERANS'AFFAIRS COMMITTEES

IN REGARD TO THE

JOINT VETERAN SERVICE ORGANIZATION HEARING
U.S. HOUSE OF REPRESENTATIVES AND U.S. SENATE

March 4, 2026

Introduction

Chairmen Moran and Bost, Ranking Members Blumenthal and Takano, and distinguished members of the Senate and House Committees on Veterans' Affairs, thank you for the opportunity to submit a written statement for the record regarding the legislative priorities of Hire Heroes USA.

Hire Heroes USA is one of the nation's leading nonprofit organizations focused on veteran and military spouse employment. Founded in 2005, we have helped more than 115,000 transitioning service members, veterans, and military spouses secure meaningful employment. We provide comprehensive, one-on-one employment services in all 50 states, supporting approximately 22,000 individuals annually at no cost to our clients.

With nearly 60 percent of our staff—including myself— being veterans and military spouses, we understand firsthand the unique strengths, values, and perspectives our veteran, transitioning service member, and military spouse clients bring to the workforce.

Hire Heroes USA is committed to providing one-on-one personalized support and dedicated guidance to those we serve, helping them build successful careers no matter where they start or where they aspire to go. The U.S. military brings together individuals from every background, experience level, and skill set. We embrace that same spirit by ensuring that every veteran and military spouse has access to the resources and opportunities needed to flourish in the civilian workforce. We uphold these same values within our own team, bringing together employees with varied skills and experiences to best serve our mission.

Hire Heroes USA appreciates the ongoing efforts of both Committees to improve outcomes for those who have served; however, our work is not yet complete. In the year ahead, we respectfully urge the Committees to focus on legislative solutions that expand employer

incentives for hiring veterans and military spouses, modernize workforce mobility, accelerate skills-based hiring, reinforce institutional trust in and respect for military service, and strengthen targeted support for veterans facing the greatest barriers to employment.

Expand Employer Incentives for Veteran and Military Spouse Employment

America cannot afford to underutilize one of its most skilled and experienced talent pipelines — veterans. Yet underemployment remains widespread, limiting economic mobility for military families and constraining our nation's workforce growth and economic competitiveness. According to The Veterans Metric Initiative, a longitudinal study conducted by Pennsylvania State University, 61% of veterans report experiencing underemployment three years after separation, with rates remaining virtually unchanged six and a half years later.[1] The challenge persists well beyond transition, as TVMI found that approximately 40 percent of all veterans are underemployed according to the Department of Labor's Occupational Information Network (O*NET) job education requirements.[2, 3]

Federal policy must strengthen employer incentives that address underemployment, improve long-term retention, and support upward career mobility for veterans. Importantly, workforce success is not defined by simply getting the client a job—it is measured by sustained, meaningful career advancement. Underemployment occurs when veterans' skills, education, and experience are not fully utilized in their roles, resulting in stalled growth and reduced earning potential.

To address these gaps, we urge the Veterans' Affairs Committees to work with their fellow elected officials in both chambers to reauthorize and modernize the Work Opportunity Tax Credit (WOTC) to better support sustainable veteran employment outcomes targeted at underemployment through the passage of the Improve and Enhance the Work Opportunity Tax Credit Act (H.R. 6231 and S. 3265), and making military spouses eligible for WOTC certification through passage of the Military Spouse Hiring Act (H.R. 2033 and S. 1027).

Of the nearly two million credits issued in 2023 through this leading hiring incentive, fewer than 200,000 supported veteran hires specifically. While the program grew by 22 percent between FY22 and FY23, veterans consistently represented only 5 to 7 percent of recipients, with

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[1] Dawne Vogt et al., "The Veterans Metrics Initiative Study of US Veterans' Experiences during Their Transition from Military Service," *BMJ Open* 8, no. 6 (2018): e020734, https://doi.org/10.1136/bmjopen-2017-020734.
[2] US Departments of Labor, Commerce Release Skills-First Hiring Guide to Help Employers Hire, Promote Workers Based on Skill, Knowledge," DOL, accessed June 3, 2025, https://www.dol.gov/newsroom/releases/osec/osec20241113.
[3] Clearinghouse for Military Family Readiness The Pennsylvania State University, An Overview of the Typical Veteran in Transition (2025), https://veteranetwork.psu.edu/wp-content/uploads/2025/03/TVMI-VETS_Transitioning-Veteran-Infographic_2025Mar26.pdf.

placements concentrated in high turnover industries such as hospitality, retail, and manufacturing. Additionally, disabled veterans qualifying through the WOTC program were only marginally more likely to be hired.[4]

When targeted effectively, however, the WOTC demonstrates strong potential. Disabled veterans hired through the program, for example, experienced average wage increases of 40 percent. The recent expiration of WOTC at the end of 2025, without a meaningful long-term extension strategy, presents a critical opportunity for reform. Reauthorization should strengthen accountability measures, improve veteran retention practices, incentivize proactive recruitment prior to conditional offers of employment, and expand eligibility to military spouses, whose unemployment rate exceeds 21 percent.[5]

Furthermore, we encourage the Veterans' Affairs Committees to consider legislative solutions that establish meaningful, scalable programs incentivizing military spouse hiring and retention, and refine statutory language to ensure veteran verification processes reflect both the letter and spirit of the law.

Remove Barriers to Stable Employment and Quality of Life for Military Families

Military spouse employment is one of the most persistent—and most solvable—challenges facing military families. Policymakers must modernize regulations to reflect the realities of a highly mobile, highly skilled, and highly capable population.

A 2024 Department of Defense survey found that 32 percent of military families considered leaving active-duty service, while satisfaction with military quality of life fell to a 20-year low of 48 percent. Permanent Change of Station (PCS) moves were a major driver of dissatisfaction and career disruption: 49% of spouses reported difficulty finding employment after relocation, and those who experienced a PCS in 2024 were 33% more likely to be unemployed than those who did not.[6]

PCS moves create significant barriers through fragmented, state-by-state professional licensing systems. When military spouses relocate, their credentials often do not transfer seamlessly, forcing them to restart certification processes or accept positions below their qualifications. This regulatory fragmentation drives widespread underemployment. Despite high levels of

[4] "WOTC Performance," DOL, accessed March 4, 2026, https://www.dol.gov/agencies/eta/wotc/performance.
[5] Proclamations, "Military Spouse Day, 2025," *The White House*, May 9, 2025, https://www.whitehouse.gov/presidential-actions/2025/05/military-spouse-day-2025/.
[6] "Military Community Survey Findings," *Military OneSource*, n.d., accessed March 4, 2026, https://www.militaryonesource.mil/data-research-and-statistics/survey-findings/spouse-survey/.

educational attainment—62 percent of military spouses hold a degree—data show persistent professional inequities: 41 percent report they should hold higher positions based on their credentials, and 41 percent report earning less than peers with similar qualifications. 27 percent have accepted employment outside their field of training.[7]

Federal and state leaders should preserve and strengthen remote and portable government employment agreements that provide continuity of work across duty stations and help stabilize household income during periods of transition.

We support the Military Spouse Hiring Act (H.R. 2033 and S. 1027) and encourage members of the Committees to work with their colleagues on Committees of jurisdiction to ensure its swift passage and implementation.

Economic stability for military families also depends on timely, predictable governance. Recent funding debates and delays in Washington have demonstrated how political uncertainty can create real-world consequences for military families, sometimes forcing them to rely on food pantries and emergency assistance. Policymakers should continue working in a bipartisan manner to provide stability for those who serve.

Strengthen and Scale Skills-Based Hiring Systems

A 2023 McKinsey study estimates that leveraging veterans' work experience through skills-based hiring could generate nearly $15 billion in economic value over the next decade.[8] Employers, including our private sector partners, increasingly recognize this untapped economic potential. However, workforce demands continue to outpace the development of informed, accessible training systems to upskill jobseekers effectively. According to the National Skills Coalition, 52 percent of jobs require education or training beyond high school but not a four-year degree — placing these roles within reach for many veterans and military spouses when supported by tailored upskilling and transition pathways.[9]

Government investment must keep pace with workforce needs by expanding support for credentialing and certification programs that integrate with proven nonprofit training providers and employer partners. We encourage lawmakers across the Committees to pursue

[7] "Military Community Survey Findings."
[8] "Hiring Veterans Can Help Reduce the US Labor Gap | McKinsey," accessed March 4, 2026, https://www.mckinsey.com/capabilities/people-and-organizational-performance/our-insights/from-the-military-to-the-workforce-how-to-leverage-veterans-skills.
[9] "Skills Mismatch," *National Skills Coalition*, n.d., accessed March 4, 2026, https://nationalskillscoalition.org/skills-mismatch/.

legislative solutions that reduce bureaucratic barriers to employment for veterans and military spouses.

Hire Heroes USA is well-positioned to advance this work through our skills translation, credentialing, and career navigation services. We are committed to building and strengthening pipelines into high-demand careers where our veteran and military spouse clients can apply their unique training, leadership, and experience.

Skills-based hiring adoption must extend beyond the private sector. Opportunity @ Work, a nonprofit advancing cross-sector implementation of skills-based practices, reports that since 2022, 25 states removed degree requirements from government job descriptions, making approximately 600,000 public-sector jobs accessible to STAR (Skilled Through Alternative Routes) candidates.[10] This positive trend continues to grow. As of February 2025, more than half of states have implemented policies targeted at accelerating skills-based hiring practices for public sector jobs.[11] This shift represents a critical opportunity for our clients—particularly the more than 75 percent of junior enlisted service members who do not hold a bachelor's degree but possess highly transferable, in-demand skills.

Specifically, we call on decisionmakers to remove barriers to quality federal jobs where our veteran clients would have the opportunity to serve other veterans, and ensure alignment between role qualifications, descriptions, and function. For example, advanced education requirements for roles with the Department of Veterans Affairs Veteran Readiness and Employment (VR&E) are a hurdle for transitioning veterans who have dedicated their time to service rather than nearly a decade of education and licensing. We applaud the recent passage of H.R. 980, the Veterans Readiness and Employment Improvement Act of 2025. We encourage the Committees to continue building on improvements to the VR&E program by examining roles and responsibilities for alignment to mission and consider re-aligning job descriptions to remove barriers for qualified veteran candidates. This may include removing degree requirements or creating on-the-job training pathways for entry-level candidates to upskill and advance to meaningful careers. By preventing veterans from accessing roles like those with VR&E, we are barring those most driven for this mission from these mission driven roles. Poor hiring practices lead to poor hiring outcomes, which ultimately compromises the quality of services provided to our veterans.

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[10] "The Impact of State Actions," accessed March 4, 2026, https://www.opportunityatwork.org/topics/reports/the-impact-of-state-actions.

[11] National Governors Association, "New Report: Growing Number of States Drop Degree Requirements," *National Governors Association*, February 11, 2025, https://www.nga.org/news/press-releases/new-report-growing-number-of-states-drop-degree-requirements/.

Federal, state, and local governments should continue eliminating unnecessary degree barriers and expanding pathways into public-sector careers for veterans and military spouses. The success of STAR job seekers demonstrates what is possible when policy aligns with workforce realities. Hire Heroes USA remains committed to educating leaders at every level of government on the value of skills-based talent and to advancing reforms that lower barriers to employment.

Honor Service, Protect Integrity, and Strengthen Public Trust

Public confidence in military service is foundational to the nation's economic strength and national security. Declining trust undermines recruitment, workforce readiness, and long-term resilience.

We applaud Chairman Moran and Ranking Member Blumenthal on the recently introduced National Veterans Strategy Act of 2026 (S. 3726) and sincerely hope to see swift passage of this important legislation. Policymakers share responsibility with employers and nonprofit leaders for ensuring military service remains recognized as a pathway to economic opportunity and personal advancement.

This legislation represents an important step toward integration and standardization of best practices to improve outcomes for veterans and military spouses across the federal government. Recent research signals a troubling shift in public perception of the military. Studies conducted in 2023 and 2025 found that fewer than half of Americans would recommend military service.[12] Additionally, 27 percent of respondents reported they did not believe military service leads to greater long-term economic success, while 54 percent were unsure of its impact. Trust in the military—largely influenced by political polarization and public discourse—has declined from 89 percent following the Iraq invasion to 70 percent in 2018, and to just 49 percent in 2025. Among Americans under age 30, only 36 percent report high levels of confidence and trust.[13, 14] These trends represent more than a perception challenge—they pose a direct risk to military recruitment and, ultimately, to national security.

Hire Heroes USA will work across communities, sectors, and generations to restore confidence in military service by elevating authentic, impact-driven client stories. At the same time, some public and private actors are looking to leverage veteran narratives to advance unrelated agendas or commercial interests. These insincere practices undermine the dignity of service and weaken

[12] "Less than Half of Americans Would Recommend Military Service for Teens | Ipsos," January 30, 2025, https://www.ipsos.com/en-us/less-half-americans-would-recommend-military-service-teens.
[13] *What Americans Think About Veterans and Military Service: Findings from a Nationally Representative Survey* (RAND Corporation, 2023), https://doi.org/10.7249/RRA1363-7.
[14] "Reagan National Defense Survey," accessed March 4, 2026, https://cloud.3dissue.net/28997/28913/29166/141576/index.html.

the public's trust in the broader veteran support community. Because veteran philanthropy is interconnected, unethical or misleading actions by any organization can damage shared credibility and limit collective capacity to serve those who have earned it.

Expand Pathways for Clients Facing the Greatest Barriers to Employment

The transition from military to civilian life is not a single event, but a complex, individualized process that shapes long-term workforce participation. Research shows that while 65 percent of veterans report feeling fully transitioned within three years of separation, 19 percent still did not feel fully transitioned more than six years later.[15] The Transition Assistance Program (TAP) has not consistently delivered the outcomes service members deserve. Rather than repeating discussions of longstanding shortcomings, this moment calls for comprehensive, evidence-based reform.

Policymakers must strengthen systems that support veterans throughout this transition—particularly those at the highest risk of economic insecurity. We urge the Committees to pursue legislative solutions that modernize TAP to better tailor transition services to individual service member needs and to more effectively integrate Non-Governmental Organization service providers into military transition programs.

Early instability following separation can lead to significant and lasting consequences. Research indicates that approximately two percent of transitioning service members experience homelessness within their first two years after separation, contributing to veterans representing more than 20 percent of homeless men and approximately six percent of the known homeless population. Suicide risk also increases following separation, with rates reaching 46.2 per 100,000 in the first year after leaving service compared to 34.7 per 100,000 overall.[16] We urge lawmakers to enact legislative solutions that increase housing-first and supportive-services funding streams for organizations delivering measurable impact for veterans at risk of homelessness, food insecurity, death by suicide, and system involvement.

During the transition process, Hire Heroes USA data show that 65 percent of clients face multiple, compounding barriers to employment, including food insecurity, mental health challenges, transportation limitations, and housing instability. Without coordinated, cross-sector

[15] Vogt et al., "The Veterans Metrics Initiative Study of US Veterans' Experiences during Their Transition from Military Service."
[16] Jack Tsai and Dorota Szymkowiak, "Retrospective Study of Homelessness among Transitioning Service Members Within Two Years after Military Service," *Administration and Policy in Mental Health* 53, no. 1 (2026): 14–23, https://doi.org/10.1007/s10488-025-01475-6.

intervention, these factors can delay workforce entry and significantly limit long-term earning potential.

While the Department of Veterans Affairs has prioritized homelessness and suicide prevention, misalignment across federal agencies has created uncertainty around the sustainability of proven service models. In particular, reduced emphasis on housing-first initiatives threatens evidence-based pathways to stability and employment, despite strong peer-reviewed research supporting their effectiveness. Federal policy addressing transition-related challenges for the most vulnerable veterans must be grounded in rigorous data, measurable outcomes, and sustained interagency coordination—not rhetoric. We encourage the Committees to continue working with non-profit and non-governmental entities for insights and solutions to these complex issues. Hire Heroes USA stands ready to partner in this work.

Conclusion

America can strengthen its economy by fully empowering and activating the talent, leadership, and experience of those who have served. Veterans and military spouses represent one of the nation's most capable and resilient workforce pipelines, yet structural barriers continue to limit labor force participation, career mobility, and earning potential. Hire Heroes USA is committed to building a strong economy that recognizes and invests in the promise of our veteran and military spouse clients. By strengthening employment pathways for military families, we not only fulfill a national obligation—we also unlock an economic opportunity that drives workforce growth, enhances business competitiveness, and supports long-term prosperity.

Thank you for the opportunity to present our legislative priorities. Hire Heroes USA looks forward to working with the Committees to reduce barriers to employment and improve services and outcomes for veterans, transitioning service members, and military spouses.

MILITARY ORDER OF THE PURPLE HEART OF THE U.S.A.

THE ONLY CONGRESSIONALLY CHARTERED VETERANS ORGANIZATION EXCLUSIVELY FOR COMBAT-WOUNDED VETERANS

STATEMENT OF

TRACEY BROWN-GREENE
National Commander

BEFORE A JOINT HEARING OF THE
SENATE AND HOUSE COMMITTEES ON VETERANS AFFAIRS

12 February 2026

Chairman Moran, Chairman Bost, Ranking Member Blumenthal and Ranking Member Takano, distinguished members of the Veteran Affairs Committee, and esteemed leaders, I am honored and humbled to represent America's Purple Heart Veterans in addressing you today. I would like to begin by congratulating all new members of Congress and expressing my gratitude to those who have returned to serve and enhance the quality of life for our nation's Veterans. With our collective efforts, I am confident that the 119th Congress will make significant strides in supporting our nation's heroes.

Previous Congressional session passed pivotal legislation, such as the VA Accountability Act, PACT Act and COMPACT Act, which have made substantial improvements in various aspects of Veterans' lives. These measures have established a presumptive link between terminal diagnoses resulting from war-related activities, employment, education, digital modernization of VA services, housing, and caregiver support. This foundation will undoubtedly guide our progress during the 119th Congress.

Our nation's Veterans answered the call to protect us from the darkest threats the world has to offer. We implore this committee and the rest of Congress to consider passing further legislation that addresses the pressing needs of our Veterans. These include:

- The Military Medals Protection Act and Purple Heart Protection Act: These measures aim to prevent Veterans from facing penalties when seeking alternative ways to continue serving our great nation. In addition, there are a plethora of non-Congressionally chartered organizations and businesses that are misusing/misrepresenting the medal's image and words Purple Heart for profit. Given that no organization other than the Military Order of the Purple Heart is the only Congressionally chartered organization to represent, protect, and preserve the honor of the Purple Heart, it calls on Congress to take decisive action to protect the integrity, honor, and ownership of the Purple Heart Medal by the Department of Defense and the Army Institute of Heraldry and restore the authorized use, given by the those two organizations, of the medal's image and trademark of the words "Purple Heart" to the MOPH. Please see the enclosed proposed Purple Heart Protection Act of 2026 and proposed Annual National Purple Heart Recognition Day proclamation.

- Major Richard Star Act: Will amend Title 10, United States Code: To enable tens of thousands of combat-injured Veterans to collect the full benefits they've earned. However, the Military Order of the Purple Heart is deeply concerned by the increasingly loose, inaccurate, and misleading use of the term "combat wounded" by various individuals and organizations and is introducing a Resolution included in this packet requesting Congress take corrective action to protect the integrity, honor, and definition of the term Combat Wounded as it relates to those men and women who have received it..

- Fulfilling the Legacy Act: Seek to make significant changes to the Survivors Benefits Program that has been affecting the financial security of Veterans who have paid into the system, but who lose the premiums paid if the covered spouse dies first.
- Legacy Survivor and Catastrophically Disabled Veterans Benefits Expansion: DIC currently provides only $1,650 per month. For the next five years, this bill would increase DIC by an additional 1% each year on top of inflation, helping over 500,000 families with their living expenses.
- Purple Heart Veterans Education Act of 2025 To authorize an individual who is awarded the Purple Heart for service in the Armed Forces to transfer unused Post-9/11 Educational Assistance to a family member, and for other purposes.
- Dental Care for Veterans Act: Will require the VA to furnish dental care in the same manner as any other medical service, and for other purposes.
- The National Green Alert Act: Originally introduced as HR 2797 in the 116th Congress and should be reintroduced in the 119th Congress. This act would provide communities with resources to assist Veterans coping with the invisible wounds of war.
- Veterans' Healthcare Improvement Act of 2026: Aims to expand access to mental health services and specialized care for Veterans.
- Homeless Veterans Assistance Act: Provides additional resources for housing, job placement, and outreach to homeless Veterans. Provides additional resources for housing, job placement, and outreach to homeless Veterans
- Military Family Support Act: Expands support services for military families, including childcare and spousal employment.

1. Let's begin with addressing the need to pass **The Military Medals Protection Act**: George Washington himself established the Badge of Military Merit, the precursor to today's Purple Heart, recognizing the profound significance of military honors. This act grants the Department of Defense exclusive trademark authority over all military medals, safeguarding them from exploitation and preserving their symbolic value. Commercializing or misusing these symbols diminishes their essence. The 113th Congress recognized this sacredness when they passed the Stolen Valor Act. Now, let's collaborate to expand their protections and restore all trade and word marks to the DOD, managed by the Institute of Heraldry, ensuring their unimpaired safeguarding. In addition, given that no organization other than MOPH is congressionally chartered to represent, protect, and preserve the honor of the Purple Heart Medal passage of this legislation will allow the DoD and Army Institute of Heraldry to restore the authorized use of the medal's image and trademark of the words "Purple Heart" to the MOPH.

2. **SB 1032 and HR 2102: The Richard Star Act** will provide for concurrent receipt of Veterans' disability compensation and retired pay for disabled retirees with combat-related disabilities, and for other purposes. This includes Veterans who have received the Purple Heart for injuries received in combat and/or acts of terrorism, both domestically or foreign related. In addition, the term "combat wounded" has a long-standing, clearly defined meaning within the United States military, historically and legally referring solely to those service-members who were wounded as a direct result of enemy action, or who died from wounds sustained in combat, and who therefore are eligible for and awarded the Purple Heart Medal. The Military Order of the Purple Heart (MOPH), is deeply concerned by the increasingly loose, inaccurate, and misleading use of the term "combat wounded" by various individuals and organizations; and therefore request Congress include MOPH as a mandatory stakeholder in any legislative discussions, hearings, advisory panels, or negotiations in which the term "combat wounded" is used, referenced, or applied—given that no organization other than MOPH is congressionally chartered to represent, protect, and preserve the honor of the Purple Heart. Please see proposed MOPH Amendment to the Richard Star Act.

3. **HR 6407: Legacy Survivor and Catastrophically Disabled Veterans Benefits Expansion:** DIC currently provides only $1,650 per month. For the next five years, this bill would increase DIC by an additional 1% each year on top of inflation, helping over 500,000 families with their living expenses. If passed, this legislation will significantly raise the monthly benefits rate for catastrophically service-connected disabled Veterans with a traumatic brain injury or other severe disabilities that require regular, round the clock, in-home medical care, offering an additional $10,000 annually. The first significant increase for this cohort of Veterans in decades

4. **HR 210: Dental Care for Veterans Act:** A long overdue piece of legislation Will require the VA to furnish dental care in the same manner as any other medical service, and for other purposes. Currently Veterans may only receive Veterans Affairs Dental Care only if they meet the current myriad of confusing number of qualifications. However, there are thousands of Veterans who need dental care but either does not qualify for VA provided Dental Care or cannot afford either VA or private Dental Care. This is an absolute travesty by denying much needed support to Veterans who have served this great nation. It is known and proven that by not taking care of one's dental needs; it can lead to 15 systemic health issues, thereby emphasizing the importance of maintaining good dental hygiene.

5. **HR 2797 (116th Congress) The National Green Alert Act**. The statistics are alarming, with new studies revealing that up to 44 Veterans per day succumb to suicide, nearly double the previous estimates. While our AMBER Alert system has saved over 1,100 children and Silver Alerts have a 95% success rate, we lack a comparable system for our at-risk Veterans. All first responders need access to the life-saving tools and resources necessary to handle the evolving challenges of decades of war and service to our nation. Wisconsin demonstrated the effectiveness of this concept when they passed H.B. 473-2018. We must expand this crucial legislation nationally to ensure our nation's heroes receive the support they deserve.

6. **HR 3676 (118th Congress): The Helping Homeless Assistance Act** aims to address the pressing issue of homelessness among Veterans. Provides additional resources for housing, job placement, and outreach to homeless Veterans. Reduces veteran homelessness and offers critical support. Approximately 33,000 Veterans will be sleeping on our streets tonight. A staggering 70% of homeless Veterans grapple with substance abuse, while 45% struggle with mental illness. This act

introduces revolutionary changes to VA healthcare by embracing alternative treatments, holistic approaches, and comprehensive mental health services. Moreover, dental care, which has been neglected within the VA, is prioritized. Unfortunately, several health conditions have been linked to poor oral health. We cannot continue to address the traumas of the 21st century with outdated solutions.

7. **The Fulfilling the Legacy Act** seeks to rectify a systemic failure that has been affecting Veterans' financial security. Consider the story of a 92-year-old Purple Heart recipient who diligently paid Survivor Benefit Plan premiums for decades, only to lose $50,000 in premiums when his wife passed away. This is not an isolated incident but a clear indication of the need for action. This act modernizes the SBP, ensuring that Veterans' investments in their families' futures are protected.

8. **SB 342: Purple Heart Veterans Education Act of 2025:** Passage of this legislation will authorize an individual who is awarded the Purple Heart to transfer unused Post-9/11 Educational Assistance to a family member, and for other purposes.

9. **HR 4567: Veterans' Healthcare Improvement Act of 2026:** Aims to expand access to mental health services and specialized care for Veterans. Improves healthcare access and quality for Veterans.

Call To Action: In addition to our legislative priorities above, it will be remiss to not mention that Military retirees have already met all the requirements to earn their healthcare benefits, and the Military Order of the Purple Heart opposes any changes to TRICARE For Life that would increase fees and shift costs from the Department of Defense (DoD) to retirees over 65 years of age who rely on TRICARE For Life. In addition, The Military Order of the Purple Heart opposes any cuts to Veterans Affairs disability benefits. Lastly, Congress needs to pass legislation prohibiting the US Department of Veterans Affairs from reducing VA Disability Benefits when a Veteran files a new claim. Too many times when a new claim is opened, the Veterans Benefits Administration (VBA) re-examines the Veteran's entire file and will look to reduce benefits rather than determine whether or not an increase is warranted based on the new claim. Many times the Veteran is not provided an opportunity to have a Predetermination Hearing to prevent the reduction or, does not learn of the reduction to his/her VA Disability Benefits until receipt of the VBA Decision Letter, if one is even sent. This must stop!

The cost of inaction extends beyond monetary losses; it involves the loss of lives, shattered families, and broken promises. Each day, 44 families tragically lose a veteran to suicide due to our delay. Every night, 33,000 Veterans who valiantly defended our nation find themselves sleeping on our streets. Moreover, countless military families face financial insecurity annually due to outdated benefit systems. Continuing to allow companies to profit while simultaneously penalizing the warriors who earned these prestigious awards diminishes the sacrifices made by our nation's warriors. These four acts represent more than mere policy changes; they embody our sacred moral obligation to those who have served.

From protecting the symbols of their sacrifice to saving lives in crisis, from revolutionizing their healthcare to securing their families' futures, each piece of legislation addresses critical gaps in our support for Veterans. As George Washington rightly recognized the importance of honoring those who

served under him, we too must recognize our duty to today's Veterans. The 119th Congress holds the opportunity and the obligation to transform how America cares for its heroes.

Which of you is ready to answer the call of our nation's heroes, as they did to defend our freedom and way of life? Let us set aside party politics and focus on the pressing issue at hand. The Military Order of the Purple Heart is seeking your support on the aforementioned acts.

NATIONAL COMMANDER, MILITARY ORDER OF THE PURPLE HEART

Tracey Brown-Greene retired from the United States Army after serving on Active Duty for 22 years. She sustained combat-related injuries in Afghanistan because of an enemy attack in 2016. Her military awards and decorations reflect her outstanding service and sacrifice, including the Bronze Star, Purple Heart, Meritorious Service Medal, and numerous other commendations.

Tracey was elected National Commander of the Military Order of the Purple Heart during 2025 at the 92nd National Convention in Reno, Nevada. A MOPH member since 2017, she previously has served as Chapter Commander, Department of Texas Commander, National Junior Vice Commander, and National Senior Vice Commander. In addition, Tracey served on multiple committees in the Order and as the MOPH FUND's Chairman of the Board.

In addition to her military accomplishments, Tracey is a dedicated scholar and lifelong learner. She holds a Bachelor of Arts in Management from American Military University, a Master of Arts in Management and Leadership from Liberty University, a Graduate Certificate in Management from North Central University, and a certificate in Women's Entrepreneurship from Cornell University. She is currently pursuing a Doctorate in Business Administration with a concentration in Financial Management.

Tracey is deeply passionate about the well-being of military veterans and their families. She is a recipient of the Congressional Veterans Commendation and holds certification as a Master Life Coach. She is committed to fostering goodwill, camaraderie, and service among combat-wounded veterans and the broader veteran community.

Residing in Harker Heights, Texas, with her family, Tracey is active in numerous veterans and civic organizations. She also volunteers with local school district initiatives and participates in a wide array of community efforts. Tracey Brown-Greene is the epitome of a citizen-Soldier—dedicated, resilient, and committed to service both in and out of uniform.

Amendment to the Richard Starr Act

Whereas, the term "combat wounded" has a long-standing, clearly defined meaning within the United States military, historically and legally referring solely to those service-members who were wounded as a direct result of enemy action, or who died from wounds sustained in combat, and who therefore are eligible for and awarded the Purple Heart Medal; and

Whereas, the Military Order of the Purple Heart (MOPH), a congressionally chartered veterans service organization founded in 1932 and dedicated exclusively to honoring, supporting, and advocating for Purple Heart recipients and the legacy of combat sacrifice, is deeply concerned by the increasingly loose, inaccurate, and misleading use of the term "combat wounded" by various individuals and organizations; and

Whereas, certain groups have publicly promoted the Richard Starr Act as a "combat wounded tax" or as legislation essential to protecting combat-wounded veterans, despite the fact that the bill does not define, address, or provide dedicated benefits to Purple Heart recipients or those actually wounded in combat; and

Whereas, the misuse of the term "combat wounded" to describe injuries unrelated to combat—such as training accidents, recreational injuries, or non-hostile incidents occurring within or outside a combat zone—diminishes the honor, meaning, and historical integrity of the Purple Heart Medal, and in some cases borders on or contributes to Stolen Valor, precisely the type of misrepresentation the Stolen Valor Act was created to prevent; and

Whereas, promoting legislation under the banner of "combat wounded" when it does not specifically benefit Purple Heart recipients misleads veterans, Congress, the media, and the American public, and risks eroding trust in the legislative process and in the organizations advocating for veterans; and

Whereas, the Military Order of the Purple Heart has repeatedly seen its name, its constituency, and its mission invoked—often inaccurately and without consultation—by organizations seeking to advance legislative efforts that do not directly support combat-wounded veterans, causing confusion and undermining MOPH's congressionally mandated role as the guardian of the Purple Heart Medal and its meaning; and

Whereas, based on a review of the Richard Starr Act, the Military Order of the Purple Heart finds that the bill, while beneficial for a limited population of medically retired service-members, does little to nothing to directly assist those who are verifiably combat wounded as defined by Purple Heart eligibility criteria; and

Whereas, there is significant public confusion, fueled by repeated misstatements, regarding what the Richard Starr Act actually accomplishes and whom it truly benefits, creating a policy environment that demands congressional clarification and corrective action;

Now, Therefore, Be It Resolved, that the Military Order of the Purple Heart respectfully requests that Congress issue a formal clarification outlining**:**

1. What the Richard Starr Act does and does not do, particularly regarding the population of Purple Heart recipients;
2. The miscommunications and misrepresentations circulating within portions of the veterans community;
3. A clear differentiation between "medically retired service-members" and "combat wounded / Purple Heart recipients," ensuring that these terms are never again conflated for legislative or political purposes and,

BE IT FURTHER RESOLVED, that if Congress intends for the Richard Starr Act to address inequities affecting "combat wounded" service members, then the legislation should be

amended to apply exclusively to those who:

- Were wounded by enemy action,
- Received the Purple Heart Medal and,
- Were medically retired prior to reaching 20 years of service.

This amendment would align the bill's scope with the terminology its advocates continue to use publicly.

BE IT FURTHER RESOLVED, that the Military Order of the Purple Heart urges Congress to include MOPH as a mandatory stakeholder in any legislative discussions, hearings, advisory panels, or negotiations in which the term and

"combat wounded" is used, referenced, or applied—given that no organization other than MOPH is congressionally chartered to represent, protect, and preserve the honor of the Purple Heart and,

BE IT FURTHER RESOLVED, that Congress should consider an alternative legislative approach if it intends to support combat-wounded veterans—specifically:

Creation of a Purple Heart Stipend

A federal, non-taxable $200 per month stipend provided to all living, verified Purple Heart recipients, regardless of retirement status, branch of service, or length of service, and to the primary DIC beneficiaries of those killed in action or deceased due to combat wounds and,

BE IT FURTHER RESOLVED, that Congress should direct the Department of Defense and the Department of Veterans Affairs to:

1. Reaffirm and publish the formal definition of "combat wounded" as it relates to awarding the Purple Heart;
2. Enforce stricter standards and penalties for individuals, organizations, or entities that misrepresent themselves as combat wounded or seek financial gain from misuse of the term;
3. Consider legislative remedies that hold accountable any group or person who knowingly benefits, financially or politically, from misusing the term "combat wounded," consistent with the intent of the Stolen Valor Act and,

BE IT FINALLY RESOLVED, that the Military Order of the Purple Heart firmly asserts that continued misuse of the term "Combat wounded" for legislative promotion is dishonorable, misleading, and disrespectful to those who have shed blood for this nation, and calls on Congress to take decisive action to protect the integrity, honor, and meaning of the Combat Wounded as it relates to the Purple Heart Medal and the men and women who been awarded it.

119th U.S. Congress the PURPLE HEART PROTECTION ACT of 2026

Protecting the recipients of the Purple Heart from fraud, word mark use and stolen valor. Supporting the goals and ideals of establishing a perpetual National Purple Heart Recognition Day on August 7 of each year.

IN THE HOUSE & SENATE OF THE UNITED STATES

_____ 2026

Sponsors: _____submitted the following Public Law; which was considered and agreed to

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PUBLIC LAW

Ref:- Purple Heart Protection Act of 2026
Proposed legislative action –

Seek Public Law (to be determined)

*** Request amendment to Public Law 109-437 of the 109th Congress.**

Action requested of: An Act in the 119th U.S. Congress
To amend Public Law 109-437 and title 18, United States Code, to enhance protections relating to the reputation, word mark and MOPH logo use of the Purple Heart name and meaning of the Purple Heart Medal and Purple Heart protection of its recipients as members of the Congressionally chartered Military Order of the Purple Heart of the U.S.A.

To establish the sole right to use the word marks/trademarks "Purple Heart" and its likeness of the Purple Heart medal in its logo as established and used since 1932.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, <<NOTE: Stolen Valor Act of 2005.>>

SECTION 1. <<NOTE: 18 USC 1 note.>> SHORT TITLE.

This amended Act may be cited as the ``Purple Heart Protection Act".

SEC. 2. <<NOTE: 18 USC 704 note.>> FINDINGS.

Congress makes the following findings:

(1) Fraudulent claims surrounding the receipt of the Purple Heart Medal awarded by the President or the Armed Forces of the United States damage the reputation and meaning of such. decorations and medals.

(2) A recipient of the Purple Heart reserves the right to use the word mark Purple Heart in all communications befitting an awardee of the Purple Heart Medal.

(3) Fraudulent claims of receipt of military decorations and medals is punishable under the Stolen Valor Act of 2005.

(4) Legislative action is necessary to protect the reputation and meaning of the Purple Heart Medal and who has the expressed legal use of the words Purple Heart – the recipients of the Purple Heart Medal and the Military Order of the Purple Heart of the U.S.A.

(5) To formally establish the Purple Heart logo of the Military Order of the Purple Heart of the U.S.A. chartered by Congress as the official emblem of the Order for its fundraising, legislative and other lawful uses as a non-profit 501 (c) 19 War Veterans Service Organization.

SEC. 3. ENHANCED PROTECTION OF MEANING OF MILITARY DECORATIONS AND MEDALS.

(a) Expansion of General Criminal Offense.--Subsection (a) of section 704 of title 18, United States Code, is amended by striking ``manufactures, or sells'' and inserting ``purchases, attempts to purchase, solicits for purchase, mails, ships, imports, exports, produces blank certificates of receipt for, manufactures, sells, attempts to sell, advertises for sale, trades, barters, or exchanges for anything of value''.

(b) Establishment of Criminal Offense Relating to False Claims About Receipt of Decorations and Medals.--Such section 704 is further amended--

(1) by redesignating subsection (b) as subsection (c);

(2) by inserting after subsection (a) the following:

``(b) False Claims About Receipt of Military Decorations or Medals.--Whoever falsely represents himself or herself, verbally or in writing, to have been awarded any decoration or medal authorized by Congress for the Armed Forces of the United States, any of the service medals or badges awarded to the members of such forces, the ribbon, button, or rosette of any such badge, decoration, or medal, or any colorable imitation of such item shall be fined under this title, imprisoned not more than six months, or both.''; and

(3) in paragraph (1) of subsection (c), as redesignated by paragraph (1) of this subsection, by inserting ``or (b)'' after ``subsection (a)''.

(c) Enhanced Penalty for Offenses Involving Certain Other Medals.--Such section 704 is further amended by adding at the end the following:

``(d) Enhanced Penalty for Offenses Involving Certain Other Medals.--**If a decoration or medal involved in an offense described in**

subsection (a) a Purple Heart awarded under section 1129 of title 10, or any replacement or duplicate medal for such medal as authorized by law, in lieu of the punishment provided in the applicable subsection, the offender shall be fined under this title.

(d) Conforming Amendments.--Subsection (c) of such section 704, as so redesignated, is further amended--

(1) by inserting ``Enhanced Penalty for Offenses Involving"

Supporting the goals and ideals of a perpetual National Purple Heart Recognition Day on August 7.

Resolved, That the House and Senate—

(1) supports the goals and ideals of National Purple Heart Recognition Day; and

(2) encourages all people of the United States—

(A) to learn about the history of the Purple Heart Medal;

(B) to honor recipients of the Purple Heart Medal; and

(C) to conduct appropriate ceremonies, activities, and programs to demonstrate support for people who have been awarded the Purple Heart Medal.

(D) to protect the Purple Heart recipients from fraud, misuse and loss of reputation due

to stolen valor or other illegal actions that effect the recipients of the Purple Heart and the

Military Order of the Purple Heart of the U.S.A.

UNITED STATES OF AMERICA PROCLAMATION –

National Purple Heart Day - August 07, 2026

August 7, 2026
WHEREAS, our Nation and its principles have been defended throughout history by brave and patriotic men and women who willingly sacrificed their own well-being for the cause of freedom and democracy; and

WHEREAS, President George Washington created the Badge of Military Merit to honor brave military personnel; and

WHEREAS, in 1932, on the 200th anniversary of George Washington's birth, the Badge of Military Merit was renamed the Purple Heart; and

WHEREAS, today the Purple Heart is awarded to honor the Combat Wounded Veterans of this country and those who made the ultimate sacrifice and never returned home; and

WHEREAS, recognizing the seventh day of August as a day to pay National tribute to those who hold the distinction of having been awarded the Purple Heart; and

WHEREAS, our Combat Veterans have earned profound and eternal gratitude from all of the people of the United States of America for their willingness to risk life and limb for the sake of this nation, its people, and our cherished freedoms.

NOW, THEREFORE, I, _____, President of the United States, do hereby proclaim **August 7, 2026, and each successive August 7 and year to be**

National Purple Heart Day

In the United States of America, I urge all people in our Nation to join me in acknowledging and honoring this Nation's 1.8 MILLION Veterans who have been killed or wounded in battle since since our Nation's founding while defending the principles of democracy, individual freedom, and human rights.

Signed this 7th day of August 2026

Signed by the President of the United States of America _____

DRAFT Purple Heart Protection Act of 2026 and Purple Heart Day proclamation August 7, 2026 by;

Joseph A. Tormala, USMC-USA (Ret) – Department of Michigan Legislative Officer,
Military Order of the Purple Heart, Chapter 1879, Michigan, Region II
joetormalaret@gmail.com

Military-Veterans Advocacy

Written Testimony/Statement for the Record in Support of Legislative Priorities:

Submitted to the Joint Session of the
United States Senate Veterans Affairs Committee United States
House Veterans Affairs Committee March 4, 2026

Commander John B. Wells, USN (Ret)
Executive Director

Introduction

Distinguished Chairmen Jerry Moran and Mike Bost and Ranking Members Blumenthal, Mark Takano, and other members of the Committee, thank you for the opportunity to present the views of Military-Veterans Advocacy® (MVA™) on our legislative priorities.

We also recognize that fiscal and political realities, which, as applied, harm our nation's veterans. The Pay As You Go Act of 2010 (Title I of Pub. L. 111-139) (PAYGO) requires costing by the Congressional Budget Office and the identification of offsets, colloquially known as "Payor's." Historically this fiscal process has delayed or blocked important veterans legislation.

MVA™ believes that veterans benefits should be exempted from the requirements of PAYGO. Veterans benefits are a legitimate cost of war. Overseas Contingency Operations (OCO OPS) are not subject to PAYGO. An Armored Cavalry Regiment is not required to mothball two Abrams and three Bradleys' to offset the cost of sending the unit overseas. Nor is a fleet required to inactivate ships or aircraft to offset the cost of the deployment. Yet when injured and/or disabled veterans return, the law requires any increase in benefits to be offset.

The ineffectiveness of PAYGO is demonstrated by the increase in the debt from $14.8 trillion in 2011 to over $36 trillion today. Often programs are enacted with budgetary illusions akin to "smoke and mirrors" that have no effect on the actual deficit. Unfortunately, this legerdemain does not seem to be utilized for veterans legislation. While budgetary neutrality is beyond the scope of this testimony, I mention it to underline the feeling of many veterans that they are used as cannon fodder and then discarded - except on Memorial Day, Veterans Day and the Fourth of July. Veterans service benefits everyone and veterans must pay their fair share.

About Military-Veterans Advocacy®

Military-Veterans Advocacy Inc.® (MVA™) is a tax-exempt IRC 50l[c][3] organization based in Slidell, Louisiana that works for the benefit of the armed forces and military veterans. Through litigation, legislation, and education, MVA™ seeks to obtain benefits for those who are serving or have served in the military. In support of this, MVA™ provides support for various legislation at the State and Federal levels as well as engaging in targeted litigation to assist those who have served. We currently have over 2300 proud Members and over 21,000 followers on our social media accounts. In 2023, our volunteer board of directors donated almost 10,00-0 hours in support of veterans. MVA™ analyzes and supports/opposes legislation, assists Congressional staffs with the drafting of legislation and initiates rule making requests to the Department of Veterans Affairs. MVA™ also files suits under the Administrative Procedures Act to obtain judicial review of veterans' legislation and regulations as well as *amicus curiae* briefs in the Courts of Appeal and the Supreme Court of the United States. MVA™ is also certified as a Continuing Legal Education provider by the

State of Louisiana to train attorneys in veterans' law and we do so throughout the nation.

MVA™ is a member of the TEAMS Coalition, the Foundation for Veterans Outreach Programs and other working groups. MVA™ works closely with Veterans Service Organizations including the United States Submarine Veterans, Inc, the National Association of Atomic Veterans, Veterans Warriors, and other groups working to secure benefits for veterans.

Military-Veterans Advocacy® Executive Director
Commander John B. Wells USN (Ret.)

MVA™'s Chairman, Commander John B. Wells, USN (Retired) has long been viewed as the technical expert on herbicide exposure. A 22-year veteran of the Navy, Commander Wells served as a Surface Warfare Officer on six different ships, with over ten years at sea. He possessed a mechanical engineering subspecialty, was qualified as a Navigator and for command at sea and served as the Chief Engineer on several Navy ships.

Since retirement, Commander Wells has become a practicing attorney with an emphasis on military and veteran's law. He is counsel on several pending cases concerning herbicide and other toxic exposures. Commander Wells was the attorney on the *Procopio v. Wilkie* 913 F. 3d 1371 (Fed. Cir. 2019) case that extended the presumption of herbicide exposure to the territorial sea of the Republic of Vietnam, which laid the groundwork for the Blue Water Navy Vietnam Veterans Act. He strongly supported, both in Congress and the courts, the extension of the herbicide presumption and to cover veterans in Thailand, Guam, American Samoa, and Johnston Island. He also initiated successful judicial review of the Appeals Modernization Act with a favorable outcome. *MVA v. Secretary of Veterans Affairs*, 7 F.4th (Fed. Cor. 2021). Since 2010 he has visited virtually every Congressional and Senatorial office to discuss the importance of enacting veterans' benefits legislation. With the onset of covid, Commander Wells has conducted virtual briefings for new Members of Congress and their staffs..

HR 1336 & S 2737 - Hyperbaric Oxygen Treatment for Traumatic Brain Injury

Enactment of HR 1336 and S 2737 is the primary goal of MVA's legislative agenda for the 119th Congress. Veterans suicide is an escalating problem. Although the number of suicides dropped slightly in the last report, the suicide rate actually increased. Post Traumatic Stress and Traumatic Brain Injuries remain the most frequent common denominator for suicide, It is tie to reverse this trend.

MVA™ has long supported the use of Hyperbaric Oxygen Treatment to treat Traumatic Brain Injury. There is an increasing body of evidence that show HBOT is an effective treatment for TBI and other neurological injuries. https://pubmed.ncbi.nlm.nih.gov/33050752/. HR 1336 & S 2737 will direct the Secretary of

Veterans Affairs to establish a pilot program to furnish hyperbaric oxygen therapy (HBOT) to a veteran who has a traumatic brain injury (TBI) and there are positive indications associated with this treatment. Our interviews with members who served in combat or in Special Operations also point to an affirmative correlation between HBOT and TBI. We believe that HBOT could potentially allow for a more successful treatment pathway for these invisible wounds.

The VA continues to be enamored with opioids for treatment of PTS/TBI. The result has not been pretty. One of our former board members was mistreated by opioids that led to his violent and fatal attack on one of his children. Another former board member was prescribed 120 Vicodin a month by the VA. An MVA™ employee was overtreated with opioids and changes from an effective to an ineffective worker incapable of performing her duties.

Current VA and Congressional opposition seems to center on a belief that more study is required. Unfortunately, the VA has a habit of filibuster by studies. This is not acceptable And since the bills only require pilot programs, what better way is there to study the results of the treatment?

Appellate Reform

MVA™ was one of the few veterans groups to oppose the Appeals Modernization Act. The AMA has been less than successful. The VA appellate system remains archaic and does not conform with the procedures used by other federal adjudication systems such as the Merit Systems Protection Board, Social Security or the Equal Employment Opportunity Commission. Special rules limit the ability of the veteran to pursue a substantive appeal or to obtain judicial review in the Court of Appeals for the Veterans Claims. Jurisdictional statues limit the ability of the Court and its supervisory court to review factual errors. Additionally, the intermediate level review authority, the Board of Veterans Appeals, is hampered by unqualified decision makers, disjointed scheduling and excessive remands. The backlog at the Board, currently about 200,000 is unconscionable. MVA estimates, based on the current backlog, that thousands of veterans will die awaiting adjudication.

Scheduling remains a serious problem.. In FY 2024 8% of hearings had to be rescheduled. 21% were cancelled (sometimes due to the veterans death) and 3% were no show. Bottom line: Only 65.7% of hearings were held as scheduled.

In 2024 71.3% of the cases appealed from the Board to the Court of Appeals for Veterans Claims were partially or totally remanded. Only 4.7% of the appeals were affirmed in whole *See* FY 2024 report to Congress. Board members are never disciplined for excessive remands.

MVA™'s attorneys practice before the Board throughout the year. The lack of qualified Board members acting as adjudicators results in hearings that are clown shows. For example, a Board member found that the statement of a helicopter pilot confirming that he flew one of his squadron mates to Da Nang was discounted because the deck log did not show the veteran left the ship. Yet the guiding Navy directive for the preparation of deck logs only

requires the Commanding Officer and embarked VIPs be logged when they leave or return to the ship. The Board also denied benefits because the ship locator log did not show the helicopter in the Blue Water Navy zone. The Ship Locator tool does not track aircraft. When remands are returned to the Board, additional evidence considered by the Regional Office is not provided to the veteran or his/her representative This is a violation of due process as outlined in *Greene v. McElroy*, 360 U.S. 474 (1959).

Remands add years to the claim/appeal and increase the backlog. Incompetence is rampant on the Board and it cannot be tolerated. Accordingly, we request the Congress to adopt some or all of the following proposals.:

- Require the board members to be qualified as Administrative Law Judges.
- Require a scheduling conference and scheduling order.
- Provide for the review and sanction of board members who have more than 30% of their decisions remanded for reasons within the control of the board member.
- Provide for a discovery process to streamline the preparation of the appeal.
- Revise § 7261(a)(4) of Title 38 to change the standard of review for factual findings from "clearly erroneous" to "abuse of discretion."
- Revise § 7261(d) of Title 38 to allow a de novo trial on the record, similar to the provisions in federal district courts and the Court of Federal Claims.
- Revise § 502 of Title 38 to vest jurisdiction in the Court of Appeals for Veterans Claims instead of the Court of Appeals for the Federal Circuit.
- Strike § 7292 and add the Court of Appeals for Veterans Claims to the general Jurisdictional statute of the Court of Appeals for the Federal Circuit.
- Modifies 38 U.S.C. § 7332[b][2] to allow the VA to release the record to the Court of Appeals for Veterans Claims & the veteran's representative when a notice of appeal is filed.

Return the Blue Water line to the theater of combat as existed prior to 2002.

The Blue Water Navy Vietnam Veterans Act, Pub. L. 116-23 granted presumptive herbicide exposure status to US service members who served in a geographic area which closely parallels the territorial sea.

Section 2(d) of the Act grants the presumption of herbicide exposure to service members who performed in an area 12-nautical miles seaward of a line drawn between certain geographic points off the coast of the Republic of Vietnam. Prior to 2002, the VA by regulation and policy, recognized the presumption of exposure in the entire area of the South China Sea covered by Executive Orders No. 11,216, (Designation of Vietnam and Waters Adjacent Thereto as a Combat Zone for the Purposes of Section 112 of the Internal Revenue Code of 1954, 30 Fed. Reg. 5817 (1965) and Exec. Order No. 11,231, Establishing the Vietnam Service Medal, 30 Fed. Reg. 8665 (1965).

In early 2002, the VA implemented a General Counsel Opinion that held veterans qualifying for the presumption of the herbicide exposure must have touched land or the internal rivers of the Republic of Vietnam. The Court of Appeals for the Federal Circuit held

in a case brought by Military-Veterans Advocacy called *Procopio v. Wilkie*, 913 F.3d 1371 that the herbicide presumption must be extended to include the bays harbor and territorial sea of Vietnam. Ships, especially aircraft carriers, outside the line are not covered.

Unfortunately, Agent Orange within the river discharge could be found several hundred kilometers from the mouth of the river within a couple of weeks. This contaminated seawater would be ingested into the distillation intake. Additionally, planes and helicopters would fly through clouds of Agent Orange. The Carrier Onboard Delivery planes would deliver, personnel, supplies, perishables, equipment and mail that was staged in and around Da Nang or other Vietnamese airfields. Cross-contamination would soon occur throughout the ship.

MVA™ is seeking legislation to amend 38 U.S.C. § 1116A(d) to substitute the coordinates delineated in Executive Order 11,216 and 11,231.

According to the Congressional Research Service, 174-thousand of 229-thousand Navy personnel who deployed to Southeast Asia were within the territorial limits of South Vietnam. This leaves approximately 55-thousand Navy personnel outside of the territorial sea, mostly on Carriers. Military-Veterans Advocacy® estimates that 20-25-thousand personnel are covered under the PACT Act due to port calls in Guam, American Samoa and Thailand. Accordingly we estimate about 30-35-thousand personnel will be covered by this extension at a cost of approximately $600 million over ten years in mandatory spending.

Guard/Plus/Choice Act

The passage of the PACT Act gave rise to unqualified, untrained and/or uncertified entities, commonly known as claims sharks. These so-called consultants charged veterans thousands of dollars with no guarantee of success. These companies concentrated on initial claims which have historically been available only for pro bono representation. Consultants have tried to create a loophole to allow them to charge veterans when attorneys and claims agents cannot.

Individual States such as New Jersey and Louisiana, fed up with continued Congressional partisan bickering, have *enacted* legislation to regulate these claims sharks. New Jersey has enacted a version of the GUARD Act that prohibits these claims sharks from practicing within the State. The law was sustained by the District Court however the 3rd Circuit remanded to address First Amendment concerns, *Veterans Guardian VA Claim Consulting LLC v. Platkin*, 133 F.4th 213 (3d Cir. 2025). Louisiana enacted a law based on the PLUS Act. MVA brought suit against the State successfully claiming that the law was unconstitutional based on federal preemption and First Amendment concerns. *Mil.-Veterans Advoc., Inc. v. Landry*, No. CV 24-00446-BAJ-RLB, 2026 WL 324017, at *1 (M.D. La. Feb. 6, 2026). The State has indicated that they may appeal this decision to the 5th Circuit.

Other States have looked at this situation and are considering legislation We do not need a

patchwork quilt of laws, especially since veterans claims cross Sate boundaries. Congress should act. We support Cong Pappas' GUARD Act and Cong. Bergman's Choice Act (with reservations). We hope that Congress will move forward to regulate this important matter.

HR 2149 - Earlier effective date for Guam (Aug 15, 1958).

Section 403(d)(5) of the PACT Act grants the presumption of herbicide exposure to service members who performed service on Guam beginning on January 9, 1962, and ending on July 31, 1980. Evidence compiled by Military-Veterans Advocacy® shows that the spraying on Guam commenced on August 15, 1958. See, Area Public Works Office *Guam Soils Conservation Series No. 2, Herbicides*, August 15 1958 which can be found 1958 Herbicides Navy (1).pdf (militaryveteransadvocacy.org)

MVA™ asks for a technical correction to modify the commencement date of herbicide exposure on Guam until August 15, 1958. MVA™ estimates that only a few dependents would be eligible for DIC at negligible cost. We believe all affected veterans are dead.

Panama Canal Zone

Last Congress Congresswoman Marie Salazar introduced HR 2447 to grant presumptive herbicide exposure status to veterans who served in or near the Panama Canal Zone (PCZ) between January 1, 1958 and December 31, 1999, or when the last military personnel departed from their official duty in the Panama Canal Zone. The bill will enable eligible veterans to receive benefits if they suffer from any of the diseases the VA has linked to herbicide exposure.

The U.S. Census Bureau Commodities by Country show 2,4-D & 2,4,5-T shipped, stored and used in Panama from 1958 until at least December 1977. This chemical, produced and shipped from 1958-1964, was code named "Agent Purple" with a higher dioxin content (30-50 PPM TCDD), whereas shipments from 1965-1977 were to have a lower dioxin content closer to 0.5 code named "Agent Orange."

As outlined in the DOD Herbicide Manual, TM 5-629, these herbicides were used routinely as needed on base. 2,4-D & 2,4,5-T was used to kill poison ivy, poison oak and sumac where troops were deployed. See page 34, 3-7. Silvex was used on golf courses, parade fields and gun ranges. See page 41, 3-6. As well as many other persistent pesticides harmful to man as listed in this Tri-service manual to be used on every base as needed. Silvex also contains 2,4,5-T and the by-product Dioxin (TCDD).

The bill allows for presumptive coverage similar to the coverage for those who served in Vietnam, along the Korean DMZ and on the base perimeters in Thailand. Unfortunately,

proving exposure is nearly impossible due to a lack of record keeping and the inability to know the precise location of spraying. What records exist corroborate the presence of herbicide in the PCZ during the 1950's, 1960's and 1970's.

The Panama Canal Zone was not included in the PACT Act.

Documents supporting the MVA™ position are available online on our website at: https://www.militaryveteransadvocacy.org/vets-of-panama.html

Okinawa

Between January 9, 1962 (and possibly earlier) the herbicide Agent Orange was shipped to, stored upon and used on United States military installations on Okinawa. Agent Orange Barrels were actually discovered on Marine Corps Air Station Futenma in August of 1981 and at a soccer pitch in Okinawa City (previously part of Kadena Air Force Base) in June of 2013.

The VA conditionally approved a rule making request filed by Military-Veterans Advocacy but its preliminary rule indicated that coverage would not include Okinawa absent a confirmation from the Department of Defense that the herbicide was used on that island, . The extensive rule making request is shown on our web site athttps://www.militaryveteransadvocacy.org/uploads/3/4/1/0/3410338/va_approval_of_mva_rulemaking_request.pdf. Evidence in the request included a form DD 250, clearly showing that 2,4,5-T was shipped to Okinawa in July of 1966. It further includes excerpts from Jon Mitchell's excellent analysis, *Poisoning the Pacific*. This book provides documentary and photographic evidence of the presence of herbicide on Okinawa during the Cold War. It also contains the later excavations of Agent Orange herbicide at MCAS Futenma and Kadena Air Force Base.

The investigation of the former Kadena discovery is memorialized in a survey by the Okinawa Defense Bureau, entitled *Former Kadena Airfield (2 5) Soi; Investigation Survey (Part 2)* which is also included in the rule making request along with a news article in *Stars and Stripes,* confirms toxic levels of 2,4,5-T, 2,4-D and its by-product 2,3,7,8-TCDD (dioxin).

Additionally, MVA™ holds sworn affidavits from a Marine who sprayed the herbicide and from an Air Force NCO who inventoried 25,000 barrels of Agent Orange at Kadena Air Force Base.

MVA™ proposes legislation to provide a presumption of herbicide exposure to those veterans who between January 9, 1962 and May 7, 1975, individually or in a unit that, as determined by the Department of Defense, operated on Okinawa or within the territorial sea of that island. To cover more recent excavations, for purposes of service on Marine Corps Air Station Futenma, the presumption is extended until the discovery of barrels of herbicide in August of 1981. For purposes of service on Kadena Air Force Base, the presumption is

extended until the discovery of herbicide on the soccer pitch in Okinawa City (previously part of Kadena AFB) in June of 2013.

The VA is empowered under 38 U.S.C. § 501 to issue regulations that are not encumbered by PAYGO requirements. They have successfully issued regulations to cover portions of Korea, portions of Thailand, and the C-123 aircraft, among others. Under the provisions of the Administrative Procedures Act, an entity such as MVA™ can request the Secretary to issue regulations. Should the Secretary decline to do so, or should the regulations be inadequate, judicial review is available.

There is no timeline required for Secretarial action.

Currently, MVA™ has several outstanding rule making requests. Unfortunately, current law does not provide a timeline for an agency response.

Request legislation to include the following timeline:

- Response/decision to approve/disapprove rule making or comments on preliminary rules due to requester 270 days after receipt.
- Provision for one extension of response date with notice to requester 180 days after original due date.
- Publication of Notice of Proposed Rulemaking 180 days from response.
- Receive comments on Proposed Rule 60 days after publication.
- Publish Final Rule 180 days after comments

Codification of this timeline will prevent the VA from merely ignoring rule making requests or delegating them to a "pending" status with no action. MVA™ strongly recommends that this timeline be made applicable to all pending Rulemakings.

Military Dependents Exposed to Toxic Exposure

The PACT Act has added several new areas of presumptions for toxic exposure. More areas such as Panama and Okinawa may be added. In some of these areas, dependents accompanied veterans to the toxic area.

Military dependents accompanied their veteran spouses to many areas throughout the globe. In areas where toxic exposure has been confirmed, the veteran receives a presumption of exposure resulting in compensation and medical care. The accompanying dependents drank the same water and breathed the same air as their military sponsor. Currently there is no provision for medical assistance for those dependents who have developed illnesses due to toxic exposure.

In a report on illnesses among the civilian population of Guam, Dr. Luis Szyfres, M.D., M.P.H. compared cancer rates among civilians on Guam with the continental United States.

He found Nasopharyngeal cancer 1,999 % higher in Guam than in Continental US, Cervical Cancer 65 % higher in Guam than in Continental US, Uterine Cancer 55 % higher in Guam than in Continental US, Liver Cancer 41 % higher in Guam than in Continental US. his included Amiotrophic Lateral Sclerosis 10,000 % higher than the rest of the world and Parkinson-Dementia Complex.25-50 fold higher than in the rest of the world, Diabetes 150 % higher in Guam than in Continental US, Ischemic Heart Disease 15 % higher in Guam than in Continental US, Kidney Failure, 12 % higher in Guam than in Continental US. *See* https://www.militaryveteransadvocacy.org/uploads/3/4/1/0/3410338/guam_report.pdf.

MVA™ is seeking legislation to amend Subchapter II of chapter 11 of title 38, United States Code, by adding at the end the following new section: "A family member of a veteran described in section 1110, 1116, 1117, 1118, 1119 and 1120 or any other pertinent Section of chapter 11 of this title, who accompanied a military sponsor for at least thirty days in a location determined by Congress or the Secretary, to any area to have been the site of a presumption of herbicide or other toxic exposure contaminant, during the period described in such section, or who was in utero during such period while the mother of such family member resided at such location, shall be eligible for hospital care, medical services, and nursing home care furnished by the Secretary pursuant to Chapter 17 for any covered condition, or any covered disability that is associated with a condition associated with toxic exposure during such period."

This is similar to the provisions of the Janey Ensminger Act passed in 2011. We are looking for medical coverage only for those non-military personnel exposed to toxic chemicals.

HR 1947 - Stellate Ganglion Treatment for PTSD at VA

This would require the VA to use the Stellate Ganglion Boc for treatment of Post Traumatic Stress. This treatment calls for the injection of a block into the stellate ganglions that control the fight or flight response. It has a dramatic effect on those PTS folks who are about to fly into a rage. The effect has often been described as similar to flipping a light switch. This treatment is used by the Department of Defense.

Pay Our Coast Guard

There is a need to address gaps in financial security for U.S. Coast Guard personnel during government shutdowns. This bill ensures that members of the Coast Guard, as well as associated support services like NOAA and the Public Health Service Commissioned Corps, receive uninterrupted pay in the event of a government shutdown. The legislation parallels protections already afforded to the Department of Defense, aiming to provide parity for the Coast Guard, which operates under the Department of Homeland Security rather than the DoD.

Conclusion

On behalf of our membership, we would like to extend our thanks to the Chairmen, Ranking Members, and remaining Committee members for the opportunity to discuss our legislative priorities.

Respectfully Submitted,

John B. Wells
Commander USN (retired)
Chairman

March 3, 2026

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

The Honorable Mike Bost
Chairman, Committee on Veterans Affairs,
U.S. House of Representatives
Washington, DC 20515

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

The Honorable Mark Takano
Ranking Member, Committee on Veterans
Affairs, U.S. House of Representatives
Washington, DC 20515

Dear Chairmen Moran and Bost and Ranking Members Blumenthal and Takano,

On behalf of the VALOR Coalition, thank you for the opportunity to submit this statement for the record of today's joint hearing of the Senate and House Committees on Veterans' Affairs regarding legislative priorities impacting America's servicemen and women and their families.

The VALOR Coalition (Veteran Alliance for Leadership, Outreach, and Recovery) is a veteran-led, nonpartisan coalition uniting leading veteran service organizations to advance safe, evidence-based psychedelic-assisted therapy (PAT) access for veterans with post-traumatic stress disorder (PTSD), traumatic brain injury (TBI), treatment resistant depression (TRD), and related conditions. Our mission is to confront the veteran suicide crisis by advocating for research-backed psychedelic-assisted therapies; supporting policy solutions grounded in safety and science; and expanding access to effective, supervised care for veterans. VALOR was founded by Veterans Exploring Treatment Solutions (VETS), the Navy SEAL Foundation, the Green Beret Foundation, and the Wounded Warrior Project (WWP), and its members include Iraq and Afghanistan Veterans of America (IAVA), the Light Up to Live Foundation, and Home Base.

Veterans are one of the most vulnerable populations when it comes to mental health. Since 2001, over 125,000 veterans have died by suicide, and 29% of Global War on Terrorism veterans are known to suffer from post-traumatic stress disorder (PTSD). The disproportionate incidence of PTSD among veterans is also a driver of the disproportionate incidence of suicide among them. We lose no less than 17 and by some

estimates as many as 44 U.S. veterans to suicide every day, at nearly double the rate of non-veteran Americans lost to suicide each year.[1][2]

VALOR formed because the veteran suicide crisis remains persistent, structural, and unacceptable; and because innovation in veteran mental health has lagged behind both the science and the urgency of the crisis. VALOR formed to ensure that innovation is not slowed by stigma, politics, or inertia.

Despite billions in prevention efforts, thousands of veterans continue to die every year. Current mental health treatment options available to our veterans through VA healthcare facilities have been far from universally effective. While existing treatments such as Cognitive Behavioral Therapy (CBT), traditional talk therapy, and commonly prescribed antidepressants including selective serotonin reuptake inhibitors (SSRIs) provide meaningful relief for some veterans, far too many continue to experience persistent and debilitating symptoms despite diligent participation in these conventional interventions.

Recent research demonstrates the remarkable potential of psychedelic-assisted therapies (PAT) to address the complex mental health challenges faced by our veterans. A study by the Stanford Brain Stimulation Lab enrolled 30 U.S. Special Operations Forces veterans and found a notable decline in PTSD, anxiety, depression, and an improvement in cognitive function post-PAT treatment.[3] A study at Ohio State's Center for Psychedelic Drug Research and Education (CPDRE) observed hundreds of veterans receiving psychedelic therapies using cognitive and behavioral questionnaires. The results indicated significant reductions in suicidal ideation, cognitive impairment, and symptoms of PTSD.[4] The Johns Hopkins Psychedelic Research Center published a study finding that two doses of psilocybin eased symptoms of major depressive disorder in adults for up to 12 months.[5] Even the U.S. Department of Veterans Affairs (VA) acknowledges that randomized controlled trials (RCTs) of MDMA-assisted therapy have shown promising results in improving PTSD symptoms.[6]

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[1] "Operation Deep Dive." *America's Warrior Partnership*, 15 January 2025, https://www.americaswarriorpartnership.org/opdd-archives

[2] "VA.org | Veteran Suicide Data and Reporting." *VA.gov*, 5 February 2026, www.mentalhealth.va.gov/suicide_prevention/data.asp.

[3] Cherian, K.N., Keynan, J.N., Anker, L. et al. Magnesium–ibogaine therapy in veterans with traumatic brain injuries. Nat Med 30, 373–381 (2024). https://doi.org/10.1038/s41591-023-02705-w

[4] Davis AK, Averill LA, Sepeda ND, Barsuglia JP, Amoroso T. Psychedelic Treatment for Trauma-Related Psychological and Cognitive Impairment Among US Special Operations Forces Veterans. Chronic Stress. 2020;4. doi:10.1177/2470547020939564

[5] Gukasyan, Natalie, et al. "Efficacy and Safety of Psilocybin-Assisted Treatment for Major Depressive Disorder: Prospective 12-Month Follow-Up." Journal of Psychopharmacology, vol. 36, no. 2, 15 Feb. 2022, pp. 151–158, journals.sagepub.com/doi/10.1177/02698811211073759, https://doi.org/10.1177/02698811211073759.

[6] "VA.gov | Veterans Affairs." Va.gov, 26 Mar. 2025, www.ptsd.va.gov/understand_tx/mdma_assisted_therapy.asp.

Since 2020, 16 states have passed psychedelic-assisted therapy legislation supporting clinical research, establishing regulated access programs, creating task forces and commissions to assess PAT and prepare recommendations for future action, and making regulatory reforms to remove barriers to research and mirror federal FDA and DEA drug rescheduling decisions. Texas was the first state in the nation to fund a clinical trial for the use of psychedelic-assisted therapies, specifically psilocybin, for veterans struggling with PTSD through HB 1802 in 2021. Since then, many other states have followed suit including; Arizona, which supported psilocybin research in 2023 with the passage of SB 1726 and ibogaine research in 2025 with the passage of HB 2871; New Jersey, establishing a Psilocybin Behavioral Health Access and Therapy Pilot Program through SB 2283 in 2025; and Georgia whose FY25 budget allocated $1,000,000 to Emory University to expand psychedelic research. Texas again led the nation in 2025 with a $50,000,000 appropriation for ibogaine clinical research and development, the largest public appropriation for psychedelic research in the United States. Currently, 32 states are considering psychedelic-assisted therapy legislation in their state legislatures.

As states across the nation take meaningful steps to advance research and responsibly explore psychedelic-assisted therapies, it is imperative that Congress act at the federal level to support and accelerate these efforts. By providing clear guidance, funding, and regulatory flexibility, the federal government can remove barriers to research, ensure safe and equitable access for veterans, and help translate promising scientific findings into real-world treatments. Coordinated federal leadership will ensure that our nation's defenders are not left behind while states explore innovative solutions to address the urgent mental health crisis facing our veterans.

We envision a future where bold alliances, evidence-based treatments, and unwavering advocacy ensure that all who wear the uniform are able to thrive following their service to our nation. We believe this can be accomplished by:

- Advocating for evidence-based treatments and expanding access to innovative therapies proven to effectively address service-related conditions such as PTSD and TBI.
- Confronting the veteran suicide epidemic by tackling the root causes of veteran suicide by educating stakeholders, supporting research, advocating for policy change, and expanding access to care.
- Building a collaborative network, uniting organizations, researchers, advocates, and policymakers committed to improving the lives of all who've served in a coalition to create change.
- Driving policy reform with veteran leadership, science-backed research, and proven strategy.

We believe veterans deserve access to the highest quality, cutting edge, and evidenced based treatments. Across the country, psychedelic-assisted therapy is showing exceptional promise for conditions like TBI, PTSD, and depression—especially among veterans for whom traditional treatments fall short. Clinical and observational studies continue to reveal outcomes far beyond conventional standards.

In closing, VALOR remains steadfast in its commitment to advancing meaningful solutions to the veteran mental health crisis. We strongly support expanded research efforts—both public and private—into innovative treatment modalities that demonstrate credible therapeutic promise. Additionally, we urge Congress to examine and remove unnecessary regulatory or statutory barriers that impede rigorous scientific study of compounds that may offer transformative healing for our nation's defenders. Our veterans deserve a research environment guided by evidence, urgency, and compassion, ensuring that safe and effective treatments can be responsibly evaluated and, when appropriate, made accessible.

The VALOR Coalition is appreciative of the opportunity to submit comments for the record. We thank you for your leadership and commitment to our nation's heroes.

Amber Capone
CEO
Veterans Exploring Treatment Solutions

Charlie Iacono
President and CEO
Green Beret Foundation

Robin King
CEO
Navy SEAL Foundation

Walt Piatt
CEO
Wounded Warrior Project

— Strength in Unity. Change in Action. —

VETERANS EDUCATION SUCCESS

STATEMENT FOR THE RECORD
LEGISLATIVE PRIORITIES SUBMITTED TO THE
SENATE AND HOUSE COMMITTEES ON VETERANS' AFFAIRS
119TH CONGRESS, SECOND SESSION

March 4, 2026

Chairmen Moran and Bost, Ranking Members Blumenthal and Takano, and Members of the Committees on Veterans' Affairs:

We thank you for the opportunity to share our legislative priorities for consideration in the second session of the 119th Congress. Veterans Education Success works on a bipartisan basis to advance higher education success for veterans, service members, and military families, and to protect the integrity and promise of the GI Bill® and other federal postsecondary education programs.

We would like to praise the bipartisan efforts of your Committees, which led to several crucial successes last year. Your strong focus on oversight and accountability was essential and remains paramount in the new Congress. We would like to note several outstanding priorities we hope to see completed by the 119th Congress, including the Student Veteran Benefit Restoration Act, the Guard and Reserve GI Bill Parity Act, and legislation enacting more substantial quality standards and mandates on interagency data sharing.

We also understand this Congress's strong interest in reducing overall costs. Therefore, we particularly highlight several policy changes that offer significant budget reductions. Today, we offer our full testimony for your consideration, outlining our top legislative priorities for this year.

We propose the following topics and recommendations for consideration, which we discuss in detail in the pages that follow:

1. Limit Wasting GI Bill Dollars on Excessive Overhead and Subpar Programs
2. Restore student veterans' education entitlement after school fraud or closure
3. Mandate interagency data sharing as it relates to federal education benefits
4. Ensure appropriate implementation of risk-based reviews
5. Ensure VA properly handles student veteran complaints about schools
6. Improve the GI Bill Comparison Tool
7. Oppose full housing allowance for online-only students – a costly and dangerous proposal
8. Protect GI Bill payments from recurring IT failures
9. Change VA's debt collection practices against student veterans
10. Forbid transcript withholding
11. Strengthen Veteran Readiness & Employment
12. Pass the Guard and Reserve GI Bill Parity Act so every day of service counts

We look forward to working closely with you and your staff members on these issues, and we thank you for the invitation to provide our perspective on these pressing topics.

1. Limit Wasting GI Bill Dollars on Excessive Overhead and Subpar Programs

Veterans count on the GI Bill to facilitate a smooth transition from military service to a successful civilian career. Veterans rely on VA's program eligibility as a "stamp of approval" to identify quality programs. Both veterans and taxpayers are entitled to a reasonable return on investment for the GI Bill.

Unfortunately, too many approved programs fail to educate veterans effectively or prepare them for a lifetime of success. Worse yet, many of these school programs cause serious harm to the veterans they are meant to help, leaving veterans with worthless credits, burdensome debts, and wasted benefits. Despite providing poor results, many of these programs and schools continue to rake in millions of taxpayer dollars through the recruitment and exploitation of veterans and the abuse of their hard-earned GI Bill benefits.

Wasting taxpayer funds on subpar education programs is entirely ***preventable.***

Excessive overhead spending and its abuse raises a basic policy question for Congress: if GI Bill funds are intended to support education, why is such a large percentage of these funds allowed to be spent on overhead? As recently as last year, the executive branch sought to cap overhead (indirect) costs related to federal grants for university research to a maximum of 15%, on the principle that public funding should primarily support the activity being funded.[1] Current federal policy is even more fiscally conservative when it comes to many taxpayer-funded programs, defaulting to a standard rate of 10% for overhead and administrative costs in certain circumstances.[2]

Congress should apply a similar guardrail to GI Bill funding by establishing a maximum overhead rate for institutions receiving GI Bill tuition and fee payments. After all, Congress's goal in funding the GI Bill with taxpayer funds is to provide veterans with an education; Congress's goal is not to fund non-education activities and overhead at universities, especially as it is often entirely superfluous or unrelated to the veterans' education.

As we've previously reported, some of the lowest-quality schools receive the most GI Bill funding. Our research found that, from 2009 to 2017, eight of the 10 schools receiving the most Post-9/11 GI Bill funds accounted for 20% of all GI Bill payments, amounting to $34.7 billion.[3] Even more concerning, seven of these 10 schools had high numbers of student complaints and had faced state and federal law enforcement actions regarding allegations of deceptive advertising, predatory recruiting, and fraudulent loan schemes[4] and spent less than one-third of the tuition they charged VA actually educating the veterans. Predictably, they struggled with outcomes: Less than 28% of their students completed a degree, and only half earned more than a high school graduate.[5]

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[1] Office of Management and Budget, *Department of Health and Human Services (HHS) 2026 Discretionary Budget Passback*, (Apr. 10, 2025), internal budget document. Available at: https://www.science.org/do/10.1126/science.zaomfqe/full/hhs2026budgetproposaldraft.pdf.

[2] Office of Management and Budget, "Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards," 2 C.F.R. § 200.414(f), https://www.ecfr.gov/current/title-2/subtitle-A/chapter-II/part-200/subpart-E/subject-group-ECFRd93f2a98b1f6455/section-200.414. Current rates allow entities without a negotiated indirect cost rate to elect up to a 10% de minimis rate to be applied to modified total direct costs.

[3] Veterans Education Success, *Schools Receiving the Most Post-9/11 GI Bill Tuition and Fee Payments Since 2009* (Mar. 2018), https://vetsedsuccess.org/wp-content/uploads/2018/03/gi-bill-cumulative-revenue-brief-2.pdf.

[4] *Id.*

[5] Veterans Education Success, *Should Colleges Spend the GI Bill on Veterans' Education or Late Night TV Ads? And Which Colleges Offer the Best Instructional Bang for the GI Bill Buck?* (2019),

Additionally, approximately 100 colleges could arguably be accused of waste and fraud because they spent less than 20% of the tuition they charged VA on education costs for the veterans. These 107 colleges charged VA a total of $703 million in GI Bill tuition and fees in 2017 alone. Still, they siphoned off $562 million in GI Bill money for non-instructional costs such as marketing, sponsorships, and consulting fees. Predictably, these schools also have abysmal student outcomes.

For example, when a bad actor school siphons over half of a veteran's GI Bill away from the veteran to pay for a corporate jet or TV ads to draw in other veterans, that in no way serves the veteran who earned his GI Bill through service and sacrifice and who deserves a real education, with real professors teaching real content. Bad actors should not be allowed to waste hard-earned GI Bill benefits.[6] It is entirely preventable. There are thousands of excellent colleges in America, and very few bad actors.

Unfortunately, enough of these predatory programs have been allowed to persist. As one would expect, the veterans we serve rightfully express anger that VA would approve schools known for producing poor outcomes or that are under a law enforcement cloud. Veterans should never have to wonder why obvious scams like FastTrain College, Retail Ready Career Center, Blue Star Learning, House of Prayer, and California Technical Academy were approved in the first place.[7, 8, 9] These schools proved to be a significant waste of taxpayer money, even before the FBI stepped in.

In the case of FastTrain College, the school was raided by the FBI and ordered to pay over $20 million for "having defrauded the U.S. Department of Education (ED) by submitting falsified documents to obtain federal student aid funds in connection with ineligible students."[10, 11]

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https://vetsedsuccess.org/should-colleges-spend-the-gi-bill-on-veterans-education-or-late-night-tv-ads-and-which-colleges-offer-the-best-instructional-bang-for-the-gi-bill-buck/.

[6] See also U.S. Dept. of Education, Federal Student Aid Fiscal Year 2024 Annual Report (2024), https://studentaid.gov/sites/default/files/fy2024-fsa-annual-report.pdf, (p. 140-143) ("FSA also received a disproportionate number of complaints from predominantly online schools. FSA received 2,764 complaints (23%) about schools where more than 80% enrolled exclusively online. In contrast, these schools accounted for only 9% of enrollment in Title IV-eligible schools during the 2023-24 school year…").

[7] Carli Teproff, *Now defunct for-profit college must pay the government $20 million, a court rules*, Miami Herald (Feb. 21, 2017), https://www.miamiherald.com/news/local/education/article134161714.html.

[8] U.S. Department of Justice Press Release, *For-Profit Trade School Owner Charged with Defrauding VA, Student Veterans* (Nov. 23, 2020), https://www.justice.gov/usao-ndtx/pr/profit-trade-school-owner-charged-defrauding-va-student-veterans.

[9] Beynon, Steve, and Thomas Novelly, "How a Church Allegedly Scammed Millions in VA Money from Vets," Military.com, (Jul. 19, 2022), https://www.military.com/daily-news/2022/07/19/how-church-allegedly-scammed-millions-va-money-vets.html.

[10] Dana Treen, *FBI raids Jacksonville offices of business college*, The Florida Times-Union (May 16, 2012), https://www.jacksonville.com/story/news/crime/2012/05/16/fbi-raids-jacksonville-offices-business-college/15866622007/.

[11] U.S. Department of Justice Press Release, *United States Prevails in Civil Suit Against For-Profit College Chain and its President for False Claims Act Violations* (Feb. 21, 2017), https://www.justice.gov/usao-sdfl/pr/united-states-prevails-civil-suit-against-profit-college-chain-and-its-president-fals-0.

Even worse, Retail Ready Career Center ran a scam offering a 6-week HVAC training for veterans while also subjecting them to abusive practices, including taking their housing allowance and making them live in a substandard [disgusting] motel.[12] The owner falsely claimed, "We have the highest success rate of any other GI Bill program out there," but the FBI and DOJ found differently.[13]

The owner of Retail Ready was eventually sentenced to more than 19 years in jail and ordered to forfeit $72 million of VA benefits to the federal government for lying to gain approval to enroll veterans; DOJ eventually recouped more than $150 million from the school.[14] According to DOJ, the owner had spent veterans' GI Bill funds on a Lamborghini, a Ferrari, a Bentley, two Mercedes-Benzes, a BMW, and real estate worth $2.5 million, among other purchases.[15]

In a similar incident in 2020, the owner of Blue Star Learning was sent to prison for 45 months and ordered to repay VA $30 million for his fraudulent GI Bill program with falsified job placements.[16] As recently as 2022, the California Technical Academy was exposed for a scheme that involved over $100 million, the most significant case of GI Bill fraud prosecuted by DOJ.[17, 18] Unfortunately, so many predatory actors continue to reap the benefits veterans earned.[19]

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[12] Eva-Marie Ayala, *Hundreds of veterans scramble after Garland for-profit college closes*, The Dallas Morning News (Sept. 28, 2017), https://www.dallasnews.com/news/education/2017/09/28/hundreds-of-veterans-scramble-after-garland-for-profit-college-closes/.

[13] *Id.*

[14] U.S. Department of Justice Press Release, *For-Profit Trade School Owner Charged with Defrauding VA, Student Veterans* (Nov. 23, 2020), https://www.justice.gov/usao-ndtx/pr/retail-ready-owner-forfeit-72m-va-tuition-fraud.

[15] *Id.*

[16] U.S. Department of Justice Press Release, *Owner of Local Technical Training School Sentenced for Defrauding the VA out of almost $30 Million in G.I. Bill Education Benefits* (Oct. 27, 2020), https://www.justice.gov/usao-sdca/pr/owner-local-technical-training-school-sentenced-defrauding-va-out-almost-30-million-gi.

[17] Veterans Education Success, *Our Press Release: Largest Post 9/11 GI Bill Fraud Case Yields Guilty Pleas* (Jun. 28, 2023), https://vetsedsuccess.org/our-press-release-largest-post-9-11-gi-bill-fraud-case-yields-guilty-pleas/.

[18] U.S. Department of Justice, *Justice Department Announces Enforcement Action Involving Over $100 Million in Losses to Department of Veterans Affairs* (Sept. 16, 2022), https://www.justice.gov/opa/pr/justice-department-announces-enforcement-action-involving-over-100-million-losses-department.

[19] 38 U.S.C. § 3672 has almost no requirements. It also incorporates, by reference, the program approval requirements of Chapters 34 and 35, but those are also minimally effectual; they only forbid, for example, bartending and personality development courses, and they restrict "radio" courses, which indicates an out-of-date statutory framework. 38 U.S.C. § 3675 (approval of accredited courses) relies heavily on the school's accreditation, but some accreditors offer no meaningful quality control, such as ACICS, which accredited ITT Tech and Corinthian Colleges. § 3675(b) also requires that the school meet the criteria in paragraphs (1), (2), (3), (14), and (15) of 38 U.S.C. § 3676(c). While 38 U.S.C. § 3676 (approval of nonaccredited courses) has more restrictions, many are undefined, including no definition of "quality" in (c)(1); no definition of teacher "qualifications" in (c)(4); no definition of "financially sound" in (c)(9) (which could easily be defined by reference to U.S. Department of Education standards); an inadequate ban on deceptive advertising in (c)(10) (which should be clarified to ban any school that has faced legal or regulatory concerns over its advertising in the prior 5 years); and no definition of "good character" in (c)(12) (which should be clarified to ban administrators and teachers who have faced legal or regulatory action or any action by a licensing board).

In 2025, the VA Office of Inspector General (OIG) announced charges against an "owner of a non-college-degree school and its certifying official [who] conspired to submit fraudulent information to conceal the entity's noncompliance with the rules and regulations of the Post-9/11 GI Bill program." The report notes that over six years, VA paid more than $17.8 million to the program.[20]

The GI Bill program approval process must be strengthened to protect student veterans from low-quality and fraudulent schools. The statutes governing program approval are seriously outdated, even referencing classes taught "by radio," and they continue to allow a low standard of entry.[21] It is time to update the statutes with minimum quality standards so that veterans can count on the VA's "stamp of approval" as the indicator of quality they—and taxpayers—expect.

Complaints from student veterans attending GI Bill-approved programs continue to underscore that subpar programs are failing to deliver; we received 362 veteran complaints last year, many of which raised concerns about program quality. For example, this is what some veterans have shared with us:

- Veteran DT: "I graduated from [my GI Bill-approved college] after 5 years, and in all that time, I never had a real-time conversation or interaction with a single teacher, not in a group or one-on-one. The way the courses were taught was totally ineffective. We would be assigned a bunch of stuff to read, and we were required to provide just two comments on an online discussion board. Occasionally, we were given assignments to complete, but the teachers never gave us feedback on the assignments."[22]

- Veteran AY: "Much of the curriculum was so outdated it might as well have been from the Stone Age. We were initially taught using the Unity and Visual Studios systems. Later, when the courses switched to modern programs… they did nothing to teach us how to use them.… I often was better off learning through tutoring, Google searches, and YouTube videos than I was following the actual instruction from its online courses. To make matters worse, the terminology and policies changed drastically from one class to another, creating confusion and hampering the learning experience. It was difficult to learn basic concepts and build upon them effectively."

- Veteran AD: "I was accepted into the VRRAP program and set up to meet with [my GI Bill-approved college] to enroll in their Dental Hygiene program.… Instructors are incompetent and inexperienced, Labs and course material are not taught, and I have to pay for a book payment plan for books costing 750 dollars that I can get on Amazon for less than 250 dollars.… I was on the president's list and dean's list for the terms I have completed, but I haven't even seen a dental dam or sterilized one piece of equipment. I am not learning any material and students are given answers to the quizzes and exams to keep them passing. Soon I have to let these students practice on me as part of the curriculum, but even our CPR AHA class was taught at a 22-student to 1-instructor ratio, so none of us are legally certified."

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[20] U.S. Department of Veterans Affairs, Office of Inspector General, "*Monthly highlights: January 2025*" (Feb. 2025), https://www.vaoig.gov/sites/default/files/document/2025-02/monthly_highlights_january_2025_1.pdf.

[21] 38 U.S.C. § 3523(c).

[22] Quotes come from the more than 4,000 student veterans who have brought complaints to Veterans Education Success. For privacy protection, the students' names and schools are withheld.

- Veteran DD: "There are… issues such as the school replaying free web seminars as their own training and using unqualified people to lead the classes. They literally go to Youtube, find the free course by someone else, then they play that during the ZOOM meeting and call it training. Everything they are doing could have been done by me for free.… They have also attempted on two occasions to place me in classes before I ever had the prerequisites to attend, they have me in classes that are not part of the program and do not serve a purpose except to show me in class…"

While the *Veterans Auto and Education Improvement Act of 2022*, codified as 38 U.S.C. § 3672A, creates a uniform application with some improvements to the approval standards, we urge the Committees to consider the following commonsense improvements to the Act:

- Expand the definition of adverse government action in 38 U.S.C. § 3672A(b)(1)(B) to all types of fraud, not just those relating to education quality that result in a fine of 5 percent of Title IV, a rarity. We believe Congress does not want a school or a CEO who engaged in any other type of fraud – such as stealing federal student aid under Title IV, as Argosy University was accused of doing – to be in charge of GI Bill funds, yet that is what the statute currently allows.
- Require sound academic policies and instructional practices, including qualified instructional staff, appropriate instructional materials, and meaningful faculty oversight of course delivery. Specifically, extend the requirements for minimum faculty credentials in § 3672A to all education programs.
- Require schools to have adequate administrative capability to administer veterans' benefits.[23]
- Require screening of a school's financial stability before its approval to avoid sudden school closures. The Veterans Benefits Administration (VBA) and State approving agencies (SAAs) appear to recognize in the risk-based survey SOP that they are not receiving sufficient financial records as part of the program approval process for unaccredited institutions.[24]

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[23] Currently, there is no requirement in Title 38 that schools devote the necessary resources to competent administration of VA programs. Congress should mandate that institutions demonstrate to the Secretary that they are capable of adequately administering the programs and that they have committed adequate administrative resources. It should also require that schools pledge to fully cover the tuition and housing costs of VA-supported students if the school suddenly loses eligibility due to institutional error, including paperwork non-compliance. Committee members may recall the problems at Howard University, when 52 VA-supported students enrolled in 14 programs at Howard suddenly discovered their programs were not properly approved for GI Bill and VR&E. The DC State Approving Agency (SAA) said the issue boiled down to failure by Howard to submit the proper paperwork. The programs affected included Howard's medical school, law school, and Master's in Social Work program. It took eight months to get the approvals cleared up. During this time, students experienced immense uncertainty and undue anxiety. They faced the possibility of having to withdraw from school, pay out-of-pocket to cover housing and living costs, or seek loans from the school and external sources, and they experienced significant stress due to the uncertainty of the situation. This scenario highlighted the challenge associated with Title 38 benefits and the relationship between VA, the SAA, the institution, and the student. Unfortunately, we do not believe this to be an issue isolated to one school. In some cases, school certifying officials (SCOs) are expected to administer benefits for well over VA's recommended ratio of support staff to students, 1 to 200. Even with this ratio, the duties of SCOs often go well beyond the responsibilities of certifying benefits, making their responsibilities increasingly difficult to handle.

[24] Veterans Benefits Administration, Office of Education Service - Oversight and Accountability Division, *Standard Operating Procedure, Risk Based Surveys* (Jan. 2, 2024). In the Standard Operating Procedure, VBA includes material regarding the process for requesting more documentation from unaccredited schools in the program approval process.

- Ensure that schools are not overcharging VA and taking GI Bill primarily for overhead. Forbid schools from siphoning GI Bill funds away from veterans and towards overhead, corporate perks, and TV ads. Our analysis found hundreds of GI Bill-approved programs that siphon more than 80% of the tuition they charge VA away from the veteran's education, to be spent on inappropriate charges like CEO jets, TV ads, and other non-instructional overhead; these programs predictably produce poor outcomes.[25] Congress should establish a maximum overhead rate of 40% for institutions receiving GI Bill tuition and fee payments so that the majority of these funds are directed toward instruction and student support.
- Require demonstrated completion and post-education economic outcomes for all admitted students as a condition of continued GI Bill eligibility.
- Require school recruiters, admissions, and counseling staff to have a fiduciary duty to tell the truth, with enforceable standards that prohibit deceptive or misleading practices and require appropriate training and oversight. Today, it is standard practice at predatory schools to give recruiters–essentially sales representatives of the schools–deceptive titles like admissions "counselor" or "advisor." The schools use high-pressure sales tactics to create false urgency to enroll prospects immediately into programs that quickly burn through veterans' GI Bill benefits and push them into taking out significant student loans, often for programs of little or no value in the labor market. An essential step in ending these abusive practices would be to require all admissions and recruitment staff at eligible institutions to serve as fiduciaries with a duty of care to the veterans they recruit.
- In the case of online classes, require actual teaching, not pre-recorded classes. Many veterans tell us their online education consists of nothing more than watching YouTube videos, with no instructor engagement. YouTube videos are an inadequate substitute for regular and substantive interactions with qualified faculty and should not be funded with GI Bill dollars. The Committees should require "regular and substantive interaction" between virtual faculty and students.[26] Regular interaction with subject matter experts is essential to ensuring student veterans are receiving a worthwhile education.[27] Additionally, Congress should exclude asynchronous hours from the count of qualifying hours for clock-hour programs, and include minimum faculty-student interaction requirements– this would represent a significant cost savings to the overall program.
- Prevent schools from overcharging veterans for repackaged content. Some institutions charge excessive tuition for commercially available materials with little added value. In one case, a veteran paid $11,000 for a program that consisted of content available elsewhere for just $69. Congress should bar schools from inflating tuition costs for repackaged or freely accessible content at VA's expense.[28]

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[25] Veterans Education Success, *Should Colleges Spend the GI Bill on Veterans' Education or Late Night TV Ads?* (Apr. 2019), https://vetsedsuccess.org/should-colleges-spend-the-gi-bill-on-veterans-education-or-late-night-tv-ads-and-which-colleges-offer-the-best-instructional-bang-for-the-gi-bill-buck/.
[26] For an historical explanation of the dangers of education programs that lack teaching, see David Whitman, *The Cautionary Tale of Correspondence Schools*, New America (Dec. 11, 2018), https://www.newamerica.org/education-policy/reports/cautionary-tale-correspondence-schools/.
[27] Veterans Education Success, *Congressional and Administration Priorities for the Next Congress*, *Submitted to the Subcommittee on Economic Opportunity, Committee on Veterans Affairs, U.S. House of Representatives* (Dec. 8, 2020), https://vetsedsuccess.org/our-written-testimony-for-the-house-veterans-affairs-economic-opportunity-subcommittee-hearing-on-2021-legislative-priorities/#_ftn1.
[28] Denis, Doug, "*Interview with Student Veteran: Doug Denis*" (Jun. 28, 2024), https://drive.google.com/file/d/1ODE10wEG99-0bKv9Khr8jbGYnPUFiEWN/view?usp=sharing.

Lastly, many schools are partnering with for-profit online program management (OPM) companies to offer numerous services, including academic instruction, even though reports expose poor student outcomes. The OPM loophole was created in 2011 by ED in direct contradiction to the statutory language of the Higher Education Act. It allows colleges to enter into revenue-sharing contracts with ineligible companies, which can then access federal dollars masquerading as the colleges with whom they share revenues.

Because VA relies on ED's guidance, veterans have become a distinct target market for OPMs, who pitch shoddy online programs to them as a convenient solution for obtaining a degree while working. We encourage the Committees to direct VA to conduct oversight of the courses provided through OPM partnerships and to pass legislation requiring more thorough approval and oversight of all such courses and their recruiting practices.

Summary of recommendations:

- Prevent colleges from siphoning GI Bill funds away from the veterans' education and wasting them on overhead or unscrupulous costs.
- Strengthen the GI Bill program approval process to safeguard student veterans from ineffective and fraudulent schools by updating outdated statutes and adding minimum quality standards – at the same time, saving taxpayer funds from being wasted on obviously subpar education programs.
- Require sound academic policies and instructional practices, adequate administrative capability for schools administering veterans' benefits, including qualified instructional staff as defined in § 3672A, appropriate instructional materials, and meaningful faculty oversight of course delivery.
- Implement financial stability screening before approval to prevent sudden school closures and ensure responsible use of VA tuition funds.
- Require demonstrated completion and post-education economic outcomes for all admitted students as a condition of Title 38 eligibility; require truthful recruiting practices; and prohibit overcharging VA.
- Address issues with online classes by requiring actual teaching, not pre-recorded sessions, and ensuring regular and substantive interaction between virtual faculty and students; exclude asynchronous hours from the count of qualifying hours for clock-hour programs; and include minimum faculty-student interaction requirements.
- Prohibit schools from overcharging veterans for repackaged or commercial, off-the-shelf content.

2. Restore Student Veterans' Education Entitlement After School Fraud or Closure

Several years ago, DOJ seized the bank accounts of the House of Prayer Christian Church – a purported "bible school" that we exposed and brought to VA's attention, as veterans were being blatantly cheated out of their GI Bill and abused by an alleged cult leader.[29, 30] The recouped funds went to the U.S. Department of the Treasury (USDT), but the defrauded veterans got nothing.

In another example, DOJ recouped more than $150 million from Retail Ready Career Center and sent the owner, Jonathan Dean Davis, to jail for 19 years after he had swindled thousands of veterans, taking their GI Bill and their housing allowance but providing nothing of value in return.[31] But when the federal government recovered $150 million, the veterans did not get their GI Bill benefits back.

Even worse, veterans are sometimes the only students who are not made whole. For example, students with federal student loans from ITT Technical Institute have had their loans discharged due to the evidence of widespread fraud or gross negligence. Yet most student veterans who used their GI Bill to attend ITT Technical Institute cannot get their GI Bill benefits restored. The GI Bill statute currently allows restoration only for students who were enrolled at or near the time a school closes or loses program approval. But students who experienced the fraud and withdrew earlier get nothing.

In general, we believe it is an absolute betrayal of student veterans that students can get their federal student loans discharged, yet veterans cannot get back their GI Bill benefits. The fact that veterans are defrauded out of their hard-earned GI Bill is blatantly counter to Congress's vision for the impact of the GI Bill. Furthermore, when the federal government successfully recovers funds from a school that engaged in fraud or gross negligence, Congress should *at minimum* require that those recovered funds be directed first toward restoring affected students' education benefits.

In the 118th Congress, the House passed H.R. 1767, the *Student Veteran Benefit Restoration Act*, by a nearly unanimous, highly bipartisan vote of 406-6. There is widespread agreement on the fundamental disparity of veterans being left out. We call on Congress to pass legislation that would finally provide veterans with a pathway to get their GI Bill benefits rightfully restored.

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[29] *United States of America v. $115,800.00 in U.S. Currency Funds,* (Jan. 6, 2023), https://vetsedsuccess.org/wp-content/uploads/2023/01/House-of-Prayer-Bible-Seminary.pdf.

[30] Veterans Education Success, *Our Letter to VA and Georgia SAA Regarding House of Prayer Christian Church* (Aug. 2020), https://vetsedsuccess.org/letter-to-va-and-georgia-saa-regarding-house-of-prayer-christian-church/.

[31] United States Attorney's Office, Northern District of Texas Press Release, *For-Profit Trade School Sentenced to Nearly 20 Years for Defrauding VA, Student Veterans* (Sept. 22, 2021), https://www.justice.gov/usao-ndtx/pr/profit-trade-school-sentenced-nearly-20-years-defrauding-va-student-veterans.

In addition, two technical fixes are needed to existing laws: First, the *Continuing Appropriations, Agriculture, Legislative Branch, Military Construction and Veterans Affairs, and Extensions Act of 2026* established the most recent authority for VA to restore GI Bill benefits to students who were pushed out of their programs due to a closure or disapproval before September 30, 2026.[32, 33]

However, VA needs to be able to continue to restore benefits when a school closes or a program is disapproved beyond this date, and we call on Congress to increase the period of coverage to a minimum of five additional years, to extend through at least September 30, 2031.

Second, a minor technical adjustment related to school closure issues would have a highly consequential impact on student veterans. At present, 38 U.S.C. § 3699 allows veterans to have their benefits restored under limited circumstances, such as a change to "a provision of law enacted after the date on which the individual enrolls at such institution affecting the approval or disapproval of courses under this chapter" or "the Secretary prescribing or modifying regulations or policies of the Department affecting such approval or disapproval." In consultation with committee staff, we urge the addition of a section (iii) that states "or for any other reason" because school closure due to a provision of law is a very narrow circumstance, and does not help the tens of thousands of veterans who are affected every year by school closures.

In addition, to support veterans who attended closed schools, colleges should be required to implement safeguards against sudden shutdowns. VA should ensure schools have an orderly closure process in which students receive adequate advanced notice, viable transfer options, and guaranteed permanent access to their transcripts and records.[34] We believe a 2020 Maryland law provides a valuable model of this approach.[35]

Summary of recommendations:

- Congress should pass a student veteran benefit restoration act.

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[32] Public Law 119–37, *Continuing Appropriations, Agriculture, Legislative Branch, Military Construction and Veterans Affairs, and Extensions Act, 2026*, Section 7202, 119th Congress, 1st Session. (2025), https://www.congress.gov/119/plaws/publ37/PLAW-119publ37.pdf.

[33] The *Senator Elizabeth Dole 21st Century Veterans Healthcare and Benefits Improvement Act* had also previously established the authority for VA to restore GI Bill benefits to students who were pushed out of their programs due to a closure or disapproval before September 30, 2025.
Public Law 118-210, *Senator Elizabeth Dole 21st Century Veterans Healthcare and Benefits Improvement Act*, Section 211, 118th Congress, 2nd Session (2024), https://www.congress.gov/bill/118th-congress/house-bill/8371; the *Fiscal Year 2024 VA Extenders Legislation* was the preceding authority for VA to restore GI Bill benefits to students who were pushed out of their programs due to a closure or disapproval before September 30, 2025. Reference Public Law No. 118-19, *Continuing Appropriations, Fiscal Year 2024 Act*, 118th Congress, First Session (Oct. 6, 2023), https://www.congress.gov/118/plaws/publ19/PLAW-118publ19.pdf.

[34] Section 207 of the *Senator Elizabeth Dole 21st Century Veterans Healthcare and Benefits Improvement Act* established the requirement for Title 38-participating institutions to provide students with an "official transcript in a digital format." However, we believe this requirement is not adequate, as most employers and virtually all institutions to which a student may wish to transfer would insist on directly receiving a transcript from previously attended schools. Transcripts supplied by students are viewed as unreliable because their indirect chain of custody could have allowed them to be altered. Furthermore, transcripts are merely a snapshot of a subset of data from the comprehensive academic records of students.

[35] Maryland orderly school closure law: SB 446 (enacted May 7, 2020), http://mgaleg.maryland.gov/mgawebsite/Legislation/Details/SB0446?ys=2020RS.

Additional recommendations (school closure-specific):

- Extend VA's expiring authority to restore GI Bill entitlement in school closure or disapproval cases for a minimum of five years.
- Amend 38 U.S.C. § 3699(b)(1)(B) by adding a new section (iii) that states "or for any other reason" because the statute is too narrow at present.
- Mandate that all VA-approved schools put in place safeguards against sudden shutdowns, such as adequate advance notice for students, viable transfer options, and guaranteed permanent access to their transcripts and records.

3. Mandate interagency data sharing as it relates to federal education benefits

In 2012, Congress enacted a law requesting that VA seek information from other federal agencies, such as the U.S. Departments of Defense (DoD), ED, and Labor (DoL), to provide student veterans with information about student outcomes at colleges.[36] Thereafter, VA – with encouragement from your Committees – was supposed to enter into MOUs with other agencies to share data on student veterans. And yet, little progress was made.

Our team embarked on a project to ensure that Congress's wishes were heeded by the agencies. We supported an interagency data-sharing pilot project housed at the U.S. Census Bureau that merged data from VA, ED, DoD, and IRS to produce the first-ever comprehensive understanding of the economic outcomes for enlisted veterans who use the Post-9/11 GI Bill. This unprecedented interagency data sharing enabled the first true analysis of the GI Bill.[37] The interagency research team was able to draw clear conclusions about veterans' GI Bill outcomes by accounting for sociodemographic data as well as military rank, military occupation, service in hostile war zones, and academic preparation at the time of enlistment (by linking data from DoD).

We commend your Committees for including, in the *Senator Elizabeth Dole 21st Century Veterans Healthcare and Benefits Improvement Act* (section 215), a requirement that VA enter into an MOU with ED and the heads of other relevant federal agencies to obtain information on student veterans' outcomes. The law states, "Such memorandum of understanding may include data sharing or computer matching agreements."

However, given that VA does not always complete what it is not explicitly required to complete, we urge the Committees to explicitly require VA to engage in interagency data sharing. We also urge the Committees to expand this provision to require VA to enter into MOUs with the IRS, DoD, and the Census Bureau. Further, we urge the Committees to expand the requirement for data-sharing MOUs to include veterans' health outcomes by collaborating with health-related agencies.

The published findings from the interagency GI Bill team demonstrate the impact of interagency data sharing:

- By including data from the DoD's testing of service members' academic preparation – through the Armed Forces Qualification Test (AFQT) – the research found that the higher the AFQT score, the more likely a veteran was to use their GI Bill, graduate from college, and have higher earnings.[38]

- By including demographic data from DoD and other agencies, the research showed that nearly 2 in 5 veterans did not use their GI Bill, often due to a lack of information or

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[36] The Improving Transparency of Education Opportunities for Veterans Act, P.L. 112-249 (2012), codified at 36 U.S.C. § 3698(c)(3)(A) and (B).

[37] The interagency research team consisted of staff from VA's National Center for Veterans Analysis and Statistics (NCVAS), the U.S. Census Bureau, and the American Institutes for Research (operating as special-sworn-status employees under the control of the Census Bureau and abiding by the laws governing the handling of sensitive federal data), and they were able to combine data from VA, the Veterans Benefits Administration (VBA), the Department of Defense (DoD), Internal Revenue Service (IRS), U.S. Census Bureau, and National Student Clearinghouse (NSC).

[38] Radford, A., Bloomfield, A., Bailey, P., Webster, B. H. Jr., & Park, H. C., "*A First Look at Post-9/11 GI Bill-Enlisted Veterans' Outcomes*" (2024), American Institutes for Research; U.S. Census Bureau; and National Center for Veterans Analysis & Statistics, U.S. Department of Veterans Affairs, https://vetsedsuccess.org/a-first-look-at-post-9-11-gi-bill-eligible-enlisted-veterans-outcomes/.

financial barriers.[39] Nonuse was highest (82%) among those separating at ages 55-65, while those leaving at E-4 or with a 10-20% disability rating were most likely to use it. Many nonparticipants were unaware that transfers had to happen on active duty, while others delayed use to maximize benefits. Some found the housing allowance insufficient, and others struggled to secure VA home loans as lenders did not count GI Bill benefits as income.[40, 41]

- By including college completion data from the National Student Clearinghouse, the research showed that veterans' college completion rate was double that of other financially independent students nationally[42] – but that veterans' completion rate was 15% lower at four-year for-profit colleges than at four-year public colleges, even after controlling for veteran and military characteristics. It also found that veterans were less likely than non-veterans to attend public flagship universities, even though veterans at public flagship universities were significantly more likely to graduate and were more likely to earn more money.[43]

- By including Census Bureau data on rurality, the interagency team found that veterans from rural and micropolitan areas were less likely to use the GI Bill.[44]

- By including earnings data from the IRS, the interagency team found:

    - Veterans who did not use their GI Bill were earning less, and the earnings gap was larger for female veterans, American Indian/Alaska Native veterans, and Black veterans.[45]

    - Veterans' earnings were higher when their college's instructional spending was higher (meaning less of their GI Bill was taken for overhead and costs unrelated to the veterans' education) – and this was true across sex, race, rurality, and

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[39] Radford, A. W., Mayer, K. M., Bloomfield, A., Bailey, P., Webster, B. H. Jr., & Park, H. C., "*Which Veterans are Forgoing Their Post-9/11 GI Bill Benefits?*" (2025), American Institutes for Research; U.S. Census Bureau; and National Center for Veterans Analysis & Statistics, U.S. Department of Veterans Affairs, https://vetsedsuccess.org/wp-content/uploads/2025/02/REPORT_Which-Veterans-Are-Forgoing-Their-Post-9-11-GI-Bill-Benefits.pdf.

[40] Jiang, J. Y., Mayer, K. M., Le, V., & Radford, A. W., "*Post-9/11 GI Bill Access and Uptake: Insights and Recommendations from Veterans*" (2025), American Institutes for Research, https://vetsedsuccess.org/wp-content/uploads/2025/02/REPORT_Post-9-11-GI-Bill-Access-and-Uptake.pdf.

[41] Radford, A. W., Bloomfield, A., Bailey, P., Mayer, K. M., Webster, B. H. Jr., & Park, H. C., "*A Deeper Look at Post-9/11 GI Bill Outcomes for American Indian/Alaska Native, Black, and Hispanic Veterans*" (2025), American Institutes for Research; U.S. Census Bureau; and National Center for Veterans Analysis & Statistics, U.S. Department of Veterans Affairs, https://vetsedsuccess.org/wp-content/uploads/2025/02/REPORT_A-Deeper-Look-at-Post-9-11-GI-Bill.pdf.

[42] *Id.*

[43] Radford, A. W., Bailey, P., Bloomfield, A., Webster, B. H. Jr., & Park, H. C., "*Post 9/11 GI Bill Eligible Enlisted Veterans' Enrollment and Outcomes at Public Flagship Institutions"* (2024), American Institutes for Research, U.S. Census Bureau, and National Center for Veterans Analysis & Statistics, U.S. Department of Veterans Affairs, https://vetsedsuccess.org/post-9-11-gi-bill-eligible-enlisted-veterans-enrollment-and-outcomes-at-public-flagship-institutions-with-a-focus-on-the-great-lakes-region/.

[44] Radford, A. W., Bailey, P., Bloomfield, A., Rockefeller, N., Webster, B. H. Jr., & Park, H. C., "*How Do Veterans' Outcomes Differ Based on the Type of Education They Received? And How are Veterans Who Have Not Used Their Education Benefits Faring?"* (2024), American Institutes for Research, U.S. Census Bureau, and National Center for Veterans Analysis & Statistics, U.S. Department of Veterans Affairs, https://vetsedsuccess.org/post-9-11-gi-bill-benefits-how-do-veterans-outcomes-differ-based-on-the-type-of-education-they-received-and-how-are-veterans-who-have-not-used-their-education-benefits-faring/.

[45] Id.

military rank, as well as overall among all veterans – yet only 1% of veterans attended colleges with the highest instructional spending.[46]

- Married veterans were more likely to complete a degree and earn more.[47]
- Veterans pursuing nondegree programs (such as certificate programs) and two-year degree programs (i.e., associate degrees) consistently earned less if they attended a for-profit program rather than a public program, even though for-profit programs consistently charged VA a higher tuition than public programs (and almost double the cost at the associate degree level).[48]
- Female veterans were significantly more likely than male veterans to use Post-9/11 GI Bill benefits and to earn a degree. Still, they earned significantly less than male veterans with the same degree. However, the earnings gap by sex was smaller for veterans than for the general population.[49]

This project demonstrates the type of information and insights that can be gleaned when agencies collaborate and share data.[50] Based on the richness of the project findings and the broad policy implications, we strongly advocate for legislative measures that promote continued data-sharing efforts to achieve these data annually. We urge your Committees to enact a law requiring VA and VBA to share data on student outcomes with other agencies for the purpose of determining GI Bill outcomes.

We also urge your Committees to urge the other committees of jurisdiction to similarly require the agencies under their jurisdiction to share data on veterans' outcomes. The Census Bureau is equipped to house and merge data from multiple agencies, as it did during the pilot project. Ongoing data sharing among agencies will enable a continued, holistic understanding of veterans' educational experiences and outcomes.

We also recommend establishing an interagency task force focused on data collaboration. This task force should be tasked with implementing a standard federal data dictionary associated with veterans, service members, and their families. It should define common data elements, following models such as the one proposed by the Bush Institute's Veteran Wellness Alliance, and execute an annual crosswalk of Office of Postsecondary Education Identifiers (OPEIDs) and VA facility codes.[51] This standardized approach would streamline data collection and analysis, allowing for more effective collaboration and informed decision-making.

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[46] *Id.*
[47] *Id.*
[48] *Id.*
[49] *Id.*
[50] Bloomfield, A., Radford, A. W., Bailey, P., Webster, B. H. Jr., & Park, H. C, "*Post-9/11 GI Bill eligible enlisted veterans' enrollment outcomes at public flagship institutions, with a focus on the Great Lakes region*" (2024), American Institutes for Research; U.S. Census Bureau; and National Center for Veterans Analysis & Statistics, U.S. Department of Veterans Affairs, https://vetsedsuccess.org/wp-content/uploads/2024/10/pgib-outcomes-public-flagship-great-lakes.pdf.
[51] Kacie Kelly and Dr. Caroline Angel, George W. Bush Presidential Center, *Common Questions to Better Serve Our Vets* (Apr. 2020), https://www.bushcenter.org/publications/common-questions-to-better-serve-our-vets.

Summary of recommendations:

- Mandate that VA engage in comprehensive data sharing with other agencies for the purpose of studying veterans' outcomes – including health outcomes – and urge other Congressional committees of jurisdiction to require the agencies under their jurisdiction to share data about veterans with VA.[52]
- Establish an interagency task force focused on interagency data collaboration efforts, including implementing a standard federal data dictionary associated with veterans, service members, and their families to define common data elements and a crosswalk of OPEIDs and VA facility codes.

[52] The U.S. Department of Education is broadly prohibited by law from sending data out; however, they would be able to accept data and run analyses to produce findings for publication.

4. Ensure appropriate implementation of risk-based reviews

In 2020, in the *Johnny Isakson and David P. Roe, M.D. Veterans Health Care and Benefits Improvement Act of 2020*, enacted January 2021,[53] Congress unanimously passed a requirement that VA conduct risk-based reviews of schools that had been put on monitoring or provisional status at ED or faced federal or state government punitive action or punitive action by their accreditor. This law wisely focuses VA's limited oversight resources, particularly within the State Approving Agencies, on the schools most likely to harm veterans by exhausting their GI Bill benefits without providing the education or career opportunities the veterans were promised. Before this law, traditional compliance surveys relied on routine cycles and too often failed to identify the institutions posing the greatest risk.

Congress's embrace of risk-based reviews was also supported by a 2011 Government Accountability Office (GAO) report and recommendation.[54] The requirement for risk-based surveys was set forth in section 1014 of the *Isakson and Roe Act* and codified at 38 U.S.C. § 3673, while the scope of such surveys was set forth in section 1013 and codified at 38 U.S.C. § 3673A, requiring VA to look at the following issues during a review: rapid increase in veteran enrollment; rapid increase in tuition and fees; student complaints; compliance with statutory requirements of honest advertising; student veteran completion rates; indicators of financial stability; and compliance with other statutes.

We urge the Committees to conduct oversight into VA's implementation of risk-based reviews of schools. We have been surprised to find glaring omissions by VA, including confusion at VA – as evidenced in their Standard Operating Procedure for SAAs – on the difference between triggering requirements for a risk-based review (outlined at 38 U.S.C. § 3673) and the topics to be reviewed during such a review (outlined at 38 U.S.C. § 3673A).[55, 56, 57,]

Despite significant congressional direction and input from external partners and the State Approving Agencies, VA has reportedly largely implemented risk-based reviews as merely advanced compliance surveys.[58] As a result, the agency has focused more on the number of surveys conducted than on whether the methodology actually identifies higher-risk institutions or produces meaningful corrective action.[59]

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[53] Johnny Isakson and David P. Roe, M.D. Veterans Health Care and Benefits Improvement Act of 2020, H.R. 7105, 116th Cong., 2nd sess., 2020, https://www.congress.gov/bill/116thcongress/house-bill/7105.
[54] U.S. Government Accountability Office, *VA Education Benefits: Actions Taken, but Outreach and Oversight Could Be Improved*, GAO-11-256 (Feb. 2011), https://www.gao.gov/assets/gao-11-256.pdf.
[55] In a letter to VA, we annotated these distinctions, available here: https://vetsedsuccess.org/wp-content/uploads/2023/03/Letter-to-VA-re-Risk-Based-Survey-SOPs-3.pdf.
[56] VBA Education Service, Oversight and Accountability Division, *Standard Operating Procedure, Risk Based Surveys* (Jul. 22, 2022), https://vetsedsuccess.org/vbas-standard-operating-procedures-for-risk-based-surveys-july-22-2022/.
[57] VBA Education Service, Oversight and Accountability Division, *Standard Operating Procedure, Targeted Risk Based Review (TRBR)* (Oct. 1, 2022), https://vetsedsuccess.org/vbas-standard-operating-procedures-for-targeted-risk-based-reviews-oct-1-2022/.
[58] Joseph W. Wescott II, *Statement Before the Subcommittee on Economic Opportunity, Committee on Veterans' Affairs, U.S. House of Representatives* (Sept. 20, 2023), https://docs.house.gov/meetings/VR/VR10/20230920/116307/HHRG-118-VR10-Wstate-WestcottIIEdDJ-20230920.pdf.
[59] William Hubbard, *Testimony Before the Subcommittee on Economic Opportunity, Committee on Veterans' Affairs, U.S. House of Representatives, on "Less Is More: The Impact of Bureaucratic Red Tape on Veterans Education Benefits"* (Sept. 20, 2023), Veterans Education Success, https://vetsedsuccess.org/wp-content/uploads/2023/09/HVAC-EO-Hearing-Testimony-SEPT-20_2023-Veterans-Education-Success.pdf.

It is also unclear whether VA has complied at all with Congress's requirement that risk-based surveys be linked to a searchable database for State Approving Agencies to use in conducting risk-based surveys, and later amendments imposed a deadline for implementation.[60]

External guidance and resources have been provided to VA, but it is unclear whether VA has taken advantage of this assistance. In 2022, The American Legion and EducationCounsel partnered with State Approving Agencies to publish the findings of their risk-based review pilot model.[61] The pilot took place in six states, including Texas, Illinois, New York, Delaware, Virginia, and Nevada. The effort established practical methods for identifying higher-risk institutions and conducting deeper reviews. Regulators and schools viewed the work positively because it produced clear insights into where institutions could improve. The results showed that targeted oversight uncovered problems that routine compliance surveys often missed.

Congress should exercise additional oversight on VA's progress in implementing these requirements. Congress should require an annual report on risk-based reviews that summarizes findings, trends, and enforcement outcomes. This information should be available to Congress, State Approving Agencies, and the public. Relevant findings should also inform caution flags on the GI Bill Comparison Tool on a rolling basis so prospective students can better assess potential risks before enrolling.

Summary of recommendations:

- Conduct oversight of VA's implementation of risk-based reviews of schools as required under § 3673 and of the database meant to assist State Approving Agencies as required under § 3673A.

[60] *Id.*

[61] Nathan Arnold, Joe Wescott, Beth Stein, and Bethany Little, *Lessons from a Risk-Based Oversight Model Designed to Protect Students and Taxpayers*, American Legion and EducationCounsel (Jan. 2022), https://educationcounsel.com/storage/IxSWhg1ghLCU3ghHMcV8vFHO7TT4FKxgA68zQoTJ.pdf.

5. Ensure VA Properly Handles Student Veteran Complaints About Schools

In 2012, Congress enacted a law with nearly unanimous support to require VA to establish a system to handle student veterans' complaints about schools, codified at 38 U.S.C. § 3698.[62, 63]

Our organization has heard from many hundreds of student veterans that they believe VA is not properly handling their complaints, including closing their complaints upon any response from a school, no matter how dubious, and failing, from the student veterans' perspective, to take their complaints seriously and have veterans' backs.

It is critical that VA properly handle student veteran complaints. It is especially important in light of significant evidence of fraud against veterans, who find their GI Bill stolen by fraudulent schools and are left with debts and no degrees.

Taxpayers also have an enormous stake in VA's improvement in handling student veterans' complaints, because student complaints are often the earliest indication of problems at a school. In essence, student veteran complaints serve as an early-warning system to protect taxpayer funds. For example, when student veterans contacted our organization with serious concerns about House of Prayer, their alerts (which we took to VA) turned out to be the credible basis of evidence about a massive scam, which ended with an FBI raid and law enforcement actions shutting down the school.

School fraud costs taxpayers enormous sums of money, and there is significant law enforcement evidence that many schools receiving the most GI Bill funds have defrauded veterans out of millions of GI Bill funds. (Consider, for example, the largest-ever law enforcement settlement of $500 million against one of the largest GI Bill schools).

The Committees should require VA to publish an annual report on student veterans' complaints and how those complaints were handled, and require VA to include more information of this nature on the Comparison Tool.

Summary of recommendations:

- Amend 38 U.S.C. § 3698 to require VA to publish an annual report on School Feedback Tool complaints, including the number and type of complaints received, whether they triggered investigations by VA or State Approving Agencies, the outcomes of those investigations, and any enforcement actions taken against participating institutions.

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[62] Improving Transparency of Education Opportunities for Veterans Act of 2012, H.R. 4057, 112th Cong., 2nd sess., 2012, https://www.congress.gov/bill/112th-congress/house-bill/4057.
[63] Pub. L. No. 112-249, 126 Stat. 2398 (Jan. 10, 2013).

6. Improve the GI Bill Comparison Tool

Congress required the GI Bill Comparison Tool in 2012 to provide GI Bill students with clear, reliable information as they decide where to use their earned benefits. It is meant to ensure informed student choice and to function as an initial safeguard, protecting veterans from poor-quality or unstable schools and helping them identify programs that will deliver real value.

However, instead of providing veterans with the whole picture, VA often withholds or inconsistently applies key information in the Tool that would influence veterans' decision-making. We have previously made comprehensive recommendations to improve the GI Bill Comparison Tool.[64, 65, 66] Today, we offer expedient changes that could significantly enhance the value of the Comparison Tool with minimal effort.

Report Student Veteran Outcomes

First, the Comparison Tool should report veteran-specific outcome data and graduates' earning data. Despite VA's goal of providing a search tool to help veterans make an informed choice about where to use their educational benefits, the Comparison Tool contains no veteran-specific outcome data. Instead, it focuses on attendance costs at, and veteran-focused services provided by, participating schools, allowing beneficiaries to search for a particular school or schools near where they live.

Moreover, in 2019, VA stopped showing College Scorecard graduation, retention, and earnings data for all students receiving federal student aid.[67] VA attempted to calculate GI Bill graduation rates for schools that voluntarily reported beneficiary completions but stopped because of "the overwhelming demand from schools."[68] Reportedly, institutions were concerned that VA was undercounting graduations because VA counted credential completion only for individuals who used VA benefits in the term in which they earned a certificate or degree. In fact, all of VA's administrative data reflects only beneficiaries using GI Bill benefits.

Veterans who exhaust their benefits before they graduate or veterans who enroll in a free community college program are missing from VA's Comparison Tool dataset. To address this, VA should regularly request a data match between its students and the National Student Clearinghouse, as it did during the interagency GI Bill data-matching project.

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[64] See Our Letter to VA on the Principles of Excellence Complaint Feedback Tool (February 18, 2022) (also discussing recommendations for the GI Bill Comparison Tool), available at https://vetsedsuccess.org/our-letter-to-va-on-the-principles-of-excellence-complaint-feedback-tool/.

[65] See Our Letter to VA Regarding January 12, 2023 Meeting and Feedback Tool (February 15, 2023), available at https://vetsedsuccess.org/our-letter-to-va-regarding-january-12-2023-meeting-and-feedback-tool/.

[66] A full list of our recommendations for the GI Bill Comparison Tool may also be found in item 5 of Our Statement for the Record: Legislative Priorities Submitted to the Senate and House Committees on Veterans Affairs 2025, available at https://vetsedsuccess.org/our-written-testimony-legislative-priorities-submitted-to-the-senate-and-house-committees-on-veterans-affairs-2025/.

[67] Retention, graduation, average student loan debt, and federal student loan "repayment" (percentage of students not making progress on paying off their loans) are still available for some schools on the full dataset, a massive excel file with data on almost 18,000 approved schools with up to 105 columns of statistics. The full dataset, primarily a resource for researchers, is accessed through a link at the bottom of the school search page where beneficiaries can find summary information on any participating institution.

[68] Personal communication with VA staff on January 24, 2020.

A number of the lessons that came out of that project would be directly applicable to future improvements to the Comparison Tool.[69, 70, 71, 72, 73, 74]

Recent changes at ED reinforce the need for this kind of outcome transparency.[75] ED has begun displaying earnings data drawn from College Scorecard data directly to students as they complete the Free Application for Federal Student Aid (FAFSA), along with a warning if a school's graduates earn less than high school graduates, reflecting the Administration's judgment that outcome information belongs in the hands of students choosing a college. That same logic should apply to VA's platforms as well. The Comparison Tool should present veteran-specific outcomes where possible, but at a minimum should incorporate ED's "low-earning warning" outcome data that the federal government already considers relevant to student decision-making during the FAFSA process.

Show Student Veterans' Complaints

Second, VA should show the whole history of student veterans' complaints. Unfortunately, in 2019, reportedly at the behest of industry lobbyists, VA adopted a policy to show in the Comparison Tool only the complaints received in the most recent 24 months. The Comparison Tool has since been updated to show complaints received in the past 6 years, thanks to the *Dole Act*,[76] but before 2019, it showed the whole history of complaints. The policy of limiting the complaint window is not veteran-centric and only benefits schools with a history of complaints.

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[69] Radford, A., Bloomfield, A., Bailey, P., Webster, B. H. Jr., & Park, H. C., "*A First Look at Post-9/11 GI Bill-Enlisted Veterans' Outcomes*" (2024), American Institutes for Research; U.S. Census Bureau; and National Center for Veterans Analysis & Statistics, U.S. Department of Veterans Affairs, https://vetsedsuccess.org/a-first-look-at-post-9-11-gi-bill-eligible-enlisted-veterans-outcomes/.

[70] Radford, A. W., Mayer, K. M., Bloomfield, A., Bailey, P., Webster, B. H. Jr., & Park, H. C., "*Which Veterans are Forgoing Their Post-9/11 GI Bill Benefits?*" (2025), American Institutes for Research; U.S. Census Bureau; and National Center for Veterans Analysis & Statistics, U.S. Department of Veterans Affairs, https://vetsedsuccess.org/wp-content/uploads/2025/02/REPORT_Which-Veterans-Are-Forgoing-Their-Post-9-11-GI-Bill-Benefits.pdf.

[71] Jiang, J. Y., Mayer, K. M., Le, V., & Radford, A. W., "*Post-9/11 GI Bill Access and Uptake: Insights and Recommendations from Veterans*" (2025), American Institutes for Research, https://vetsedsuccess.org/wp-content/uploads/2025/02/REPORT_Post-9-11-GI-Bill-Access-and-Uptake.pdf.

[72] Radford, A. W., Bloomfield, A., Bailey, P., Mayer, K. M., Webster, B. H. Jr., & Park, H. C., "*A Deeper Look at Post-9/11 GI Bill Outcomes for American Indian/Alaska Native, Black, and Hispanic Veterans*" (2025), American Institutes for Research; U.S. Census Bureau; and National Center for Veterans Analysis & Statistics, U.S. Department of Veterans Affairs, https://vetsedsuccess.org/wp-content/uploads/2025/02/REPORT_A-Deeper-Look-at-Post-9-11-GI-Bill.pdf.

[73] *Id.*

[74] Radford, A. W., Bailey, P., Bloomfield, A., Webster, B. H. Jr., & Park, H. C., "*Post 9/11 GI Bill Eligible Enlisted Veterans' Enrollment and Outcomes at Public Flagship Institutions"* (2024), American Institutes for Research, U.S. Census Bureau, and National Center for Veterans Analysis & Statistics, U.S. Department of Veterans Affairs, https://vetsedsuccess.org/post-9-11-gi-bill-eligible-enlisted-veterans-enrollment-and-outcomes-at-public-flagship-institutions-with-a-focus-on-the-great-lakes-region/.

[75] Federal Student Aid, "New Lower Earnings Indicator on the FAFSA® Form," Federal Student Aid Knowledge Center, (Dec. 3, 2025), https://fsapartners.ed.gov/knowledge-center/library/electronic-announcements/2025-12-03/new-lower-earnings-indicator-fafsar-form.

[76] Public Law 118-210, *Senator Elizabeth Dole 21st Century Veterans Healthcare and Benefits Improvement Act*, Section 215 (c)(1)(D), 118th Congress, 2nd Session (2024), https://www.congress.gov/bill/118th-congress/house-bill/8371.

The history, volume, and nature of complaints are relevant information and should not be hidden from veterans. Student veteran complaints counted on the GI Bill Comparison Tool are received by VA through its School Feedback Tool, which was established under Executive Order 13607.[77] It was further codified in 38 U.S.C. § 3698(b)(2), which requires the Secretary to provide "a centralized mechanism for tracking and publishing feedback from students and State approving agencies regarding the quality of instruction, recruiting practices, and post-graduation employment placement."[78] VA reviews student complaints and categorizes them by underlying issue before totaling them for display.

Student veterans should be allowed to decide for themselves whether and to what extent a school's history of complaints by other veterans matters in their decision-making. SAAs, accreditors, other federal agencies, and academic researchers also would benefit from knowing a school's history of student complaints. VA should return to its original practice of including a school's full history of complaints in the GI Bill Comparison Tool.

Show Whether Student Veterans' Complaints Were Handled

Third, VA should expand the complaint information conveyed on the Comparison Tool to indicate whether the school responded to the complaint and whether the student was satisfied with the response. This would not require VA to collect new information from schools, as VA already controls the complaint process, receives school responses, and determines when a complaint is closed. All complaints should be listed on the GI Bill Comparison Tool as closed either "to the satisfaction" of the student or not, which is relevant information for other student veterans. It should also be noted on the Comparison Tool when schools fail to respond to complaints.

Disclosing information about school response rates and student satisfaction with schools' responses adds context to complaints and helps veterans make informed choices. Finally, adding a basic indicator of whether a school responded and whether the veteran found the response satisfactory would meaningfully build on the existing process. While VA does not currently capture veteran satisfaction in a standardized, reportable way, establishing that data point would provide valuable context for prospective students.

The GI Bill School Feedback Tool should also give students the option to make the narrative portion of their complaint public on the Comparison Tool. Narratives would give prospective GI Bill students a real sense of the experiences of fellow student veterans at a school. Complaint databases used by both the government (CFPB) and non-governmental entities, such as the Better Business Bureau, include the narrative portions of consumer complaints.
As a leading example, CFPB's consumer complaint database allows users to view narrative complaints alongside standardized indicators.[79] These show whether the company responded, whether the response was timely, and whether the complaint was resolved to the consumer's satisfaction or not. The database also includes filtering and export tools that make the information usable rather than merely visible. VA should adopt this model and incorporate basic PII review and redaction as needed.

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[77] Exec. Order No. 13607, 77 FR 25861 (2012).
[78] Veterans Education Success, "Public Comment on the Principles of Excellence Complaint Feedback Tool," (Feb. 18, 2022), https://vetsedsuccess.org/wp-content/uploads/2022/04/VBA-Student-Complaint-System-Comment.pdf.
[79] Consumer Financial Protection Bureau, "Consumer Complaint Database," (accessed Dec. 12, 2025), https://www.consumerfinance.gov/data-research/consumer-complaints/search/.

Properly Implement Caution Flags

Fourth, VA should ensure that caution flags are displayed when a school has experienced any "increased legal or regulatory scrutiny."[80] This would warn veterans about potentially predatory programs and highlight information about oversight and enforcement actions against a school. The Comparison Tool's caution flags are an exceptional consumer disclosure tool for capturing attention, but VA does not always post a caution flag when an action has occurred. Of specific concern is that VA does not appear to post caution flags when an SAA determines that a school failed to comply with the law and imposes a consequence, even a temporary suspension of a program. See, for example, our letter regarding Wheeling University.[81] Prospective students comparing schools should know whether a school has been the subject of an oversight action by the SAA.

As a general matter, caution flags are not consistently posted. For example, in the Comparison Tool, several of the DeVry University locations[82] correctly display a caution flag indicating that DeVry University agreed to a settlement with the Federal Trade Commission, but, inexplicably, almost half of the DeVry University locations in the Comparison Tool do not have the caution flag. The main campus for DeVry University, listed as Lisle, IL, in the Comparison Tool,[83] does not even have the caution flag. All of DeVry's campus locations should display the caution flag so that veterans across all locations can see it and make an informed choice. This failure to consistently post caution flags is not an isolated incident. See, for example, our letters to VA regarding ASA College, Bay State College, and IEC schools, alerting VA that caution flags should have been added for oversight and enforcement actions.[84]

Caution flags for enforcement and oversight actions provide critical information for veterans who are considering where to use their hard-earned GI Bill benefits. Whether the failure to include a caution flag is due to a mistake or an internal policy, we urge you to make sure VA has the policies and procedures that will result in caution flags being posted for all oversight and enforcement actions.

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[80] VA's "GI Bill ® Comparison Tool: About this Tool" page explains about the Caution Flags, "These are indicators VA has determined potential students should pay attention to and consider before enrolling in a program of education. A caution flag means VA or other federal agencies like the Department of Education or Department of Defense have applied increased regulatory or legal scrutiny to a program of education." The page is available at https://www.benefits.va.gov/gibill/comparison_tool/about_this_tool.asp#CF (last accessed September 25, 2025).

[81] Our Letter to Department of Veterans Affairs on the GI Bill Comparison Tool Information for Wheeling University (September 12, 2022), available at https://vetsedsuccess.org/our-letter-to-department-of-veterans-affairs-on-the-gi-bill-comparison-tool-information-for-wheeling-university/.

[82] GI Bill Comparison Tool entry for "DeVry University" search. https://www.va.gov/education/gi-bill-comparison-tool/?search=name&name=DeVry%20University&excludeVettec=true.

[83] See the Comparison Tool entry for the Newark, CA, location, which lists other school locations. The Newark, CA, entry in the Comparison Tool does have a caution flag for the FTC Settlement. https://www.va.gov/education/gi-bill-comparison-tool/institution/21801105 (last accessed September 25, 2025).

[84] Our Letter to VA Regarding ASA College (November 21, 2022), available at https://vetsedsuccess.org/letter-to-va-regarding-asa-college/; Our Letter to VA Regarding Bay State College (November 21, 2022), available at https://vetsedsuccess.org/letter-to-va-regarding-bay-state-college/; Our Letter to VA Regarding Florida Career College, UEI College, and United Education Institute (October 26, 2023), available at https://vetsedsuccess.org/our-letter-to-va-regarding-florida-career-college-uei-college-and-united-education-institute.

Ensure VA Has Veterans' Backs

Section 215(c)(1)(A) of the Dole Act[85] amends 38 U.S.C. § 3698(b)(2)(A) to allow schools to challenge the inclusion of student complaints in VA's GI Bill Comparison Tool and publish their responses. Although intended to address allegedly inaccurate information, in practice, the provision serves to protect schools from real oversight, while discouraging veterans from reporting legitimate concerns. Veterans tell us they feel VA does not have their backs because VA seems to prioritize schools' responses over veterans' concerns. Recall, of course, that most complaints from veterans regard a handful of bad actor schools.

As it stands, the Tool already provides only limited information about complaints, and does not publish the veterans' narratives. Allowing schools to contest even the existence of a complaint will make it harder for prospective student veterans and the public to see when and what concerns have been raised. In our experience, student complaints are often the earliest warning sign of fraud or abuse, and Congress should ensure the system protects transparency. Veterans should feel encouraged to come forward to speak about issues rather than face these barriers to reporting problems. We call on Congress to adjust the law in the following ways:

- Do not allow institutions to challenge the inclusion of student veterans' complaints in the publicly available data about a school.
- Give student veterans the option to publish the narrative portion of their complaints and to respond to a school's claims about the veterans' complaints.
- Require VA to include in the Comparison Tool whether the complaint was resolved to the student veteran's satisfaction.
- Repeal or amend section 215 of the *Dole Act* to ensure that veterans have the opportunity to respond to a school's claims.

These changes would ensure the Comparison Tool serves its purpose of providing veterans with transparent information while holding schools accountable.

Summary of Recommendations:

- Restore outcome transparency to the GI Bill Comparison Tool by adding veteran-specific completion and earnings data, and, at a minimum, reinstating College Scorecard graduation, retention, and low-earning warning data, so veterans can judge educational value, not just price and services.
- Return to displaying a school's full complaint history so veterans can see long-term patterns of misconduct rather than a truncated snapshot.
- Show whether schools responded to complaints, whether responses were timely, and whether veterans were satisfied, and allow reviewed narrative complaints with appropriate redaction to provide real context instead of summary totals.
- Require consistent caution flags across all locations whenever there has been oversight or enforcement action, including State Approving Agency findings and federal settlements.
- Amend 38 U.S.C. § 3698(b)(2)(A) to ensure that if an institution may contest a complaint, the student veteran has an equal opportunity to publish the narrative and respond to the institution's claims, and that the existence of a complaint cannot be withheld from public view during or after any review process.

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[85] Public Law 118-210, *Senator Elizabeth Dole 21st Century Veterans Healthcare and Benefits Improvement Act*, 118th Congress, 2nd Session (2024), https://www.congress.gov/bill/118th-congress/house-bill/8371.

7. Oppose full housing allowance for online-only students – a costly and dangerous proposal

Given the existing and more compelling unmet needs of veterans, we believe the high federal costs of increasing the monthly housing allowance (MHA) for online-only students should not be a top spending priority for the Veterans' Affairs Committees.

Based on estimates from VA, an annualized cost for increasing MHA for online-only students is expected to reach ***more than $15 billion over 10 years***.[86] We continue to urge Congress to set this idea aside and instead prioritize issues such as GI Bill parity for Guard and Reserve service, improvements to Chapter 35 for survivors and dependents, and the restoration of the GI Bill for defrauded student veterans.

The simple fact is that remote learning expanded during the pandemic, when campuses were closed, but those emergency conditions have passed, and higher education has largely returned to in-person instruction. Additionally, there are clear policy reasons not to pursue full housing allowance for online students:

- **Risks of Fully Online Instruction.** Evidence from the pandemic-era shift to remote instruction shows measurable learning loss associated with fully online education. The 2022 National Assessment of Educational Progress found that decades of academic progress were erased following the move to remote learning.[87] Research on veterans' education outcomes raises similar concerns. The interagency report published by VA, the U.S. Census Bureau, and the American Institutes for Research found that veterans attending schools with a higher percent of fully online education had lower completion rates and weaker earnings outcomes.[88] Together, these findings reinforce what many student veterans report: that programs built around asynchronous online instruction often provide limited engagement with instructors, and less overall learning. These programs naturally have weaker educational outcomes, while evidence indicates that some level of in-person instruction remains an important component of effective education.

- **Fueling Poor-Performing Schools.** The Committees, student veterans, and taxpayers alike should heavily weigh the demonstrated outcomes of online programs and consider whether or not these programs are worthy of valuable GI Bill resources. *Inside Higher Ed* looked at the 8-year completion rate of the 2015-2016 cohort at large online institutions.[89] The results of that analysis paint a stark picture, as evident in the chart that follows.

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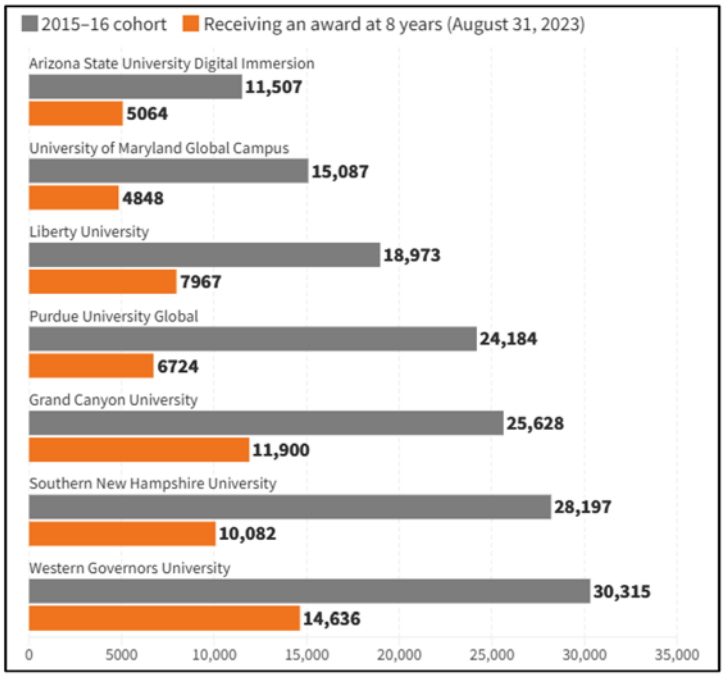
[86] U.S. Department of Veterans Affairs, *Statement of Joseph Garcia, Executive Director, Education Service, Veterans Benefits Administration, Department of Veterans Affairs (VA), before the Committee on Veterans' Affairs Subcommittee on Economic Opportunity, U.S. House of Representatives* (Oct. 18, 2023), https://docs.house.gov/meetings/VR/VR10/20231102/116445/HHRG-118-VR10-Wstate-GarciaJ-20231102.pdf.

[87] National Center for Education Statistics, *National Assessment of Educational Progress 2022 Mathematics and Reading Assessments*, (Oct. 24, 2022), https://www.nationsreportcard.gov/highlights/ltt/2022/.

[88] Radford, A., Bloomfield, A., Bailey, P., Webster, B. H. Jr., & Park, H. C., "*A First Look at Post-9/11 GI Bill-Enlisted Veterans' Outcomes*" (2024), American Institutes for Research; U.S. Census Bureau; and National Center for Veterans Analysis & Statistics, U.S. Department of Veterans Affairs, https://vetsedsuccess.org/a-first-look-at-post-9-11-gi-bill-eligible-enlisted-veterans-outcomes/.

[89] Michael Nietzel, "*Students in For-Profit Online Programs Less Likely to Complete College, Finds New Study*," Forbes (Nov. 19, 2023), https://www.forbes.com/sites/michaeltnietzel/2023/11/19/students-in-for-profit-online-programs-less-likely-to-complete-college-finds-new-study/.

And even more specific to this population of students, a 2023 study published by the Annenberg Institute at Brown University found, "Exclusively online students with military service were 11.4 percentage points *less likely* to earn their bachelor's degree compared to peers with military service not enrolled in exclusively online



programs."[90]

- **Marketing Tool for Bad Actors.** Predatory schools would use the availability of an increased housing allowance as a selling point to target veterans to attend predatory and exploitative programs. In the aftermath of finally closing the 90/10 loophole, a shift to a full housing allowance for solely online colleges would re-establish veterans as targets for unscrupulous schools. Many of these schools have been sued by law enforcement and fined by federal agencies for defrauding students, and can reasonably be expected to abuse this change.[91, 92]

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[90] Justin C. Ortagus, Rodney Hughes, and Hope Allchin, *The Role and Influence of Exclusively Online Degree Programs in Higher Education*, EdWorkingPaper: 23-879, Annenberg Institute at Brown University (2023), https://doi.org/10.26300/xksc-2v33.

[91] *People of the State of California v. Ashford University, et.al.*, 37-2018-00046134-CU-MC-CTL, Statement of Decision (hereinafter, "Order"), filed Mar. 3, 2022, available at https://oag.ca.gov/system/files/attachments/press-docs/37-2018-00046134-CU-MC-CTL_ROA-696_03-03-22_Statement_of_Decision_1646669688827.pdf.

[92] San Francisco Film School, Facebook Ad, "*Did you know Veterans can learn filmmaking without moving and receive California VA Housing Benefits?*" (Dec. 2, 2022). Video: https://drive.google.com/file/d/1MskPB4YvpESedeQy08FnaDFXXe5a0l5F/view?usp=sharing;

- **Incentivizing Students to Leave Flagship Public Universities.** Due to the higher housing allowance, such a policy change would incentivize veterans to leave high-quality, flagship public universities in low-housing-cost states – such as Kansas, Illinois, Wisconsin, and Texas – and enroll in national online college chains. Current housing allowance rates for in-person and hybrid learners are based on DOD housing allowance rates (BAH) for an "E-5 with dependents."[93] Over 60% of DOD's 339 BAH zones have housing costs less than the national average,[94] in some cases half of the national average. If Congress enacted the full housing allowance for online students, veterans attending high-quality public colleges would receive less housing assistance than those attending low-quality online colleges.

We urge the Committees not to move forward with any proposals increasing the MHA rate for online-only students. Instead, a near-term solution would be for Congress to direct an unbiased study of online learning outcomes regarding Title 38 veterans' education benefits.

Summary of recommendations:

- Oppose full housing allowance for online-only students.

Screenshot: https://drive.google.com/file/d/1Zt8nQnM7cGmOrYs-RtF6lL6LHt6pMwZ7/view?usp=sharing; Original Link: https://www.facebook.com/story.php/?story_fbid=546688560252299&id=112861392131638&__rdr.

[93] U.S. Department of Veterans Affairs, *Post-9/11 GI Bill (Chapter 33): How does VA determine my monthly housing allowance (MHA)?* (2023), www.va.gov/education/about-gi-bill-benefits/post-9-11/#how-does-va-determine-my-month.

[94] Defense Travel Management Office, *Basic Allowance for Housing Rate Lookup* (2023), https://www.travel.dod.mil/allowances/basic-allowance-for-hou,sing/bah-rate-lookup/.

8. Protect GI Bill Payments from Recurring IT Failures

From the very beginning of the Post-9/11 GI Bill, VA experienced delays in GI Bill distribution and was forced to issue emergency payments of up to $3,000 to more than 25,000 veterans who were left without their funds.[95] The following year, delayed payments persisted, and nearly 50,000 veterans continued to experience difficulties with VA's failures.[96, 97]

More recently, while implementing the Forever GI Bill, VA experienced major IT failures in the fall of 2018.[98] Housing payments for as many as 180,000 student veterans were delayed due to computer system updates and processing issues.[99]

A separate—but all too familiar—breakdown occurred in 2023 when VA's rollout of the digital enrollment system reportedly triggered an unexpected gap in housing payments.[100] We testified that "VBA publicly announced a technical flaw that resulted in more than 280,000 student veterans' being delayed on their monthly housing allowance (MHA) GI Bill payments. For nearly 4,000 of these veterans, VBA had to work with Treasury to mail hard-copy checks to the individuals to ensure continuity of on-time payments."[101] Congress should require VA to implement reliable technical safeguards, transparent timelines, and actionable contingency plans because delays should be anticipated.

Continuing the trend of IT failures and poor communication, VA once again left students scrambling this past fall with delays to Chapter 35 and other VA benefits. These benefits are fundamental to whether a student can remain enrolled, maintain housing stability, and cover the daily costs of attendance. When those funds disappear, the consequences are immediate and personal, as we saw throughout the semester.

One student veteran wrote to us to describe the difficult position she faced as a result of the delays:

> I have not received one of my payments and it's almost 90 days. I had my vehicle repossessed last week and I am facing eviction with late fees that are mounting[.] I am attending out of state school and I have no family near me. I am in dire need of assistance please help me. I can't get any answers from the emails I sent and the phone calls that go unanswered. I checked the VA benefits website and it shows that my benefits are eligible, but they have not issued any payments. This goes back to August. This is affecting my life tremendously.

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[95] Philpott, Tom. "VA, lawmakers share blame for GI Bill delay," *Stars and Stripes*, (Oct. 17, 2009), https://www.stripes.com/news/2009-10-17/military-update-va-lawmakers-share-blame-for-gi-bill-delay-1991955.html.

[96] Daniel, Lisa. "VA Seeks to Eliminate Claims Processing Backlog, Official Says," Army.mil, (Dec. 18, 2010), https://www.army.mil/article/49646/va_seeks_to_eliminate_claims_processing_backlog_official_says.

[97] Scholarships.com. "GI Bill Backlog Continues into Spring," *Scholarships.com Blog*, (Jan. 8, 2010), https://www.scholarships.com/blog/gi-bill-backlog-continues-into-spring.

[98] Veterans of Foreign Wars. "Delayed Housing Payments Impacting 180,000 Student Veterans," *VFW Archives*, (Oct. 2018), h,,ttps://www.vfw.org/media-and-events/latest-releases/archives/2018/10/delayed-housing-payments-impacting-180000-student-veterans.

[99] *Id.*

[100] Garcia, Joseph. "Update on Post 9/11 GI Bill MHA Delayed Payment for March 2023," *Veterans Benefits Administration*, (Apr. 19, 2023), https://content.govdelivery.com/accounts/USVAVBA/bulletins/355e1e1.

[101] Veterans Education Success. "Statement for the Record Submitted to the Senate Committee on Veterans Affairs 118th Congress, First Session," (Apr. 26, 2023), https://vetsedsuccess.org/wp-content/uploads/2023/04/Veterans-Education-Success-Statement-For-the-Record-SVAC-4-26-2023.pdf.

Dylan Virrueta-Torres, who served as a Boatswain's Mate in the US Navy for five years and now attends Simpson University, shared:

> Beginning of fall semester 2025 my pay for school was delayed for two months, during that time I tried to check in [to] the VA hotline (it was shutdown and in furlow) I got redirected each time and every person that answered the phone either has no access to my info, or didn't know how to help, I called local congress representatives, I even went to navy federal for hardship loans and it was denied due to me not being a federal employee. Being in school put me in a weird circumstance where I relied on that money but don't meet requirements for help; if it wasn't for my loving fiancée and my job I would have been evicted and dropped out of school.

What made this situation more damaging was not simply the payment disruption, but the utter lack of communication. This is fundamentally a leadership failure, not merely a contractual error. VA was aware in August about the risk of payment delays.[102] VA later described the payment failure as being the result of a technical malfunction of their IT rollout.[103]

Once students became aware of missing payments, no one could get answers because the GI Bill hotline was classified as non-essential during the federal government shutdown—an issue we hope the Committee will address by requiring VA to deem the hotline an essential service. Yet, in the intervening months, no steps were taken to inform GI Bill students and stakeholders of the impending challenges.

Adding to this perspective, Joshua Rider, the Executive Director of the Center for Adult and Veteran Services at Kent State University, had this to share:

> I have served in a leadership capacity in the area of military-connected student benefits for 16 years and have been a School Certifying Official [SCO] for 20 years. The recent debacle involving Chapter 35 benefits had the largest negative impact I have witnessed since the rollout of the Post-9/11 GI Bill in 2009-10 and the initial issues with paper checks. I would like to open by saying that this is an extremely vulnerable population, as they are the dependents and spouses of 100% Permanent/Totally disabled veterans.
>
> Kent State is just one of 37 publicly funded institutions in the state of Ohio. In the Fall 2025 term, we certified 297 Chapter 35 students. Of that number 50% were affected by the technical and processing errors. This means that 148 students were without $1,536 per month until December. That's $6,144 per student or $909,312 for the population. Those funds are used for both on and off-campus room and board. We worked with our students living in campus housing to ensure there were no issues with their food or housing. However, 40% of those affected students live off campus. For those 59 students, landlords and grocery stores are unwilling to assist with a $6,144 payment delay.
>
> In summary, these are vulnerable students who were stripped of entitled funds upon which they and their families depend to fund their most basic needs: food, shelter, and heat. Kent State is just one example. If you multiply that number by 37, the regional impact is immense.

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[102] Krupnick, Matt. "'Complete nightmare': Student veterans, advisers say VA cuts are derailing their educations," *The Hechinger Report*, (Aug. 12, 2025), https://hechingerreport.org/complete-nightmare-student-veterans-advisers-say-va-cuts-are-derailing-their-educations/.
[103] *Id.*

Recall that this was the third significant technology transition involving GI Bill payments in recent years that has caused considerable payment delays during implementation. Each was scheduled at the beginning of an academic term, when even minor interruptions can quickly lead to adverse outcomes for students. Modernizing systems is essential, but modernization that jeopardizes the delivery of core benefits is misguided. When the scheduling of VA's actions guarantees maximum disruption if anything goes wrong, the planning has already fallen short.

The recurring theme of "technical glitches" (and the newer theme of "contract failures") that inevitably leaves thousands of GI Bill students missing their education benefits is simply unacceptable. While VA always has an excuse for the error, the impact of these debacles falls on veterans and their families, who are forced to shoulder the burden of VA's repeated failures.

There are practical steps VA should adopt to ensure this is avoided moving forward. Congress should direct VA to avoid releasing education benefit system upgrades during critical enrollment or disbursement windows and require independent certification of readiness before launch. A continuity plan is needed so that if one system fails or is offline, another is ready to take over. VA must adopt more rigorous testing of technology solutions and independent verification of efficacy. VA should also implement staged technology rollouts that prevent failures from reaching students in the first place.

Institutions should receive clear guidance to avoid penalizing students for late payments due to circumstances beyond their control. Most importantly, when VA becomes aware of a significant risk to on-time payments, it should proactively share that information with students, institutions, policymakers, and advocates before financial harm occurs. Education benefits delivery must be treated as an essential function that does not pause when other parts of government do.

Student veterans, survivors, and their families do not view their education benefits as optional. Oftentimes, they plan their lives around these benefits because that is what they were told they could count on. VA must build on the lessons learned from these failures to reestablish trust with GI Bill students.

Summary of recommendations:

- Implement reliable technical safeguards, transparent timelines, and actionable contingency plans for any failure to administer education benefits as otherwise anticipated.
- Adopt more rigorous testing of technology solutions and independent verification of efficacy; implement staged technology rollouts that prevent failures from reaching students in the first place.
- Provide proactive, plain-language notifications to students, schools, and oversight entities whenever payment risks are identified.
- Avoid releasing education benefit system upgrades during critical student enrollment or disbursement windows; instead, deploy upgrades during times of the year that are less likely to affect students negatively, and require independent certification of readiness before launch.
- Finally, strengthen oversight requirements, mandate transparent performance metrics, and ensure that students are not left bearing the cost of VA's failures.

9. Change VA's debt collection practices against student veterans

VA's debt collection for "retroactive readjustments" of GI Bill benefits awarded to a veteran is of special concern, and we urge the Committees to halt this practice. A "retroactive readjustment" means that VA adjusts a veteran's GI Bill eligibility after the veteran has already used his GI Bill. If the problem was a VA error and a veteran relied on VA's procedures in good faith and was not engaging in malfeasance, then subjecting the veteran to debt collection is unfair.

One problem for veterans is that VA's letters alerting veterans of a debt are often confusing and sent to outdated addresses. While Section 1019 of the *Isakson-Roe* Act has addressed some of the underlying factors associated with GI Bill overpayments, the issue of VA debt collection practices has not been comprehensively addressed.

We support the prohibition of VA from executing clawbacks based "solely on administrative error" or "error in judgment," consistent with 38 U.S.C. § 5112(b)(10). However, it is our firm belief that VA defines administrative error quite narrowly based on the number of clawbacks that still occur.[104] For instance, VA takes the position that if the beneficiary "should have known" they were not entitled to the benefit, then the overpayment was not due solely to administrative error.[105] VA's assessment of whether a beneficiary should have known they were not entitled to the benefit may disregard the realistic and practical limits of a student veteran's understanding at the time of payment. It is also possible that the student's misunderstanding stems from information originally provided by VA.

We urge Congress to ban VA's authority to claw back overpayments when the overpayment is VA's error and establish a limitation period after which clawbacks are prohibited, except for fraud or malfeasance.

Summary of recommendations:

- Halt the practice of VA's "retroactive readjustments."
- Improve debt notification processes to prevent veterans from being surprised by unclear or outdated notices.
- Establish a limitations period after which GI Bill clawbacks are prohibited, except for fraud or malfeasance.

[104] VA regulations associated with debt collection are 38 C.F.R. § 21.9695(b) and 38 C.F.R. § 21.9635(r).
[105] A review of VA guidance on debt collection underscores how narrow VA interpretations are, especially in the case of administrative error. For reference, see https://www.knowva.ebenefits.va.gov/system/templates/selfservice/va_ssnew/help/customer/locale/en-US/portal/554400000001018/content/554400000179474/M21-1-Part-VI-Subpart-i-Chapter-2-Section-B-Correcting-the-Erroneous-Payment-of-Benefits-to-a-Beneficiary#3.

10. Forbid transcript withholding

Student veterans lack the same protections against transcript withholding as other students in higher education. Transcript withholding is a frequent practice wherein colleges withhold students' academic transcripts for outstanding balances, even when the debt is disputed, and can withhold transcripts even for minor charges like parking fees. It is one of the most common debt-collection tactics used by colleges across all sectors.

Hundreds of student veterans, service members, and their families have brought complaints to us about unfair transcript withholding and its negative impact on their lives. In March 2022, we published a report analyzing how transcript withholding affects the veteran and military communities.[106] Of these student veteran complaints we received:

- 35% are related to disputed debts, often due to inaccurate billing or students believing their GI Bill or other educational benefits from VA or DoD covered the cost of attendance.
- 34% are general complaints about transcript withholding.
- 20% are related to debt arising from deceptive or predatory institutional practices.
- 7% are related to closed school issues.
- 4% are related to complaints over loans that the veterans did not authorize.

Transcript withholding has particularly severe consequences for student veterans. It can prevent them from transferring schools, re-enrolling, or pursuing an advanced degree if they have already graduated. It can also undermine a student's eligibility for a job interview and even some military promotions.

While current ED regulations significantly limit transcript withholding, these rules are subject to change. We urge the Committees to enact Title 38 legislation to prohibit transcript withholding to collect outstanding debt from former students, irrespective of the periods covered by VA benefits, and we thank Representative John Mannion and James Moylan for championing this legislation.

Summary of recommendations:

- Pass *H.R. 5436, To amend title 38, United States Code, to prohibit an educational institution from withholding a transcript from an individual who pursued a course or program of education at such institution using Post-9/11 educational assistance.*

[106] Veterans Education Success, *The Student Veteran Experience with Transcript Withholding* (Mar. 2022), https://vetsedsuccess.org/the-student-veteran-experience-with-transcript-withholding/.

11. Strengthen Veteran Readiness & Employment

As outlined in our previous statements to Congress, we have continued to receive complaints from veterans about VR&E.[107, 108, 109] Recent complaints continue to tell the story that the process for VR&E benefits is often too complicated and stressful. Veterans get tired of fighting for what they deserve. All too often, some counselors prove to be unresponsive or even antagonistic to a veteran's interests.

Highlighted below are specific areas of concern raised by veterans who have contacted us, followed by recommendations for potential solutions to the challenges they face.

A. Veterans feel VR&E and its counselors steer them away from high-quality programs or push them to enroll in low-quality programs.

Many veterans have told us that VR&E counselors steer them away from top colleges and towards low-quality online programs. One recent veteran, a 100% disabled 12-year service member, was denied approval for an Ivy League business school. The counselor dismissed it as too expensive despite its clear career advantages and the likelihood of higher earnings. Veterans find the approval process arbitrary, as the same schools are approved for others.

B. Veterans complain that applying for and using VR&E benefits is too difficult; counselors have denied their admission to the VR&E program, denied their education program, or refused to cover certain programmatic costs without a reasonable explanation, causing tremendous stress.

One veteran was denied funding for essential coursework materials, including a laptop, with no apparent reason beyond a vague claim of insufficient funds. Others report difficulty using VR&E for graduate or professional degrees, with counselors blocking doctoral programs and instead approving degrees that do not align with their disabilities or vocational goals. Some counselors improperly decide that advanced degrees are unnecessary, even after veterans have already started their programs. Many veterans believe counselors lack training to assess how disabilities impact career options.

C. VR&E counselors are often challenging to reach and do not provide timely information and responses to veterans.

Veterans frequently report unresponsive, incompetent, or even antagonistic counselors who seem more focused on disqualifying them than helping. Some are repeatedly reassigned counselors, receiving conflicting guidance and decisions. Many worry about retaliation.

One veteran considered withdrawing from VR&E entirely after a year without a response from his counselor. A medically retired Army veteran struggled for over six months to even start the program.

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[107] Veterans Education Success, "VES Written Statement on Evaluating the Effectiveness of VA Vocational Rehabilitation and Employment Programs Before the House Committee on Veterans' Affairs Subcommittee on Economic Opportunity" (Jun. 4, 2019), https://vetsedsuccess.org/wp-content/uploads/2019/06/VES_SFR_VRE_06032019-1.pdf.

[108] Veterans Education Success, "Our Statement for the Record on the Topic of 'Veteran Readiness and Employment: Is VA Succeeding?'" (Sept. 15, 2022), https://vetsedsuccess.org/wp-content/uploads/2022/09/VES-SFR-VRE-Hearing-HVAC-EO-September-15-2022.pdf.

[109] Veterans Education Success, "Our Statement for the Record on the Topic of 'Examining the Effectiveness of the Veterans Readiness and Employment (VR&E) Program'" (Dec. 11, 2024), https://vetsedsuccess.org/wp-content/uploads/2024/12/Statement-For-the-Record-VRE-HVAC-EO-Dec-2024.pdf.

Based on the issues addressed above, we make the following recommendations for the Committees' consideration:

- **Staff Ratio.** Reduce the maximum client-to-counselor ratio from 125 to 85 to ensure veterans receive timely, individualized support. While VA has worked to reduce this number, 125 remains too high for counselors to address veterans' needs adequately, and veterans continue to report unresponsive counselors.
- **Counseling Consistency.** Require increased training for VR&E counselors to ensure consistent, high-quality guidance. Too many veterans are steered into low-quality schools while others are approved for top-tier institutions. Counselors should be trained to avoid recommending schools with federal caution flags or law enforcement actions. They should be empowered to approve graduate degrees when needed to help veterans achieve their vocational goals. Additional training and explicit guidance would improve program delivery and the veteran experience.
- **System Modernization.** Continue to improve and modernize the VR&E case management system to prevent payment delays and reduce administrative burdens. Given the financial hardships many veterans face, timely payments are critical. We commend the e-VA Document Repository and Automation Initiative, which significantly reduces the burden on both veterans and counselors by streamlining required documentation.
- **Housing Allowance Parity.** Establish a Monthly Housing Allowance (MHA) for VR&E students at rates comparable to the Post-9/11 GI Bill to keep pace with rising living costs.[110]

We thank the Committees for your attention to this critical issue and consideration of these recommendations. We will continue to provide feedback based on what we hear from the veterans with whom we work on an ongoing basis.

Summary of recommendations:

- Decrease the maximum client-to-counselor ratio from 125 to 85 to ensure veterans receive timely, individualized support.
- Mandate standardized, comprehensive training for VR&E counselors to ensure consistent, high-quality guidance, prevent arbitrary school denials, and adequately evaluate graduate and professional degree programs.
- Prohibit VR&E counselors from requiring veterans to attend low-quality online programs instead of high-quality, reputable colleges and from imposing sudden enrollment deadlines that force veterans into suboptimal education choices, and require reasonable accommodations for transcript access and administrative delays.
- Direct VA to modernize the case management system to prevent payment delays and reduce administrative burdens on veterans.
- Establish Monthly Housing Allowance parity between VR&E and Post-9/11 GI Bill students to reflect real cost-of-living needs.

[110] Veterans Education Success, "Statement for the Record, House Committee on Veterans' Affairs Economic Opportunity Subcommittee Hearing, *Getting Veterans to Work after COVID-19*" (Jul. 21, 2020), https://vetsedsuccess.org/our-sfr-for-july-21-hvac-economic-opportunity-subcommittee-hearing-getting-veterans-to-work-after-covid-19/.

12. Pass the Guard and Reserve GI Bill Parity Act so every day of service counts

We call on Congress to address a long-overdue issue affecting the eligibility of reserve component members for the Post-9/11 GI Bill® by passing the *Guard and Reserve GI Bill Parity Act*. The current law mandates that Guard and Reserve members must have served at least 90 cumulative or 30 continuous days on active duty to accrue "qualifying days," creating a disadvantage in accessing their deserved GI Bill educational benefits. Despite the obligation for reserve component members to "serve in uniform" and fulfill duty responsibilities for a minimum of 39 non-consecutive days each fiscal year, these periods of service do not contribute toward Post-9/11 GI Bill eligibility.

This discrepancy disadvantages reserve component members compared to their active component counterparts. While active duty members can receive Post-9/11 GI Bill credit for a training day, reservists currently cannot receive credit for the same service. The increased reliance on reserve capabilities has underscored the necessity for component interoperability. Unfortunately, the strides made toward interoperability have not been matched by fair recognition and rewards for the skills and efforts required.

An Operational Assessment of Reserve Component Forces in Afghanistan, conducted by the Institute for Defense Analyses, revealed no discernible performance differences between components in Operations Iraqi Freedom and Enduring Freedom. The study emphasizes that reserve forces were fulfilling their assigned tasks without significant variations from their active-duty counterparts. The shared burden and risk between both components highlight the importance of acknowledging the contributions of Guard and Reserve members.

To address this disparity, we strongly urge Congress to count all paid points days of Reserve and National Guard service members towards receiving the Post-9/11 GI Bill.[111] This encompasses days for training, active military service, inactive training, and general duty. This adjustment aims to ensure equitable treatment and recognizes the crucial contributions of reserve component members to military readiness. It is essential to promote fairness and acknowledge their vital role without compromising the integrity of the GI Bill system.

Summary of recommendations:

- Pass the Guard and Reserve GI Bill Parity Act so that a day in uniform truly counts as such.

[111] The term "paid points days" refers to days in which a service member receives credit in both retirement points and monetary compensation for that day of service. This is to differentiate between time served merely for points, such as off-duty education, versus time served for points and pay, such as a regular duty day.

Conclusion

Veterans Education Success sincerely appreciates the opportunity to express our legislative priorities before the Committees. The higher education industry continues to evolve in these dynamic times, and we emphasize the importance of maintaining high standards. Student veterans, taxpayers, and Congress must expect the best outcomes from the use of hard-earned GI Bill benefits.

We look forward to enacting these priorities and are grateful for the continued opportunities to collaborate on these initiatives.

Information Required by Rule XI, Clause 2(g)(4) of the House of Representatives and the Rules of the House Committee on Veterans' Affairs

Pursuant to Rule XI, clause 2(g)(4) of the House of Representatives, Veterans Education Success has not received any federal grants in Fiscal Year 2026, nor has it received any federal grants in the two previous Fiscal Years.

Information Required by the Rules of the House Committee on Veterans' Affairs Regarding Foreign Government and Foreign Adversary Funding

Pursuant to the Rules of the House Committee on Veterans Affairs, and consistent with the definitions set forth in P.L. 118-50, Division H, § 2(g)(1), Veterans Education Success has not received any contracts, grants, or payments originating with a foreign government, a foreign adversary-controlled entity, or an entity or country of particular concern.

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