

ENSURING VETERANS' SMOOTH TRANSITION ACT

JANUARY 6, 2022.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. TAKANO, from the Committee on Veterans' Affairs,
submitted the following

R E P O R T

together with

DISSENTING VIEWS

[To accompany H.R. 4673]

[Including cost estimate of the Congressional Budget Office]

The Committee on Veterans' Affairs, to whom was referred the bill (H.R. 4673) to amend title 38, United States Code, to provide for the automatic enrollment of eligible veterans in patient enrollment system of Department of Veterans Affairs, and for other purposes, having considered the same, reports favorably thereon without amendment and recommends that the bill do pass.

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PURPOSE AND SUMMARY

H.R. 4673, the Ensuring Veterans' Smooth Transition Act or the EVEST Act, was introduced by Chairman Mark Takano on July 22, 2021. H.R. 4673 would become effective upon passage into law and would provide for improvements to servicemembers' transitions to civilian life by automatically enrolling all eligible veterans into the Department of Veterans Affairs (VA) patient enrollment system.

BACKGROUND AND NEED FOR LEGISLATION

H.R. 4673 automatically enrolls eligible service members into VA healthcare during the transition process and gives service members an opt-out should they wish to not enroll. This is accomplished by the Department of Defense (DOD) providing information from the Defense Manpower Data Center (DMDC) to VA for purposes of enrollment. Veterans are provided notice within 60 days of enrollment and given instructions for how they may opt out.

Currently, veterans eligible for VA health care must proactively decide to enroll with VA using online, phone, or in person services. However, veterans often are unclear about their eligibility status, meaning that some attempt to enroll when they are not eligible, and many more fail to enroll due to a lack of understanding that they are eligible for care. For example, many of the 175,000 veterans who served in Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), and Operation New Dawn (OND) are unaware of their eligibility for five years of VA health care upon separation. These veterans would no longer have to guess their status—they would simply be enrolled, made aware of their enrollment, and be given an option of opt-out of care should they wish.

Providing care immediately upon separation is crucial for veterans, as the first few months after transitioning out of the military are a time of stress and place veterans at high risk for mental health challenges, including suicide. The Committee believes strongly that no veteran should have to struggle with navigating the VA bureaucracy to enroll in care. By ensuring a smooth care transition, this legislation will lower new veterans' risks for problems and promote easier access to care. Care that is offered sooner is more effective and likely to lower costs for VA and taxpayers. In addition, providing care when needed can reduce the likelihood of veterans becoming homeless or seriously ill.

This legislation has the support of many Veteran Service Organizations and health organizations such as Paralyzed Veterans of America, Disabled American Veterans, the Nurses Organization of Veterans Affairs, and the Veterans Healthcare Policy Institute (VHPI). VHPI noted that

a disproportionate number of veterans' suicide attempts occur during the period following separation from military service. That fact was the impetus underlying Executive Order 13822 granting VA mental health care for veterans during the transitional first year. Veterans are more likely to utilize these

life-saving mental health services if all their care is in one place. . . . The EVEST Act in turn would foster quicker access of VA health care that is critical in an acute crisis.

H.R. 4673 uses DoD systems that are already in place through DMDC and the Transition Assistance Program, as well as VA's existing patient enrollment system, to enable a warm handoff from DOD to VA.

HEARINGS

Pursuant to clause 3(c)(6) of rule XIII of the Rules of the House of Representatives, the Committee held the following hearings which were used to develop H.R. 4673:

On April 29, 2019, the House Veterans' Affairs Committee held a hearing titled "Tragic Trends: Suicide Prevention Among Veterans." The following witnesses testified: Dr. Shelli Avenevoli, Deputy Director, National Institutes of Mental Health, Dr. Keita Franklin, National Director of Suicide Prevention, Department of Veterans Affairs, Dr. Richard McKeon, Chief, Suicide Prevention Branch, Substance Abuse and Mental Health Services Administration, Dr. Richard Stone, Executive in Charge, Veterans Health Administration, Department of Veterans Affairs.

On May 21, 2019, the House Veterans' Affairs Committee held a joint hearing with the House Armed Services Committee titled "Military and Veteran Suicide: Understanding the Problem and Preparing for the Future." The following witnesses testified: Dr. Elizabeth Van Winkle, Executive Director, Force Resiliency, Office of the Under Secretary for Personnel and Readiness, U.S. Department of Defense, Captain Mike Colston, M.D., Director, Mental Health Policy and Oversight, U.S. Department of Defense, Dr. Keita Franklin, National Director of Suicide Prevention, U.S. Department of Veterans Affairs, Michael Fischer, Chief Readjustment Counseling Officer, U.S. Department of Veterans Affairs.

On January 29, 2020, the House Veterans' Affairs Committee held a hearing titled "Caring for Veterans in Crisis: Ensuring a Comprehensive Health System Approach." The following witnesses testified: Ms. Renee Oshinski, Deputy Under Secretary for Health for Operations and Management, Veterans Health Administration, U.S. Department of Veterans Affairs, Dr. David Carroll, Executive Director, Office of Mental Health and Suicide Prevention, Veterans Health Administration, U.S. Department of Veterans Affairs, Mr. Frederick Jackson, Senior Executive Director, Office of Security and Law Enforcement, U.S. Department of Veterans Affairs, Dr. Julie Kroviak, Deputy Assistant Inspector General for Healthcare Inspections, VA Office of Inspector General, U.S. Department of Veterans Affairs, Dr. C. Edward Coffey, Affiliate Professor of Psychiatry and Behavioral Sciences, Medical University of South Carolina Charleston, SC.

On September 9, 2020, the House Veterans' Affairs Committee held a legislative hearing on various bills introduced during the 116th Congress, including a discussion draft of H.R. 4673 which was included at that time in the Veterans Comprehensive Prevention, Access to Care, and Treatment (Vet-

erans COMPACT) Act of 2020. The following witnesses testified: Ms. Lindsay Church, Executive Director, Minority Veterans of America (MVA); Ms. Maureen Elias, Associate Legislative Director, Government Relations, Paralyzed Veterans of America (PVA); Ms. Joy Ilem, National Legislative Director, Disabled American Veterans (DAV); Mr. Patrick Murray, Director, National Legislative Service, Veterans of Foreign Wars (VFW); Dr. Russell Lemle, Veterans Healthcare Policy Institute (VHPI); and Mr. Jim Lorraine, Lt. Col., USAF, (Ret.), President & CEO, America's Warrior Partnership.

On May 12, 2020, the House Veterans' Affairs Committee Economic Opportunity Subcommittee held a hearing titled "Military Transition During the COVID-19 Pandemic." There were two witness panels for this hearing. The first panel saw the following witnesses testify: Vivian Richards, Program Manager, Minority Veterans of America, Dr. J. Michael Haynie, PhD., Vice Chancellor for Strategic Initiatives and Innovations, Institute for Veteran and Military Families, Syracuse University, Jennifer Dane Executive Director, Modern Military Association of America, Matt Stevens, Chief Executive Officer, The Honor Foundation, Carolyn Lee, Executive Director, The Manufacturing Institute, Patrick Murray, Legislative Director, Veterans of Foreign Wars. The second panel saw the following witnesses testify: William Mansell, Director, Defense Support Services, Department of Defense, James Rodriguez, Acting Assistant Secretary, Veterans' Employment & Training Service, Department of Labor, Cheryl Rawls, Executive Director, Outreach, Transition and Economic Development Service (OTED), Veterans Benefits Administration, Dr. Lawrencina Pierce, Deputy Director, Outreach, Transition and Economic Development Service (OTED), Veterans Benefits Administration, Joshua Lashbrook, Assistant Director of Operations Support and Digital GI Bill Program Lead, Education Service, Veterans Benefits Administration.

On September 22, 2021, the House Veterans' Affairs Committee held a hearing titled "Veterans Suicide Prevention: Innovative Research and Expanded Public Health Efforts." There were two witness panels for this hearing where the following witnesses testified. On the first panel: Kameron Matthews, MD, JD, Assistant Under Secretary for Health—Clinical Services, Matthew Miller, PhD, MPH, Executive Director, Suicide Prevention Program, Lisa Brenner, PhD, Director, Rocky Mountain Mental Illness Research Education and Clinical Center (MIRECC) for Suicide Prevention. On the second panel: Tammy Barlet, Deputy Legislative Director, Veterans of Foreign Wars (VFW), Kaitlynne Hetrick, Associate, Government Affairs Iraq and Afghanistan Veterans of America (IAVA), Jennifer Silva, Chief Program Officer Wounded Warrior Project (WWP), Chief William ("Bill") Smith, Chairman, National Indian Health Board (NIHB), Nick Armendariz, Veteran, Rajeev Ramchand, PhD, Co-Director, RAND Epstein Family Veterans Policy Research Institute, Senior Behavioral Scientist, RAND Corporation.

On October 27, 2021, the House Veterans Affairs Committee held a hearing titled "Lessons Learned? Building a Culture of

Patient Safety Withing the Veterans Health Administration.” There was one witness panel where the following witnesses testified: Dr. Julie Kroviak, Deputy Assistant Inspector General for Healthcare Inspections, Office of Inspector General, U.S. Department of Veterans Affairs, Ms. Sharon Silas, Director, Health Care Team, U.S. Government Accountability Office, Ms. Renee Oshinski, Assistant Under Secretary for Health for Operations, Veterans Health Administration, U.S. Department of Veterans Affairs, Dr. Gerard Cox, Assistant Under Secretary for Health for Quality and Patient Safety, Veterans Health Administration, U.S. Department of Veterans Affairs, Dr. Teresa Boyd, Network Director VA Northwest Health Network (VISN 20), Veterans Health Administration, U.S. Department of Veterans Affairs.

SUBCOMMITTEE CONSIDERATION

H.R. 4673 was not considered in Subcommittee.

COMMITTEE CONSIDERATION

On July 28, 2021, the Full Committee met in an open markup session, a quorum being present, and ordered H.R. 4673 reported favorably to the House of Representatives by a roll call vote of 16–10.

COMMITTEE VOTES

Clause 3(b) of rule XIII of the Rules of the House of Representatives requires the Committee to list the recorded votes on the motion to report the legislation and amendments thereto.

There was one amendment offered by Ranking Member Bost to H.R. 4673, which was not agreed to by a voice vote.

There was one recorded vote on a motion by Congressman Mike Levin of California to favorably report H.R. 4673, as introduced, to the U.S. House of Representatives, which was agreed to by a roll call vote of 16–10.

ONE HUNDRED SEVENTEENTH CONGRESS
 U.S. HOUSE OF REPRESENTATIVES
 COMMITTEE ON VETERANS' AFFAIRS

OPEN:	X
MEETING:	X
ROOM NUMBER:	Virtual

FULL COMMITTEE ROLL CALL VOTES

Date: 7/28/21

Roll Call #: 1

Bill No: H.R. 4673, Ensuring Veterans' Smooth Transition (EVEST) Act

Description: A motion to favorably report H.R. 4673, as introduced, to the U.S. House of Representatives, agreed to by a roll call vote of 16 – 10

NAME	AYE	NO	NOTES
MAJORITY MEMBERS			
1. Mark Takano, CA, Chairman	X		
2. Julia Brownley, CA	X		
3. Conor Lamb, PA	X		
4. Mike Levin, CA	X		
5. Chris Pappas, NH	X		
6. Elaine G. Luria, VA	X		
7. Frank Mrvan, IN	X		
8. Gregorio Kilili Camacho Sablan, MP	X		
9. Lauren Underwood, IL	X		
10. Colin Z. Allred, TX	X		
11. Lois Frankel, FL	X		
12. Anthony Brown, MD	X		
13. Elissa Slotkin, MI	X		
14. David Trone, MD	X		
15. Marcy Kaptur, OH			
16. Raul Ruiz, CA	X		
17. Ruben Gallego, AZ	X		
MINORITY MEMBERS			
18. Mike Bost, IL, Ranking Member		X	
19. Amata Coleman Radewagen, AS			
20. Jack Bergman, MI		X	
21. Jim Banks, IN		X	
22. Chip Roy, TX			
23. Greg Murphy, NC		X	
24. Tracey Mann, KS		X	
25. Barry Moore, AL		X	
26. Nancy Mace, SC			
27. Madison Cawthorn, NC		X	
28. Troy Nehls, TX		X	
29. Matt Rosendale, MT		X	
30. Mariannette Miller-Meeks, IA		X	
Total	16	10	

Mr. Chairman, for this vote there are 16 Ayes and 10 Noes.

COMMITTEE OVERSIGHT FINDINGS

In compliance with clause 3(c)(1) of rule XIII and clause (2)(b)(1) of rule X of the Rules of the House of Representatives, the Committee's oversight findings and recommendations are reflected in the descriptive portions of this report.

STATEMENT OF GENERAL PERFORMANCE GOALS AND OBJECTIVES

In accordance with clause 3(c)(4) of rule XIII of the Rules of the House of Representatives, the Committee establishes the following performance goals and objectives for this legislation: effective upon passage into law,

NEW BUDGET AUTHORITY, ENTITLEMENT AUTHORITY, AND TAX EXPENDITURES

In compliance with clause 3(c)(2) of rule XIII of the Rules of the House of Representatives, the Committee adopts as its own the estimate of new budget authority, entitlement authority, or tax expenditures or revenues contained in the cost estimate prepared by the Director of the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974.

EARMARKS AND TAX AND TARIFF BENEFITS

H.R. 4673 does not contain any Congressional earmarks, limited tax benefits, or limited tariff benefits as defined in clause 9 of rule XXI of the Rules of the House of Representatives.

COMMITTEE COST ESTIMATE

The Committee adopts as its own the cost estimate on H.R. 4673 prepared by the Director of the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974.

CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

Pursuant to clause 3(c)(3) of rule XIII of the Rules of the House of Representatives, the following is the cost estimate for H.R. 4673 provided by the Director of the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974:

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, December 13, 2021.

Hon. MARK TAKANO,
*Chairman, Committee on Veterans' Affairs,
House of Representatives, Washington, DC.*

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for H.R. 4673, the Ensuring Veterans' Smooth Transition Act.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contact is Etaf Khan.

Sincerely,

PHILLIP L. SWAGEL,
Director.

Enclosure.

H.R. 4673, Ensuring Veterans' Smooth Transition Act			
As ordered reported by the House Committee on Veterans' Affairs on July 28, 2021			
By Fiscal Year, Millions of Dollars	2022	2022-2026	2022-2031
Direct Spending (Outlays)	0	0	0
Revenues	0	0	0
Increase or Decrease (-) in the Deficit	0	0	0
Spending Subject to Appropriation (Outlays)	38	3,060	not estimated
Statutory pay-as-you-go procedures apply?	No	Mandate Effects	
Increases on-budget deficits in any of the four consecutive 10-year periods beginning in 2032?	No	Contains intergovernmental mandate?	No
		Contains private-sector mandate?	No

H.R. 4673 would require the Department of Veterans Affairs (VA) to automatically enroll eligible veterans in the department's patient enrollment system for VA health care benefits and services. That requirement would only apply to veterans who leave the armed forces after enactment. The bill also would require VA to provide veterans with an electronic mechanism for disenrolling from the VA health care system.

CBO expects that most newly separated and eligible veterans will enroll in VA health care under current law. Using data from VA, CBO estimates that under the bill about 58,000 additional veterans would be automatically enrolled in 2022, and a similar number of veterans would be enrolled in each subsequent year. After accounting for the voluntary disenrollment of some veterans, CBO estimates that about 250,000 of those who would be automatically enrolled would remain enrolled by 2026. Accounting for a gradual increase in the use of VA health care by automatically enrolled veterans, CBO estimates that those veterans would receive care that costs on average \$3,900 each year. In total, implementing that requirement would cost \$3.1 billion over the 2022–2026 period. Such spending would be subject to the appropriation of the estimated amounts.

The bill also would require VA to provide veterans with digital certificates of enrollment and an electronic method to opt out of the system. Using costs for similar information technology efforts, CBO estimates that satisfying those requirements would cost \$2 million over the 2022–2026 period. Such spending would be subject to the availability of appropriated funds.

The costs of the legislation, detailed in Table 1, fall within budget function 700 (veterans benefits and services).

TABLE 1.—ESTIMATED INCREASES IN SPENDING SUBJECT TO APPROPRIATION UNDER H.R. 4673

	By fiscal year, millions of dollars—					
	2022	2023	2024	2025	2026	2022–2026
Health Care (Auto-enroll):						
Estimated Authorization	42	130	411	960	1,745	3,288
Estimated Outlays	37	119	376	889	1,637	3,058

TABLE 1.—ESTIMATED INCREASES IN SPENDING SUBJECT TO APPROPRIATION UNDER H.R. 4673—Continued

	By fiscal year, millions of dollars—					
	2022	2023	2024	2025	2026	2022–2026
System Requirements:						
Estimated Authorization	1	*	*	*	*	2
Estimated Outlays	1	*	*	*	*	2
Total Changes:						
Estimated Authorization	43	130	411	960	1,746	3,290
Estimated Outlays	38	119	376	889	1,638	3,060

Components may not sum to totals because of rounding. * = between zero and \$500,000.

The CBO staff contact for this estimate is Etaf Khan. The estimate was reviewed by Leo Lex, Deputy Director of Budget Analysis.

FEDERAL MANDATES STATEMENT

The Committee adopts as its own the estimate of Federal mandates regarding H.R. 4673 prepared by the Director of the Congressional Budget Office pursuant to section 423 of the Unfunded Mandates Reform Act.

ADVISORY COMMITTEE STATEMENT

No advisory committees within the meaning of section 5(b) of the Federal Advisory Committee Act would be created by H.R. 4673.

CONSTITUTIONAL AUTHORITY STATEMENT

Pursuant to Article I, section 8 of the United States Constitution, H.R. 4673 is authorized by Congress' power to "provide for the common Defense and general Welfare of the United States."

APPLICABILITY TO LEGISLATIVE BRANCH

The Committee finds that H.R. 4673 does not relate to the terms and conditions of employment or access to public services or accommodations within the legislative branch.

STATEMENT ON DUPLICATION OF FEDERAL PROGRAMS

Pursuant to clause 3(c)(5) of rule XIII of the Rules of the House of Representatives, the Committee finds that no provision of H.R. 5545 establishes or reauthorizes a program of the Federal Government known to be duplicative of another Federal program, a program that was included in any report from the Government Accountability Office to Congress pursuant to section 21 of Public Law 111–139, or a program related to a program identified in the most recent Catalog of Federal Domestic Assistance.

DISCLOSURE OF DIRECTED RULEMAKING

Pursuant to clause 3(c)(5) of rule XIII, the Committee estimates that H.R. 4673 contains no directed rule making that would require the Secretary to prescribe regulations.

SECTION-BY-SECTION ANALYSIS OF THE LEGISLATION

Section 1: Short Title: This Act may be cited as the “Ensuring Veterans’ Smooth Transition Act” or the “EVEST Act”.

Section 2: Directs the Secretary of VA to use the DoD’s DMDC to automatically enroll veterans in the patient enrollment system. The Secretary is instructed to then provide all veterans enrolled under this act a notice within 60 days of veterans’ enrollment status and instructions for how veterans may opt out of such enrollment.

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3(e) of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italics, existing law in which no change is proposed is shown in roman):

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3(e) of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (new matter is printed in italics and existing law in which no change is proposed is shown in roman):

TITLE 38, UNITED STATES CODE

* * * * *

PART II—GENERAL BENEFITS

* * * * *

CHAPTER 17—HOSPITAL, NURSING HOME, DOMICILIARY, AND MEDICAL CARE

SUBCHAPTER I—GENERAL

* * * * *

§ 1705. Management of health care: patient enrollment system

(a) In managing the provision of hospital care and medical services under section 1710(a) of this title, the Secretary, in accordance with regulations the Secretary shall prescribe, shall establish and operate a system of annual patient enrollment. The Secretary shall manage the enrollment of veterans in accordance with the following priorities, in the order listed:

- (1) Veterans with service-connected disabilities rated 50 percent or greater and veterans who were awarded the medal of honor under section 7271, 8291, or 9271 of title 10 or section 491 of title 14.
- (2) Veterans with service-connected disabilities rated 30 percent or 40 percent.
- (3) Veterans who are former prisoners of war or who were awarded the Purple Heart, veterans with service-connected dis-

abilities rated 10 percent or 20 percent, and veterans described in subparagraphs (B) and (C) of section 1710(a)(2) of this title.

(4) Veterans who are in receipt of increased pension based on a need of regular aid and attendance or by reason of being permanently housebound and other veterans who are catastrophically disabled.

(5) Veterans not covered by paragraphs (1) through (4) who are unable to defray the expenses of necessary care as determined under section 1722(a) of this title.

(6) All other veterans eligible for hospital care, medical services, and nursing home care under section 1710(a)(2) of this title.

(7) Veterans described in section 1710(a)(3) of this title who are eligible for treatment as a low-income family under section 3(b) of the United States Housing Act of 1937 (42 U.S.C. 1437a(b)) for the area in which such veterans reside, regardless of whether such veterans are treated as single person families under paragraph (3)(A) of such section 3(b) or as families under paragraph (3)(B) of such section 3(b).

(8) Veterans described in section 1710(a)(3) of this title who are not covered by paragraph (7).

(b) In the design of an enrollment system under subsection (a), the Secretary—

(1) shall ensure that the system will be managed in a manner to ensure that the provision of care to enrollees is timely and acceptable in quality;

(2) may establish additional priorities within each priority group specified in subsection (a), as the Secretary determines necessary; and

(3) may provide for exceptions to the specified priorities where dictated by compelling medical reasons.

(c)(1) The Secretary may not provide hospital care or medical services to a veteran under paragraph (2) or (3) of section 1710(a) of this title unless the veteran enrolls in the system of patient enrollment established by the Secretary under subsection (a).

(2) The Secretary shall provide hospital care and medical services under section 1710(a)(1) of this title, and under subparagraph (B) of section 1710(a)(2) of this title, for the 12-month period following such veteran's discharge or release from service, to any veteran referred to in such sections for a disability specified in the applicable subparagraph of such section, notwithstanding the failure of the veteran to enroll in the system of patient enrollment referred to in subsection (a) of this section.

(d)(1) The Secretary shall enroll each veteran described in subsection (a) in the patient enrollment system under this section by not later than 60 days after receiving the information described in paragraph (3) with respect to the veteran.

(2) Not later than 60 days after enrolling a veteran under paragraph (1), the Secretary shall provide to the veteran—

(A) notice of the veteran's enrollment; and

(B) instructions for how the veteran may opt out of such enrollment, at the election of the veteran.

(3) The information described in this paragraph is the appropriate information concerning eligibility for enrollment in the patient enrollment system under this section, as provided by the De-

fense Manpower Data Center of the Department of Defense, or such successor entity of the Department.

* * * * *

MINORITY VIEWS

Clause 2(c) of rule XIII of the Rules of the House of Representatives requires each report by a committee on a public matter to include any additional, minority, supplemental, or dissenting views submitted pursuant to clause 2(1) of rule XI of the Rules of the House of Representatives by one or more members of the committee. The minority views of members of the Committee are as follows:

DISSENTING VIEWS

The Minority offers the following dissenting views regarding H.R. 4673.

H.R. 4673, the “Ensuring Veterans’ Smooth Transition Act” or “EVEST Act” is a bill introduced by Chairman Mark Takano July 22, 2021. This bill has no other co-sponsors, nor does it have a companion bill in the Senate. The bill directs the Secretary of the Department of Veterans Affairs (VA) to use information concerning eligibility for enrollment as provided by the Defense Manpower Data Center of Department of Defense to automatically enroll veterans in the patient enrollment system. All veterans enrolled under this act must receive notice within 60 days as to their enrollment status via an electronic version of the certificate of eligibility along with an electronic mechanism by which the veteran may opt out of such enrollment.

The Minority appreciates the intent of this bill, which is to support transitioning servicemembers by helping to connect them seamlessly with VA hospital care and medical services. Currently servicemembers are encouraged to enroll for VA healthcare and coached through the application process while attending mandatory Transition Assistance Program sessions prior to discharge or retirement. While in theory an automatic enrollment may appear less onerous, there are simply too many unknowns to proceed with this bill as written and without appropriate review.

First, the Majority has failed to exercise legislative due diligence. The Majority’s report of H.R. 4673, cites a September 9, 2020 House Veterans’ Affairs Full Committee a legislative hearing on various bills introduced during the 116th Congress, including a discussion draft of H.R. 4673 which was included at that time as a provision within in the Veterans Comprehensive Prevention, Access to Care, and Treatment (Veterans COMPACT) Act of 2020. VA did not testify at that hearing and its statement for the record did not address this specific language. Rather, the language considered at this hearing was limited to requiring the provision of hospital care and medical services to veterans during the one-year period following discharge or release from active service regardless of enrollment status. Here, the language in H.R. 4673 is extremely dissimilar in that it would create an automatic lifetime of eligibility for VA health care. The reliance on a dissimilar bill from a previous Congress is misplaced.

Moreover, current stakeholders have not had the opportunity to provide input into this legislation. Over half of the members of the Committee are new in the 117th Congress. Also, we have a new Administration. As such, Congress has not had the benefit of receiving testimony on this proposal. Many of the concerns posed below could have been addressed if the Majority had included this bill in one of number of legislative hearings held by the Sub-

committee on Health or the Subcommittee on Economic Opportunity in the last year.

Second, the Majority failed to consider the serious policy concerns regarding the potential impact on the VA healthcare system should this bill be enacted. No views have been provided by VA, VSOs, or any other stakeholders on the scope of this language. According to VA 2022 Budget documents, 9.2 million veterans are enrolled for hospital care and medical services. Of that number, 7.1 million veterans actually received treatment at a VA or community care facility. Budgets are determined by historical enrollment versus utilization. To increase enrollment without insight as to associated increases in utilization or other requirements would create a potential imbalance between budgetary needs and reality.

Third, to proceed with an expansion at this time is premature. Last Congress passed Public Law 116–171, the “Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019.” A provision in that law required VA to submit a strategic plan for the provision of health care to any veteran during the one-year period following the discharge or release of the veteran from active service. The plan has been delayed beyond its October 2021 required date due to coordination issues with the Department of Defense. This language recognized the need for, as well as the challenges of, offering blanket access to healthcare during the critical one-year transition period after leaving military service. This strategic plan is now expected to be released in early 2022.

Fourth, the Majority failed to consider the disparity among the veteran populations that this bill will create. The Majority rightly asserts in their report, that providing care immediately upon separation is crucial for veterans as the first few months after transitioning out of the military can be a time of stress and high risk for mental health challenges. The Minority joins in strongly believing that no veteran should have to struggle with navigating VA bureaucracy to enroll in care. The Minority also recognizes that the current priority group system that governs eligibility for care in the V.A. healthcare system is outdated and in need of reform. Unfortunately, automatic enrollment offered to only those who separate or retire on or after the date of bill enactment, that is only newly separating servicemembers, does not address the larger issue.

As we saw with the veteran demand for vaccinations among a population that is not eligible for VA healthcare due to income levels or lack of a service connection rating, a disparity will result from this bill which will certainly result in similar issues of equity. The Caregiver Program of Comprehensive Assistance for Family Caregivers is another example of the problems generated by inequitable treatment of one era of veterans versus another. The Majority’s report cites as an example that many of the 175,000 veterans who served in Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), and Operation New Dawn (OND) are unaware of their eligibility for five years of VA health care upon separation. Ironically, this bill will likely not help many of these veterans who have most likely already separated.

Finally, there are serious concerns as to the cost of this legislation and, given the lack of any VA testimony or formal views pre-

sented on this language, are equally unsure as to the true costs for this bill. The Congressional Budget Office (CBO) states that this bill will have a significant discretionary cost of \$3.1 billion over five years due to an influx of new veteran enrollees. In addition to the cost, Congress has no idea how significant the impact of an automatic enrollment will be on the VA healthcare system. This uncertainty includes potential impacts on access to care for other veterans with potentially greater needs, VA staffing and facility requirements, or impact on budgetary projections. Furthermore, there is no proposed offset for this discretionary spending. Since the beginning of the 117th Congress, the members of the Majority and Minority have joined in a pledge to address the needs of toxic-exposed servicemembers and veterans as a top priority. CBO has concluded that the cost to expand these benefits to toxic-exposed veterans will be in the hundreds of billions of dollars in both mandatory and discretionary costs. While the mechanics of addressing the needs of toxic-exposed veterans still a matter of debate, the Majority believes that committing to significant cost outside of this priority, and in a manner that may not impact this population, is premature.

During the Full Committee markup of the bill, I offered an amendment intended to address the Minority's grave concerns with Chairman Takano's language. The amendment would have replaced the underlying bill with the text from H.R. 1216, the Modernizing Veterans Health Care Eligibility Act, creating a bipartisan commission to evaluate eligibility for care and to recommend a path to improving eligibility for not only transitioning servicemembers but also for other groups of veterans who are, arguably, not well-served today. This amendment was voted down by the Majority. Not only would this amendment have provided a more measured, fiscally responsible, and frankly more veteran-focused approach to enrollment eligibility for VA healthcare, it would have included all veterans not just those separating or retiring after passage of H.R. 4673. This amendment would have given the Committee the information, data, and time needed to consider expanding responsibly, an opportunity to understand the true cost and implications of enrolling more veterans in VA healthcare, and most importantly to gather the views of not only VA but numerous other stakeholders in the process. In failing to address the larger issue of enrollment, and equity in eligibility, I am unable to support H.R. 4673.

MIKE BOST,
Ranking Member.

