S. HRG. 119–247

HEARING TO CONSIDER PENDING LEGISLATION

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

ONE HUNDRED NINETEENTH CONGRESS

FIRST SESSION

DECEMBER 10, 2025

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HEARING TO CONSIDER PENDING LEGISLATION

WEDNESDAY, DECEMBER 10, 2025

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

The Committee met, pursuant to notice, at 4:01 p.m., in Room SR–418, Russell Senate Office Building, Hon. Jerry Moran, Chairman of the Committee, presiding.

Present: Senators Moran, Boozman, Tillis, Cramer, Sheehy, Blumenthal, Murray, Hassan, King, and Slotkin.

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

Chairman MORAN. Good afternoon. Our Committee will come to order. I express my gratitude to our witnesses for joining us today. We're going to consider 24 pieces of legislation sponsored by me, the Ranking Member, and Senators from both sides of the aisle.

That includes two bills that I introduced; the Fisher House Availability Act would allow families of service members to stay at VA Fisher Houses if the service member is being treated at a nearby VA Fisher House—I'm sorry, I didn't say that right—is being treated near a VA Fisher House while still prioritizing space for family members of VA patients; and the SERVE Act, which would improve relationships between the VA medical centers and military treatment facilities to improve access to care for service members and veterans, and increase training opportunities for the VA and DoD healthcare providers.

I appreciate the support of this legislation, that it's received from my colleagues and across Capitol Hill, as well as from veterans service organizations community, and I'm pleased to see its inclusion in fiscal year 2026 NDAA. I look forward to it being enacted into law, and seeing how it will benefit the veteran and military communities moving forward.

And turning back to today's hearing, as we move away a moment from NDAA, the bills on the agenda today represent a number of bipartisan priorities that would build on the successes Congress has achieved in expanding access to care and benefits for veteran survivors and their families. A notion that all of us on this Committee share.

I'm grateful to the sponsors of all of these bills for their work on these pieces of legislation. I'm grateful to the VA for providing technical assistance on the legislation, and to our veterans service orga-

nizations partners for working well with us to improve and advance the bills.

With that, I yield to the Ranking Member, Senator Blumenthal.

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

Senator BLUMENTHAL. Thanks, Mr. Chairman. I appreciate the opportunity to hear testimony on some very important bipartisan legislation today. But before we begin, I think we have to recognize the importance of votes that we will take tomorrow, one of them to extend the healthcare tax credits under the Affordable Care Act (ACA) that will affect literally 267,000 veterans who rely on the ACA enhanced premium tax credits to afford health insurance.

And whether you support the ACA, whether you have other views on what might be a perfect system in the long run, if we had tons of time; the simple fact is we face a deadline of the end of the year when these tax credits will expire, and 267,000 veterans will no longer be able to afford ACA coverage if these credits are not extended. These are primarily veterans who are not eligible for Medicaid, TRICARE, or Medicare, and often not eligible to get their care through the VA, leaving them with the ACA Marketplace plans as the only option for healthcare coverage.

The ACA isn't perfect. We need to lower the costs of healthcare generally. We need to work on reforms, and we need to eliminate any fraud that exists in these programs. But the fact of the matter is, the consequences of failing to extend these tax credits will be devastating for veterans and their families. Veterans will be forced to navigate a perfect storm, an understaffed VA healthcare system, increased wait times for VA healthcare, Medicaid cuts, and the loss of affordable health insurance. They deserve better. So, do millions of Americans who will be impacted by the potential failure to extend these tax credits. I hope that we approve them to the benefit of those veterans and countless other Americans affected.

On the legislation today, I want to particularly thank Mr. Stichman for his work alongside the Yale Veterans Legal Services Clinic to improve how a federal appellate court's process VA appeals. I've worked with the Yale Veterans Legal Services Clinic over the years, and I know how important their work is.

Generally, the Veterans Appeals Efficiency Act, which I co-led with Senator Banks, is one of the many bills that we're here to discuss. And I will be supporting many, if not all of them, for example, the Molly Loomis Act, which would build on the promise of the PACT Act by exploring health conditions prevalent among descendants of veterans who were exposed to toxic substances during their service.

And we have to confront as well the painful legacy of discrimination. The Commission on Equity and Reconciliation in the Uniformed Services Act would investigate the harm done to LGBTQ+ service members and veterans, many of whom received punitive discharges, and were forced to hide their identities, and ultimately, denied benefits.

These measures are not partisan. This Committee generally is not partisan. And I welcome the support of my Republican col-

leagues for many of these important measures that we hopefully will advance after today's hearing. Thank you.

Chairman MORAN. Thank you, Ranking Member. I'll introduce our first panel. Testifying today from the Department of Veterans Affairs is Margarita Devlin, the Principal Deputy Under Secretary for Benefits. And she's accompanied by Thomas O'Toole, the Acting Assistant Under Secretary for Health for Clinical Services, Veterans Health Administration.

Thank you both for being here. And Ms. Devlin, I now recognize you for your opening statement.

PANEL I

STATEMENT OF MARGARITA DEVLIN, MA, CRC, PRINCIPAL DEPUTY UNDER SECRETARY FOR BENEFITS, U.S. DEPARTMENT OF VETERANS AFFAIRS ACCOMPANIED BY THOMAS O'TOOLE, MD, ACTING ASSISTANT UNDER SECRETARY FOR HEALTH FOR CLINICAL SERVICES, VETERANS HEALTH ADMINISTRATION

Ms. DEVLIN. Good afternoon, Chairman Moran, and Ranking Member Blumenthal. Thank you for inviting us to speak on VA's views on the legislation before us today. I am joined by Dr. Thomas O'Toole, Deputy Assistant Under Secretary for Health from the Veterans Administration.

Before we begin, I'd like to apologize for the delay in providing testimony to this Committee. VA is working on process improvements, internally as well as externally, to ensure that this is prevented in the future.

Chairman MORAN. Thank you for your regrets and apologies, and we'll consider this probably most likely external challenges. Thank you very much.

Ms. DEVLIN. Thank you. There are 24 bills on today's agenda, and while I won't be able to address each one of them in my opening remarks, I welcome the opportunity to answer your questions and provide any additional information the Committee may need.

VA's full views on the bills are submitted for the record in written testimony. VA has noted in our official views where important amendments would be needed to ensure feasibility of implementation. I will highlight several bills where VA either supports or supports the intent.

VA supports the Fisher House Availability Act of 2025, introduced by Chairman Moran. This bill would expand access to temporary lodging in Fisher Houses or other appropriate facilities for veterans and their families, not only when the veteran is receiving care, but also when a family member is receiving care. We appreciate the Chairman's leadership on this compassionate and practical proposal, and support the bill subject to availability of appropriations.

VA also supports the intent of the SERVE Act, also introduced by Chairman Moran, which seeks to improve access to care for veterans by leveraging the Department of War facilities and providers. While VA does not support the bill as currently drafted, we value our longstanding partnership with the Department of War, and are

confident that our cooperative relationship will continue to ensure veterans receive high quality care. We welcome the opportunity to work with the Committee to refine the bill's language, and ensure clarity around provider roles, veteran choice, and coordination of care.

Suicide prevention remains one of Secretary Collins' top priorities, and VA appreciates the intent behind the Saving Our Veterans Lives Act, introduced by Senator King. While we do not support the bill as drafted due to concerns about scope and cost, particularly the $5 million annual authorization, we are proud to report that VA has already launched a lockbox distribution program for enrolled veterans at medium to high risk of suicide who have access to firearms. This program includes provider ordering, tracking, and distribution, and is supported by VA's mandatory suicide prevention training, VA S.A.V.E., which continues to be updated and expanded.

VA appreciates the intent of the Molly R. Loomis Act, which would mandate research on health conditions in descendants of veterans exposed to toxic substances. While we support the goal of better understanding long-term impacts, we believe our existing programs, particularly those conducted in partnership with the National Academies of Sciences, already provides a robust framework for this research.

VA supports the intent of the Purple Heart Veterans Education Act, introduced by Senator Murray, which would allow Purple Heart recipients to transfer Post-9/11 GI Bill benefits to dependents. However, we recommend amending the bill to clarify the role of the Secretary of War in the transfer process, as current law requires coordination with the Department of War for approval and management of transferred benefits.

The VA appreciates the intent of the Obligations to Aberdeen's Trusted Heroes or OATH Act of 2025, introduced by Ranking Member Blumenthal. While VA cites concerns regarding various sections as written, and subject to appropriations, we welcome the opportunity to continue working with you and your staff to amend the language.

VA also appreciates the goals of the Veterans Appeals Efficiency Act, introduced by Senator Banks and Ranking Member Blumenthal. We support efforts to improve transparency in the appeals process, but recommend amendments to ensure feasibility. For example, we suggest reporting legacy and AMA appeals remand separately, which would allow VA a sunset reporting on legacy remand once they are completed.

We also recommend against the requirement to track and report when VBA adjudicators do not follow board remand instructions. Implementing this would require building a new review system for all post-remand decisions, demanding significant staff and IT resources. Even with system upgrades, VA anticipates several challenges in accurately tracking non-compliance. For instance, if the agency of original jurisdiction grants a claim without following the board's instructions, it's unclear whether that outcome would be considered non-compliance under the bill's language.

Furthermore, under the Appeals Modernization Act, post-remand decisions are not automatically returned to the board. As a result,

VA cannot confirm compliance with remand instructions unless the veteran chooses to appeal.

Mr. Chairman, that concludes my statement. Thank you again for the opportunity to discuss these important legislative proposals to improve benefits for veterans, service members and their families. While I was unable to cover all the bills in my opening remarks, my colleague and I will be happy to answer any questions the Committee may have.

[The prepared statement of Ms. Devlin appears on pages 37–96 of the Appendix.]

Chairman MORAN. Thank you, Ms. Devlin. And I thank you and the VA for providing technical assistance in support of the SERVE Act, which I have indicated earlier, is now included in this year's NDAA.

Ms. Devlin and Dr. O'Toole, besides the mandates that are included in the SERVE Act to improve healthcare resource sharing between the VA and DoD, how else do you think the VA, DoD, and Congress could work together to improve access to care for service members and veterans in both of these federal healthcare programs? What do we do to make this a better broader system?

Ms. DEVLIN. I'll ask my colleague from VHA to answer that.

Dr. O'TOOLE. Thank you, Senator. And I think the question speaks to, I think, an opportunity for us. Both systems have a long history of collaborating together. Both systems have a shared mission, and clearly, we want to also ultimately improve the transition from active duty to civilian life, and hopefully, VA care.

I think there are several things that we, I think the SERVE Act is a great step forward for us, and I appreciate the opportunity for us to continue to work with you and your staff on some of the concerns that we have. I think as we move forward, issues of the processes of credentialing, and privileging, and potentially working together with clinicians in military treatment facilities in a more seamless capacity is an opportunity.

I look at models that we have, for instance, with the Lovell FHCC and Chicago health system as a strong collaborative model for us to continue to develop. But you know, I think this is an important and prioritized area for us.

Chairman MORAN. Thank you for those suggestions and those comments. I want to speak just a moment about Fisher House, and express my gratitude to those involved in Fisher House for the tremendous service they provide to veterans and to service members. The issue that's addressed in this legislation was in part a result from the VA continuing a practice that they had previously due to lack of clarity in the law.

This bill is designed to make clarity, and I want to make sure that you agree to support this legislation. But there's no question, what that clarity is now. Let me say it this way, that ambiguity is no longer going to necessitate any decline of the opportunity to serve service members' families.

Dr. O'TOOLE. Happy to speak to that. And that is exactly what we have heard from our facilities, is they've also looked at the bill that this provides that level of clarity. So, thank you.

Chairman MORAN. And then, finally, let me turn to Senator Blumenthal—Senator Blumenthal.

Senator BLUMENTHAL. Thanks, Mr. Chairman. I want to focus on the ACA tax credits. I've seen an estimate that a 1-percent increase in reliance by veterans on VA healthcare produces $2.6 billion in additional costs. So, if 267,000 veterans are denied the ACA tax credits and they are not extended, presumably some major number will go to the VA healthcare system, significantly raising the cost to the VA. Have you done an analysis on the impact on the VA healthcare system of 267,000 veterans losing their ACA health insurance coverage?

Dr. O'TOOLE. Yes, I'm not aware of an analysis. I would definitely—I take your word in terms of that transition, but I can't speak to any specific analyses or numbers and would have to take it for the record, sir.

Senator BLUMENTHAL. So, it would be fair to say that the additional cost of VA healthcare system is going to be in the billions of dollars if we fail, that is, if the United States Senate failed to vote tomorrow to extend these healthcare subsidies?

Dr. O'TOOLE. Based on what you're describing in terms of the numbers and your analyses, yes, sir.

Senator BLUMENTHAL. And you don't dispute them?

Dr. O'TOOLE. No reason to dispute them. But I also, again, want to be clear that I we have not done the analysis. I have not done the analysis to be able to——

Senator BLUMENTHAL. Well, you'd be in a position to dispute them if they sounded wildly wrong.

Dr. O'TOOLE. Yes, if they sounded wildly, yes, I would.

Senator BLUMENTHAL. You know there have been recent reports about the apparent demise of the DOGE program, but the VA still has yet to share, by the way, despite bipartisan requests; a full list of the thousands of contracts that have been cut by Secretary Collins in connection with the DOGE Elon Musk program.

The VA has yet to respond to my May 19th letter demanding a full accounting of these haphazard cuts. And despite promises from multiple VA leaders to brief this Committee on the cuts, we have yet to receive a briefing within the VBA and the VHA. Do you have a full list of all the contracts canceled as a consequence of DOGE, or because of the slashing cuts made by the VA Secretary?

Ms. DEVLIN. Senator, thank you for the question. I rejoined VBA in May of this year, so I wasn't there for the DOGE activities. However, I can tell you that we have the contracts that we need to support our mission.

Senator BLUMENTHAL. Well, do you have a list of all the contracts that have been canceled?

Ms. DEVLIN. I don't personally have that list, no.

Senator BLUMENTHAL. Does anyone?

Ms. DEVLIN. I'd have to get back to you on that, sir.

Senator BLUMENTHAL. Do you know, Dr. O'Toole?

Dr. O'TOOLE. I don't, and again, I'd have to—we'd have to get back to you on that.

Senator BLUMENTHAL. I can't speak for the Committee, but I can for myself. I have no clue as to what excuse there could be for failing to provide us with that list after so many months, so many

communications in hearings, and the letter that I did. So, if you could take that message back, I would appreciate it.

Dr. O'Toole, the last time you were here was in May. My office sent a request to the VA immediately preceding that hearing for data that we used to receive from the department. Some of it was publicly available, regarding VA and community care wait times, VA wait times, and community care wait times. 200 days later since I made that request, I have not received any of the information that I asked for.

As the Deputy Assistant Under Secretary for Health for Clinical Services, you oversee VHA field operations. When was the last time you received updates on wait times at the VA or for community care?

Dr. O'TOOLE. Well, sir, we track IC data related to VA wait times on a frequent basis. And we do track that. I would have to defer to my colleagues in the IVC office in terms of what the community wait times are.

Senator BLUMENTHAL. Can you give us an update?

Dr. O'TOOLE. Off the top of my head, no, but I'm happy to, you know——

Senator BLUMENTHAL. Can you give us an update before we leave for the holiday break?

Dr. O'TOOLE. I will definitely try to, sir. Yes.

Senator BLUMENTHAL. Thank you. my time has expired. That completes my questions. Thank you.

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

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

Senator TILLIS. Thank you, Mr. Chair. Dr. O'Toole, Senator Blumenthal asked you about the 250,000 or so people who may be on ACA subsidized care. Do we know whether or not—I mean, can you try and identify—frankly, if they're VA-eligible, I would prefer for them to be getting care from the VA. I understand the fiscal impact, but this may represent an opportunity to find a swathe of people who are going out to the exchange buying healthcare coverage when we can give them the extraordinary coverage that they could get within the VA.

The concern I have with that is it's kind of like calling roll by asking people who are absent to raise their hand? How would we find those people and what was the basis for the analytics? I mean, it's one thing to estimate, but how can we get to a level of granularity where we know who they are, and we can reach out to them and say there is an alternative whether or not the subsidies get extended?

Dr. O'TOOLE. Yes, it's a great question, sir. And, you know, having been practicing in the VA for 20 years, I'm always an advocate of the care that we provide in that system. I don't know, and we'd have to get back to you in terms of what type of——

Senator TILLIS. And clearly, if we have an influx and covered veterans, then we're going to have to deal with funding. But if they're not getting the subsidy on the exchange, there may be a source of funding there that we should talk about. So, I think it would be

helpful for us to get that regardless of what occurs, because I'm always looking for veterans to get the best care that they can. And I believe that's through the VA when given the option, if they're eligible for it.

Ms. Devlin, you covered, I think, about 8 or 10 of the bills on the list that I have before me. Do you have a formal position that you've communicated to us on the other pending bills, the longer list?

Ms. DEVLIN. Yes, sir. We submitted testimony for the record on all bills.

Senator TILLIS. Okay. I haven't seen it. Are there any hard nos? Not only do you not agree with the intent, you think it's a bad idea?

Ms. DEVLIN. We did have some opposition.

Senator TILLIS. Like, as in "No, we don't want this policy to be passed," and that's in the record?

Ms. DEVLIN. Yes.

Senator TILLIS. Thank you. Then the only other question I had specifically—actually, let me see if I can find the bill. Oh, yes, 2807, Restoring Eligibility Standards for Placement in Eligible Cemeteries. What's your position on that?

Ms. DEVLIN. Thank you for the question. Our NCA partners are not here to testify on that bill. We——

Senator TILLIS. But was that submitted to the record?

Ms. DEVLIN. It was, sir.

Senator TILLIS. And what was the position in the record?

Ms. DEVLIN. If you can give just one moment, I will look it up in the testimony [turns pages in notebook]. If you'd like to ask me another question while I look it up?

Senator TILLIS. No, that's the last one.

Ms. DEVLIN. Oh, okay.

Senator TILLIS. Sooner you get that one, sooner you get rid of me.

Ms. DEVLIN. Trying to avoid the awkwardness of going through the——

Senator TILLIS. That's okay. Appreciate your preparation.

Ms. DEVLIN. Absolutely, yes, sir. Thankfully, they're in numerical order.

Senator TILLIS. Yes. If staff have feedback, y'all can whisper in my ear, too.

Ms. DEVLIN. I wanted to give you the exact language just so that I don't go on the record with the wrong language.

Senator TILLIS. Well, the only reason out this entire list, I think I'm only co-sponsor on the Purple Heart Veterans Education Act. But that one gets out to me. It stands out in that I think that we have to have pretty significant consultation with the DOJ.

It sounds like, directionally, you are supportive. I've had the staff provide me something, but we really need to get that right. There are clearly instances where I can think of a tragic event in North Carolina where it would be appropriate for this, I believe, my personal opinion, appropriate.

The circumstances at face value would not justify maybe making an exception. But I do think we need to look at it, but we need to have a very tight set of standards, and I think strong consultation with DOJ before I'd be willing to support it. Thank you, Mr. Chair.

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

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

Senator MURRAY. Thank you, Mr. Chairman. You know, President Trump came into office saying that he would make IVF free. Instead, not only has the President not done a thing to lower the cost of IVF, he stood by as Speaker Johnson cut a very straightforward provision to make IVF more affordable for service members as part of this year's NDAA. And on that note, I'm really disappointed to see that my Veteran Families Health Services Act was left off of the agenda today. That bill would give more service members and veterans the opportunity to grow their families, including through IVF, by expanding the fertility services that are covered under VA and DoD healthcare.

It just seems like Republicans in this Administration really talk a big game about IVF, but when it comes to actual policy, it's pretty clear who's in the driver's seat; anti-abortion extremists like Speaker Johnson. So, I just want to make it clear, I think it's pretty outrageous that Republicans won't lift a finger to help our service members, or anyone for that matter, to access IVF. And I think it is really important everybody here understands that.

Dr. O'Toole, are you aware that service members face a higher rate of infertility compared to the rest of the population?

Dr. O'TOOLE. I am not directly familiar with it, ma'am, but I take your word on it.

Senator MURRAY. Well, it is true. And our service members, as we all know, they lay their lives on the line for our country. And I really believe, and I think many people do, that the least we can do is help them start their families when they come home. So, again, I'm registering my deep disappointment and hope that that can change.

Let me move on. As the daughter of a Purple Heart veteran, I know how much they sacrifice for our country. I take seriously our responsibility to be there for them when they need it the most. And unfortunately, right now, not all Purple Heart veterans are treated equally when it comes to their benefits. For example, post-9/11 veterans can transfer their GI benefits to their descendants while they're still in service.

However, one of my constituents reached out to tell me about a problem he was facing because he received his Purple Heart after his service and was unable to transfer his GI Bill benefits to his daughter when she was looking to go to college. So, the bill that I'm offering, which I'm glad to see on the agenda today, would fix that loophole.

Ms. Devlin, you mentioned you wanted to see some changes, but let me just ask you, are you supportive of this legislation?

Ms. DEVLIN. We do support the intent of this, and it's really technical amendments to ensure Department of War is involved in the process as they're responsible for the process of transferring eligibility.

Senator MURRAY. Well, I'm happy to talk with you about what your recommendations are, but I think this is a really important piece of legislation. I hope we can move on it.

And let me ask about the Molly R. Loomis Research for Descendants of Toxic Exposed Veterans Act. This is a bill that's really near and dear to me. Molly is a Washington State resident. She was born with spina bifida and it's believed to be caused by her father's exposure to Agent Orange when he served in Vietnam. And despite research showing descendants of toxic-exposed veterans experience lifelong medical issues, there is yet to be a comprehensive government-led study of this issue.

So, my bill simply takes a very critical step forward by requiring research on health conditions that are prevalent in the descendants of veterans who were exposed to toxic substances during their service. Ms. Devlin, talk a little bit first about how this research would prepare VA to help future generations of veterans who've been affected by toxic exposure.

Ms. DEVLIN. Thank you for the question. We take research objectives very seriously. And of course, for individuals with spina bifida whose parents were exposed to toxic substances, there is the Chapter 18 program which supports them. And that program continues today to support those dependents.

There has been no significant association that we've seen through the National Academy of Sciences research to indicate that there are generational impacts based on toxic exposures, but we do have the infrastructure in place. And in fact, with the PACT Act, we have the infrastructure in place to determine which research objectives to take on with the working groups that exist already.

Senator MURRAY. Well, it's my understanding that there is research showing that descendants of toxic-exposed veterans do experience lifelong medical issues. I think it is really important for us to look at this to make sure they are getting the support they need. So, I thank you for your inclusion of this bill on the agenda today.

Chairman MORAN. Senator Murray, thank you. I have taken an interest a long time ago in regard to next generation affecting the next generation by service of their parents or their grandparents. And look forward to working with you on this and other pieces of legislation.

Senator MURRAY. Thank you.

Chairman MORAN. Senator Cramer.

HON. KEVIN CRAMER,
U.S. SENATOR FROM NORTH DAKOTA

Senator CRAMER. Thank you, Mr. Chairman. And thank you both for being here today. I want to talk a little bit about and get some feedback on my legislation that I introduced with Senator Sheehy from Montana, an even larger and more rural state than North Dakota. It's called the Critical Access for Veterans Care Act.

I believe you're familiar with it. I mean, the VA did testify to it, I know. I'm going to just read a little bit of it. It reads a little bit like the girls I used to ask out in high school, and they'd say, well, we like you a lot and you have a good personality. Says, "The VA strongly agrees with the intent to improve the quality and availability of care to veterans in highly rural areas like Montana and North Dakota. We support the goal of improving access for rural veterans and want to work with the Committee to clarify how this new authority would integrate with existing VA care processes."

You know, in states as rural as North Dakota and Montana, we have very limited VA providers and facilities. In North Dakota, we have one hospital in Fargo, which is the very eastern edge of the state, we have, I think, eight CBOCs, and the community care program literally can be a lifeline. And I say can be because the thing that prevents it from being a lifeline as often as it ought to be, is of course, are all the roadblocks that get put up; all the fine print, all the exceptions, all the slow walking and administrative hurdles for the veterans and the providers themselves to participate.

So, we've seen some administrations, prior administrations, intentionally put up some of these roadblocks and to deter veterans from using these options, even though it's the law and an option that we've all told veterans many times it's available to them.

After hearing from veterans and rural healthcare providers and leaders across North Dakota, I proposed the solution, as I said, with Senator Sheehy. And it was to simplify access to the critical access network, whether it's critical access hospitals rural health clinics, and the model.

And as a point of emphasis, you guys, critical access is a designation specific to healthcare providers where they're the only hospital or the only provider in an entire region many miles between the providers. Our system, our VA system, effectively discriminates against our veterans compared to their neighbors, their non-veteran neighbors and friends and family, by giving them less access to care that's readily available than they have currently.

And so, I mean, we just have so much opportunity here. Obviously, I'm always willing to work to improve the details of legislation. We want to get it right. But parts of the testimony seem to indicate that the VA wants to maintain the control, and that's always the deal. All the good language in the world. However, you know, as long as we agree that that's not really a culture change that's maintaining of control.

So, the goal is to give rural veterans access to local critical access hospitals without the strings attached. I mean, we talk about wait lines in the waiting room that Senator Blumenthal talked about. That is one thing. But the wait lines we're talking about are days, and weeks, and months to get permission to get the care that they need across the street, rather than across the state. So, I understand, and again, want to make the language clear.

You probably hear it quite a bit, I know I do, that prior authorization process for veterans is a nightmare. It not only takes a long time, and oftentimes gets the wrong result, but it's just awful to do. So, anyway, I worry that if the bill's watered down, quite honestly, that we turn this authority back over to the bureaucracy to decide.

I want to say I've got a lot of support, Mr. Chairman, and I have several letters here, including from the American Hospital Association supporting the legislation as it is, other leaders, rural healthcare leaders from across North Dakota. And I would like to submit them all for the record, if it's okay.

Chairman MORAN. Without objection, so ordered.

[The information referred to appears on pages 129–136 of the Appendix.]

Senator CRAMER. All right. Anyway, with whatever time remain, which is now 25 seconds, Dr. O'Toole, maybe you could just elaborate a little bit on my rant.

Dr. O'TOOLE. Sure. I thank you, Senator. And let me say, you know, first we strongly support definitely the intent and the need for this legislation as it relates to rural veterans. I think the sticking point, which you noted, is really how do we create some clarity in language and direction as it relates to prior authorization versus clinical necessity. That can be achievable, and we're very much looking forward to working with you and how we get appropriate language to make that work.

Senator CRAMER. Thank you.

Chairman CRAMER. Senator Hassan.

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

Senator HASSAN. Well, thanks, Mr. Chairman, and Ranking Member Blumenthal for the hearing. To both Ms. Devlin and Dr. O'Toole, thank you for your service to our Nation's veterans.

Ms. Devlin, this may actually be a question that Dr. O'Toole is better positioned to answer, but as you both know, in May, President Trump signed an Executive order that required the Secretary of the VA to direct a feasibility study and create an action plan regarding bringing a full service VA hospital to New Hampshire. This action plan was due to the President last month.

A few weeks ago, my New Hampshire colleagues and I wrote a letter to the Secretary asking him to make that action plan publicly available so that Granite Staters can see it, have input, provide feedback. So, can you, whichever one of you is in a better position to respond, can you please tell me when this action plan will be made available for my constituents to review and comment on?

Dr. O'TOOLE. Senator, I'll take that one on. I don't have the specific information. I will say that this is a priority of the Secretary. It is something that I know a lot of people are working on, and we will take it for the record to get that information for you.

Senator HASSAN. I would appreciate that. We liked having the Secretary come in person to Manchester a little bit ago. It was a really good visit, but we really need to see the action on this. And we've been asking for a while.

Ms. Devlin, I want to change gears a bit now and discuss how scammers are targeting veterans. I bet everybody here has gotten a text, email, phone call and been the target of a scam. According to the Federal Trade Commission, veterans and military retirees reported nearly $420 million lost to fraud just last year. And when you include active military members, reservists, and their families, that number climbs to more than $580 million.

According to the FTC, the top type of fraud affecting our military and veterans was imposter scams. Those types of scams alone add up to almost $200 million. Ms. Devlin, can you please discuss how scams and financial losses can affect veterans and their families, and what the VA is doing about it?

Ms. DEVLIN. Thank you for the question. We take this very seriously, and we have multiple efforts underway to prevent fraud from even happening, from even affecting a veteran. But it does af-

fect veterans. And so, what I'd like to share with you is that we have in the last couple years prevented $9.6 million from being stolen from veterans' accounts. The bad guys are always changing their approaches, and we're always evolving to make sure we're one step ahead of them as much as we can.

So, a lot of what happens is really the redirect, the attempt to redirect finances from a veteran's account to another account. And those are the—that's the $9.6 million that we prevented from happening. And when it does happen, we provide one-on-one remediation support.

So, if a veteran or a service member or family member is subject to or victim of fraud, we'll provide remediation support one-on-one through our fraud team. And we do extensive outreach and communications, even with the latest fraud scheme where veterans are getting a message saying they have a VA overpayment, and it's not true. And we've sent out communications and reached millions of veterans with that information.

Senator HASSAN. Well, I appreciate that very much. And you mentioned your fraud prevention or your fraud remediation teams. One of the things I'd like to continue to do is work with you to address this issue and find ways to strengthen our support and prevent even more losses. One way we can do that is to make sure that the VA's efforts on scam prevention and education are fully supported.

Senator Cornyn and I introduced the bipartisan VSAFE Act, which would require that the VA have a scam and fraud evasion officer, ensuring that such a position is codified and congressionally supported so that there's a specific person in office to lead the VA scam profession efforts across administrations. And so, I'd love to work with you on that legislation, and also, interested on what additional ways you think that Congress and the VA can work together to address scam—scams and fraud.

Ms. DEVLIN. Happy to work with you on that. Absolutely.

Senator HASSAN. Yes. Just for my colleagues' knowledge, if they don't know, that the overall cost of these scams now economy-wide around the world is over a $1 trillion in losses a year. It is now outpacing the illicit drug trade. So, it's just something we all got to really take on together. Thanks so much.

Chairman MORAN. Senator Hassan, thank you. Senator Boozman is recognized.

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

Senator BOOZMAN. Thank you for being here, and we appreciate you and Senator Blumenthal for calling the meeting. And this is really good stuff that we're discussing.

I want to start with discussing the Veteran Burial Timeliness and Death Certificate Accountability Act. Families of veterans have suffered delays in certifying their loved ones passing as long as eight weeks. This creates difficulties for the families to receive death benefits received with burial honors, and forces local government to maintain possession of the veteran's body.

Mr. O'Toole, does VA policy allow a physician assistant to certify a death certificate in states that require a physician or coroner to certify?

Dr. O'TOOLE. Thank you, Senator. And specifically related to this bill, I want to note that the VA supports it absolutely, although there are some amendments that we would recommend.

The first is that physician assistants who are practicing as independent providers in primary care specifically, we feel should be included in those clinicians able to sign a death certificate, which is standard practice in many states already.

Our other request is that we go for—instead of 48 hours, to two business days, which is our current practice, and also reflects the challenges with 95 percent of the deaths occurring outside of a VA facility, some of the logistic requirements dealing with holidays, weekends, and so forth.

Senator BOOZMAN. Very good. Can you explain the processes a VA physician must go through to sign a death certificate, and compare that process for when a veteran passes away outside of a VA facility?

Dr. O'TOOLE. I can tell you from my own experience. Usually, it's a notification by the medical examiner or a mortician's office about a death, and then, and requesting the certification be completed in a certain time. Obviously, it is greatly facilitated if that patient has been seen recently. And records are appreciated for natural causes.

Again, it's a little bit trickier if the patient has not been seen recently or the death occurred in a circumstance that might not be consistent. And that's pretty usual, whether it's within the VA or outside the VA system.

We recently stood up in office and put out a directive as well as training for all of our VA clinicians that's intended to clarify and codify those processes internally for us.

Senator BOOZMAN. Very good. Ms. Devlin, can you speak to the importance of death benefits for the families of veterans, and the consequences of delaying their delivery?

Ms. DEVLIN. Absolutely. We work with many sources of information for first notice of death because we want to make sure that the survivors receive their benefits in the most timely manner. We've reduced our inventory of dependency and indemnity compensation claims dramatically working on getting those timely benefits to survivors.

Senator BOOZMAN. Very good. I'm proud to be an original cosponsor of the VSAFE Act of 2025. Veterans are uniquely targeted by scammers to exploit their access to benefits. Ms. Devlin, can you talk about the legal difficulties in recovery from a scam?

Ms. DEVLIN. I'm not an expert in legal recovery from scams, but I can tell you we take very seriously protecting our veterans from fraudsters. We have many efforts underway, and as I mentioned earlier, the bad guys are always changing their techniques, which means we have to be sharp and continually evolving our practices.

We saved veterans from multiple fraud attempts based on our efforts. And I can tell you that identity theft and other types of fraud can be very catastrophic for families. Financial loss of credit, all sorts of problems can result. And that's why we provide one-on-one

remediation to our veterans and their families if that does happen to them.

Senator BOOZMAN. What does the VA lack in ability the scam and fraud officer could provide?

Ms. DEVLIN. I'm sorry, can you repeat the question?

Senator BOOZMAN. What does the VA lack in ability that a scam and fraud officer could provide?

Ms. DEVLIN. I think we have the capability now creating a fraud officer. We did support the bill. Having that position codified in law would strengthen our capabilities just for the mere fact of that position being a permanent position. And that put, that individual would work with all of the administrations, because we have unique situations in VBA, and VHA, and NCA that are uniquely different in terms of how fraud can affect our veterans that we serve.

Senator BOOZMAN. Very good. We appreciate it. These not little things. There are things that really do affect people a great deal, and both with inconvenience, and as you pointed out, Ms. Devlin, just the adverse things that can happen as a result of the scams. And then, two, not being able to get a death certificate in a timely fashion. And we can argue about what timely is, but in some cases, it's not timely. We do need to correct that because it really does put people in difficult situations. So, thank you, Mr. Chairman.

Chairman MORAN. Senator Boozman, thank you. Senator King.

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

Senator KING. Thank you, Mr. Chairman. I wanted to talk a bit about S. 926, a bill that Senator Sheehy and I have introduced. Senator Gallego and Collins have also joined in support.

It involves falls prevention. I'm sorry, that's next. It involves a lockbox for firearms. I don't have to talk to you about the grave history of suicides among our veterans. 75 percent of which involve firearms. I did a calculation; about one veteran every two hours takes their own life with a firearm. And what we're proposing here is based on a successful program in Utah where it's basically a free lockbox for veterans that apply. There's no Second Amendment issues, purely voluntary. And the research, as I'm sure you know, Doctor, if you can lengthen the time between ideation and action, you're going to save lives.

I know that the department has a kind of pilot program and they're worried about the cost, but I hate to think that cost is going to be the barrier to saving a life. I mean, what's the value of one veteran's life saved? So, I hope you'll take a closer look at this bill. I don't think it's the—we estimate $5 million a year. That would be 33,000 lockboxes, and that's a pretty good uptake rate. So, Doctor, your thoughts, and I hope I can move you a bit on this.

Dr. O'TOOLE. Well, thank you, Senator. And first thank you for introducing this bill. And I know we've talked about it previously, and this is obviously a priority for the Secretary. It's a priority for the VA. Any suicide is one too many. And you're absolutely right. Anything that creates some space between that impulse and that action, whether it's in securing medications or securing firearms, critically important and it'll save lives.

We need to work with you on this. I think our concerns about the recommended appropriated amount of $5 million is something that I'm hoping we can work through to be able to hopefully create some comfort in terms of what is the right amount.

Our efforts to date have been focused on providing lockboxes to those veterans identified as having moderate or severe risk, and clearly coupling that with the wraparound services, and mental health services, and social support services that hopefully will help.

Senator KING. And that's a very limited uptake.

Dr. O'TOOLE. Absolutely. We need to do more. And I was going to add also, we have the gun cables that are more generally available. But the technology and the capacities with lockboxes is preferable to the cables.

Senator KING. Let's continue our discussion——

Dr. O'TOOLE. Yes.

Senator KING [continuing]. Because I think this is, like I say, every two hours, a veteran dies by firearm suicide, and we ought to be doing whatever we can. And Mr. Chairman, I'd like to submit for the record, I think it's communications from 24 different groups supporting this bill. So, if I can submit that for the record.

Chairman MORAN. Without objection.

[The information referred to appears on pages 137–166 of the Appendix.]

Senator KING. The second issue I want to talk about briefly is falls. One out of every four people over 65 have a debilitating fall. The cost of one fractured hip is between $40,000 and $50,000. Falls prevention to me is the low hanging fruit of lowering the cost of healthcare. It's an epidemic in this country. And Senator Rounds, and I, and Senator Blumenthal have a bill that basically puts a focus on this issue within the department by creating an Office of Falls Prevention.

And my philosophy of management is you need somebody in charge who's responsible for a particular program, otherwise it just falls away. The way I used to put it in business was "one throat to choke." And what I'm talking about is somebody who's responsible every day when they get up, saying, "How can we prevent falls among veterans?"

So, again, I think you've been somewhat negative about this bill, but seriously, this is something, as I say, it's the low hanging fruit of prevention not only a financial cause, but of the terrible toll that it takes on our veterans and their families.

Dr. O'TOOLE. No. And you're absolutely right. I mean, falls are a preventable cause of significant morbidity and mortality, and we obviously, with our aging veteran population need to have that focus.

Our concern or basis for objection is that much of the work is underway. We launched a falls office within the National Office of Patient Safety this past year. And we are doing a lot of the things that the legislation calls for. And our concern is that creating or enacting the legislation, we don't want that to be taken from the momentum of what we are currently doing. But, again, let me please extend the offer for us to be able to work with your office

to be able to find some common ground to be able to move this forward.

Senator KING. I appreciate that. And it may be just some modifications to what you're already doing and sort of beefing it up, because again, this is a real opportunity to relieve a lot of pain and suffering for our veterans, but also pain and suffering for the taxpayers. Thank you. Thank you, Mr. Chairman.

Chairman MORAN. Thank you. Senator Slotkin.

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

Senator SLOTKIN. Thank you, Chairman. Thanks for having this hearing. And you're coming to the end because I'm at the end of the dais, so it's almost over. And I appreciate you really have had, like, the grab bag of issues. So, it's not like a hearing on one issue. Thank you for taking all of our particular questions.

I want to follow-up on an issue I feel very strongly about, which is toxic exposure for our veterans, particularly burn pits. You know, I was a CIA officer, not a veteran, but lived in Iraq for many years of my life. And the burn pit exposure, I mean, you didn't have to be a doctor to understand that it's pretty crazy to live close to a place where you burn all kinds of trash. And we passed the PACT Act, which I think was a really important lesson that we weren't going to let the 9/11 veterans have to fight for 30 years the way that the Agent Orange exposure folks in Vietnam had to fight.

And so, you know, we got a bunch of new veterans into VA care who had served in places where we burn our trash. And I was proud to play a really small part of that. But the bill that I'm interested now is kind of like the next set of—the next part of that story which is the Molly R. Loomis Research for Descendants of Toxic Exposed Veterans Act. It's basically this question that I think is unknown right now is, if you are exposed to toxic exposure burn pits and you've served for a long time, what, if anything, do you pass on to your kids? And I think there's like a—a lot of open questions here about that.

And so, the bill is just basically, can we research that? Can we get some data behind that? But I understand the VA is against it. Can you walk me through your sort of feeling on the bill, but then just what's the next step the VA is looking at for toxic exposure, particularly for the 9/11-era veteran?

Ms. DEVLIN. Yes. Thank you so much for that question. We believe that we have the infrastructure in place. Part of it was put in place by the PACT Act to research conditions, exposures that we believe have science behind them. And we do some preliminary research, and then we determine which ones we need to delve into and do the more extensive research.

We work with the National Academy of Science and Medicine and Engineering on these. There's not been a significant association shown at this point that shows any descendants impact of toxic exposures. We are researching some other exposures, and I'm happy to share those with you, but they're not——

Senator SLOTKIN. But you have some sort of program that's been funded by the VA or sponsored by the VA that looks at the descendant piece, not other—because certainly, we had a long debate

in the PACT Act about which conditions would qualify. Do we actually have science to link to the toxic exposure, which I get, but is there actually a funded project looking at the descendant piece, the children?

Ms. DEVLIN. It's not specifically looking at descendants. We determine, as I mentioned, which exposures, which locations, particles, specific items that veterans are exposed to during service and determine which ones require further research. As I indicated, the last research on toxic exposures for descendants, which was in 2018, did not show a significant association.

Senator SLOTKIN. Well, maybe I'd just like to see it. Because we hear this, and again, you know, I understand we need the science behind it, but we certainly hear from veterans, that era of folks many of them have had children and they feel like there's similarities across what they're seeing in their own children. So, I just think it's important that we understand and have done the work. But I'll look at the 2018 stuff, but I certainly think the demand signal is there.

Ms. DEVLIN. Happy to share it with you.

Senator SLOTKIN. Thank you. And then the other issue I just wanted to talk about was on this kind of communication when veterans leave the VA system and go out on the open market for their care. It's something that has been much discussed here. We keep hearing that there's problems when someone goes out into community care in like their records coming back to the VA. That there's this drop off.

And so, again, there is a bill, a bipartisan bill, the Caring for our Veterans Health Act, which would just improve information sharing between the VA and these normal providers out on the market. Can I get your thoughts on that? Because we want them to get the care, but then it shouldn't be up to the veteran to have to slog and get the records back to the VA.

Dr. O'TOOLE. No, absolutely. And I appreciate you bringing it up. It's a concern and a challenge for us. And we, the OIG, has investigated, looked at it, identified issues and problems as well. Much of the efforts involved are going to be captured in the next gen contract with an enhanced role for the TPAs, the third-party administrators, in terms of collecting and managing those records.

And our position on this bill is that we are better served working through a contractual and business arrangement, rather than having to legislate for the outcomes that we're trying to achieve. But absolutely, we share your same concerns with this, and it's more of a strategy issue.

Senator SLOTKIN. Great. Happy to keep talking about it. Thank you, Chairman. I yield back.

Chairman MORAN. Senator Slotkin, thank you. I was just expressing to Senator Blumenthal that I think he and I, to my knowledge, were the first to introduce legislation and it became law. It was the Toxic Exposure Research Act of 2015 that looked at the consequences to the next generation of toxically exposed veterans.

My awareness of this issue came from the Vietnam Veterans of America Forum conference they had in Wichita, Kansas that I attended. And it's why I indicated to Senator Murray that I'm interested in continuing—she asked similar questions to yours—inter-

ested in working with you and others to see that the answer I was going to ask Ms. Devlin—what I think I heard her say, and I think that research was done, according to that Toxic Exposure Act of 2015, and the conclusion of that research was what?

Ms. DEVLIN. So, the conclusion of that research from 2018 was that there was no significant association between toxic exposures in the Asia areas were related to children, descendants of those veterans.

Chairman MORAN. What did that research consist of? How was that research conducted?

Ms. DEVLIN. It was conducted in collaboration with the National Academy of Sciences, Engineering, and Medicine. So, we can provide the report to you.

Chairman MORAN. I've seen it, but it has been a while.

Ms. DEVLIN. Okay. Sorry. It has been a while.

Chairman MORAN. And then, did you also indicate that, perhaps as a result of that conclusion, the research conclusion, that there is no research currently ongoing at the VA related to this topic with the next generation, or their veteran parent, or grandparent?

Ms. DEVLIN. Not to my awareness, unless Dr. O'Toole is familiar. No, not to my awareness. Not on descendants specifically.

Chairman MORAN. Senator Slotkin, again, I have an interest in this topic, Senator Blumenthal.

Senator BLUMENTHAL. Just to clarify, are you aware of other research outside the VA that's ongoing with respect to this issue?

Ms. DEVLIN. I'm not aware of any research on descendants. Are you, Dr. O'Toole?

Dr. O'TOOLE. Yes, I'm not aware, but I will also say I haven't been actively tracking. We do track it actively as part of the PACT Act of current veterans. But as far as descendants go, I don't know. And, you know, 2018 was a while back.

Chairman MORAN. Well, and 10 years ago, what I recall from the conference I attended, it was very vivid. It sticks with me 10 years later about a significant circumstances I heard about and saw related to veterans and their next generation. Senator Slotkin.

Senator SLOTKIN. Yes. I just will say briefly and while again we certainly have heard from Vietnam veterans their perception that things can be passed on to their kids but would just offer, and I'm not a scientist, but Agent Orange exposure can't be exactly the same as burn pit exposure. And I just think, you know, it at a minimum, if you have a bipartisan interest in supporting that kind of research, I think it's sort of part of what we owe to folks if there's a possibility that it affects their children, I'd be happy to see this Committee push it forward.

Senator BLUMENTHAL. I think that, if I may, Mr. Chairman——

Chairman MORAN. Senator Blumenthal.

Senator BLUMENTHAL. I think Senator Slotkin is absolutely right that this area really cries out for some bipartisan action. And I'm struck by the stories that I have heard from veterans about children bearing the diseases and afflictions that are attributed by medical experts to the exposure to the burn pits and other kinds of toxic substances, including in this country at Camp Lejeune, parents having children who may be affected by the contamination of

that water there. So, thank you, Mr. Chairman, and thank you Senator Slotkin.

Chairman MORAN. Good. Thank you, Ms. Devlin, and you, Dr. O'Toole, for joining us today. And now we dismiss you. It sounds like a harsh word. We'll now ask the next panel to approach the desk and join us. Thank you.

Testifying on the second panel is Morgan Brown, the National Legislative Director for the Paralyzed Veterans of America; Nancy Springer, the Associate Director of the National Legislative Service for the Veterans of Foreign Wars; and Barton Stichman, the Cofounder and Special Counsel for the National Veterans Legal Service Program.

Thank all three of you for being here. And with that, Mr. Brown, I'll recognize you first.

PANEL II

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

Mr. BROWN. Well, thank you, Mr. Chairman, and Ranking Member Blumenthal, and Members of the Committee. Paralyzed Veterans of America would like to thank you for the opportunity to testify on some of the pending legislation impacting VA that the community or the Committee is reviewing today.

Obviously, there are many bills on the docket, so I'm going to limit my comments to just three of them that we feel most closely impact our members. First, PVA supports the Review Every Veteran's Claim Act, which seeks to limit VA's authority to deny a veteran's claim solely on the veteran's failure to appear for medical examination that's associated with the claim.

Thousands of veterans claim for service-connection, claims for increase and for other benefits like total disability, individual unemployability, and aid in attendance, have been denied solely because of missing an examination. There are many legitimate reasons why a veteran may not be able to attend a scheduled exam. We are also aware of numerous instances where VA contractors erroneously recorded the veteran as a no-show.

Veterans with SCI/D often encounter multiple barriers in travel when compared to other veterans and are apt to miss some of these appointments. We believe that passage of this legislation will ensure that a missed exam isn't the only basis for denying the veteran's claim. VA should also carefully consider whether an examination is needed since many veterans with SCI/D already received most of their care through the department's SCI/D system of care. Therefore, their records have adequate information to provide an accurate picture of their disabilities.

We also support the Veterans Appeals Efficiency Act, which would establish additional reporting and tracking requirements for the Veterans Benefits Administration and the Board of Veterans Appeals, such as information on higher level reviews, supplemental claims, and notices of disagreement.

It also requires the tracking of claims pending in the national work queue not assigned to an adjudicator, cases that are re-

manded by the Board, Veterans Appeals Improvement and Modernization Act cases pending a hearing, and when a decision-maker did not comply with the board's decision.

We recognize the value of and support efforts to track meaningful data to improve the effectiveness and accuracy of the claims process. However, the data sought by this legislation will be meaningless unless the department addresses the problems that hinder their ability to obtain proper medical opinions since this continues to result in remandable errors.

This act would also give the board the authority to aggregate certain claims. And while PVA does not oppose allowing the board to aggregate appeals involving common questions of law or fact, we believe that before that can be done, a feasibility study should be conducted and the findings reviewed, then legislation based on those findings should be brought forth.

And then, finally, in times of fiscal constraint, joint use agreements between DoD and VA should be highly prized for their ability to increase access to care for service members and veterans while reducing overall federal spending.

Such agreements allow for the sharing of medical personnel, facilities, and resources, which can lead to faster access to high quality care and improved medical outcomes. They also reduce bureaucracy and improve the efficiency of the system. DoD and VA have had the authority to execute these types of agreements for decades, but have never really used them to achieve their full potential.

PVA supports the SERVE Act, which reinforces some of these existing authorities and will improve access to healthcare by improving collaboration and increasing the use of these agreements between the two departments.

I thank you again for the opportunity to share our views on some of the bills, and I'll be happy to answer any questions you may have.

[The prepared statement of Mr. Brown appears on pages 97–105 of the Appendix.]

Chairman MORAN. Mr. Brown, thank you so much. Ms. Springer, your testimony please.

STATEMENT OF NANCY A. SPRINGER, ACTING DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES

Ms. SPRINGER. Good afternoon, Chairman Moran Ranking Member Blumenthal, and Members of the Committee. On behalf of the men and women of the Veterans of Foreign Wars of the United States and its auxiliary, thank you for the opportunity to provide our remarks on the legislation pending before this Committee. My written testimony includes the VFW's positions on all the bills under consideration. This afternoon, I'll highlight three.

First, the VFW supports S. 1657, Review Every Veteran's Claim Act of 2025, legislation we have championed for the last few years. This bill would amend Title 38 to ensure that VA may not deny a disability claim solely because of veteran missed a compensation pension or CMP examination.

We believe this bill would move VA toward a more flexible and veteran-centered claims process as scheduling conflicts do arise and veterans should not be penalized when unavailable. We understand that veterans miss CMP appointments for many reasons such as illness, lack of transportation, work conflicts, or just simple misunderstandings. They should not be forced to restart their entire claim because of a single missed appointment.

The VFW has assisted many veterans who had to reopen claims for this reason alone. Starting a claim from the beginning is unnecessarily burdensome and can be mentally exhausting. Instead, we recommend that VA return the claim to the work queue with a missed medical examination flag so the process can resume exactly where it stopped.

We also recommend that when the evidence already in the file clearly establishes both the existence and severity of the disability, it would lead to a favorable outcome, VA should adjudicate the claim based on that evidence alone. Conversely, when the record is insufficient, a CMP examination should remain mandatory to ensure a fully informed decision.

Next, the VFW supports S. 1992, Veterans Appeals Efficiency Act of 2025, which would give the Board of Veterans Appeals or BVA, and the Court of Appeals for Veterans Claims, additional tools to improve the efficiency of the appeals process, reduce the backlog of appeals at BVA, and allow appellants to receive quicker decisions.

Specifically, it would allow BVA to aggregate similar claims and decide multiple appeals simultaneously. It will grant BVA Presidential authority, if feasible, that would reduce repetitive litigation and promote greater decisional uniformity. It would clarify evidentiary support for an advancement on-the-docket request, and the typical timeline for a decision. For a Court of Appeals for Veterans Claims, the ability to expand the court's ability to certify class actions, helping resolve systemic issues that affect many veterans similarly at once and would codify the court's authority to issue limited remands, which would allow BVA to correct a specific error without reopening an entire multi-issue appeal. Although limited remands would enhance efficiency, they're rarely used because no clear criteria currently exists. This legislation would change that.

Today, many veterans wait up to two years for a BVA decision, longer if they request a hearing. With the number of pending and projected appeals, BVA cannot likely make meaningful progress using its current processes. These tools will provide an opportunity to break that paradigm and streamline the appeals process.

Finally, we support the bill's enhanced reporting and data tracking requirements. However, we recommend two additions to increase accuracy. First, track the impact of natural disasters on docket advancement as they can significantly delay case movement, and track cases in which an eligible survivor requests substitution for deceased claimant for purpose of pursuing the claim to completion.

Lastly, the VFW supports the discussion draft entitled Sharing Essential Resources for Veterans Everywhere or SERVE Act. Its proposal would strengthen collaboration and resource sharing between VA and Department of Defense for DoD to expand

healthcare access for veterans, especially those who live near military medical treatment facilities.

Allowing veterans, particularly those in rural or underserved areas to utilize nearby military hospitals and clinics, would reduce travel burdens, shorten wait times, make better use of federal medical capacity that might otherwise go unused. Increased resource sharing would also promote better systems integration between DoD and VA, support cross credentialing of staff and facilitate joint training, all of which would contribute to better continuity of care, both active-duty service members and veterans.

While successful implementation would require attention to funding, staffing, and data integration, this proposal would represent a significant opportunity to better leverage existing federal healthcare resources for veterans.

Chairman Moran, Ranking Member Blumenthal, thank you again for the opportunity to share the VFWs remarks. I look forward to answering your questions.

[The prepared statement of Ms. Springer appears on pages 106–117 of the Appendix.]

Chairman MORAN. Thank you very much. Mr. Stichman.

STATEMENT OF BARTON STICHMAN, CO-FOUNDER AND SPECIAL COUNSEL, NATIONAL VETERANS LEGAL SERVICES PROGRAM

Mr. STICHMAN. I'd like to thank Chairman Moran, Ranking Member Blumenthal, and the Members of this Committee for the opportunity for NVLSP to present our views regarding the pending legislation before the Committee.

NVLSP firmly supports, as do my colleagues on this panel, the Veterans Appeals Efficiency Act, S. 1992, which contains several reforms that would meaningfully improve speed, accuracy, and efficiency in the adjudication of benefit claims at the VA and at the Veterans Court.

First, the Veterans Appeals Efficiency Act would restore the supplemental jurisdiction the Veterans Court used to have in cases in which a veteran denied benefits by the BVA, seek certification of his appeal to the Veterans Court as a class action. S. 1992 would overrule the recent decision of the Federal Circuit in *Skaar* v. *McDonough*. The rule announced in *Skaar* bars the large majority of similarly situated veterans with pending claims at the BVA or RO from being included in the class and counting toward the numerosity requirement of there being at least 40 putative class members.

S. 1992 would require the Veterans Court to use the same approach used by all other Article III courts who handle class actions, namely counting toward the numerosity requirement similarly situated veterans with appeals of pending before the BVA or on supplemental claims before the regional offices. This would ensure the continued viability of class actions, which for years have helped streamline the VA benefit system.

Second, section 2(e) of S. 1992 would encourage the court to exercise its existing authority to issue limited remands. Currently, when the Veterans Court encounters a defect that requires agency

action on one issue in an appeal involving multiple issues, the court typically remands the entire case back to the BVA for correction of one error without addressing any of the other issues. This piecemeal approach adds years to the adjudication process and results in substantial delays for veterans.

Although the court possesses the ability to issue limited remands while retaining jurisdiction over the rest of the case, it rarely does so because its authority is not well-defined, and current precedent confines its use to exceptional circumstances.

The Veterans Appeals Efficiency Act codifies the court's existing authority to order limited remands and instructs the Veterans Court to develop guidelines governing their use, including authority to require the BVA to act within a specified timeframe so that the case may expeditiously return to the court for a final court decision that disposes of the entire appeal.

By directing the court to articulate standards for when and how limited remands may be used, this bill will enable all participants in the system to understand when limited remands are available and the proper process for requesting them. This reform turns an underused mechanism into a practical accessible means of reducing delay and expediting relief.

In addition, NVLSP supports section 2(d)(i) of the Veterans Appeals Efficiency Act, which aims to reduce the backlog of veterans' benefits appeals by confirming the BVA's authority to aggregate appeals. While more than 70 other federal agencies have rules that facilitate aggregation of administrative appeals, the BVA is an outlier and insisting it lacks power ever to group together appeals raising the same question of law or fact for efficient adjudication.

The bill would codify the authority of the BVA to aggregate claims in appropriate cases after a federally funded research and development center does an assessment with VSO input of the feasibility of BVA aggravation and Presidential decision-making. I'd be happy to answer any questions you may have. Thank you.

[The prepared statement of Mr. Stichman appears on pages 118–125 of the Appendix.]

Chairman MORAN. Strictly back to my practice of law or law school, I'm not sure which, but something sounded familiar in your testimony. Senator Blumenthal.

Senator BLUMENTHAL. I just want to apologize. I have another commitment that I have to go to, but I actually think this testimony has been very important, and I have really no substantive questions. If I think of any, I will pose them in writing to you. But I want to thank every one of you for your service, and we hopefully, will move forward. Thank you.

And I thank the Chairman for his courtesy. I also want to put in the record, if I may, Mr. Chairman, an analysis from the Urban Institute, I believe I referred to it earlier, that provides the basis for the number 267,000 veterans that I mentioned earlier as the number who would lose their insurance if the subsidies are not extended.

Chairman MORAN. There's no objection. It's to be entered.

Senator BLUMENTHAL. Thank you.

[The information referred to appears on pages 167–168 of the Appendix.]

Chairman MORAN. Senator King. Is it helpful if you go before I do?

Senator KING. I'm fine, you go ahead.

Chairman MORAN. Well, now that I've offered, you could accept. [Laughter.]

Chairman MORAN. Senator King's bill along with Senator Banks', S. 1657. And I consider its passage a priority. It seems odd to me that it's necessary, and I was wondering if any of you have the statistics that demonstrate how often someone is denied their opportunity for a claim because of missing a physician's appointment? Is it a significant problem, or it's a rarity? I'll check with my caseworkers and I'll find out.

Mr. BROWN. Mr. Chairman, I don't think it's a data point that we actually track per se. But we are aware from time to time talking with our service officers that they're having to go back after the fact and attempt to get a—one of our members back into the system.

Chairman MORAN. Well, certainly if the VA cannot—I mean, encourage the VA to fix the problem itself immediately. In the absence of that, or maybe even in with that occurring, I look forward to the passage of this piece of legislation.

I want to ask about the SERVE Act, really, for each of you or any of you who have a thought that you'd like to share. From your vantage points working directly with service members and veterans, where do you see the biggest gap in health services during transition from DoD to VA? And do you believe this legislation can be a part of the solutions to those problems and desire to improve the continuity of care? Mr. Brown, you seemed perhaps the most anxious.

Mr. BROWN. So, I was going to say, I was just thinking, what would be the greatest area for me. And if you don't mind, I'll share like my personal experience.

Chairman MORAN. Please do.

Mr. BROWN. Currently, I'm fortunate that my primary care manager for VA is a provider that I saw while I was serving on active duty. And I think that one of the bigger advantages in terms of transition, if we were to expand access for veterans to be seen in the DoD system, certainly being able to see a provider that already knows your history so you don't have to repeat it would be a clear advantage.

Chairman MORAN. You had heads nodding behind you, so you've hit upon a point that apparently needed to be made. And I assume that the availability of that opportunity is going to be geographic. It depends on where that provider is and where that veteran is.

Mr. BROWN. That is quite true, as I just happen to live outside of Andrews Air Force Base, and she works at the CBOC on Allentown Road. So, most fortunate.

Chairman MORAN. Anyone else? Ms. Springer?

Ms. SPRINGER. And Mr. Chairman, I would go along with Mr. Brown's comments, and I'll use a personal story as well. I don't use VA care, I'm a TRICARE beneficiary, but very similar in some

cases. And I think transitioning from active duty to a veteran status, there's a lack of familiarity in the process.

I use a military clinic on board of Fort Myer, which is very close to my house, and that is just like being on active duty. I go there. I have a primary care manager, they get me in for appointments. If they can't do it, they send me to another clinic in the military treatment facility realm, or they send me out in town.

But it's very familiar, and I think that would help transitioning service members to keep up with their medical, get signed up and go to a place that's familiar, which is a military treatment facility.

Chairman MORAN. You know, part of my interest in this legislation revolves around Fort Riley, and Irwin Army Hospital, and then the VA in Topeka, in particular, but VA hospitals in Kansas. And as you described that, I was thinking, well, that'd be a rare thing in Kansas because we live so far from Fort Riley and the Irwin Army Hospital, for example.

But that's for a lot of veterans, for a lot of service members who retire near the last place they served or the place they served and want to retire to. There is a military hospital that would be of great benefit that you just described to me. So, I appreciate both of those stories. Mr. Stichman, anything you want to add?

Mr. STICHMAN. No, I have nothing further to add to that.

Chairman MORAN. Thank you. And one more question, and that's on the Fisher House, just for my help. I think this is a piece of legislation that we will be able to pass and it will be coming into law, but I'll be visiting or speaking about it with my colleagues, either in person or on the floor of the Senate.

And based upon your members' experiences, how significant is the unmet demand for lodging today? And do you believe expanding eligibility will improve access to care? Why or why not? What role does housing play in access to care, and is it a challenge in many places? Ms. Springer, you seem the most interested.

Ms. SPRINGER. I'll take a stab at it, Mr. Chairman. This hasn't been brought to my attention as a huge problem. But anytime you go get care, you have to think about the logistics, and you have to think about where am I going to house my family members? How much is it going to cost, and how is that going to affect my willingness to go?

And if there is an unused space in these Fisher Houses, which are wonderful institutions, if there's unused space, I think that's a very positive thing to do. Rather than have it sit empty, have people fill it up, active-duty members and families on a space available basis, I think is a very good thing. And we support this proposal.

Chairman MORAN. Thank you. And I, again, would use the opportunity to thank Fisher House and what great work they do across the Nation. Senator King.

Senator KING. I'd like to join you in the thanks to the Fisher Foundation for the work they do. It's amazing. On the issue of transition, we had a bill before our hearing, I think it'll be at our next markup, that would allow active-duty service members to preenroll in the VA healthcare before they transition out so there's no gap. Mr. Brown, do you have any views on that idea?

Mr. BROWN. I believe we would support that legislation.

Senator KING. Good. That's what I was hoping you would say. Let the record show Mr. Brown, you heard me in my exchange with the doctor about falls and we have a bill in to deal with the—to try to focus the attention of the VA on falls. Give me your thoughts on that, please.

Mr. BROWN. So, PVA supports your legislation. I listened, I think you've mentioned it twice now. One out of four veterans over the age of 60—was it, or was 65?

Senator KING. 65.

Mr. BROWN. So, I don't meet the second criteria yet, but I did meet the first criteria. And I was thinking that, well, you got to count me twice, because I've had two major falls that have resulted in a significant health issue. One that not only incapacitated me for several months, but it also required my wife to take off time off work to like get me to my appointments, and back and forth extensive physical therapy and the like.

So, I personally understand the value of fall prevention. And we know that every major area, service area within VHA, certainly has their individual fall prevention programs. It's extremely important for veterans with SCI, MS and ALS. But I do agree with you that I think that VA would benefit from having like that one single point of contact.

And from the sounds of things from Mr. O'Toole's testimony, it sounds like they're already headed in that direction. And I'm sure you'll look into that with them and verify that. But otherwise, we think that your legislation is appropriate.

Senator KING. Thank you. Any other comments on that? Ms. Springer?

Ms. SPRINGER. Yes. Senator, we would actually propose that the existing structures the VA already has be strengthened. There are already offices that deal with falls prevention instead of—we're not really in favor of creating a separate office for that, but instead, take those offices that are already doing this and strengthen them. Codify what they're doing, and ensure that some kind of discussion about falls is at every medical appointment, not just an annual physical, but every time that veteran comes in for care. Somebody's asking about falls because I agree it's a very significant problem and it can lead to other more serious health problems.

Senator KING. We'll look forward to working with Dr. O'Toole and the agency to focus how to strengthen, as you say, the current structure, and give it a focus that will increase the effectiveness.

Second issue I wanted to talk about was the bill that I mentioned, with Senator Sheehy, on safe gun storage. Ms. Springer, do you have any thoughts about that issue?

Ms. SPRINGER. Yes, we support that bill. We are very aware of the problem with suicides in our veteran population. And we do think that that would help decrease those incidents. Anything we can do to separate a person who may be having an impulsive thought and lethal means is something that we would support. And I think that you can easily roll this out and get it up and running. We do support this bill.

Senator KING. Mr. Brown, did you have a comment?

Mr. BROWN. PVA shares the same view.

Senator KING. Thank you. Thank you, Mr. Chairman. Thank you for this hearing.

Chairman MORAN. Thank you, Senator King. Let me ask this panel. You heard the testimony of the VA, Ms. Devlin, and Dr. O'Toole. Anything you heard that you want me to ask them in a written question? Is there something that they said or didn't say that you'd like me to further explore? Apparently, Dr. O'Toole and Ms. Devlin passed the test.

Okay. I think we are going to conclude the hearing. And I want to, again, thank the second panel for their testimony as well as the first. And I thank our members of the audience and the Members of our Committee for being here today.

Senators who would like to submit written questions for the record to today's witnesses or additional statements have a week to do so, and ask our witnesses to respond any questions for the record they receive following today's hearing in a timely manner.

Chairman MORAN. And we've had conversations this afternoon about how we want to have a markup on these bills and move forward. And I've asked the staff to try to schedule that as expeditiously as we can accomplish. So, we intend to move forward.

Senator KING. Is that expeditiously Senate time or real-world time?

Chairman MORAN. Well, I can tell you the Senate time has something to do with whether or not we will be expeditious.

Senator KING. Yes, sir.

Chairman MORAN. They're related.

Senator KING. I do have one piece of advice for you. If St. Peter ever comes to you and says, "You have 10 minutes to live," your response would be, "Could it be during a 10-minute Senate vote?"

[Laughter.]

Senator KING. Because you'll have about an hour.

Chairman MORAN. Well said.

[Laughter.]

Chairman MORAN. With that, our hearing is adjourned.

[Whereupon, at 5:30 p.m., the hearing was adjourned.]

A P P E N D I X

Hearing Agenda

UNITED STATES SENATE
COMMITTEE ON VETERANS' AFFAIRS

Pending Legislation

Wednesday, December 10, 2025
4:00 p.m.
Russell Senate Office Building, Room 418

1. S. 342, the Purple Heart Veterans Education Act (Murray)
2. S. 668, the SAFE STEPS for Veterans Act (King)
3. S. 926, the Saving Our Veterans Lives Act of 2025 (King/Sheehy)
4. S. 1116, the Ensuring Veterans' Final Resting Place Act of 2025 (Banks/Collins/Rosen)
5. S. 1657, the Review Every Veteran's Claim Act (Banks/King)
6. S. 1665, the Obligations to Aberdeen's Trusted Heroes (OATH) Act of 2025 (Blumenthal)
7. S. 1868, the Critical Access for Veterans Care Act (Cramer/Sheehy)
8. S. 1992, Veterans Appeals Efficiency Act of 2025 (Banks/Blumenthal)
9. S. 2061, the Molly R. Loomis Research for Descendants of Toxic Exposed Veterans Act of 2025 (Blumenthal/Murray)
10. S. 2220, the Fighting for the Overlooked Recognition of Groups Operating in Toxic Test Environments in Nevada (FORGOTTEN) Veterans Act of 2025 (Rosen/Cortez Masto)
11. S. 2264, the Advancing VA's Emergency Response to (AVERT) Crises Act of 2025 (Blumenthal)
12. S. 2309, the Veteran Burial Timeliness and Death Certificate Accountability Act (Boozman/Hassan/Cornyn)
13. S. 2328, the Military Learning for Credit Act of 2025 (Coons/Ernst)
14. S. 2333, the Health Records Enhancement Act (Welch)
15. S. 2397, the Caring for our Veterans Health Act of 2025 (Ricketts/King)
16. S. 2683, the VSAFE Act of 2025 (Cornyn/Hassan/Boozman/King)
17. S. 2737, the Veterans National Traumatic Brain Injury Treatment Act (Tuberville)

18. S. 2807, Restoring Eligibility Standards for Placement in Eligible Cemeteries and Tombs (RESPECT) Act (Cornyn/Hirono/Murkowski/Fettman/R. Scott/Schiff)

19. S. 3033, the Improving Access to Care for Rural Veterans Act (Duckworth/Blackburn)

20. S. 3119, the Fisher House Availability Act (Moran)

21. S. 3303, the Leveraging Integrated Networks in Communities for Veterans Act (Sullivan)

22. S. _____, the Sharing Essential Resources for Veterans Everywhere (SERVE) Act (Moran)

23. S. _____, the Commission on Equity and Reconciliation in the Uniformed Services Act (Blumenthal)

24. S. _____, the Get Justice Involved Veterans BACK HOME Act (King)

Prepared Statements

STATEMENT OF
MS. J. MARGARITA DEVLIN,
PRINCIPAL DEPUTY UNDER SECRETARY FOR BENEFITS
PERFORMING THE DELEGABLE DUTIES OF THE
UNDER SECRETARY FOR BENEFITS,
VETERANS BENEFITS ADMINISTRATION (VBA),
DEPARTMENT OF VETERANS AFFAIRS (VA)
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

December 10, 2025

Chairman Moran, Ranking Member Blumenthal, and other Members of the Committee: thank you for inviting us here today to discuss 24 bills that would affect VA programs and services. Joining me today is Dr. Thomas O'Toole, Deputy Assistant Under Secretary for Health for Clinical Services from the Veterans Health Administration (VHA).

S. 342 Purple Heart Veterans Education Act of 2025

Summary: This bill would add a new 38 U.S.C. § 3319A that would authorize Veterans entitled to Post-9/11 GI Bill educational assistance who are awarded the Purple Heart for service in the Armed Forces occurring on or after September 11, 2001, to transfer a portion of their entitlement up to 36 months to one or more of their dependents. The monthly rate of payment to a dependent would be the same as the rate of payment that would otherwise be payable to the individual making the transfer, and the recipient of the transferred entitlement would generally be entitled to educational assistance in the same manner as the transferor. The transferor would be charged entitlement at the rate of one month for each month of transferred entitlement used. The dependent would be treated as the eligible individual for purposes of any administrative provisions. In the event of an overpayment relating to the dependent, both the dependent and the individual transferring the entitlement would be jointly and severally liable to the United States for the overpayment. If a veteran who has designated one or more transferees for transfer of entitlement dies before transferring all such entitlement, the remaining months of entitlement must be evenly distributed among the surviving designated transferees who are eligible to use them.

In addition, a child to whom entitlement is transferred would not be able to use such entitlement until completion of secondary school or until the child turns 18, and may use any transferred entitlement without regard to the 15-year delimiting date but only until the child turns 26, unless the child is a Veteran's or Service member's primary provider of personal care services. Also, if a transferee has been prevented from pursuing a program of education before turning 26 because an educational institution or

training establishment closed based on an executive order or due to an emergency situation, VA will extend the period for using entitlement.

Position: VA supports the intent of this bill, but cites concerns with the bill language and the need for additional funding.

Views: Currently, under 38 U.S.C. § 3319(a), transfers of educational assistance must first be approved by the Department of War (DoW), which may authorize the transfer "in the national security interests of the United States." This bill would not require DoW approval for transfers of educational assistance by individuals awarded the Purple Heart. Instead, new § 3319A(a) would allow any Purple Heart recipient entitled to Post-9/11 educational assistance to transfer entitlement to an eligible dependent based on authorization by the Secretary of Veterans Affairs.

In addition, new § 3319A(f) would allow an individual transferring entitlement to modify or revoke the unused portion of any transferred entitlement at any time by submitting written notice to the Secretary of Veterans Affairs. If an eligible Purple Heart recipient qualifies to transfer benefits under 38 U.S.C. § 3319, a transfer would have to be coordinated with DoW, even though VA approves the transfer requests. All transferred benefits are currently administered through DoW systems. VA believes implementation of this section would be most efficient if management of transferred benefits continues to use the current system, which would require notification of any revocation or modification to both DoW and VA. Thus, VA recommends including a requirement to also notify the Secretary of War in this section for an individual transferring entitlement to modify or revoke transferred entitlement.

Post-9/11 GI Bill transfer-of-entitlement modifications and revocations are dictated to VA by DoW Instructions dated September 27, 2018, which state that milConnect (https://milconnect.dmdc.osd.mil/milconnect/) must be used for all transfer modifications and revocations. Once DoW receives and approves these requests, it enters the information into VA's system (Veteran Information System (VIS)) for VA to view and manage transferees' benefits. Maintaining the current process, even if the Secretary of War does not have to approve transfers, would best serve the management of transferred entitlement. Even though the bill would direct VA and DoW to coordinate with each other to facilitate entitlement transfers in 38 U.S.C. § 3319A(l), for purposes of consistency, VA recommends that Congress clarify that the current process would apply to initial transfer requests as well.

Furthermore, the bill would specify in 38 U.S.C. § 3319A(h)(4)(A) that the death of the transferor would not affect the transferee's use of entitlement. The bill would also specify in 38 U.S.C. § 3319A(h)(4)(B) that if an individual entitled to educational assistance had designated a transferee or transferees but had not transferred all entitlement at the time of death, VA would evenly distribute entitlement between all transferees who are not otherwise precluded from using the benefits. This language precludes surviving dependents of a Veteran who receives the Purple Heart posthumously because a Veteran can only designate dependent transferees once

approved to transfer benefits. In the case of posthumous Purple Heart recipients, this could only occur after the Veteran's death when under current law a legal transfer cannot occur to these undesignated transferees. Also, the benefits would not automatically transfer to the surviving dependents even if the Purple Heart recipient's dependents were listed as dependents in a DoW or VA system since the Purple Heart recipient would have had to specifically designate the dependents for the transfer of entitlement. In addition, this bill would authorize a dependent in receipt of transferred benefits to transfer entitlement to another eligible dependent if the individual transferring entitlement dies before the dependent has used all of the transferred entitlement.

Cost Estimate: VA does not have a cost estimate for this bill.

S. 668 Supporting Access to Falls Education and Prevention and Strengthening Training Efforts and Promoting Safety Initiatives for Veterans Act of 2025 (SAFE STEPS for Veterans Act of 2025)

Summary: Section 2(a) would establish a new 38 U.S.C. § 7310B regarding an Office of Falls Prevention. Proposed § 7310(B(a) would require the Under Secretary for Health (USH) to establish and operate in the Veterans Health Administration (VHA) an Office of Falls Prevention (the Office), which would be located in VA Central Office and would be headed by the Chief Officer of Falls Prevention, who would report to the USH. The USH would have to provide the Office with such staff and other support as may be necessary to effectively carry out its functions. The USH could reorganize existing offices within VHA as of the date of the enactment of this section to avoid duplication with the functions of the Office.

Proposed § 7310B(b) would define the functions of the Office as: (1) providing a central office for monitoring and encouraging VHA's activities with respect to the provision, evaluation, and improvement of health care services relating to falls prevention provided to Veterans by VA; (2) developing and implementing standards of care for the provision by VA of health care services relating to falls prevention; (3) monitoring and identifying deficiencies in standards of care for the provision of health care services relating to falls prevention, providing technical assistance to VA medical facilities and VA programs that support Veterans in their own homes, addressing and remedying deficiencies of such facilities and programs, and performing oversight of implementation of such standards of care; (4) monitoring and identifying deficiencies in standards of care for the provision of health care services relating to falls prevention through the community and providing recommendations to the appropriate office to address and remedy any deficiencies; (5) overseeing distribution of resources and information related to falls prevention for Veterans; (6) promoting the expansion and improvement of VHA clinical, research, and educational activities with respect to health care services relating to falls prevention, including research activities on falls prevention conducted between VA's Office of Research and Development (ORD) and the National Institute on Aging; (7) promoting the development or expansion of rigorous quality assessment or improvement processes designed to prevent falls; (8) coordinating home modification and adaptation programs administered by the Under Secretary for Benefits

(USB) under 38 U.S.C. chapter 21 and 38 U.S.C. § 1717(a)(2); and (9) carrying out such other duties as the USH may require.

Proposed § 7310B(c) would require the Chief Officer to oversee and support a national education campaign directed principally to Veterans determined to be at risk for falls, their families, and their health care providers. The campaign would have to focus on reducing falls, falls with major injury, and repeat falls for Veterans receiving VA care and increasing awareness of available benefits, grants, devices, or services provided by VA that would aid Veterans in reducing falls and preventing repeat falls. The Chief Officer would also be responsible for awarding grants or contracts to qualified organizations for the purpose of supporting local education campaigns focusing on reducing falls, falls with major injury, and repeat falls for Veterans receiving VA care.

Proposed § 7310B(d) would require the Chief Officer work with ORD and the National Institute on Aging to develop research for evidence-based falls prevention programs that would benefit Veterans, including programs that overlap with VA priorities, programs that may focus on or be of particular benefit to Veterans, and programs that may include participants with multiple comorbidities. The bill would further set forth additional requirements associated with these efforts. VA and the National Institute on Aging would have to establish a joint subject matter expert panel to develop recommendations for falls prevention interventions for Veterans with service-connected disabilities, including home modification interventions. VA and the National Institute on Aging would have to establish this panel within 180 days of the date of enactment, with responsibility for selecting its 8 members equally divided between the 2 agencies.

Section 2(b) of the bill would amend section 203(c) of the Older Americans Act of 1965 (42 U.S.C. § 3013(c)), which generally establishes requirements regarding Federal agency consultation, to include VA among the agencies that could be included in an Interagency Coordinating Committee on Healthy Aging and Age-Friendly Communities. It would also include the Veterans' Affairs Committees of the House of Representatives and the Senate among those receiving regular reports to Congress.

Section 2(c) would require VA, not later than 180 days after the date of enactment, to issue or update VHA Directives for facilities and providers relating to safe patient handling and mobility policies at the national, Veterans Integrated Service Network (VISN), and health-care system levels. These directives would have to require biennial training for providers, ensure that any medical facility where patients may need assistance with transfer or mobility have access to safe patient handling and mobility technology appropriate for the setting to enable safe transfer and mobilization for access to care and activities of daily living for Veterans who are paralyzed or who need assistance with mobility, and requiring all emergency settings have immediate access to safe patient handling and mobility technology to enable safe transfer, fall recovery, and repositioning.

Section 2(d) would require VA to determine the feasibility and advisability of carrying out a pilot program to provide home improvements and structural alterations to

prevent falls for all Veterans eligible for those services from VA. Not later than 1 year after the date of enactment, VA would have to submit to Congress a report indicating its plans to carry out a pilot program to provide home improvements and structural alterations to prevent falls for all Veterans eligible for those services from VA and specifying why VA determined that it was not feasible or advisable to carry out such a pilot program. If VA carries out the pilot program, not later than 180 days after termination of the pilot program, VA would have to submit to Congress a report on lessons learned from the pilot program and any recommendations on extending or expanding the pilot program.

Section 2(e) would require VA, not later than 2 years after the date of enactment, to submit to Congress a report on falls prevention initiatives within VA. This report would have to evaluate, for the 3-year period preceding the date of enactment, 10 different elements regarding VA programs and services.

Section 3(a) would amend 38 U.S.C. § 1710A, which generally establishes conditions under which VA must provide nursing home care to service-connected Veterans, to require VA to ensure that a licensed physical therapist or licensed occupational therapist conducts a falls risk assessment for individuals determined by a physician to have fallen or to be at risk of falling during the previous 1-year period during the stay of the individual in the nursing home. Section 3(b) would amend 38 U.S.C. § 1710B, which generally requires VA to provide extended care services to eligible Veterans, to include among those services the conduct of an annual falls risk assessment and the provision of fall prevention services by a licensed physical therapist or licensed occupational therapist.

Position: VA does not support the bill.

Views: VA remains committed to the journey to high reliability and maintaining a culture of zero harm, Veteran safety, and whole health, and fall prevention and management is one component of safe mobility for Veterans as falls and resulting injuries are one of the most common adverse patient events in VA. Falls and their consequences can be devastating, especially for elderly Veterans, and represent a major public health problem around the world. However, VA does not support this bill because current efforts and authority are sufficient to achieve the intended results of this bill and because technical issues with the bill would create unnecessary legal uncertainty.

In terms of current efforts, VA's National Center for Patient Safety established the Fall Prevention and Management program in FY 2025; this program advocates for coordinated, interdisciplinary fall risk screening, prevention, and management strategies. This program is targeted at reducing fall-related injuries, aligning procedures, and providing comprehensive standardized guidance for fall event reporting. Significant foundational work for this effort has already been accomplished, including initial work to draft a national directive, establishing a national steering committee, implementing a pilot project to expand fall event reporting, and creating a resource center for VA

professionals. VA is concerned that enacting this legislation could disrupt these current efforts, which could actually delay efforts to reduce falls among Veterans.

VA has technical concerns with the bill as well that create unnecessary legal uncertainty. For example, in proposed § 7310B(b)(4), the bill refers to monitoring and identifying deficiencies in standards of care for the provision of health care services relating to falls prevention "through the community pursuant to this title." It is unclear if this is intended to refer to the Veterans Community Care Program (VCCP) operated under 38 U.S.C. § 1703; if the VCCP was not the intended reference, we recommend the bill be revised for clarity. Additionally, proposed § 7310B(c)(2) would seemingly authorize the Chief Officer to award grants, but the legislation contains no further specific authority that would be needed to execute a grant program. In the absence of such authority, VA would rely on the contracting authority provided under this paragraph instead. Further, the proposed pilot program authority under subsection (d) is unclear, both as to whether VA is required to execute the program at all (it appears to be permissive in this respect) and how this pilot program would differ from VA's existing authority to furnish home improvements and structural alterations.

Cost Estimate: VA does not have a cost estimate for this bill.

S. 926 Saving Our Veterans Lives Act of 2025

Summary: Section 2(a)(1) would create a new 38 U.S.C. § 1720M, subsection (a) of which would require VA to carry out a program to provide to eligible individuals, upon their request, covered items (or a redeemable voucher to aid in the distribution of a covered item) and information relating to the benefits of, and options for, secure firearm storage. The term "covered item" would be defined in proposed § 1720M(e) to mean a lock box that: is used for the secure storage of a firearm and ammunition; is designed, intended, and marketed to prevent unauthorized access to a firearm or ammunition; may be unlocked only by means of a key, combination, or other similar means; is in compliance with the applicable standard of the American Society for Testing and Materials F2456-20, or any successor standard; is manufactured in the United States; and is not eligible or intended for commercial or individual resale. The term "eligible Veteran" would be defined in the same proposed subsection to mean a Veteran or an individual described in 38 U.S.C. § 1720I(b), which generally refers to former Service members with other-than-honorable discharges and who have other qualifying service.

Proposed § 1720M(b) would authorize VA, in carrying out the program required by subsection (a), to work with organizations that have experience, expertise, and business knowledge regarding secure firearm storage and secure firearm storage devices.

Proposed § 1720M(c) would require VA to design and carry out a public education campaign to inform eligible individuals of the availability of covered items under subsection (a). In carrying out the public education campaign, VA could partner with organizations that have experience with respect to secure firearm storage devices.

VA would have to include in the public education campaign material that assures eligible individuals that their participation in the program would not impact lawful ownership of firearms.

Proposed § 1720M(d) would require VA, not later than October 1, 2025, and annually thereafter, to submit to Congress a report that includes a description of the program under subsection (a), the number of covered items distributed by VA and the number of covered items redeemed outside of VA under the program during the period covered by the report, an assessment of efforts made to increase outreach and distribution of covered items under the program to eligible individuals who are not enrolled in VA health care, an assessment of any obstacles to increasing outreach to eligible individuals who are enrolled in VA health care and to such individuals who are not, and an identification of additional steps that will be taken in the following year to improve the processes through which eligible individuals receive a covered item under the program.

Section 2(a)(2) would make a clerical amendment to reflect the amendment made by paragraph (1).

Section 2(b) would require VA, in consultation with representatives of organizations and agencies that are subject to a memorandum of understanding with VA on preventing Veteran suicide and other such entities as VA determines appropriate, to develop an informational video on secure storage of firearms as a suicide prevention strategy and publish such informational video on a VA website. VA would also have to publish information to inform individuals who participate in the program under the proposed § 1720M that any lockbox furnished pursuant to such program is not eligible or intended for commercial or individual resale.

Section 2(c) would establish a rule of construction that nothing in this Act could be construed: to collect personally identifiable information of an individual who participates in the program under the proposed § 1720M for the purpose of tracking firearm ownership; to require any such individual to register a firearm with VA or any other Federal, state, tribal, or local unit of government; to require mandatory firearm storage for any such individual; to prohibit any such individual from purchasing, owning, or possessing a firearm under 18 U.S.C. § 922; to discourage the lawful ownership of firearms; or to create or maintain a list of individuals participating in the program.

Section 2(d) would authorize to be appropriated to VA $5 million for each of FY 2026 through 2036 to carry out this section and the amendments made by this section.

Position: VA does not support this bill as drafted.

Views: VA strongly agrees with efforts to reduce Veteran suicide, which may include providing lock boxes to Veterans. However, the bill as drafted is too broad, and the resources needed to implement would significantly exceed the authorized

appropriation of $5 million per year. We welcome the opportunity to meet with the Committee to pursue amendments that would address the concerns described below and align with VA's current program.

Late last year, VA established a lock box distribution program, where VA providers can place orders for lock boxes for enrolled Veterans. VA's program also includes education materials for Veterans and clinicians. VA clinical practice guidelines recommend the distribution of lock boxes as a risk mitigation strategy for Veterans at risk of suicide. Our current efforts are focused on Veterans with a risk of suicide, documented within the last 12 months, placing them at medium- to high-risk of suicide who have access to firearms; this access includes peripheral access, where a Veteran may not own a firearm, but may live in a home where someone else does. Through VA's current initiative, providers can place orders for lock boxes, track these orders, and ensure distribution.

The bill would require VA to develop education and training content, as well as a public education campaign, but VA is already working to increase awareness of firearm safety programs like the one described above. The bill is fairly prescriptive in terms of what material must be developed (an informational video), and how this would be developed. VA currently provides materials developed in collaboration with organizations like the National Shooting Sports Foundation (NSSF) and others, which we believe to be sufficient for our current needs. VA has not engaged in a broader public awareness campaign because VA cannot furnish lock boxes to persons other than enrolled Veterans with a documented clinical need. To avoid confusion, our communications are focused on enrolled Veterans and providers to ensure they can access available resources. Additionally, VA's mandatory suicide prevention training course, VA S.A.V.E. (Spot, Ask, Validate, Encourage), includes information on accessing lock boxes through VA, and VA's collaboration with PsychArmor has supported updating this content and distributing it more widely.

VA has concerns about the scope of this bill, which would require VA to carry out the program to provide lock boxes to all Veterans, not just those enrolled in VA care, and not just those at risk of suicide. It would also include former Service members whose service does not qualify them as Veterans for purposes of title 38, United States Code. VA estimates that the lock boxes it distributes cost, on average, $150 each, so making these available to all 18 million Veterans in the United States, with no limitation on the number of lock boxes that could be obtained, could result in a significant drain on VA resources. Further, given the specific parameters that lock boxes must meet, this may increase the average cost per box even more. For example, VA does not currently provide fingerprint-enabled boxes, as the purpose of the lock boxes is to create time and space between suicidal ideation and action and a digitally accessible device would frustrate that purpose. However, if VA were required to make these available under the program, the costs could also increase.

Given these concerns, we anticipate that the $5 million authorization limit would be reached well before the demand had been met, which would likely lead to frustration

on the part of Veterans who may have greater need, including Veterans with a risk of suicide, documented within the last 12 months, placing them at medium- to high-risk of suicide who have access to firearms, but who are unable to be among the first to receive a lock box under this program. We further note that the $5 million in authorization would also be applicable to the outreach and education efforts, which by themselves could easily eclipse the authorized limit.

Beyond these substantive concerns, VA has several technical comments on the bill that we can share with the Committee upon request.

Cost Estimate: VA does not have a cost estimate for this bill at this time.

S. 1116 Ensuring Veterans' Final Resting Place Act of 2025

Summary: This bill would amend 38 U.S.C. § 2306(h), which currently authorizes VA to provide, in lieu of burial in a national cemetery and other memorialization benefits, a plaque or urn to commemorate the memory of a Veteran whose remains are cremated and not interred. This bill would allow, in addition to a plaque or urn, burial in a national cemetery or other memorialization benefits for the Veteran.

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

Views: VA shares Congress' apparent view that this authority should be amended.

Congress is aware of the negative comments VA received when it published a notice of proposed rulemaking implementing the plaque-and-urn benefit. VA took specific steps in its regulatory documents to ensure members of the public would be aware that acceptance of the plaque or urn benefit would be in lieu of other memorialization or burial benefits. Most of the comments received on the rulemaking raised concerns regarding the waiver of future eligibility for burial or memorialization benefits through acceptance of a commemorative plaque or urn. We appreciate Congress' effort to introduce this bill to address the concerns but note that the bill raises other concerns.

This bill would remove the current language in 38 U.S.C. § 2306(h) that prohibits VA from providing a headstone or marker under section 2306 or any burial benefit under 38 U.S.C. § 2402 for any individual who has received a commemorative plaque or urn. In doing so, families that choose cremation as the manner of disposition would be able to first receive a plaque or urn and then apply for and receive a headstone or marker or burial benefits in a national cemetery. This arrangement would create an inequity for families that choose to inter their loved ones in a casket, as the urn or plaque benefit is only available to individuals whose remains are cremated. Additionally, there are increased costs associated with this bill, as headstones or markers and burial benefits

would now be available in addition to the plaque or urn benefit, and many more families would choose to receive the additional benefits.

VA has faithfully taken steps to implement the law as enacted. VA understands the desire of some survivors to retain the cremated remains of a loved one, as well as their desire to feel that VA has provided appropriate recognition of their loved one's service. VA notes that two benefits are currently available to such families—burial flags and Presidential Memorial Certificates—neither of which require families to forfeit other benefits. We support Congress' efforts to provide a meaningful benefit to these survivors. VA would like to work with the Committee to discuss more equitable or cost-effective solutions.

Cost Estimate: VA estimates this bill would have significant costs to the Discretionary account of $3.3 million in 2026, $67.3 million over 5 years, and $210.3 million over 10 years.

S. 1657 Review Every Veteran's Claim Act of 2025

Summary: Section 2 of this bill would amend the heading of 38 U.S.C. § 5103A(d) to read "Medical Examination for Claims for Benefits." Section 2 would also amend section 5103A(d)(2) by striking "treat an examination or opinion as being necessary to make a decision on a claim for purposes of" and inserting "provide for a medical examination or obtain a medical opinion under." Finally, this bill would add a new section 5103A(d)(3) specifying: "If a veteran fails to appear for a medical examination provided by the Secretary in conjunction with a claim for a benefit under a law administered by the Secretary, the Secretary may not deny such claim on the sole basis that such veteran failed to appear for such medical examination."

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

Views: Generally, VA must review and consider all the evidence gathered in support of the claim. Currently, however, 38 CFR § 3.655(b) requires VA to deny a claim if a Veteran fails to report for an examination as part of a supplemental claim, a claim for increase, or an original claim other than an original compensation claim. This bill would prohibit denying such claims on the sole basis of failure to report for an examination. Revision to 38 CFR § 3.655(b) would be required.

Currently, VA has a statutory duty under 38 U.S.C. § 5103A to provide a medical examination or obtain a medical opinion when such examination or opinion is necessary to decide a compensation claim. A medical examination or opinion is necessary to decide a claim where the evidence of record contains competent evidence that the claimant has a current disability associated with their active military, naval, air, or space service, but the medical evidence of record is insufficient for VA to decide the claim.

VA notes that, while this bill would prohibit denial of a claim solely on the basis that a Veteran failed to appear for a VA medical examination, cases may remain where, without the examination, there is insufficient evidence to support entitlement. Hence, even if this bill were enacted, claims may still be denied in those circumstances. The only difference would be that the denial would be due to lack of sufficient evidence rather than for failure to appear for the examination alone.

VA seeks to augment the language of the bill to address the situation where a Veteran does not report for a scheduled VA medical examination and there is not sufficient evidence of record to determine impairment level. Not closing a claim unless and until a Veteran reports for a scheduled VA medical examination may lead to a significant negative impact on VA claims timeliness. VA suggests that the bill include the following sentence at the end of new paragraph (d)(3): "In such circumstance, the claim will be determined based on the evidence of record."

Additionally, this bill would eliminate the current regulatory difference under 38 CFR § 3.655(b) between how failure to report for an examination is treated in conjunction with an original compensation claim (i.e., the first initial claim for one or more benefits administered by VA) and in conjunction with a claim for increase or a supplemental claim.

VA supports this bill because it would reinforce VA's general practice of reviewing and considering the full body of evidence before deciding a claim, which includes when the Veteran fails to report to VA medical examination. VA notes that the risks and costs associated with implementing this bill could be substantially mitigated if 38 CFR § 3.655(b) was not eliminated by specifying that failure to report results in a rating determination based on the evidence of record.

However, VA notes its concern that this bill may have the effect of continuing and worsening the practices of those involved in the for-profit industry that prepares and submits Disability Benefits Questionnaires (DBQs) who often provide inconsistent and questionable disability impairment descriptions in exchange for large fees and a portion of any future VA compensation benefits awarded. These bad actors intentionally and specifically instruct Veterans not to report for their scheduled VA disability examinations. Despite this concern, VA claims processors will continue to evaluate all evidence, including privately completed DBQs. If a DBQ shows indicators of potential inauthenticity or fraud, claims processors can assign it low or no probative value. Should authenticity or alteration concerns arise, further development may be necessary, such as validating results with the provider, obtaining medical records, arranging a VA examination, or referring to the Office of Inspector General.

Cost Estimate: VA does not have a cost estimate for this bill.

S. 1665 Obligations to Aberdeen's Trusted Heroes Act of 2025 (OATH Act of 2025

Summary: Section 2 of the bill would amend 38 U.S.C. § 5100 to add a definition of the term "secrecy oath program," which would apply for purposes of chapter 51. This term would mean a United States Government program in which participants are required to sign a non-disclosure agreement (NDA) preventing the disclosure of any information regarding the program under penalty of court-martial or criminal punishment.

Position: VA cites concerns with this section.

Views: VA cites concerns that this definition appears to be overly broad, as it is not limited to NDAs related to military operations that could form the basis for a compensation claim. If a Service member were required to sign an NDA for a reason unrelated to military preparation or operations, that would technically meet the requirements of participation in a "secrecy oath program." If the reason for the NDA, however, were organizational or in such a context as to present no risk of harm to the Service member, it is unclear why that would necessarily establish a different effective date for compensation for a disability completely unrelated to participation in the secrecy oath program.

Summary: Section 3(a) of the bill would amend 38 U.S.C. § 6303, which generally deals with outreach services by VA. Specifically, not later than 90 days after the date on which participants in a secrecy oath program (as defined in 38 U.S.C. § 5100, as amended) are released from the oath taken under such program, VA would have to identify the Veterans who participated in the program, notify them of all VA benefits and services for which they may be eligible, and distribute information about such benefits and services (and other governmental programs VA determines would be beneficial to Veterans). If VA identified Veterans who should have been notified under the previous provision but who did not receive such notice, VA would have to provide this notice to these Veterans.

Section 3(b) would require VA, not later than 90 days after enactment, to identify the Veterans who participated in the secrecy oath program at Edgewood Arsenal at Aberdeen Proving Ground, Maryland, at any time between January 1, 1948, and December 31, 1975, notify such Veterans of all VA benefits and services for which they may be eligible, and distribute the information described above.

Position: VA does not support this section, unless amended, and subject to the availability of appropriations.

Views: VA cites concerns with section 3(a) of this bill. The identification of participants in secrecy oath programs will require collaboration between VA and DoW, which results in delays for the Veteran. The timely notification of participants may be hindered by incomplete or outdated contact data, particularly in cases where individuals have not previously sought VA benefits or where records are fragmented across various

systems and databases. Additionally, updates to VA correspondence and VA systems would likely be required to tailor notifications to Veterans who were participants in secrecy oath programs. As such, VA respectfully suggests a period of at least 180 days to ensure sufficient time for information sharing between agencies, participant identification and location, and potential system and correspondence updates.

VA further notes that it may be extremely difficult to identify when Veterans are released from an oath under a secrecy oath program. Beyond such information being defined in the NDA (to which VA would not be a party), NDAs may not establish a single, common date applicable to all persons subject to them. For example, an NDA may state that information may not be disclosed until 5 years after the signing of the NDA, or 5 years after the completion of the activities associated with the NDA. Such unknowable and variable timelines would likely mean that VA would have to rely on the provision allowing VA to provide notice whenever VA identified Veterans who should have been notified; in other words, it seems unlikely that in many cases, VA could provide notice within the 90-day period contemplated by the bill.

VA does not support section 3(b) of this bill, unless amended. Section 3(b) would establish as the relevant period for participation in the Edgewood Arsenal testing program at Aberdeen Proving Ground as beginning on January 1, 1948, and ending on December 31, 1975. However, according to a DoW Deployment Health Support Directorate Fact Sheet (Version 07-01-2006), Edgewood Arsenal Chemical Agent Exposure Studies occurred from 1955 to 1975. VA has concerns that the date range provided in section 3(b) may include Veterans who participated in testing at Aberdeen Proving Ground but who were not participants in the Edgewood Arsenal testing program and, therefore, were not subject to the Edgewood Arsenal secrecy oath. VA currently has an established Integrated Project Team (IPT) that is working towards identifying Edgewood Arsenal testing program participants. The IPT is establishing claim tracking mechanisms, notification processes, and claims processing guidance.

Summary: Section 4 of the bill would amend 38 U.S.C. § 5110, which generally sets forth the effective dates of awards, to state that the effective date of an award of disability compensation to Veterans who participated in a secrecy oath program (including at Edgewood Arsenal at Aberdeen Proving Ground, Maryland, at any time between January 1, 1948, and December 31, 1975) would be the day following the date of the Veteran's discharge or release.

Position: VA does not support this section, unless amended, and subject to the availability of appropriations.

Views: VA does not support section 4 of this bill, unless amended. VA is concerned that section 4, as written, could afford a Veteran an effective date prior to the date a disability arose, i.e., the date entitlement is shown.

Veterans often seek service connection for later-developing conditions that did not manifest while in service or shortly after discharge or release. In those instances, section 4 would potentially entitle a Veteran to years, even decades, of backpay regardless of when the disability first began. Consistent with concerns expressed regarding section 2, VA likewise is concerned that section 4, as written, would entitle a Veteran to such an effective date regardless of whether the particular disability was related to his or her participation in the secrecy oath program. Such outcomes are contrary to the principle uniformly reflected throughout title 38, U.S.C., that compensation should not be paid for a period during which a Veteran is not suffering from a disability resulting from service.

Moreover, the effective date that section 4 of this bill would establish is not required by the remedial holding of the United States Court of Appeals for the Federal Circuit in *Taylor v. McDonough*, 71 F.4th 909 (2023) (*en banc*). There, the court held that, when a Veteran has been determined to be entitled to benefits for one or more disabilities stemming from participation in the Edgewood Arsenal testing program, the required effective date of such benefits is the date that the Veteran would have had in the absence of the challenged government conduct (i.e., imposition of the secrecy oath). *Id.* At 946. While this date *may* correspond to the day following discharge or release when facts show that a disability arose during service, *Taylor* does not compel such a date when a disability did not manifest until years later.

VA presumes that the intent of this bill is to effectuate the holding of *Taylor* consistently with the effective date principles established throughout the rest of the statutory scheme. One way to achieve this would be to amend proposed 38 U.S.C. § 5110(b)(5)(A) to read as follows: "The effective date of an award of disability compensation to a veteran described in subparagraph (B) of this paragraph shall be the day following the date of the veteran's discharge or release, or the date fixed in accordance with the facts found, whichever is later."

Furthermore, VA does not support section 4, unless amended, to the extent that this provision purports to define participation in the Edgewood Arsenal testing program. As previously explained, VA is concerned that the date range specified in section 4 may include Veterans who participated in testing at Aberdeen Proving Ground but who were not participants in the Edgewood Arsenal testing program conducted from 1955 to 1975 and thus were not subject to the Edgewood Arsenal secrecy oath.

Cost Estimate: VA does not have a cost estimate for this bill.

S. 1868 Critical Access for Veterans Care Act

Summary: Section 2(a) would amend 38 U.S.C. § 1703(d))(1), which generally establishes eligibility criteria for the VCCP, to include a new basis of eligibility for community care. Under proposed § 1703(d)(1)(F), a covered Veteran would be eligible to elect to receive care through the VCCP for care or services sought at a critical access hospital or provider-based rural health clinic affiliated with such hospital (including care

or services sought from an eligible VCCP provider located in the surrounding community due to a referral from a CAH/RHC provider of such hospital or clinic due to a referral from such hospital or clinic), if the Veteran resided within 35 miles of such hospital or clinic.

Section 2(b) would amend 38 U.S.C. § 1703(a)(3), which generally limits the receipt of care or services under the VCCP to care or services authorized by VA, to create an exception as set forth in a new proposed § 1703(d)(5). The proposed § 1703(d)(5) would state that VA could not require a covered Veteran to receive authorization or a referral prior to the receipt of care under the new § 1703(d)(1)(F).

Section 2(c) would amend 38 U.S.C. § 1703(i), which generally establishes rules for payment rates for care and services under the VCCP, to provide in a new paragraph (7) specific payment rates for providers under the VCCP. Specifically, at a critical access hospital, VA would have to pay the critical access hospital rate established under the Medicare program instead of a service-based rate. For care or services furnished at a provider-based rural health clinic affiliated with such hospital, VA would have to pay the rate specified under section 1833 of the Social Security Act (42 U.S.C. 1395l). Additionally, claims for covered Veterans receiving care under proposed § 1703(d)(1)(F) would have to include an identifier denoting the care or services provided under that authority; such claims would have to be reimbursed at the cost-based level under the Medicare program. VA, in consultation with the Centers for Medicare & Medicaid Services, could furnish additional guidance regarding this claims process in accordance with the best practices of Medicare Administrative Contractors (MAC) in processing cost-based reimbursement for services furnished at critical access hospitals or provider-based rural health clinics affiliated with such hospitals. Finally, claims for covered Veterans receiving care under the proposed § 1703(d)(1)(F) would have to be reviewed, and payment would have to be issued, in accordance with the findings of such review not later than 60 days after submission of the claim.

Section 2(d) would amend 38 U.S.C. § 1703(o) (which we believe should be a reference to subsection (q)) to include a definition of the term "critical access hospital," which would have the meaning given that term in section 1861(mm) of the Social Security Act (42 U.S.C. § 1395x(mm)).

Section 2(e) would require VA, not later than 1 year after the date of enactment, to submit to Congress a report on third party administrators (TPA) and community care providers concerning the implementation of these amendments, including timely approval and payment of claims under the proposed § 1703(d)(1)(F), and overall user experience associated with care or services provided pursuant to these amendments.

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

Views: VA strongly agrees with the intent to improve the quality and availability of care to Veterans in highly rural areas, like Montana and North Dakota. We support the

goal of improving access for rural Veterans and want to work with the Committee to clarify how this new authority would integrate with existing VA care processes.

The bill would create a new eligibility pathway under38 U.S.C. § 1703(d)(1)(F). We recommend further clarification on how this authority would interact with the VA's existing requirement to determine clinical-necessity under § 1710 while ensuring the bill's removal of prior authorization is implemented as intended by Congress. , Congress has created other authorities in §§ 1720J, 1725, 1725A, and 1728 – where pre-authorization is not required. If Congress were to create a specific exception to prior authorization, VA would implement that direction, but VArecommends ensuring the language clearly aligns with operational requirements. We note that the bill does not alter VA's responsibility to determine whether care is clinically necessary; it only would remove the requirement for priority authorization for eligible Veterans under this provisions.

We believe further discussion can help ensure the bill's implementation aligns with the Committee's intent, while providing the best access to care for rural Veterans and supporting consistent operations across VA and community care providers.

Cost Estimate: VA does not have a cost estimate for this bill.

S. 1992 Veterans Appeals Efficiency Act of 2025

Summary: Section 2(a) would amend 38 U.S.C. § 5109B to require VA to provide Congress with annual reports on the average length of time that a claim, or issue within a claim, is pending with the Secretary following a remand from the Board; the number of cases advanced on the Board's docket; and the number of appeals dismissed by the Board.

Position: VA supports the intent of the bill, subject to the availability of appropriations, but cites concerns with the current bill as drafted. The Department shares its positions on each subpart for clarity. VA cites concerns with section 2(a).

Views: VA cites concerns with the portion of section 2(a) requiring a report on the average length of administrative adjudication following Board remands. As an initial matter, VA cites concerns with the phrase "or issue within a claim" as a criterion for reporting. The Appeals Modernization Act (AMA; P.L. 115-55) does not contain a definition of "issue," so that term should be clarified in the statute as having the meaning set forth by VA in 38 CFR § 3.151(c), which treats disability compensation for each individual disability as a separate issue. Assuming that is the definition envisioned, VA does not currently have the technical capacity to reliably track timeliness at the issue level. Particularly in the case of legacy appeals, multiple appealed issues may be aggregated into a single Board decision, which, if tracked under current capabilities as one claim, could unintentionally skew the average timelines required under this bill. Achieving the technical capability to implement the bill would require expenditure of

substantial program and information technology resources and, therefore, require appropriations. VA does not have a cost estimate.

VA proposes that, if this provision moves forward, the bill should disaggregate the reporting requirement into the average for legacy claim remands and for remands under AMA because once all legacy remands are completed, the need for reporting on the legacy system remands would cease.

VA also cites concern with the portion of section 2(a) that would require reporting on the number of cases advanced on the docket (AOD) to be disaggregated by the reason provided in the request. While VA can report the number of cases granted AOD after a decision is rendered, disaggregated by reason (i.e., age, financial distress, serious illness, other), current systems do not track motion denial reasons.

VA further cites concern with the portion of section 2(a) that would require reporting on the number of Board dismissals, disaggregated by dismissals due to the claimant's death, and whether the death was a suicide. First, while VA currently can report the number of dismissals due to death, Board systems do not track cause of death. Second, this raises substantial privacy concerns, including the risk of exposing personal information, compromising confidentiality laws, and retraumatizing surviving families.

The agency is currently notified by the Social Security Administration (SSA) once a claimant has passed away. A death certificate may not always be of record to determine that the appeal should be dismissed, and the record may contain incomplete evidence to establish that a Veteran passed away by suicide. Therefore, VA cautions that any reporting on this specific data point may not be accurate or beneficial given the limited nature of available information and the privacy concerns noted above. Moreover, VA cautions that this requested data point may create an unintended perceived correlation between a pending appeal and Veteran suicide.

Summary: Section 2(b) would require the Secretary to prescribe guidelines for advancement of a case on the Board's dockets.

Position: VA does not support this provision.

Views: VA does not support this provision, which would require the Board to prescribe guidelines for AOD, including the type of evidence required to support the motion. VA views this provision as a duplicative and unnecessary requirement. The criteria for advancement on the docket—e.g., advanced age (defined as 75 years or older), serious illness, and severe financial hardship -- are already contained in statue and regulations. The Board applies the relevant statutes and regulations to guide its determinations on motions for AOD to ensure that those appellants most in need of an

expedited decision receive priority processing. Decisions with an AOD status comprised approximately 24% of the Board's fiscal year (FY) 2025 caseload.

Summary: Section 2(c) would add new section 38 U.S.C. § 5109C to require the Secretary to track data, and submit to Congress an annual report, regarding whether each claim for a particular benefit is: continuously pursued, filed in the national Work Queue but not assigned for adjudication, afforded expeditious treatment by VBA, remanded by the Board, or pending a Board hearing. The Secretary would also be required to track instances where a VBA adjudicator does not comply with remand instructions of the Board, supplemental claims filed within continuous pursuit after a finally adjudicated decision, and "first notices" submitted to the Secretary of death of individuals in receipt of VA benefits.

Position: VA cites concerns with portions of this provision and opposes other portions of it.

Views: This section would require VA to substantially modify its systems to track and report numerous aspects of claims processing. As expressed below, some proposed tracking requirements would impose a heavy and, in our view, unnecessary burden on the Board.

VA cites concern with the portion of section (2)(c)(1) that would require VA to track claims, and issues within claims, that are continuously pursued. As an initial matter, we incorporate our suggestion above (in our views on section 2(a)) regarding the definition of "issue." Additionally, the Board has no ability to track this information within its current case management systems, partly due to a lack of consistency in how claims are identified, and efforts to do so would require significant information technology development and testing resources to achieve changes in business processes and necessary system integration across VA. This would create a heavy and unnecessary resource burden on the Board.

VA opposes the portion of section 2(c)(1) that would require VA tracking and reporting on instances in which a VBA adjudicator does not comply with instructions in a Board remand decision. Complying with this requirement for AMA appeals would involve an entirely new structure and review program covering all post-remand Agency of Original Jurisdiction (AOJ) decisions, which would require considerable additional personnel resources and information technology development costs. This increased resource burden would divert valuable personnel and financial resources away from the Board's focus on deciding pending appeals as swiftly and fairly as possible. Tracking compliance with Board remands also would require increased system integration to track remands and would require significant VA technological development and testing to successfully accomplish.

Even with system modification, tracking noncompliance with Board remands presents practical problems with obtaining accurate data. First, compliance with a Board remand is a subjective measure that might not be consistently captured by individual Veterans Law Judges for several reasons, and this would lead to inconsistent data of questionable reliability for potential intervention strategies. Second, if the AOJ grants the claim in full without conducting the development directed by the Board, it is unclear if this would trigger reporting requirements under a failure to comply even though the claim has been resolved in the Veteran's favor. Third, for AMA claims, unless the post-remand AOJ decision is appealed to the Board within 1 year, there is no system in place, and no practical system we can envision, to determine whether the AOJ has complied with the Board's remand. Under the AMA, claims are not automatically returned to the Board following a post-remand AOJ decision. Thus, the Board does not review those claims for compliance with remand instructions. Legacy claim remands are, of course, a diminishing percentage of all Board remands.

To the extent this provision relies on the duties imposed on the Board in section 2(d) with respect to remand compliance, please see our views expressed below on that section.

Should the Committee nevertheless decide to move forward with this provision, VA requests that the statutory language clarify whether the term "remand" encompasses both legacy remands and AMA remands.

VA cites concerns with the portion of section 2(c)(1) that would require VA to track and maintain information specifically for supplemental claims, including disaggregation between those filed within a year of the last VA decision (within continuous pursuit) and those filed outside of that period.

VA's Veterans Benefits Management System application is not designed to track the date of prior decisions for each issue in any given supplemental claim. While the required supplemental claims form asks the claimant to identify the specific issues and the date of the VA decision notice, this data is not recorded in VA systems and is used only by claims processors who are responsible for reviewing all claim submissions and evidence of record to determine if the claimant has maintained continuous pursuit.

Therefore, VA expresses concern with the current technological capabilities of the agency to comply with the statutory requirements for these reports given that VA's current systems do not capture this data. Appropriations would be necessary, but VA does not have a cost estimate at this time.

Summary: Section 2(d)(1) would expand the authority of the Board to aggregate claims that contain common issues of law or fact. The Secretary would be required to submit a report to Congress, every 5 years, on the aggregation of claims.

Section 2(d)(2) would require the Secretary to ensure substantial compliance with Board remands, except where the Board has determined that evidence added to the record after a remand is sufficient to resolve the underlying issues or where the remand decision was unnecessary, in which case the agency of original jurisdiction may "waive" the compliance requirement.

Position: VA does not support this provision.

Views: Section 2(d)(1) of the bill would provide the Chairman of the Board the authority to aggregate certain claims. Attempting to aggregate different Veterans' appeals would substantially alter the Board's case processes and would upend docket order rules in unfair ways for many Veterans with pending appeals.

First, this section would create a statutory conflict with 38 U.S.C. § 7107(a)(4), which requires the Board to decide each case before the Board "in regular order according to its respective place on the docket." Additional statutory language would be needed to address this tension and make clear how the Board can aggregate appeals without violating the docket order requirement. Similarly, statutory guidance would need to be provided on the timing applicable to a Veteran's right to a hearing and right to determine the scope of the evidentiary record in their case. *See* 38 U.S.C. §§ 7105(b)(3), 7107(c), 7113. It is unclear who would get the opportunity for a hearing before the decision on the common question, and what the evidentiary record would be for such a decision. Even with statutory rules explicitly addressing these disconnects, the aggregation of appeals with different evidence windows would add further confusion to the AMA system at a time when Veterans and representatives are still becoming familiar with the nuances of the AMA.

Second, the aggregation of different Veterans' appeals would be a sharp departure from the Board's longstanding role in evaluating the particular and unique facts and circumstances for each appeal that is filed at the Board. A claim for benefits is first adjudicated by the AOJ. If an adverse decision by the AOJ is appealed to the Board, the Board will review the claim de novo and decide all questions of law and fact necessary to adjudicate the claim for benefits. Aggregation would apply a legal or factual conclusion to an entire class of claimants, but without appropriate consideration of the specific and unique facts of each case. If the goal of this bill is efficiency, the Board is at its most efficient when it is resolving individual cases based on the particular facts at issue. This has been the Board's task for decades. In contrast, in addition to the agency's general authority to promulgate regulations interpreting statutory provisions, it is the VA Office of General Counsel (OGC) and the U.S. Court of Appeals for Veterans Claims (CAVC) that are tasked with issuing precedential opinions for common questions of law or fact. *See* 38 U.S.C. §§ 7104(c), 7261. To be clear, it would only delay appeal resolution if cases that are ready for adjudication

are: (1) paused by the Chairman in order to provide appropriate due process for aggregation, then (2) joined with other cases for a decision on the common question, and then (3) placed back in the queue for another decision on the particular facts of the individual case. This is because, even after aggregation, each appeal would have to be adjudicated on its own factual basis and would require independent analysis. The evidence of record for each individual case is still unique and would have to be evaluated individually. Therefore, aggregating appeals would not speed up the process for any Veteran. Also, we note that most appeals decided by the Board include multiple disability compensation claims. This dynamic will lower the system-wide productivity value of aggregation. Even if one claim is resolved via an aggregated case and removed from the original pending appeal, the other claims in the appeal must still be decided. The record still must be reviewed, and a decision still must be drafted. In addition, aggregation would require a significant amount of attorney and/or Board resources to determine what metrics would be applied in choosing cases for aggregation and on-going review of the Board's entire, transitory, pending inventory of approximately 187,000 cases to identify a common class of Veterans. We note concern that there would likely be a new cottage industry of cases related to disputes over whether someone should or should not have been included in an aggregated case, and those decisions might be subject to appeal, meaning additional delay, by years, of the underlying merits adjudication.

There are also significant technological resource concerns, as the Board's case-processing system (Caseflow) is not currently designed to docket, process, or otherwise track aggregated appeals. Aggregation would require the Board to completely revise its case management systems, to include integration with other VA systems, to allow this entirely new method of moving cases ahead of others. It would require both a complete overhaul of the Board's docketing system and would also require other potential changes for unforeseen consequences.

If Congress is nevertheless interested in granting the Board this authority, VA recommends adding the words "in the sole discretion of the Chairman" to the proposed new sentence of § 7104, such that "the Chairman may, in the sole discretion of the Chairman, aggregate such appeals." This would reinforce a principle that the word "may" already suggests that aggregation would be solely in the discretion of the Chairman. We also suggest, for purposes of promoting efficiency, that Congress consider adding a sentence that affirmatively states that any aggregation decision made by the Chairman is final and not subject to appeal to the court. Otherwise, the provision would invite litigation by claimants seeking to enforce a perceived right to aggregation.

Section 2(d)(2) would require the Secretary, "acting through a member of the Board," to ensure substantial compliance with any Board decision to remand a claim. The AOJ would be permitted to waive this requirement if a Board member determines that evidence added to the evidentiary record after the date of the Board remand decision is sufficient to resolve the underlying issues or such a decision was unnecessary. Respectfully, VA does not understand how this section would work—

namely, how the AOJ would waive the requirement based on a determination of a Board member who has no jurisdiction over, or involvement with, the claim at that point.

To the extent that this provision contemplates active oversight by a Veterans Law Judge of AOJ claims processing following a remand, such requirement would be grossly inefficient and resource intensive with little quantifiable benefit, given that the current system affords claimants who receive an AOJ decision on remand the right to appeal to the Board to correct any perceived AOJ error, including non-compliance with the Board's remand instructions. If the Board were required to review every claim it remands for AOJ compliance, as well as adjudicate AOJ requests for waivers, the Board estimates that the resource drain would effectively cut Board annual adjudications by at least half. Approximately 57,000 appeals adjudicated during FY 2023 included at least one issue remanded by the Board. Using that data as a benchmark, the provision would require at least 57,000 additional Veterans Law Judge reviews and opinions to be rendered per year, consuming valuable judicial resources.

This would lead to an exponential growth in pending appeals and impose additional delays on all cases. Overall, this would make the VA appeals system markedly less efficient, contrary to the purpose of the AMA and would be harmful to Veterans, particularly those who have already waited a long time for resolution of their appeals.

To the extent the intention of this provision is to ensure substantial compliance with Board remands, that duty is already part of binding caselaw. *Stegall v. West*, 11 Vet. App. 268, 271 (1998). If Congress wishes to codify that duty, it could simply state in the bill that "a remand by the Board imposes upon the Secretary a duty to ensure substantial compliance with the terms of the remand, absent a grant of the remanded issue."

Summary: Section 2(e) would expand the jurisdiction of the CAVC to certify classes with respect to claimants who are awaiting a Board decision, or who have received a Board decision and filed a supplemental claim within 1 year. This section would also allow the CAVC to remand questions of law or fact to the Board, while maintaining jurisdiction under a stay of judicial proceedings, where the Board has failed to (a) address an issue raised by the clamant (or the record) or (b) provide adequate reasons or bases.

Position: VA does not support this provision.

Views: Section 2(e) of the bill would revise 38 U.S.C. § 7252 to expand the jurisdiction of the CAVC. This expansion would not promote efficient claim resolution, would create confusion for and potentially prejudice Veterans, and is unnecessary.

This section would grant the CAVC jurisdiction over a claim currently being processed by VA, if it satisfies a class definition certified by the CAVC. This would create confusion for Veterans as to which entity has jurisdiction over their claim, not to mention delay if VA pauses claim processing to await the CAVC's decision. Veterans who have filed a notice of disagreement and expect Board review, or who have filed a supplemental claim and expect the VA regional office to review their new evidence (proposed § 7252(b)(1)(A)(ii) includes claimants who have chosen to file a supplemental claim rather than a CAVC appeal after a Board decision), would suddenly find that the CAVC, an entity which they may have chosen to avoid, has jurisdiction over and can issue a binding decision on their case. The bill provides no due process protection for such Veterans, who could find themselves personally bound by an unfavorable decision that they did not request, in a proceeding that they may not have known about. Although the bill refers to Veterans who "have not opted out" in proposed § 7252(b)(2), it provides no protections on opt-out procedures. Even if it did, it would be very confusing for a Veteran to weigh the advantages and disadvantages of opting-out, with high stakes for that choice, since an unfavorable class ruling personally binds class members, i.e., once the CAVC has decided the issue, the Veteran is permanently foreclosed from providing alternative arguments on it.

This expansion is also unnecessary, as the CAVC already has the authority to issue precedential decisions on common questions of law or fact. Through a precedential decision, it can create a binding rule of law that VA must apply to all claims currently being processed. Precedential decisions are more advantageous for Veterans, because unfavorable precedents can be distinguished, whereas unfavorable class action rulings are personally binding for class members. Meanwhile, favorable precedents are no less advantageous, on balance, than favorable class action rulings, as VA must abide by both.

Moreover, as a matter of efficiency, it is unclear the benefit of bestowing the CAVC with direct jurisdiction over claims currently pending with VA, as the Court's jurisdiction is to review Board decisions, 38 U.S.C. § 7252(a), not to decide pending claims in the first instance, which is prohibited by 38 U.S.C. § 7261(c). Thus, the CAVC would presumably be granted "supplemental jurisdiction," a term which may need to be better defined, over the claim to address a common question—but then remand it for the Board and possibly the regional office to address the case's individual facts in the first instance. If the claimant disagrees with the Board's or regional office's individual fact determinations, or on legal rulings outside the scope of the class issues, the case will then return to the CAVC a second time. This process would not promote efficient claim resolution.

Finally, this expansion of CAVC jurisdiction is contrary to the very well-documented and carefully considered legislation that originally created the CAVC in 1988, especially the debate about the appropriate jurisdictional scope of the court to review only "final" decisions by the Board. While the Senate had passed Veterans' judicial review bills in five previous sessions, the House did not pass such a bill until a compromise emerged (the Veterans' Judicial Review Act) that limited the nature of the

court that would be created: an appellate court that would be authorized to review questions of law and fact arising from a final agency action (a Board decision), but would not have jurisdiction over claims still proceeding through the "unique and desirable" administrative system, would not "have arrogated [ ] power" to "run the VA's claims system, and decide its cases for it," and could be singularly focused on Board decisions to avoid the "burden[ ]" and "delay" attendant with district court-like jurisdiction. S. Rpt. 100-418 (1988); H. Rpt. 100-963 (1988); 134 Cong. Rec. H9253 (October 3, 1988); 134 Cong. Rec. H10333 (October 19, 1988).

Section 2(e) would further provide that class members may submit a supplemental claim, notice of disagreement (NOD), or request for higher-level review (HLR), during the period between the filing of the motion for class action and 60 days after the later of the CAVC's final decision "with respect to such claim" or "with respect to such motion for class action." At the outset, it is unclear what "claim" is being referred to in the language "with respect to such claim." More importantly, however, the intent of this subsection is unclear. If the intent is to broaden the timeframe for these claimants to submit their supplemental claims, NODs, and requests for HLR, VA recommends replacing the "may submit" language here with "shall not be prohibited from submitting" language. Even with that replacement, however, this subsection would create confusing timelines, as VA processors evaluating whether a supplemental claim, NOD, or request for HLR is timely might have to review all recent motions for class action at the CAVC, determine whether the claimant was within the class definition, and determine the date of the CAVC's final decision on the motion and the claim, all to determine timeliness. Such a task does not promote efficiency.

Moreover, on the issue of agency timelines, some Veterans may think they satisfy the class definition, that the CAVC has supplemental jurisdiction over their claim, and that they need not meet ordinary agency timelines, but—if they are wrong—their claim is final and there is no recourse. Again, the potential for confusion with supplemental jurisdiction outweighs any speculative potential benefits.

Section 2(e) would next permit tolling when a claim is decided by the Board during the period the CAVC is reviewing a motion for class action. If the Committee moves forward with this section, VA recommends replacing the word "if" with "until" to clarify the length of the tolling and inserting a comma between the terms "review" and "the deadline."

Finally, section 2(e) would authorize the CAVC to issue limited remands to the Board, while retaining jurisdiction, for purposes of addressing a relevant issue or providing adequate reasons or bases. We note that the CAVC has issued limited remands in rare instances, so the court may believe it already has such authority. This authority would disrupt Board efficiency and could also create a perpetual loop between the Board and the CAVC if the court continues to determine that the Board's reasons and bases are inadequate. This could have a similar effect as the remand loop between the Board and the AOJ experienced in the legacy process that the AMA was intended to cure. In addition, the Board would need to build new functionality in its

Caseflow digital management system to accommodate this type of remand, which would require significant resources.

We also note that the section is unclear as to what would happen if the limited remand results in a conclusion by the Board that there was a duty to assist error that needs to be corrected by the AOJ. It is unclear whether the Board could remand the case to correct that error, or whether the court would still have jurisdiction. The statute should directly address this eventuality.

If Congress is nevertheless interested in exploring this authority, VA recommends making this authority part of a 6-month pilot program to test its efficiency. VA also recommends that Congress require the CAVC to give the Board at least 180 days to issue its supplementary decision, to account for other Veterans' appeals that have been waiting. Finally, VA recommends that Congress preclude entitlement to Equal Access to Justice Act (EAJA) fees on the basis of the CAVC ordering a limited remand, so as to prevent potential manipulation. At present, only about 20% of the average of 8,000-10,000 appeals filed with the CAVC each year are reviewed by the court's judges. The remaining 80% are set aside and remanded to the Board for further adjudication by order of the Clerk pursuant to agreement of the parties. This generates approximately $45-50 million in EAJA fees per year, regardless of the fact that most remands ultimately do not lead to a changed result for the Veteran. If EAJA is not precluded from this limited remand authority, a similar trend is likely to appear.

Summary: Section 2(f) of the bill would require the Board Chairman to carry out a study to identify questions of law or fact the Board commonly considers for which precedential guidance would assist the Board in issuing final decisions on such appeals.

Position: VA does not support this provision.

Views: To the extent that the provision is intended to increase consistency across Board decisions, this is a burdensome and unnecessary means. The CAVC issues dozens of precedential opinions per year on commonly arising questions of law. In addition, the Board already has the authority to request an opinion from VA's OGC when it identifies a legal issue that warrants precedential guidance. And questions of fact are generally case-specific and not appropriate for precedential guidance.

Summary: Section 2(g) would require VA to enter into an agreement with a Federally funded research and development center (FFRDC) to assess modifying the authority of the Board to issue precedential decisions with respect to questions of law or fact.

Position: VA cites concerns with this provision.

Views: The complexity and scope of this proposal would require significant resources to enter into that contractual agreement – probably several million dollars, at a minimum – that could require resource trade-offs within the current Board budget. That does not account for the acquisition and legal resources needed to execute and monitor performance of the agreement. Because such a study would evaluate a potentially substantial change to the Board's adjudication of appeals, the time and personnel resources involved with those participating would be extensive. The evaluation and full consideration of various options would be a large and complex undertaking, especially given the Board's historic role of issuing nonprecedential decisions.

The section also would require VA to begin developing policies and procedures to implement the FFRDC recommendations no later than 90 days after receipt of the FFRDC assessment, and to complete such development 6 months thereafter. But the policies or procedures to implement recommendations could be significant and complex and would have to go through multiple levels of internal review, as well as potentially notice and comment rulemaking, to carefully debate and consider the revision and overhaul of various regulations, processes, and procedures. Thus, it would take significantly longer than 90 days and 6 months to begin developing and to complete the necessary policies and procedures required under this proposal.

VA also cites concerns with the assignment of authority to FFRDCs without clear statutory guidance on their role as determining authorities within VA. While an independent assessment of the feasibility of Board precedential decisions and the consolidation of appeals could yield valuable insights, the requirement for strict implementation of the findings appears to unduly restrict the Secretary's decision-making authority for final implementation, under which the Secretary considers the overarching needs of the agency.

Cost Estimate: VA does not have a cost estimate for this bill.

S. 2061 Molly R. Loomis Research for Descendants of Toxic Exposed Veterans Act of 2025

Summary: Section 2(a) of this bill would amend section 501 of the Honoring our Promise to Address Comprehensive Toxics Act of 2022, which generally sets forth the functions of the Toxic Exposure Research Working Group, to include a requirement that the Working Group establish a Federal interagency task force to conduct collaborative research activities.

Section 2(b) would amend section 501(c), which sets forth reporting requirements for the Working Group, to require a report, not later than 1 year from the date of enactment, containing a description of the collaborative research activities identified by the Working Group, the findings of the members of the Working Group with

respect to such collaborative research activities, and such recommendations as the Working Group may have for legislative or administrative action to improve collaborative research activities among members of the Working Group. Annually, during the five-year period covered by the Working Group's strategic plan, it would have to report to Congress a summary of the collaborative research activities carried out by the members of the Working Group and the findings of the members with respect to such activities, a progress report on implementation of the strategic plan developed by the Working Group, and the Working Group's recommendations for legislative or administrative action to improve collaborative research activities among the Working Group's members.

Section 2(c) would require the Working Group and the Agency for Toxic Substances and Disease Registry (ATSDR), not later than 180 days after the date of enactment, to establish an interagency task force to conduct research on the diagnosis and treatment of health conditions of descendants of toxic-exposed Veterans and maintain a publicly available website with information on the activities and findings of ATSDR, including a review of all relevant data to determine the strength of evidence for a positive association between a health condition researched and a toxic exposure risk activity based on the categories set forth under 38 U.S.C. § 1173(c)(2) (which sets forth four categories including sufficient, equipoise and above, below equipoise, and against).

Position: VA does not support the bill.

Views: This bill would duplicate work performed by the National Academies of Sciences, Engineering, and Medicine (NASEM). NASEM, an independent, non-government organization, has an agreement with VA to conduct extensive reviews of the health effects of military service, particularly focusing on Gulf War- and Vietnam-era-Veterans and their associated exposures. Their reports categorize the strength of association between military service and health outcomes into several levels, from sufficient evidence of a causal relationship to limited evidence of association.

Scientific evidence suggests that toxic exposure-induced generational effects have not occurred in military Service members who deployed to the Southeast and Southwest Asia theaters of operation. The Working Group has since established a framework for toxic exposures research that covers multiple categories, including environmental, occupational, situational, and training contexts. In this context, we believe current efforts satisfy the intended outcome of the bill.

Cost Estimate: VA does not have a cost estimate for this bill.

S. 2220 Fighting for the Overlooked Recognition of Groups Operating in Toxic Test Environments in Nevada (FORGOTTEN) Act of 2025

Summary: Section 2(a) of the bill would require DoW to expand the Individual Longitudinal exposure Record (ILER) to document all toxic exposures of members of the Armed Forces, including those that occur within the United States, so such

information can be available for VA when such members transition to civilian life. Information relating to all-hazard occupational data and environmental hazards that were known or found later to which the member was exposed, including through conducting any monitoring in an area in which the member may have been exposed, would have to be included.

Section 2(b) would require DoW to expand ILER to include medical encounter information relating to toxic exposures (such as diagnosis, treatment, and laboratory data) and medical concerns that should be addressed regarding possible toxic exposures for members of the Armed Forces so it can be available for VA when such members have transitioned to civilian life.

Section 2(c) would require DoW and VA to ensure that ILER is available, for purposes of improving internal processes, to VA and DoW health care providers, epidemiologists, and researchers, as well as VA disability evaluation and benefits determinations specialists.

Section 2(d) would require DoW to document in the Service records of a member of the Armed Forces whether such member served at a location where there was a potential of toxic exposure. In carrying out this requirement, DoW would have to ensure that service at any location that is classified would be protected from disclosure and could contain a box to be checked to indicate that a member of the Armed Forces served at a location where there was a potential for toxic exposure.

Position: VA defers to DoW in part on this section but otherwise supports this section, subject to the availability of appropriations.

Views: Sections 2(b) and 2(d) would establish requirements for DoW, and VA defers to DoW on those provisions. Sections 2(a) and 2(c) would generally reinforce current requirements regarding ILER, and VA supports these efforts. Capturing toxic exposure information in ILER allows VA to process claims under 38 U.S.C. § 1168 more accurately when a Veteran participated in a toxic exposure risk activity (TERA). Participation in a TERA can also establish eligibility to enroll in VA health care under 38 U.S.C. § 1710(e)(1)(G),

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Summary: Section 3 would state that members of the Armed Forces and DoW civilian employees who are or have been stationed or employed at a covered facility would be presumed to have been exposed to toxic substances. The term "covered facility" would mean any facility on the most recent list of facilities covered by the Energy Employees Occupational Illness Compensation Program Act of 2000 (EEOICPA) 42 U.S.C. § 7384 *et seq.*) published in the Federal Register by the Department of Energy.

Position: VA cites concerns with this section.

Views: VA strongly agrees that individuals exposed to radiation or toxic substances should be compensated for their losses, but we note that it is unclear what legal effect would result from Service members and civilians being "presumed to have been exposed to toxic substances." If the intent is for this presumption to result in the provision of benefits, the EEOICPA already provides a compensation program for the civilian men and women who, over the past 80 years, have performed duties uniquely related to the nuclear weapons production and testing programs of the Department of Energy and its predecessor agencies. Workers from certain Atomic Weapons Employers are also covered under the Act. In this context, section 3 may duplicate other provisions of law. VA defers to the Department of Labor on the exact nature of any overlap.

Summary: Section 4(a) would require DoW to classify the Nevada Test and Training Range (NTTR) as a location where contamination occurred. Section 4(b) would require the Air Force to establish a process to identify current and former members of the Armed Forces that were stationed at the NTTR since January 27, 1951. The Air Force would have to establish a process to permit current and former members of the Armed Forces to provide documentation of evidence of their assignment within the NTTR to assist the Air Force in identifying those current and former members. The Air Force would have to make all efforts to identify current and former members of the Armed Forces who were stationed at the NTTR and could not require current or former members of the Armed Forces to submit evidence of their stationing.

Position: VA generally defers to DoW on this section.

Views: VA generally defers to DoW on this section, as it would establish requirements for that Department. However, we note that once DoW identifies the cohort of Veterans who served at the NTTR, VA could use this information to support the delivery of benefits and health care to eligible Veterans.

Summary: Section 5 would amend 38 U.S.C. § 1112(c)(3)(B), which defines the term "radiation risk activity" in the context of presumptions relating to certain diseases and disabilities, to include, at any time on or after January 27, 1951, onsite participation in any aspect of the development, construction, operation, or maintenance of a military installation (as defined in 10 U.S.C. § 2801) at a covered location at the NTTR. It would also add a new definition in § 1112(c)(3)(C) to define the term "covered location at the Nevada Test and Training Range" to mean a location at the NTTR where there was a potential of toxic exposure.

Position: VA cites concerns with this section.

Views: VA cites concerns with this section. The bill would define the term "covered location at the Nevada Test and Training Range" to mean a location "where there was a potential of toxic exposure," but the definition would qualify the new clause under the definition of "radiation-risk activity." If there is a reason why generalized "toxic exposure" is included as separate and distinct from radiation, VA recommends including that information and considering adding that exposure information outside of this radiation-specific statute. We also note that there is no end date for qualifying service at the NTTR; VA defers to DoW on whether there are continuing risks of radiation exposure, but including a specific exposure end date would allow for more precise implementation.

VA further recommends that DoW or the Department of Energy provide sufficient evidence to support the inclusion of service at NTTR as a radiation risk activity. Air sampling studies since 1963 have shown insignificant airborne plutonium levels at the nearest occupied workplace on the NTTR, below global levels detected after historical nuclear tests.

Summary: Section 6 would amend 38 U.S.C. § 1119, which generally deals with presumptions of toxic exposure, to amend the definition of "covered veteran" to include any Veteran who, on or after January 27, 1951, performed active military, naval, air, or space service while assigned to a duty station in, including airspace above, a covered location at the NTTR. It would define the term "covered location at the Nevada Test and Training Range" to mean a location at the NTTR where there was a potential of toxic exposure.

Position: VA cites concerns with this section.

Views: VA cites concerns with this section because it would amend the definition of "covered veteran" for purposes of section 1119, which generally establishes eligibility limited to service in the Southwest Asia Theater of Operations (on or after August 2, 1990, active service while assigned to a duty station in Bahrain, Iraq, Kuwait, Oman, Qatar, Saudi Arabia, Somalia, or the United Arab Emirates; and on or after September 11, 2001, active service while assigned to a duty station in Afghanistan, Djibouti, Egypt, Jordan, Lebanon, Syria, Yemen, or Uzbekistan). Including service in the NTTR with these cohorts would create confusion and unnecessary complexity for implementation of benefits for these populations. The proposal would also create operational challenges as VA systems currently use automation and streamlined procedures to increase claims processing efficiency; revising this definition would require burdensome procedural and system updates to separate Veterans who served at the NTTR from other "covered veterans." If Congress intends to move forward, creating a separate statutory authority defining the presumption of exposure for NTTR Veterans would be more effective and would avoid these concerns.

Summary: Section 7 would amend 38 U.S.C. § 1120, which generally establishes presumptions of service connection for certain diseases associated with exposure to burn pits and other toxins, to include, only in the case of covered Veterans described through the amendments made by section 6 of this bill, lipomas and tumor related conditions.

Position: VA cites concerns with this section.

Views: As noted in the discussion of section 6, VA recommends against including Veterans who served in the NTTR in the definition of "covered veterans." Creating a separate authority would again be clearer. Additionally, VA notes there is no proven connection between radiation exposure and lipomas. Causes of lipoma are thought to be genetic predisposition, trauma that may trigger lipoma growth, hormonal changes (such as seen in women during childbearing years), obesity, or several syndromes that are noted to have increased risk of lipomas as part of the disease. VA also notes it is unclear what it meant by "tumor related conditions."

Cost Estimate: VA does not have a cost estimate for this bill.

S. 2264 Advancing VA's Emergency Response to (AVERT) Crises Act of 2025

Summary: Section 2(a) of the bill would require VA to submit to Congress, within 180 days of enactment, a report outlining the roles and responsibilities of all offices within VA involved with emergency management. Section 2(b) would require VA, in preparing the report, to consult with the Comptroller General, VA's Inspector General, the Secretary of Homeland Security, and such other Federal agencies as the Secretary considers relevant to obtain insights from their experience and trends that they have found, and such recommendations they may have with respect to VA's management of emergency management functions. Section 2(c) would set forth the required contents of the report required by subsection (a).

Position: VA has no objection to this section, subject to the availability of appropriations.

Views: VA has no objection to this section but notes that a specific reporting requirement is unnecessary. VA can provide information to Congress upon its request, so legislation is unnecessary. VA routinely consults with interagency partners to obtain insights and identify areas for improvement regarding our emergency management programs and disaster operations support. These observations are regularly integrated into our continuous improvement efforts.

Additionally, VA has been conducting workforce optimization planning over the past year, including a review of emergency management roles and responsibilities across the enterprise to ensure an emergency management program that is enterprise

focused, regionally coordinated, and locally executed. VA expects to complete this review along with analysis of the feasibility and advisability of consolidating or centralizing key functions by the end of the year. VA can provide information to Congress upon its request once the analysis is completed.

Summary: Section 3(a) of the bill would require VA, within 180 days of enactment, to submit to Congress a report on VA's Regional Readiness Centers (RRC). Section 3(b) would set forth the required contents of the report required by subsection (a).

Position: VA has no objection to this section, subject to the availability of appropriations.

Views: VA has no objection to this section but notes that, in compliance with section 401 of the Joseph Maxwell Cleland and Robert Joseph Dole Memorial Veterans Benefits and Health Care Improvement Act of 2022 (division U of P.L. 117-328; 38 U.S.C. § 8121, note), VHA is standing down the RRCs that the Defense Logistics Agency (DLA) is operating in support of the personal protective equipment stockpile. VA anticipates an estimated $12M per year cost savings.

VA is required by section 401 to create and maintain a critical item list of medical supplies, equipment, and devices essential to patient care and emergency response. This list ensures VA medical centers (VAMC) maintain or obtain an adequate supply of mission-critical medical items, especially during supply chain disruptions, public health emergencies, or other disasters. VA is prohibited from exclusively relying on stockpile material and instead must use DLA's Warstopper Program as the first choice for response.

As noted in the discussion of section 3, VA can provide information to Congress upon its request, so legislation is not necessary. VA expects to sunset fully the two remaining RRCs by March 2026. The agreement with DLA for the warehouses will stay in place for emergency situations to allow for mobilization if necessary. Zero (0) RRCs will remain.

Summary: Section 4 of the bill would require VA to submit to Congress a report, not later than 90 days after enactment, on current limitations preventing the Federal Emergency Management Agency (FEMA) from providing fuel or other resources to VA during emergencies, whether VA requires congressional action to allow such resource sharing, whether VA has been able to coordinate with FEMA during prior emergencies or Fourth Mission activations due to a lack of authority, and whether VA requires Congressional action to address the lack of coordination with FEMA.

Position: VA has no objection to this section, subject to the availability of appropriations.

Views: VA has no objection to this section, but as noted with sections 2 and 3, VA can provide information to Congress upon its request, so legislation is not necessary

VA works in close coordination with FEMA and all interagency partners before, during, and after a disaster. VA provides liaisons to the National Response Coordination Center during incident response specifically to ensure coordinated resource sharing and a unified national response. Disruptions to fuel supply and fuel shortages in hard-hit communities following a disaster are common. These disruptions and shortages hinder or prevent local workforces and responders, including VA health care workers, from providing care and services to Veterans and disaster survivors. Although VA and FEMA have the means to obtain and distribute fuel to affected communities, VA does not have the authority to permit VA employees or responders to use VA-purchased fuel. Additionally, VA's workforce does not meet the definition of "responder" and has not been able to use FEMA "responder" fuel brought into affected communities. VA is working with FEMA to ensure a better understanding of how VA's health care workforce and other staff are activated as responders to meet the needs of Veterans and disaster survivors during and after an incident.

Cost Estimate: Veterans Affairs estimates $335,700 for the required reports.

S. 2309 Veteran Burial Timeliness and Death Certificate Accountability Act

Summary: Section 2 of the bill would state Congress' findings that states and counties have reported significant delays in the signing of death certificates for Veterans who pass away from natural causes, that such delays (caused by the refusal of, or postponement by, VA physicians) have, in some cases lasted as long as eight weeks, and that such delays prevent the timely burial of deceased Veterans and access to survivor benefits.

Section 3(a) of the bill would require VA physicians or nurse practitioners who are the primary care providers of a Veteran who dies of natural causes to certify the death of the Veteran not later than 48 hours after the physician or nurse practitioner learns of such death. It would further provide that if a VA physician or nurse practitioner could not comply with that requirement, a coroner or medical examiner in the jurisdiction where the death occurred could certify such death.

Section 3(b) would require VA, not later than 1 year from enactment and annually thereafter, to submit to Congress a report regarding compliance with subsection (a). Each report would have to include the percentage of cases in which a VA physician or nurse practitioner complied with subsection (a), the number of cases in which a VA physician or nurse practitioner could not comply, and an identification of the most common reasons why they were unable to comply.

Section 3(c) would provide a rule of construction that nothing in this Act could require any VA employee, including a physician or nurse practitioner, to take an action not in compliance with the laws, regulations, or requirements of the appropriate jurisdiction in which the employee is licensed or practicing, or in which a death may need to be certified.

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

Views: VA supports this bill, subject to amendments, because alleviating delays in the certification of a Veteran's death would support continued collaboration and information sharing between VBA and VHA in support of faster claims decisions for survivors. VA recognizes and has proactively implemented measures to address concerns this bill aims to address. On June 25, 2025, VA published VHA Notice 2025-03, "Survivors Assistance and Memorial Support," which provides a framework to ensure standardized clinical and operational processes, training, and oversight to support primary survivors and next of kin. This Notice addresses a number of the provisions outlined in the bill.

VA recommends amending the bill in two ways. First, the bill's requirements for VA physicians or nurse practitioners to certify a Veteran's death within 48 hours is unduly specific and would be difficult or impossible to meet in some situations. VHA Notice 2025-03 requires VA health care providers to sign death certificates within 2 business days of notification, adhering to state and local laws. This standard of 2 business days allows for necessary information gathering, accommodates providers' schedules, and respects state and local laws. Over 95% of Veteran deaths occur outside VA facilities, making timely completion complex due to the need for collateral history from various sources and other jurisdictional requirements. VA recommends changing the 48-hour requirement to a 2-business day requirement. Further changes may be needed to account for variations that may arise based on where the Veteran died.

In addition, this bill would exclude Physician Assistants (PA) from certifying death certificates. VHA policy includes PAs as certifying health care providers because PAs are trusted, licensed clinicians who significantly contribute to VA's health care system. VA recommends amending the bill to allow PAs to certify the death, in addition to physicians and nurse practitioners.

We also note that the reporting provisions outlined in section 3(b) would require enhancements to current data systems and pose significant operational challenges.

Cost Estimate: VA does not have a cost estimate for this bill.

S. 2328 Military Learning for Credit Act of 2025

Summary: This bill would allow an individual entitled to educational assistance under 38 U.S.C. chapters 30, 32, 33, 34, or 35 or any other provision of law providing educational assistance to a veteran or another individual in connection with the service of a veteran in the Armed Forces, to use educational benefits to cover the cost of covered examinations and assessments up to $500 to receive credit toward degrees awarded by institutions of higher learning for approved programs of education. The bill would require VA to charge the number of months of entitlement equal to the cost of the examination or assessment divided by the monthly rate of Veterans' educational assistance to which the individual is entitled at the time of the examination or assessment. This entitlement charge would not affect entitlement to educational assistance under a law administered by DoW, including entitlement under DoW's Tuition Assistance Program. The examinations and assessments that would be covered under this bill are the following: a DANTES Subject Standardized Test Program (DSST) examination; a College Level Examination Program (CLEP) examination; the National Career Readiness Certificate examination; any other examination of a similar nature to these specified exams; and an assessment by an institution of higher learning of a portfolio or written narrative by a student with supporting documentation that demonstrates prior military training or learning.

Position: VA supports this bill, subject to amendment and the availability of appropriations.

Views: Under current law, VA pays benefits to eligible beneficiaries for examinations and assessments as defined in 38 U.S.C. § 3452(b) to include "national tests providing an opportunity for course credit at institutions of higher learning (such as the ... College-Level Examination Program (CLEP))." However, VA's current authority does not restrict payments to $500, and the bill would not amend or remove VA's existing authority to pay without restriction. If this bill were to become law without amendment to current law, there would be an inconsistency among the various statutes. The bill includes a $500 maximum payment for each examination or assessment. To ensure clarity, we recommend making explicit that this cap applies solely to payments made under this new authority and does not modify existing authority at 38 U.S.C. §§ 3452(b), 3315, 3315A, and 3315B. This avoids any unintended interaction with the current GI Bill provisions.

We suggest adding a new subsection (a) to read as follows: "Nothing in this section modifies existing authority found in 38 U.S.C. §§ 3452(b), 3315, 3315A, and 3315B." and redesignating all succeeding subsections accordingly.

Additionally, for individuals who want to use their educational benefits to cover the cost of examinations and assessments, it is unclear what is meant by basing entitlement charges on "the monthly rate of veterans educational assistance to which the individual is entitled" as required by section 2(d) of the bill. In fact, some beneficiaries do not receive any monthly payments. Instead, we recommend replacing the language in subsection (d) with language similar to the language in current statutes, such as 38 U.S.C. §§ 3315, 3315A, and 3315B, that base entitlement charges on a sum

certain. VA could work with the Committee to identify all the statutory provisions that would need to be changed to eliminate VA's current statutory authority to pay these benefits.

Additionally, in section 2(b)(1), this bill would identify chapters 30, 32, 33, 34, and 35 benefits as benefits that can be used to cover the cost of examinations and assessments. VA recommends Congress consider the removal of chapter 32 because currently no new beneficiaries can qualify for benefits under chapter 32. It is unclear whether chapter 1606 beneficiaries would be able to use their benefits for examinations and assessments under section 2(b)(2) of the bill, which would allow benefits under "any other provision of law providing educational assistance" to be used. As this statement is vague and seems to imply other educational assistance programs could qualify as well, VA recommends removing this provision.

Cost Estimate: VA does not have a cost estimate for this bill.

S. 2333 Health Records Enhancement Act

Summary: Section 2(a) would require, not later than 1 year from the date of enactment, VA and DoD to jointly take actions necessary to ensure that the health records of VA and DoD may be updated with observed health conditions and other relevant health information of a deceased enrollee by an individual designated by such deceased enrollee or, if no such individual is designated, an immediate family member of such deceased enrollee. Section 2(b) would require VA and DoD to jointly provide for a process by which an individual could make a designation for purposes of subsection (a). Section 2(c) would provide that any update would supplement information contained in the deceased enrollee's health records and could not modify information contained in such records. Section 2(d) would define the term "immediate family member" to mean the spouse, parent, brother, sister, or adult child of a deceased enrollee, or an adult person to whom the individual stands in loco parentis. The term "deceased enrollee" would mean an individual who, at the time of death, was enrolled in VA health care or was entitled to care under the TRICARE program as defined in 10 U.S.C. § 1072.

Position: VA supports the bill, if amended and subject to the availability of appropriations.

Views: The bill's restriction on modifying the health records of deceased Veterans, only allowing additions, conflicts with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule. Under the HIPAA Privacy Rule, personal representatives of deceased individuals have the right to request amendments to health information, which include making corrections, deletions, or additions if they believe the information is inaccurate or incomplete (45 CFR § 164.526).

To ensure clarity and compliance, the bill should explicitly state that the prohibition on modifying records of deceased Veterans, while allowing only additions, is

notwithstanding the HIPAA Privacy Rule. This approach would ensure that any new, relevant information can be added to health records without altering or deleting existing data, thereby maintaining the original information documented at the time of care.

Cost Estimate: VA does not have a cost estimate for this bill.

S. 2397 Coordinating and Aligning Records to Improve and Normalize Governance for Our Veterans Health Act of 2025 (CARING for Our Veterans Health Act of 2025

Summary: Section 2(a) would require the USH to ensure that the Office of Integrated Veteran Care (IVC, or successor office): (1) develops guidance for the efforts of VAMCs in obtaining final medical documentation after a Veteran receives services from a community care provider pursuant to a referral from that VAMC; (2) establishes goals and related performance measures for VAMCs in obtaining initial and final medical documentation from community care providers; (3) establishes and monitors goals and related performance measures for the completion by such providers of core trainings and ensures that such providers complete the required training course; and (4) takes steps to ensure IVC and any contractor communicate clear and accurate information to such providers regarding the core trainings recommended or required by IVC, including whether such training is recommended or required.

Section 2(b) would require VA, not later than 120 days after the date of enactment and every 120 days thereafter until all of the requirements under subsection (a) are fully implemented, to report to Congress on the steps taken to implement those requirements.

Position: VA supports the intent of this bill, subject to amendments and the availability of appropriations, but does not support the bill as written.

Views: VA supports the intent of this bill and is working to improve the receipt of medical records from VCCP providers. However, VA believes the bill would duplicate existing requirements and could be overly prescriptive. VA is already mandated by 38 U.S.C. § 1703(a)(2)(A) to ensure the scheduling of medical appointments in a timely manner and to establish a mechanism to receive medical records from non-Department providers. Additionally, section 105(a)(1)(D) of the Senator Elizabeth Dole 21st Century Healthcare and Benefits Improvement Act (Public Law 118-210) requires VA to carry out a pilot program to improve the timely return of medical record documentation for care provided under the Veterans Community Care Program.

The upcoming Community Care Network (CCN) Next Generation contract is designed to encompass all of the requirements proposed by the bill and further VA's existing authorities.

Some aspects of the bill's text may benefit from further clarification. For example, section 2(a)(1) refers to "final medical documentation," while section 2(a)(2) refers to both initial and final medical documentation.

Additionally, VA believes that administrative (primarily contractual), rather than legislative, solutions would be more effective in developing stronger enforcement mechanisms to ensure providers comply with medical record submission requirements. These alternatives would be better than legislation because they would be easier to alter if needed. VA is open to collaborating with the Committee to develop these appropriate solutions.

Cost Estimate: VA does not have a cost estimate for this bill.

S. 2683 Veterans Scam And Fraud Evasion Act of 2025 (VSAFE Act of 2025)

Summary: Section 2 of this bill would establish a new 38 U.S.C. § 325, subsection (a) of which would establish in VA a VSAFE Officer who would be responsible for fraud and scam prevention, reporting, and incident response plans at VA and serve as a central point of contact to direct Veterans to resources to prevent and mitigate fraud and scams.

Proposed § 325(b) would set forth the responsibilities of this Officer, which would include: (1) providing comprehensive communication from VA to VA employees and Veterans, their families, caregivers, and survivors during strategic and time-sensitive fraud and scam incidents; (2) establishing consistent guidance across VA for employees and Veterans, their families, caregivers, and survivors on how to identify, report, and avoid fraud and scam attempts; (3) promoting the VSAFE Fraud Hotline and VSAFE.gov website and identifying other identity theft resources available to Veterans, their families, caregivers, and survivors, including with respect to actions VA has taken to protect the identities of Veterans and their beneficiaries; (4) developing methods to monitor fraud and scam metrics within VA to provide internal and external reporting, establish advanced data analytics, and facilitate proactive and robust fraud and scam trend identification; (5) developing comprehensive training plans for VA employees fielding fraud and scam inquiries and reports; (6) coordinating with VA's Office of Inspector General (OIG) and other Federal departments and agencies to create a whole-of-Government view within VA to improve fraud prevention efforts within VA, identify the proper avenues for Veterans to report fraud attempts and receive assistance, and identify opportunities for coordination with other Federal departments and agencies; and (7) consulting with Veterans Service Organizations (VSO) and state, local, and tribal governments, as necessary, to improve the understanding of fraud and scam risks within VA.

Proposed § 325(c) would provide that nothing in this section would authorize an increase in the number of full-time employees otherwise authorized for VA.

Proposed § 325(d) would establish a rule of construction that nothing in this section could be construed to limit OIG's authority as otherwise provided in title 38, U.S.C., or in chapter 4 of title 5, U.S.C. (commonly referred to as the Inspector General Act of 1978).

Section 3 would amend 38 U.S.C. § 5503(d)(7), which generally limits pension payments for certain Veterans, by extending the sunset date of this provision from November 30, 2031, to January 30, 2032.

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

Views: VA supports efforts to ensure that Veterans, their families, and all VA beneficiaries are not the victims of fraud or scams. In January 2023, VA created the VSAFE Officer to lead VA's efforts in alignment with current VA efforts to enhance coordination across VA and the Federal Government.

VA recommends the bill clearly establish the VSAFE Officer within the Veterans Experience Office (VEO); this placement would ensure appropriate prioritization of coordinated and unified fraud prevention and response both internally and externally. Furthermore, the position would support partnership engagement to increase access, build trust, and participate in conversations at the appropriate level needed for the program to effectively carry out initiatives across VA, including setting strategy, framework, policy, and other guidance within VA.

In 2024, VA established the VSAFE Fraud Hotline (1-833-38V-SAFE) and VSAFE.gov website as a whole-of-Government front door designed in collaboration with others to provide resources to protect and support Service members, Veterans, their families, caregivers, and survivors from fraud and scams.

VA has technical amendments to this section to ensure clarity of authority and purpose; we also note that 38 U.S.C. § 325 already exists (establishing VEO), so this bill would either need to create a new section in title 38, U.S.C., or the bill could amend 38 U.S.C. § 325 to include the VSAFE Officer if VA's recommendation above to include the VSAFE Officer in VEO is adopted. We would be happy to work with the Committee to ensure such amendments are incorporated into the bill.

Cost Estimate: VA does not have a cost estimate for this bill.

S. 2737 Veterans National Traumatic Brain Injury Treatment Act

Summary: Section 2(a) of the bill would require VA to implement a pilot program to furnish hyperbaric oxygen therapy (HBOT) to Veterans with traumatic brain injury (TBI) or posttraumatic stress disorder (PTSD) through health care providers who are not VA employees, Medicare providers, DoD, the Indian Health Service (IHS), or Federally qualified health centers.

Section 2(b) would require VA to select two Veterans Integrated Service Networks (VISN) in which to operate the pilot program.

Section 2(c) would require any medical facility at which a Veteran receives HBOT under the pilot program be accredited by the Joint Commission on Accreditation of Hospital Organizations (the Joint Commission), the Undersea and Hyperbaric Medical Society, or another appropriate organization that has expertise and objectivity comparable to that of the Joint Commission or the Undersea and Hyperbaric Medical Society.

Section 2(d) would establish in the general fund of the Treasury the VA HBOT Fund; the sole source of monies for the Fund would be from donations received by VA for the express purpose of providing HBOT under the pilot program. Amounts in the Fund would be available to VA without FY limitation to pay for HBOT.

Section 2(e) would require the pilot program and VA HBOT Fund to terminate on the day that is 3 years after the date of the enactment of this Act.

Section 2(f) would define HBOT to mean hyperbaric oxygen therapy with a medical device either approved by the Food and Drug Administration (FDA) or issued an investigational device exemption by FDA.

Section 3 would require, not later than 1 year after the date of enactment, the Comptroller General to submit to Congress an update to the report the Comptroller General published on December 18, 2015, and titled "Research on Hyperbaric Oxygen Therapy to Treat Traumatic Brain Injury and Post-Traumatic Stress Disorder." The update would have to include an assessment of clinical trials conducted since the publication of the 2015 report by VA, DoD, and private entities regarding the use of HBOT to treat TBI and PTSD.

Section 4 would amend 38 U.S.C. § 5503(d)(7), which generally limits pension payments for certain Veterans, by extending the sunset date of this provision from November 30, 2031, to October 30, 2034.

Position: VA does not support the bill.

Views: There is no scientific basis to support the clinical efficacy of HBOT as a treatment for PTSD, and there is a strong clinical basis that HBOT is not recommended for treating TBI. In this context, we are concerned that this bill could result in adverse health outcomes for participating Veterans and there is also little ability to monitor performance with definitive, evidence-based metrics. In addition, the bill would result in significant burdens on Veterans in terms of the time commitment involved in treatment and potential personal liability for portions of treatment that are not covered by VA (such as travel or room and board, if applicable). Further, the resources associated with

providing this treatment in terms of clinical and administrative time would mean fewer resources for evidence-based therapies for Veterans.

In 2017, VA initiated a clinical (non-research) program to evaluate the feasibility of referring Veterans diagnosed with PTSD (with or without a history of mild TBI) for HBOT treatment provided by DOW or community providers. This clinical program evaluation was designed to better understand the treatment protocol requirements and burdens on Veterans and VA in the context of PTSD treatment. The evaluation was not designed to examine or measure the efficacy of HBOT as a treatment for PTSD, TBI, or any other indication. VA proactively began the clinical program evaluation to understand the logistical and administrative requirements and barriers for providing this treatment for these indications, which are considered "off-label" because they have not been approved by FDA. VA's clinical program evaluation found that fewer than half of the Veterans referred completed the full course of HBOT treatment. Some Veterans were not interested in engaging or continuing treatment due to the treatment schedule (appointments are scheduled for 1 to 2 hours per day, 5 days a week, for 4 to 8 weeks), the need to travel, or the availability of evidence-based treatment alternatives. We anticipate that similar results could occur if this bill were enacted, in which case Veterans would be delayed in receiving evidence-based care to treat their conditions.

VA and DOW have developed evidence-based clinical practice guidelines (CPG) for both TBI and PTSD. The most recent update for the TBI CPGs was completed in June 2021, while the most recent update for the PTSD CPGs was completed in June 2023. The CPGs for PTSD found there is insufficient evidence to recommend for or against HBOT as a treatment for PTSD. The CPGs for TBI strongly recommend against the use of HBOT for the treatment of patients with symptoms attributed to mild TBI. Published results of scientifically rigorous VA and DOW research on TBI have repeatedly shown that HBOT has the same impact as a placebo and no clinically relevant long-term effects.[1][2][3][4][5][6] In addition to the lack of patient improvement, the use of HBOT after a mild TBI may have harmful impacts, including seizures. Emerging treatments are often marketed to patients struggling with chronic symptoms, and providers need to understand the potential negative impacts that referrals for unfounded treatments can have on the provider-patient relationship. The CPGs explain that when treatments do not work, it may lead to disappointment; damage to a patient's trust; an increased likelihood of the patient taking on a "sick role;" and even harm to the patient.

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[1] Walker WC, Franke LM, Cifu DX, Hart BB. Randomized, sham-controlled, feasibility trial of hyperbaric oxygen for service members with postconcussion syndrome: Cognitive and psychomotor outcomes 1 week postintervention. Neurorehabilitation & Neural Repair. 2014;28(5):420-432.

[2] Cifu DX, Walker WC, West SL, et al. Hyperbaric oxygen for blast-related postconcussion syndrome: Three-month outcomes. Annals of Neurology. 2014;75(2):277-286.

[3] Wolf G, Cifu D, Baugh L, Carne W, Profenna L. The effect of hyperbaric oxygen on symptoms after mild traumatic brain injury. J Neurotrauma. 2012;29(17):2606-2612.

[4] Miller RS, Weaver LK, Bahraini N, et al. Effects of hyperbaric oxygen on symptoms and quality of life among service members with persistent postconcussion symptoms: A randomized clinical trial. JAMA Internal Medicine. 2015;175(1):43-52.

[5] Weaver LK, Chhoeu A, Lindblad AS, Churchill S, Deru K, Wilson SH. Executive summary: The brain injury and mechanism of action of hyperbaric oxygen for persistent post-concussive symptoms after mTBI (BIMA) study. Undersea & Hyperbaric Medicine. 2016;43(5):485-489.

[6] Boussi-Gross R, Golan H, Fishlev G, et al. HBOT can improve post-concussion syndrome years after mild traumatic brain injury - randomized prospective trial. PLoS One. 2013;8(11):e79995.

Given the evidence of harm in the literature and FDA's findings, the CPGs conclude that HBOT is not currently identified as a safe or effective treatment after mild TBI.

VA also has procedural concerns with this bill. Initially, the bill seems to establish a parallel program to VCCP for HBOT. Congress enacted VCCP to consolidate the various community care programs and to simplify eligibility by establishing a common set of criteria to determine when Veterans would qualify for community care. This bill appears to require VA to furnish this care exclusively through non-VA providers regardless of whether VA could furnish treatment for PTSD or TBI. The bill expressly excludes VA, Medicare, DoD, and IHS providers, as well as Federally qualified health centers. Given this narrow range of potentially eligible entities, it is not clear that VA would have any means to verify the quality of those providers or the quality of services they would furnish under this bill; while the bill would require accreditation, it would permit accreditation by the Joint Commission, the Undersea and Hyperbaric Medical Society, or another organization with expertise and objectivity comparable to such organizations. Additionally, this narrow scope of eligible providers could both limit Veterans' access to timely care and would very likely increase costs to VA as there would likely need to be a separate referral, scheduling, and follow-up process created for this authority. We recognize that there is a limited number of providers and HBOT treatment centers, but imposing additional restrictions would seem to make implementation more difficult and costly. Further, given that multiple treatments are often required and the limited number of providers, the likelihood that Veterans would need to travel to receive this care is high. This may be inconvenient and place a significant financial burden on patients.

The bill does not define which Veterans could receive care under this authority; it is unclear whether this is limited to enrolled Veterans or if another population would apply. Additionally, there are no criteria set forth in the bill to determine when HBOT would be offered to Veterans – whether this would be required to be a treatment of first resort or last resort; purely at the Veteran's election; or as otherwise clinically indicated. We emphasize that providers must determine that care is medically necessary and in the best interest of the patient to furnish it in accordance with current legal and ethical standards. We would infer these requirements would continue to apply if this legislation were to become law in the absence of specific language to this effect, but we recommend the bill include such requirements to reduce the potential for confusion. Given the CPGs described above strongly recommend against the use of HBOT for the treatment of patients with symptoms attributed to mild TBI, it is not clear that VA actually could refer such patients for treatment.

The funding mechanism proposed in this bill also raises significant questions and concerns. No other VA program operates under such parameters as proposed by this bill, so VA would need to develop new procedures and requirements to govern the use of an account like this. It is unclear whether there would be sufficient funds donated to VA to cover the costs of treatment. VA would need to wait until there were sufficient resources in the new HBOT Fund to support the delivery of care, which could delay VA's implementation of this (potentially by months or years). VA would need to develop

new processes and procedures to determine who would manage these funds in VA and how the funding would be distributed. It is also unclear whether a new administrative office would be needed to handle the financial aspects that are unique to this arrangement. This could result in additional oversight costs that would divert funds from Veterans' care.

We strongly encourage that if Congress wants to create a new program, it should fund this through conventional appropriations measures, rather than relying on donated funds that are dependent on voluntary contributions from third parties. This both ensures accountability for Congress (by ensuring Congress is responsible for funding these programs appropriately) and reliability for VA (by ensuring that there is a clear and dedicated resource pool for different programs).

VA defers to the Comptroller General on section 3.

VA notes that section 4 of the bill appears unnecessary, as it seems intended to provide a funding offset for the costs of the bill; however, because section 2(d) of the bill would create the HBOT Fund, this extension would not seem necessary.

Cost Estimate: VA does not have a cost estimate for this bill.

S. 2807 Restoring the Sanctity of Public Entombments, Cemeteries, and Tributes Act of 2025 (RESPECT Act of 2025)

Summary: This bill would amend the current applicability date for the authority to reconsider decisions of the Secretary of Veterans Affairs or the Secretary of the Army to inter the remains or honor the memory of a person in a national cemetery.

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

Views: VA shares Congress' view that this authority should be amended. This bill would expand VA's authority to reconsider previous interment and memorialization decisions by changing the applicability date for VA to reconsider such decisions under 38 U.S.C. § 2411(d), from on or after December 20, 2013, to on or after June 18, 1973 – the date of the enactment of P.L. 93-43, the "National Cemeteries Act of 1973," which established the National Cemetery System (now the National Cemetery Administration (NCA))—if VA finds the decedent committed a Federal or state capital crime or a Federal or state crime that would cause the decedent to meet the definition of a tier III sex offender under section 111 of the Sex Offender Registration and Notification Act (SORNA).

The bill attempts to align the applicability date of the reconsideration authority in 38 U.S.C. § 2411(d) with the National Cemeteries Act by repealing the applicability date in section 2(c) of P.L. 113-65, which made the reconsideration authority effective from

date of enactment for decisions made on or after December 20, 2013. However, because § 2411 as a whole only applies to applications for interment or memorialization made on or after November 21, 1997, *see* P.L. 105-116, section 1(c), changing the applicability date of subsection (d) could create confusion. In other words, the bill would make the applicability date of subsection (d) earlier than the applicability date of its parent section. Without also changing the applicability date of the parent section, it is unclear what effect this change would have.

That said, VA notes that if Congress were to change the applicability date of § 2411 as a whole to align it with the National Cemeteries Act, such a change would make § 2411's prohibition retroactive to 1973. This could create its own problems, as there may be persons who were buried or interred in a national cemetery prior to November 21, 1997, whose burial would then be in violation of the law. VA is willing and available to work with Congress on legislation to clarify these applicability date issues.

Additionally, the bill would eliminate foreseeable interpretive challenges or confusion regarding the effective date of SORNA in relation to the effective date of the National Cemeteries Act. It does this by replacing the requirement for an offender to actually be considered a tier III sex offender under SORNA with a requirement that the offender meet the definition of a tier III sex offender under that Act.

VA does not anticipate that the bill would create a significant impact on the operations of NCA. As a result of receiving inquiries about interments that VA could not reconsider because they occurred prior to December 20, 2013, NCA is aware of seven interments in VA national cemeteries that would be subject to reconsideration if this bill became law. VA believes that a statutory change to the applicability date may result in the public making VA aware of additional interments that may be subject to reconsideration.

Cost Estimate: VA does not have a cost estimate for this bill.

S. 3033 Improving Access to Care for Rural Veterans Act

Summary: Section 2(a) would require VA to require that each VA medical facility enter into a partnership with a hospital in a rural area. Each partnership entered could include an agreement for the provision of telehealth, co-location, or leasing of space or equipment, training, care coordination, emergency services (including transportation), or other services as determined appropriate. The purpose of these partnerships would be to provide greater access to care for Veterans in rural areas and to reduce costs to all entities within the partnership.

Section 2(b) would allow VA to waive the requirement under subsection (a) with respect to a medical facility for a period of up to five years, subject to such requirements as VA may establish, if VA notifies Congress of the waiver at least 48 hours before the waiver takes effect. VA could renew a waiver with respect to a medical facility only if VA,

in consultation with the head of the medical facility, evaluated the need for the waiver and determined that waiver was necessary.

Section 2(c) could require VA, not later than 180 days after the date of enactment, to provide a briefing to Congress on VA's plans for implementing the requirement in subsection (a). This briefing would have to include a timeline for implementation; an identification of the VA official responsible for oversight and implementation; an update on the establishment of any office, task force, or personnel assignments to support implementation; a description of VA's plan for oversight of such requirement; a standardized form or forms to be used for waivers and an explanation of the criteria for eligibility for a waiver; and such other information as VA considers to be of interest to Congress.

Section 2(d) would require VA, not later than two years from the date of enactment, and biennially thereafter, to submit to Congress a report on the operation and performance of these partnerships. The report would have to include new partnerships established since the date of the last report (or enactment), existing partnerships, and an assessment of the success of all partnerships in delivering services to Veterans in rural areas.

Section 2(e) would require VA to ensure that all VA medical facilities that are seeing patients are compliant with subsection (a), or have received a waiver under subsection (b), by not later than 3 years after the date of enactment. For any new facilities established after the date of enactment, VA would have to ensure such facility is compliant with subsection (a), or has received a waiver under subsection (b), by not later than 3 years after the date on which patients are first seen at the facility.

Section 2(f) would state the requirements and authorities under this section would be in addition to, and separate from, the authority under 38 U.S.C. § 8153 (which generally authorizes VA to share health care resources between VA and non-VA facilities, providers, or entities).

Section 2(g) would define various terms, including the term "partnership," which would mean a leasing or co-location agreement, a memorandum of understanding, a partnership agreement, an employment contract, an independent contractor agreement, a service agreement, or any other similar agreement. The term "rural" would have the meaning given that term under the Rural-Urban Commuting Areas (RUCA) coding system of the Department of Agriculture.

Position: VA does not support the bill.

Views: VA fully supports working with community hospitals, particularly in rural areas, to expand access to care for Veterans and other beneficiaries. VA has contracts, either directly or through a TPA, with many such hospitals that allow them to furnish care to eligible Veterans. VA also has academic affiliate agreements with institutions in rural areas to support the coordination and sharing of health care resources.

However, VA has several key concerns with the bill, as it would require VA to enter into "partnerships," which appear to be a different type of arrangement than the contracts or agreements described above. First, while the bill states the purpose of a partnership would be to "provide greater access to care for veterans in rural areas and to reduce costs to all entities within the partnership," this is unclear on several levels. Initially, it is not apparent that only Veterans would be able to receive care under these partnerships. If a rural hospital, for example, agreed to provide care to Veterans, it may also ask the VA facility to see or furnish care to non-Veterans. It is unclear if this type of arrangement would be permissible. Moreover, the bill would establish two purposes (increasing access for Veterans and reducing costs for all entities within the partnership), but these purposes may be incompatible in at least some situations. It may require VA to increase expenditures so that a rural hospital would provide treatment to eligible Veterans. Further, if a partnership included five parties, and costs were reduced for four of them but not for the fifth, such an arrangement would appear to be contrary to the purpose provision in section 2(a)(3), even if all parties would benefit, albeit to varying degrees. It is not clear if this type of arrangement would be permissible.

Second, the bill focuses on creating "partnerships" and defines the term, but it does so in a way inconsistent with general principles of Federal contracting. Partnerships generally, although not exclusively, do not involve the exchange of funds, and it is unclear whether the bill intends for VA or rural hospitals to exchange funds. Several identified forms of a partnership – such as leases, employment contracts, and independent contractor agreements – would presumably do so, although others – such as a memorandum of understanding – may not. VA recommends a clearer term – even a more general term – be used, such as "agreement" so that VA could use the correct instrument for the applicable type of relationship.

The bill is also unclear as to what types of hospitals would be able to enter into these agreements in the first place. The bill does not define which entities are eligible beyond subsection (a)(1), which merely requires they be "a hospital in a rural area." VA operates many hospitals in rural areas, as do other Federal entities (including DoD). It is unclear if a VA medical facility could enter into an agreement with another VA medical facility to satisfy the requirements of this bill, so long as one or more of those facilities was a "hospital in a rural area."

Additionally, the scope of VA facilities subject to the requirements this bill would establish is unclear. The bill refers to "each medical facility of the Department," but that could include a number of smaller facilities that may lack the infrastructure or support to enter into such agreements. If the intent is to include only VAMCs or VA health care systems (at the exclusion of community-based outpatient clinics or similar facilities), we recommend the bill clearly state that.

Section 2(f) is also unclear. It purports to establish this authority as independent from VA's health care resource sharing authority under 38 U.S.C. § 8153, but it does not explain what this new authority is or what this being independent of § 8153 means.

Section 8153 is a critical authority VA uses frequently to contract for health care resources. Agreements entered into under the authority of § 8153 are subject to the Federal Acquisition Regulations (FAR). We strongly recommend against any provision that might otherwise limit or curtail the authority under § 8153, but it is not apparent if that is the intent of this language. If this is simply stating that VA can use § 8153 to enter into agreements under this section, but that it is not required to do so, the language is unnecessary. If the intent of this provision is to create a non-FAR based contracting or agreement authority, that raises a host of concerns in terms of procurement rules that would require significant additional discussion.

VA also has concerns with the bill's definition of rural as having the meaning given that term in the Department of Agriculture's RUCA coding system. We believe a clearer definition would state that an area is considered rural if it has a code other than 1 or 1.1 in the RUCA coding system.

Cost Estimate: VA does not have a cost estimate for this bill.

S. 3119 Fisher House Availability Act of 2025

Summary: This bill would amend 38 U.S.C. § 1708, which allows VA to furnish certain persons with temporary lodging in a Fisher house or another appropriate facility. Specifically, it would amend § 1708(a) to remove the condition that temporary lodging be in connection with the examination, treatment, or care of a Veteran under chapter 17 or in connection with benefits administered by VA. It would also amend § 1708(b), which defines which persons can receive lodging under subsection (a). It would clarify one provision, in subsection (b)(2), which refers to eligibility for family members of Veterans. Under a proposed § 1708(b)(3), on a space-available basis, VA could provide temporary lodging to eligible individuals (which would be defined as members of the Armed Forces, regardless of duty status, or any individual on active duty) who must travel a significant distance to receive care or services at a VA or non-VA facility. Family members (and others who provide the equivalent of familial support) of eligible individuals could also receive temporary lodging when accompanying such eligible individuals for such care. Under a proposed § 1708(b)(4), on a space-available basis, VA could provide temporary lodging to family members of Veterans who must travel a significant distance for the family member to receive care or services at a VA or non-VA facility, as well as the Veteran and others who accompany such family member and provide the equivalent of familial support for the family member during the receipt of such care or services. Finally, under a proposed § 1708(b)(5), on a space-available basis, VA could provide temporary lodging to family members of eligible individuals who must travel a significant distance for the family member to receive care or services at a VA or non-VA facility and the eligible individual and others who accompany such family member and provide the equivalent of familial support for the family member during the receipt of such care or services. Effectively, these changes would allow VA, on a space-available basis, to furnish temporary lodging when eligible individuals receive care, when Veterans' family members receive care, and when eligible individuals' family

members receive care. This lodging would be available for both the patient and the family members (or those providing the equivalent of familial support).

The bill would amend what is currently § 1708(e) (but would be redesignated as subsection (d)) to require that VA's regulations include provisions establishing criteria for providing access to temporary lodging facilities on a space-available basis under subsection (b)(3)-(5), as described above.

Finally, the bill would amend what is currently § 1708(c), but which would be redesignated as § 1708(e), providing definitions for this section, to define the term "eligible individual" as described above. It would also amend the definition of "Fisher house" to include a reference to the Fisher House Foundation, Inc., as well.

Position: VA supports this bill, subject to the availability of appropriations.

Views: VA supports allowing Fisher Houses to provide lodging, on a space available basis, to Service members who receive care at VA facilities and their families. This has been a longstanding practice at VA, most recently adopted through VHA Directive 1107, Department of Veterans Affairs Fisher Houses and Other Temporary Lodging (October 19, 2023), but current law is ambiguous in this respect. We appreciate that this draft includes recommended technical edits from VA to ensure that all Veterans, Service members, and their families could receive temporary lodging under § 1708 when either the Veteran, Service member, or family member requires care.

Cost Estimate: VA does not have a cost estimate for this bill.

S. 3303 Leveraging Integrated Networks in Community for Veterans Act (LINC VA Act)

Summary: Section 2(a) of this draft bill would require, not later than 1 year after the date on which VA submits to Congress the report required by section 201(k)(1) of the Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019 (the Hannon Act; 38 U.S.C. § 1720F, note), VA's Center for Innovation for Care and Payment to carry out a pilot program under which VA would establish community integration network infrastructure to provide services for Veterans.

Section 2(b) would require VA, in carrying out the pilot program, to establish a new or enhance an existing interoperable technology network that enables the coordination of public and private providers and payors of services for Veterans, including services such as nutritional assistance, housing, health care (including preventive health intervention, chronic disease management, and behavioral health care), transportation, job training, child development or care, caregiving and respite care, disability assistance, suicide prevention, sexual assault services, legal aid, and DoD transition programs, and other services as determined by VA. The new or existing network would also need to include additional program elements.

Section 2(c) would require VA to carry out the pilot program at not fewer than one facility in each VISN.

Section 2(d) would require VA, in carrying out the pilot program, to coordinate with existing community networks.

Section 2(e) would require VA to track the accuracy of referrals of Veterans to community networks under the pilot program, the response time of providers to which such Veterans are referred, and the outcome of the initial meeting between a Veteran and a provider.

Section 2(f) would require VA, not later than 3 years after amounts are first appropriated to carry out the pilot program, to submit to Congress a report indicating the social service needs of Veterans reflected by the use of services under the community integration network infrastructure established under the pilot program.

Section 2(g) would require the Comptroller General to conduct an evaluation that measures the overall impact of the community integration network infrastructure with respect to changes in individual and population health outcomes among Veterans, changes in access to health care or social services among Veterans, and such other factors as the Comptroller General considers appropriate.

Section 2(h) would define terms for purposes of this Act. Paragraph (1) would define the term "community integration network infrastructure" to mean infrastructure used to enable the coordination, alignment, and connection of covered entities for purposes of communication, service coordination, and referral management of services, with respect to services specified in subsection (b)(1)(A). Section 2(h)(2) would define the term "covered entity" to mean any community-based organization that accepts referrals from health care organizations and that provides services described in subsection (b)(1)(A); public or private health care provider organizations; public or private funded payors of health care services (including home- or community-based services); state, local, territorial, or tribal health and social services agencies; state public housing authorities or housing finance agencies; public health information exchanges or public health information networks as defined by VA; or other similar entities as determined by VA.

Position: VA supports the intent of section 2 subject to the availability of appropriations, but cites concerns with the language as drafted.

Views: VA strongly agrees with the need to engage communities to develop and promote resources for Veterans and other beneficiaries; many of the areas of focus identified in the bill are important issues facing the Veteran community. However, there are several key undefined elements of the proposed pilot program. The bill describes a wide range of potential entities that could participate; however, it is unclear whether the bill intends for VA to have a role in vetting organizations or providers participating in the

network, and if so, how VA would do so fairly and competently. Similarly, if the intent is to ensure that only enrolled Veterans are participating in the pilot program, for example, we would have a clear means of ensuring VA can provide such support and services. If this is intended to allow any Veteran or former Service member to use these resources, it is unclear whether VA would need to evaluate and determine eligibility, and if so, how it would do so. It is unclear if the pilot program is meant to operate by VA referring Veterans to specific providers or if this is intended to be a self-referral model; if the latter, the tracking requirements in subsection (e) would likely be very difficult to meet.

It is unclear if organizations would need to have a license or be approved through some type of accreditation process to ensure that Veterans are accessing safe, legitimate, and quality service providers; this would make sense, but it would involve significant administrative expense in areas where VA has comparatively little experience. It is similarly unclear what level of participation or interest there would be among potential community organizations and providers; it may make more sense to conduct a market assessment or analysis before requiring VA to construct and operate a network if no entities or providers are interested in participating in the first place. Finally, the intended outcomes are not clear. Presumably, facilitating connections between Veterans and providers, and between different providers, is intended to provide a greater network of support for Veterans and their families, but it is not clear how VA would measure these outcomes. Again, given the societal nature of many of the issues addressed in the bill, defining discrete outcomes or metrics would likely be difficult and imprecise.

Beyond these general concerns, the bill presents implementation challenges for VA in several areas. First, the bill is unclear as to whether VA would be able to establish the type of network required by section 2(b) of the bill, particularly within 1 year of enactment. The type of interoperable technology network could be incredibly complex and expensive to develop, implement, and maintain, given the variability in terms of services, providers, and resources of those providers to meet the needs of Veterans participating in this program; this is even more complicated given the need to exchange personal health information and other sensitive data across multiple networks, which can raise substantial privacy and security concerns. VA would need to execute new agreements, including data security agreements, with external parties to ensure compliance and protection; this would add both time and cost to the project. Given the responsibilities of other Federal agencies, as well as local and state governments, integration and coordination are critical. The impact to information technology (IT) development and sustainment resources would be significant and, if not fully funded in addition to existing priorities, would likely be devastating to other projects. The specificity of the bill in several areas – for example, identifying specific ICD-10 codes – would exacerbate the difficulty of implementation and increase cost. Additionally, community entities would also likely face resource challenges in connecting to and using the IT networks VA would create.

The bill could also more clearly address the various statutory requirements related to collecting and sharing information by VA and non-VA parties using the exchange.

We would appreciate the opportunity to discuss the intent of this proposal. VA is in the process of implementing the Assessing Circumstances & Offering Resources for Needs (ACORN) screening tool to proactively identify and address deficits in health-related social needs (HRSN) impacting Veterans' health and wellness. HRSNs (also identified as social determinants of health/social risks) are social and economic aspects that affect the health and well-being of Veterans and their families, caregivers, and survivors. Some examples include homelessness, food insecurity, unemployment, social isolation and loneliness, and transportation. Proactive screening is the first step in identifying and offering clinical interventions where authorized and appropriate, including community resource referrals to address unmet HRSNs. The ACORN screening tool has been implemented at 86 VAMCs in at least one clinical care setting.

Summary: Section 3 would require VA to collect from Veterans enrolled in VA care, as part of routine screenings conducted under the laws administered by VA, information related to social determinants that may factor into the health of such Veterans. The information would have to include standardized definitions for identifying social determinants of health needs identified in the ICD-10 diagnostic codes Z55 through Z63, Z65, and Z75 (as in effect on the date of enactment). The definitions would have to incorporate measures for quantifying the relative severity of any such social determinant of health need identified in an individual.

Position: VA supports the intent of section 3 subject to the availability of appropriations, but cites concerns with the language as drafted.

Views: As noted above, VA is working to implement the ACORN screening tool to identify and address deficits in health-related social needs, and this may address some of the intended outcomes of this section. However, VA does not have the capacity to collect the data required by this section, as this would require Bidirectional Health Information Exchange (BHIE) capabilities with community facilities, which would likely come at significant expense. Also, as noted above, VA's efforts through the ACORN Initiative may already address some of the intended outcomes of this section. VA believes it would be more prudent to wait for the results of this effort before imposing system-wide requirements that may present cost and implementation challenges without being more effective.

Additionally, as a technical matter, section 3 appears to create a permanent requirement for VA to collect information related to social determinants of health for VA health care enrollees. VA recommends that any permanent requirements be included through an amendment to chapter 17 of title 38, U.S.C., to allow for ease of reference and identification.

Cost Estimate: VA does not have a cost estimate for this bill.

S. XXXX Sharing Essential Resources for Veterans Everywhere Act (SERVE Act)

Summary: Section 2(a) would require DoD and VA, not less frequently than annually, to conduct outreach to increase awareness among Veterans enrolled in VA health care of the ability of those Veterans to receive care at military medical treatment facilities (MTF). Section 2(b) would require VA to ensure training for staff and contractors involved in scheduling, or assisting in scheduling, appointments for care under the VCCP specifically includes training regarding options for referrals to DoD facilities and providers. Section 2(c) would amend 38 U.S.C. § 1703(g), which generally authorizes VA to establish a tiered network of VCCP providers so long as VA does not prioritize providers in a manner that limits the choice of covered Veterans to select an eligible provider from whom to receive care. This amendment would require VA, subject to paragraph (2) (described above as preserving a Veteran's choice of provider) to consider DoD a preferred provider.

Section 2(d) would require DoD and VA to develop and implement action plans at covered facilities to expand the partnership between VA and DoD with respect to the provision of health care, improve communication between VA and pertinent command and director leadership of MTFs, increase utilization of military MTFs with excess capacity, increase case volume and complexity for graduate medical education (GME) programs of DoD and VA, improve resource sharing agreements or permits between DoD and VA (which would also ensure lessened barriers to shared facility spaces), and increase access to care for enrolled Veterans in areas in which an MTF is located that is identified by DoD as having excess capacity. The action plans would have to include: streamlining the credentialing and privileging of health care providers to provide health care for beneficiaries in DoD and VA medical facilities; expediting access to DoD installations for VA staff and beneficiaries; including in-kind or non-cash payment or reimbursement options for expenses incurred by either DoD or VA; allowing eligible Veterans to seek certain services at MTFs without referral or preauthorization from VA, for which reimbursement to DoD would be made; designating a coordinator within each covered facility to serve as a liaison between DoD and VA and to lead the implementation of such action plan; monitoring the effectiveness of such action plan on an ongoing basis, including establishing relevant performance goals and collecting data to assess progress toward these goals; and prioritizing the integration of relevant IT and other systems or processes to enable seamless information sharing, referrals, and ancillary orders, payment methodologies and billing processes, and workload attribution when VA personnel provide services at DoD facilities or vice versa. Before implementing any action plan at a covered facility, DoD and VA would have to ensure that approval of the action plan is obtained from the co-chairs of the VA-DoD Joint Executive Committee, the local installation commander for the DoD facility, and the VAMC director with respect to any VA facility. Not later than 90 days after the date of enactment, DoD and VA would have to submit to Congress a report containing the

required action plans. Not later than 1 year after submitting this report, DoD and VA would have to submit to Congress a report containing a status update on the progress of implementing the required action plans and recommendations for developing subsequent action plans for each facility with respect to which there is a sharing agreement in place.

Section 2(e) would require DoD and VA to ensure there is a lead coordinator at each DoD and VA facility, as the case may be, with respect to which there is a sharing agreement in place. DoD and VA would have to maintain on a publicly available website a list of all sharing agreements in place between DoD and VA medical facilities.

Section 2(f) would require DoD and VA to carry out this section notwithstanding any limitation or requirement under 10 U.S.C. § 1104, which is DoD's general authority regarding health care resource sharing with VA, or 38 U.S.C. § 8111, which is VA's general authority regarding health care resource sharing with DoD.

Section 2(g) would permit DoD and VA to use funds available in the DoD-VA Health Care Sharing Incentive Fund established under 38 U.S.C. § 8111(d)(2) to implement this section.

Section 2(h) would provide a rule of construction that nothing in this section could be construed to require Veterans to seek care in DoD facilities.

Section 2(i) would amend 38 U.S.C. § 5503(d)(7), which generally limits pension payments for certain Veterans, by extending the sunset date of this provision from November 30, 2031, to April 30, 2032.

Section 2(j) would define various terms, including the term "covered facility," which would mean an MTF as defined in 10 U.S.C. § 1073e(j) or a VA medical facility located nearby such an MTF.

Position: VA supports the intent of this bill, subject to amendments and the availability of appropriations, but does not support the bill as drafted.

Views: VA strongly supports collaboration between VA and DoD to promote the health and well-being of those who wear and have worn the uniform. The two Departments have a long history of collaboration and will continue their work in this area. We welcome the opportunity to discuss this work with the Committee and to explore ways of further strengthening this collaboration. However, VA has concerns with the bill as drafted. Initially, VA seeks clarity on the proposed amendment to § 1703(g) that would require VA to consider a DoD provider to be a "preferred provider." This could result in longer travel or wait times for Veterans than may be available through VA's community care network. This could also strain DoD facilities, particularly given that other provisions seem to focus more specifically on MTFs with excess capacity (see, e.g., subsection (d)(1)(F)). However, section 2(h) seems to expressly prohibit VA

from requiring Veterans to seek care in DoD facilities. The term "preferred provider" usually means either a provider that would receive a request to furnish services before other providers or a provider who receives preferential terms (such as higher payment rates). VA seeks clarity on whether the bill intends for VA to provide preferential terms to DoD.

We also have some concern that the bill, in attempting to integrate operations between the two Departments, could create confusion as to whether a Veteran at an MTF is receiving VCCP care (if a VA provider, for example, were furnishing such care). VA's regulations for the VCCP currently state that if a provider is an employee of VA, they may not furnish care under the VCCP when acting within the scope of their VA employment.

Additionally, one critical element of the required action plan includes allowing eligible Veterans to seek care at MTFs, as well as allowing DoD-eligible individuals to seek care at VA facilities, without referral or prior authorization from VA. If DoD or VA then refer eligible individuals visiting their respective facilities to a community provider for follow-up care, the authority, covered services, and community funding, would need to be defined to provide clear guidelines for VA and DoD.

VA is concerned that DoD providers may not know how to apply the complex web of VA legal authorities that determine individual Veterans' eligibility and their authorized medical benefits, which differ from DoD's eligibility and benefits. Without prior authorization from VA, Veterans could be responsible for costs that neither DoD nor VA would be authorized to pay. VA seeks further guidance on how this authority is intended to be interpreted relative to 10 U.S.C. § 1104 and 38 U.S.C. § 8111. VA would be open to discussing concerns within a larger framework in consultation with DoD and the committee to determine the best path forward.

If Congress wishes to create conditions under which certain Veterans can access certain services without prior authorization, we recommend against doing so in § 1703.

VA also has technical concerns and comments with the bill. We would appreciate the opportunity to meet with the Committee to discuss these concerns.

Cost Estimate: VA does not have a cost estimate for this bill.

S. XXXX Get Justice-Involved Veterans Behavioral Assistance and Care for Key Health Outcomes to Maintain Empowerment Act (Get Justice-Involved Veterans BACK HOME Act)

Summary: Section 2(a) of the bill would require VA to carry out a pilot program to furnish mental health care to incarcerated Veterans, with a priority given to Veterans with a service-connected disability relating to PTSD, TBI, or military sexual trauma (MST). Section 2(b) would require VA to carry out the pilot program at not fewer than five facilities, which would have to represent large and small facilities and urban and

rural settings; they also would have to have already established separate housing units for Veterans. Section 2(c) would require VA to develop the pilot program in coordination with relevant state or Federal agencies responsible for the incarceration of Veterans. Section 2(d) would require VA, in carrying out the pilot program, to provide incarcerated Veterans telemental health services, if the facility at which the Veteran is incarcerated has necessary infrastructure for the provision of such services. If the provision of telemental health services was not feasible, VA would have to provide incarcerated Veterans under the pilot program mental health services through the use of mobile mental health units close to the facility at which the Veteran is incarcerated or mental health services through other means. Section 2(e) would require VA to furnish mental health care under the pilot program through the use of VA health care providers; VA could not use non-VA health care providers. A health care provider furnishing mental health care under the pilot program would have to provide treatment and assessment of medical conditions. A health provider could not provide an assessment or evaluation of current or future disability claims. VA would have to create a hub of health care providers that only provide care to incarcerated Veterans and operate separately from any medical facility or VISN. Section 2(f) would define the terms incarcerated Veteran, MST, service-connected, Veteran, and Vet Center.

Position: VA does not support this section.

Views: VA appreciates that the current draft of this bill has addressed some of the technical concerns VA previously identified, but VA still has concerns with the current version of the bill. VA's regulations at 38 CFR § 17.38(c)(5) provide that VA does not furnish, as part of the medical benefits package, "hospital and outpatient care for a veteran who is either a patient or inmate in an institution of another government agency if that agency has a duty to give the care or services." This regulation, in turn, is based on 38 U.S.C. § 1710(h), which states, "Nothing in this section requires the Secretary to furnish care to a veteran to whom another agency of Federal, State, or local government has a duty under law to provide care in an institution of such government." The bill appears intended to countermand this language in § 1710(h), but if that is the intent, it should do so clearly.

Additionally, the bill would require VA to furnish care to incarcerated Veteran, but access to incarcerated persons is subject to the jurisdiction of the correctional facility itself, so if the facility refused to provide access, VA would fail in its obligation here through no fault of its own. Further, even within correctional facilities, there may be varying levels of security that could interfere with VA's capacity to furnish care (and could present a risk to VA employees providing care in person, if that were authorized) and an available option.

VA has other technical comments and concerns with this section, including concerns over how tort claims would be handled and liability assigned. The bill is also unclear, in section 2(b), as to whether the correctional facilities would need to have already established separate housing units for Veterans or if VA facilities would have to do so; we presume the correctional facilities were intended, but we recommend

clarifying this. Additionally, it is unclear whether the bill intends to apply copayment requirements otherwise applicable under chapter 17 to care furnished under this section; we recommend the bill clearly address this issue (including whether this is care provided pursuant to § 1710).

Summary: Section 3(a) would establish a new 18 U.S.C. § 4015 regarding housing for incarcerated Veterans. Proposed § 4015(a) would require the Director of the Bureau of Prisons to, wherever feasible, establish dedicated wards or housing units for incarcerated Veterans in Federal correctional institutions to provide an environment conducive to the discipline, structure, and order familiar to Veterans to facilitate more effective mental health treatment, peer support, and rehabilitation efforts. Proposed § 4015(b) would require the head of each institution with a Veteran housing unit to collaborate with local VA facilities to ensure that, with respect to the Veteran housing unit, correctional staff are trained regarding the needs of Veterans, resources are allocated for their needs, and rehabilitation programming is tailored to their needs. Proposed § 4015(c) would require the Director of the Bureau of Prison to, at a minimum, create structured Veteran-focused programs if the Federal correctional institution lacks the capacity or resources for a Veteran housing unit. Section 3(b) would make a clerical amendment to reflect the amendment made by subsection (a).

Position: VA defers to the Bureau of Prisons (BOP) on this section.

Views: VA defers to the BOP on this section, as it would establish new requirements for the BOP Director.

Summary: Section 4 of the bill would amend 38 U.S.C. § 5313(a), which generally establishes limits on payment of compensation and dependency and indemnity compensation to persons incarcerated for conviction of a felony, by adding a new paragraph (3). Proposed § 5313(a)(3) would require VA to ensure that, for any individual whose receipt of compensation or dependency and indemnity compensation is interrupted pursuant to § 5313(a)(1) for a period of incarceration, resumption of such payments resume automatically after the end of such period of incarceration.

Position: VA cites concerns with this section.

Views: VA notes that it currently has provisions in place for the resumption of benefit payments following a Veteran's release from incarceration. Pursuant to 38 CFR §§ 3.665(i) and 3.666, VA must resume payment of the released Veteran's award from the date of release from incarceration if VA receives notice of release within 1 year following release; otherwise, VA must resume the award from the date of receipt of notice of release.

Also, VA presumes the term "automatically" used in section 4 means that benefits will resume on the calendar date of release from incarceration without the claimant being required to submit documentation of his or her release. VA identifies that the proposed language for 38 U.S.C. § 5313(a)(3) would require system updates and enhancements to applicable computer matching agreements (CMA). The current CMAs with the BOP and SSA do not result in VA being notified upon a beneficiary's release from incarceration.

VA notes that there is no effective date provided within the draft bill. As such, VA understands these changes would be effective upon enactment. Necessary system and form updates may impact implementation timelines if the proposed bill is enacted. If enacted, VA estimates these updates would take approximately 24 months to be completed.

Additionally, VA identifies that an automatic resumption of benefits upon release from incarceration would not allow VA an opportunity to verify a claimant's continued eligibility for benefits. Automatic resumption as proposed may invite an increase in improper payments under the Payment Integrity Information Act of 2019, as a beneficiary's eligibility would be subject to financial, dependency, or disability status changes that may have occurred during incarceration.

VA notes that the bill as drafted would create disparate treatment for beneficiaries who are incarcerated while in receipt of Veterans' or survivors' pension, as the bill is silent on this issue. If the proposed language of the bill is expanded to include the pension program, then an amendment to 38 U.S.C. § 1505 would be required. VA notes that 38 U.S.C. § 5313 applies only to disability compensation and DIC.

Lastly, VA reiterates that benefits are currently restored back to an effective date congruent with the date of a beneficiary's release from incarceration, as long as VA is notified of the release within 1 year of the event, per 38 CFR §§ 3.665(i) and 3.666.

Summary: Section 5 of the bill would make technical changes to section 302 of part C of title I of the Omnibus Crime Control and Safe Streets Act (34 U.S.C. § 10132). In addition to making technical changes, proposed § 10132(c) would add a new paragraph (15) that would authorize the Bureau of Prisons to collect and analyze comprehensive information concerning incarceration of Veterans. Proposed § 10132(g) would add a paragraph requiring, not later than 180 days after enactment of subsection (g)(2), and annually thereafter, the BOP Director to submit to Congress a report describing the data collected and analyzed under § 10132 related to Veterans who are incarcerated in state and Federal Prisons.

Position: VA defers to the Department of Justice on this section.

Views: VA defers to the Department of Justice on this section because it would affect responsibilities for the Bureau of Prisons.

Cost Estimate: VA does not have a cost estimate for this bill.

S. XXXX Commission on Equity and Reconciliation in the Uniformed Services Act

Summary: Section 2(a) would establish the Commission on Equity and Reconciliation in the Uniformed Services (referred to as the "Commission"). Section 2(b) would set forth more than 15 duties the Commission would be responsible to perform.

Section 3(a) would require the Commission to be composed of 15 members, who would have to be appointed not later than 30 days after the date of enactment; it also would define who would appoint such members (including members of the Executive Branch and Legislative Branch). Section 3(b) would require that all members of the Commission be persons who are exceptionally qualified to serve on the Commission by virtue of their education, training, activism, or experience, particularly in the fields of advocating for LGBTQ+ members of the uniformed services. Section 3(c) would state that Commission members would serve for the life of the Commission; vacancies in the Commission would not affect the powers of the Commission and would be filled in the same manner in which the original appointment was made. Section 3(d) would require the President to call the first meeting of the Commission not later than 30 days after the later of the following: the date of enactment or the date of the enactment of an Act that makes appropriations to carry out this Act. Section 3(e) would require eight members of the Commission to establish a quorum. A lesser number could hold hearings.
Section 3(f) would require the Commission to elect a Chair and Vice Chair from among its members who would serve in that position for the life of the Commission.
Section 3(g) would allow each member of the Commission to be compensated at a rate not to exceed the daily equivalent of the annual rate of basic pay in effect for a position at level IV of the Executive Schedule under 5 U.S.C. § 5315 for each date during which the member is performing Commission duties. If a member of the Commission is a full-time officer or employee of the United States or a Member of Congress, they would receive no additional pay, allowances, or benefits for their service to the Commission. Each Commission member would receive travel expenses.

Section 4(a) would allow the Commission to hold hearings for purpose of carrying out the provisions of this Act. Section 4(b) would allow any subcommittee or member of the Commission to, if authorized by the Commission, to take any action which the Commission is authorized to take. Section 4(c) would allow the Commission to acquire directly from the head of any department, agency, or instrumentality of the executive branch of the Federal Government, available information which the Commission considers useful in the discharge of its duties. All departments, agencies and instrumentalities of the Executive Branch would be required to cooperate with the Commission and furnish all information required by Commission to the extent permitted by law.

Section 5 would set forth various administrative provisions regarding the Commission, including staff appointments and compensation, applicability of civil service laws, procurement of services from experts and consultants, agreements for procurement of financial and administrative services, and authority to enter into contracts.

Section 6 would require the Commission to terminate 90 days after the date on which the final report is submitted.

Section 7 would authorize to be appropriated necessary sums to carry out this Act. Amounts available to the Commission would remain available until the termination of the Commission.

Section 8 would define the terms "servicemember" and "uniformed services" to have the same meaning given those terms in 50 U.S.C. § 3911 and 10 U.S.C. § 101, respectively.

Position: VA does not support the bill.

Views: VA does not support the bill because it would establish a new commission with broad investigative and oversight authorities that extend beyond VA's mission and statutory responsibilities. The proposed Commission's structure, authorities, and operational requirements could create duplicative processes, jurisdictional conflicts, and administrative burdens without improving the services or benefits VA provides to Veterans.

The Commission's duties in Section 2(b) encompass more than 15 functions, many of which involve direct oversight, review, and acquisition of information from multiple Executive Branch agencies, including those outside VA's jurisdiction. VA's statutory role is focused on providing health care, benefits, and memorial services to Veterans and their families. The Commission's mandate to address broad questions of equity and reconciliation across all uniformed services extends into military policy and personnel actions that are under the purview of DoD and other agencies. Creating a new, multi-agency oversight body would overlap with existing offices—such as the Office of the Inspector General, and congressional oversight committees—potentially leading to conflicting recommendations and inefficiencies.

VA also has technical concerns with the bill. For example, section 3(c) states, "A vacancy in the Commission...shall be filled in the same manner in which the original appointment was made." However, this could create confusion in some situations. The first eight members, for example, would be appointed by the Chair and Ranking Members of different Congressional committees. However, the parties that control those Chairs and Ranking Members are subject to change based on the composition of Congress. Consequently, if control of one chamber changed from one Congress to the next, and a vacancy occurred in the second Congress, one party may end up being able

to select both representatives on the Commission by previously having been the Chair and now being the Ranking Member (or vice versa). It is also unclear whether funding for the Commission would be obtained from appropriations made available to VA or if separate funds would be appropriated specifically to the Commission. VA would not support the diversion of funds Congress has appropriated for VA to the Commission instead.

Cost Estimate: VA does not have a cost estimate for this bill.

Conclusion

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

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STATEMENT OF MORGAN BROWN

NATIONAL LEGISLATIVE DIRECTOR

PARALYZED VETERANS OF AMERICA

BEFORE THE

SENATE COMMITTEE ON VETERANS' AFFAIRS

ON

PENDING LEGISLATION

DECEMBER 10, 2025

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

S. 342, the Purple Heart Veterans Education Act

This legislation would allow veterans who received a Purple Heart after leaving military service to transfer their education benefits to their dependents. The GI Bill is not tied to military achievements. Instead, it's tied to periods of service or duration. It was well understood that the transferability option was intended for retention of military servicemembers when Congress passed the Post 9/11 GI Bill. Purple Heart recipients are granted 100 percent of the GI Bill, regardless of how long they served. Our only concern is that carving out exceptions for transferability could be a slippery slope that leads to unintended consequences.

S. 668, the SAFE STEPS for Veterans Act

According to the Centers for Disease Control, falls are the leading cause of injury and death among adults ages 65 and over. More than 1 in 4 older adults fall each year, leading to 41,000 deaths, 3.6 million emergency department visits, and 1.2 million hospital stays. Falls from aging Americans result in about $80 billion in medical costs every year. Given the tremendous cost to the government, as well as the individual, and because half of the estimated 16.5 million living veterans are over 65, it makes sense to reorient existing VA prevention programs towards a more proactive posture.

PVA supports this legislation, which would establish an Office of Falls Prevention within the Veterans Health Administration (VHA) tasked with preemptively identifying and treating veterans at risk of falling. It also establishes a falls prevention coordinator within VHA who would serve as the department's point person on federal panels focused on falls prevention, including the Administration on Community Living's Interagency Coordinating Committee on Aging. The falls prevention coordinator would be required to develop a national education campaign to promote injury prevention programs and work with the National Institutes of Health to develop veterans-specific research for evidence-based falls prevention programs. The bill also requires annual falls risk assessments to be carried out by a licensed physical therapist for veterans receiving extended care services throughout the VA. Early intervention and prevention strategies help reduce the likelihood of fall-related injuries that could lead to serious health complications. By identifying and addressing individual risk factors, VA providers can develop tailored plans to mitigate these risks, improving the health and wellbeing of the veteran.

Finally, we strongly support the inclusion of a pilot program for home modifications to incorporate evidence-based falls prevention programs. We urge the committee to also consider passage of S. 1644, the Autonomy for Disabled Veterans Act, which would increase the amount available through the Home Improvements and Structural Alterations grant. These grants provide financial assistance for medically necessary improvements and structural changes to a veteran's primary residence, ensuring they can safely reside in their homes.

S. 926, the Saving Our Veterans Lives Act of 2025

Veterans are more likely than the general population to own firearms.[1] Those with access to firearms are more than three times as likely as those without access to die by suicide.[2] Firearms are the most common means used by veterans for suicide and over 69 percent of veteran suicides in 2019 involved a firearm.[3] PVA supports this legislation, which seeks to furnish eligible veterans with secure firearm storage boxes or redeemable vouchers to allow them to purchase one. It also directs VA to conduct an extensive public campaign to raise awareness about the new benefit and allows the VA to partner with entities to raise awareness about the availability of this assistance.

[1] Firearm Ownership Among a Nationally Representative Sample of U.S. Veterans - American Journal of Preventive Medicine.
[2] Conner, A., Azrael, D., & Miller, M. (2019). Suicide case-fatality rates in the United States, 2007 to 2014: A nationwide population-based study. Annals of Internal Medicine, 171(12), 885–895. - Search.
[3] Lethal Means Safety Among Veterans at Risk for Suicide.

S. 1116, the Ensuring Veterans' Final Resting Place Act of 2025

Under current law, if a veteran's family chooses to have the VA furnish a commemorative plaque or urn for their loved one, they inadvertently forfeit the option of later interring the veteran at a national cemetery, which requires either a headstone or a marker at the gravesite. PVA has no objections to this bill, which allows surviving family members to later have the veteran interred at a VA National Cemetery, if they cover the cost of the urn or plaque that was initially received from the VA.

S. 1657, the Review Every Veteran's Claim Act

PVA strongly supports this legislation, which seeks to limit the VA's authority to deny a veteran's claim solely based on the veteran's failure to appear for a medical examination associated with the claim. Thousands of veterans' claims for service connection, claims for increase, and for other benefits like Total Disability Individual Unemployability and Aid and Attendance have been denied solely because of missing an examination. There are many legitimate reasons why a veteran may not be able to attend a scheduled exam. We are also aware of numerous instances where VA contractors erroneously record the veteran as a "no show." Veterans with SCI/D often encounter multiple barriers in travel when compared to other veterans and are apt to miss some of these appointments. We believe that passage of this legislation will ensure that a missed exam isn't the only basis for denying a veteran's claim. VA should also carefully consider whether an examination is needed since many veterans with SCI/D already receive most of their care through the department's SCI/D system of care. Their records have adequate information to provide an accurate picture of their disabilities.

S. 1665, the Obligations to Aberdeen's Trusted Heroes (OATH) Act of 2025

PVA supports the OATH Act, which would provide a clear definition of secrecy oath programs; require VA to provide notice of available benefits and services to eligible veterans of those programs; and assign an equitable effective date to eligible veterans who seek benefits. While the military may consider the use of secrecy oath programs necessary for our national security, these programs can result in devastating health issues for the veterans who served in them. But those veterans are unable to seek VA benefits or assistance because of the nature of their service, until the Department of Defense (DOD) releases them from the oath. This bill will provide long-needed equitable treatment for this group of veterans, by requiring outreach from VA and permitting the earliest possible effective date for their claims.

S.1868, the Critical Access for Veterans Care Act

According to the VA, there are 2.7 million rural and highly rural veterans enrolled in the VHA. More than half of those enrolled in VA's health care system (54 percent) are 65 or older. They often have multiple comorbidities, which require complex case management.[4]

This legislation would allow veterans to self-refer to designated Critical Access Hospitals[5] or affiliated clinics within 35 miles of their residence, bypassing the need for prior authorization from the VA. The hospital would then be able to refer these veterans to other providers and specialists without any review or oversight of the VA.

This prevents VHA from performing its critical role in managing veterans care and restricts VA from requiring referrals or prior authorization for community care services. Uncoordinated care like this would most certainly lead to rapidly rising costs and draining off resources needed for VA direct care. Therefore, we have grave concerns about the impact this legislation would have on catastrophically disabled veterans.

S. 1992, Veterans Appeals Efficiency Act of 2025

This bill would establish additional reporting and tracking requirements for the Veterans Benefits Administration and the Board of Veterans' Appeals (Board), such as information on Higher Level Reviews, Supplemental Claims, and Notices of Disagreement. It also requires the tracking of claims pending in the National Work Queue, not assigned to an adjudicator; cases that are remanded by the Board; Veteran Appeals Improvement and Modernization Act cases pending a hearing; and when a decisionmaker did not comply with the Board's decision. We recognize the value of and support efforts to track meaningful data to improve the effectiveness and accuracy of the claims process. However, the data sought by this legislation will be meaningless unless VA addresses the problems that hinder their ability to obtain proper medical opinions, since this continues to result in remandable errors.

This legislation would also give the Board the authority to aggregate certain claims. While PVA does not oppose allowing the Board to aggregate appeals involving common questions of law or fact, we believe that before that can be done a feasibility study should be conducted, and the findings reviewed. Then, legislation based on those findings could be brought forth.

S. 2061, the Molly R. Loomis Research for Descendants of Toxic Exposed Veterans Act of 2025

Military servicemembers are frequently exposed to environmental pollutants that can cause a variety of diseases such as rare cancers, heart conditions, and chronic lung ailments. The

[4] RURAL VETERANS - Office of Rural Health.
[5] Critical Access Hospitals, CMS.gov.

descendants of these veterans are also likely to experience similar health challenges, which are believed to be related to their parents' or grandparents' exposure to toxic chemicals. PVA supports this bill, which establishes a multiagency task force to conduct research on the diagnosis and treatment of health conditions of descendants of veterans exposed to toxic substances during their military service. This research would be authorized through the Toxic Exposure Research Working Group, which was established by the Honoring our PACT Act of 2022 (P.L. 117-168).

S. 2264, the Advancing VA's Emergency Response to (AVERT) Crises Act of 2025

PVA supports this legislation, which seeks to preserve VA's ability to fulfil its Fourth Mission; thereby enhancing the nation's preparedness for national emergencies, including war, terrorist attacks, pandemics, and natural disasters. Ensuring the department has the resources it needs to respond to these emergencies and improving its coordination with other federal agencies will help ensure the VA can properly fulfill its critical mission to assist veterans and the nation during times of crisis.

S. 2309, the Veteran Burial Timeliness and Death Certificate Accountability Act

This bill seeks to address the significant delays, which can be as long as eight weeks, in certifying veterans' death certificates. These delays could hinder survivors' timely application for benefits. Currently, the VA has faced systemic barriers that have caused these delays, such as having only 25 percent of their physicians enrolled in the Electronic Death Registration System (EDRS), which is needed for the certification process.

VA issued VHA Notice 2025-03 in June 2025, which establishes interim policy regarding updated oversight requirements for the Survivors Assistance and Memorial Support (SAMS) Program, formerly known as Decedent Affairs[6]. Under paragraph l(2) of the new policy, it states the death certificate of a veteran be signed within two business days of the veteran's death and as defined by state and local laws. The VHA Notice does not replace VHA Directive 1601B.04, Decedent Affairs, dated December 1, 2017, but rather supplements it. It also states that the notice establishes interim policy regarding updated oversight requirements for the SAMS Program.

This bill does not include mandates for expanding registration amongst VA doctors into EDRS nor does it increase staffing, which could leave those 25 percent who are registered doing all the certifications for the death certificates. A concern would be that these physicians would be rushed into signing documents with less than accurate information causing headaches for the family when trying to file for benefits.

[6] https://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=12296.

This policy change is temporary and will expire on June 30, 2026. We believe it would be prudent to wait until this change has been examined and reviewed to see how successfully it was implemented, the accuracy of death certificates, and whether more physicians are enrolling in EDRS. We want to commend Secretary Collins for addressing this issue swiftly and look forward to the changes he directed being reflected in final policy.

S. 2328, the Military Learning for Credit Act of 2025

It is common for veterans to discover that courses taken while in uniform do not transfer to other institutions of higher learning. The Military Learning for Credit Act would ease the financial responsibility for veterans who decide to go back to school using their GI Bill, but who discover they may need additional assessments to enroll in and/or avoid repeat courses. PVA supports this legislation.

S. 2333, the Health Records Enhancement Act

There are many reasons why a veteran's medical records may be incomplete. For example, veterans can receive care through multiple programs (TRICARE, Medicare, private insurance, and VA and its community care partners) and numerous points of service (primary care, specialty care, urgent care, or the emergency room). The increased variables raise the likelihood that documentation from their visit won't reach their VA healthcare file. The Health Records Enhancement Act seeks to improve the accuracy of medical records for deceased veterans by allowing surviving family members or designated caregivers to add missing records or other relevant data to their records. PVA has no objections to this legislation.

S. 2397, the Caring for our Veterans Health Act of 2025

Having access to treatment information in medical records from VA's community care providers is critical to ensuring continuity of care for the veteran and effective patient management. An August 2025 VA Office of Inspector General report[7] highlighted the challenges some VA facilities face while attempting to retrieve these records. Just 82 percent of three million community care consults reviewed had the medical records returned, indicating that a significant gap in data management still exists. PVA supports this effort to close that gap by requiring VA's Under Secretary for Health to implement guidelines to ensure tracking of medical documentation after a veteran receives care from a community provider. This would enable the VA's Office of Integrated Veteran Care to ensure veterans receive the standard of care they need and deserve.

[7] Facilities Faced Challenges Retrieving Medical Records from Community Providers and Importing Them into Veterans' Electronic Health Records.

S. 2683, the VSAFE Act of 2025

Last month, VA sounded the alarm about a new scam targeting veterans, surviving spouses, and family members who receive VA benefits. The scammers pretend to be VA representatives collecting an overpayment of benefits. The official looking letters, emails, and texts often include fake VA logos and use letterhead that appears to be genuine. It makes it extremely difficult to distinguish them from official VA communications. Veterans are often targeted by scams due to their access to government resources and trust in official institutions. Thus, PVA supports efforts like the VSAFE Act to protect them. This bill would establish a Fraud Evasion Officer within the department, and the person serving in this role would be responsible for scam and fraud prevention, reporting, and incident response plans at the VA.

S. 3119, the Fisher House Availability Act

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

Senate Discussion Draft, the Veterans National Traumatic Brain Injury Treatment Act

Hyperbaric Oxygen Therapy (HBOT) is a well-established treatment for a variety of conditions, including decompression illness, carbon monoxide poisoning, or compromised skin grafts and flaps. However, its safety and efficacy in treating traumatic brain injury (TBI) or post-traumatic stress disorder (PTSD) is unclear. PVA has no objections to this legislation, which seeks to establish a pilot program at the VA to assess the effectiveness of HBOT for these conditions.

Senate Discussion Draft, the Leveraging Integrated Networks in Communities (LINC) for Veterans Act

The LINC VA Act seeks to help veterans by improving the coordination between public and private social services and the VA. It requires the department to carry out a pilot program to establish community integration network infrastructure for services for veterans and collect information from veterans about social determinants that may impact their health. Using a new or existing network, the program would test the coordination of public and private providers and payors of services for veterans for things such as nutritional assistance, transportation, job training, caregiving or respite care, and disability assistance. PVA supports the draft bill and is confident the results of the pilot will enable VA and Congress to better understand the needs of veterans in certain subpopulations, such as those with catastrophic disabilities; racial or ethnic minorities; women veterans; and those residing in rural or underserved parts of the country.

Senate Discussion Draft, the SERVE Act

In times of fiscal constraint, joint use agreements between DOD and VA should be highly prized for their ability to increase access to care for servicemembers and veterans while reducing overall federal spending. Such agreements allow for the sharing of medical personnel, facilities, and resources which can lead to faster access to high quality care and improved medical outcomes. They also reduce bureaucracy and improve the efficiency of the system. DOD and VA have had the authority to execute these types of agreements for decades but have never used them to their full potential.

This draft legislation seeks to improve access to healthcare by improving collaboration and increasing the use of these agreements between the two departments. This includes allowing VA access to underutilized space at military medical treatment facilities (MTF) and the development of action plans that address the cross-credentialing of providers. It would also expedite base access for VA beneficiaries, integrate IT systems between the two departments, and designate coordinators in each department to manage implementation of the agreement. Agreements between VA and MTFs have been effective in the past, but often faltered whenever personality differences arose between the VA facility director or MTF commander. We support this effort to restate Congress's expectations for these types of agreements. We believe the draft bill's performance monitoring mechanisms and reporting requirements will help ensure success where others have failed.

Senate Discussion Draft, the Improving Access to Care for Rural Veterans Act

This draft legislation allows VA to enter into partnership agreements with rural hospitals to provide care for veterans residing in these areas. This includes the development of a standardized, renewable waiver process if a VA medical facility is unable to establish a partnership or agreement with a rural hospital. This authority seems like those granted to VA through the VA MISSION Act of 2018 (P.L. 115-182). We believe the committee should further consider those authorities before advancing this legislation. Also, the term VA medical facilities should be changed to VA medical centers (VAMC) since the earlier term implies that Community-Based Outpatient Clinics and Vet Centers could execute agreements on their own, even though they are extensions of a VAMC.

Senate Discussion Draft, the Get Justice Involved Veterans BACK HOME Act

PVA supports this draft legislation, which instructs VA to establish a pilot program to furnish mental health care to incarcerated veterans. Emphasis would be placed on those with service-connected ratings for PTSD, TBI, and conditions related to military sexual trauma. It does, however, restrict the use of community care providers, which we believe may hinder the support this effort is intended to provide.

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

STATEMENT OF

NANCY SPRINGER, ACTING DIRECTOR
NATIONAL LEGISLATIVE SERVICE
VETERANS OF FOREIGN WARS OF THE UNITED STATES

BEFORE THE

UNITED STATES SENATE
COMMITTEE ON VETERANS' AFFAIRS

WITH RESPECT TO

Pending Legislation

Washington, D.C. December 10, 2025

Chairman Moran, Ranking Member Blumenthal, and members of the committee, on behalf of the men and women of the Veterans of Foreign Wars of the United States (VFW) and its Auxiliary, I would like to thank you for the opportunity to speak on these subjects.

S.342, Purple Heart Veterans Education Act of 2025

The VFW supports this legislation to authorize Post-9/11 GI Bill transferability for Purple Heart recipients who have been discharged or released from active duty. Under current law, only service members who are still on active duty may transfer unused education benefits to eligible dependents.

Purple Heart recipients have made extraordinary sacrifices in service to our nation. They should not be subjected to arbitrary delimiting dates or technical barriers that prevent their families from accessing earned education benefits. This proposal would correct this issue, ensuring that combat-wounded veterans would be able to provide education opportunities to their spouses and children regardless of duty status or date of discharge.

S.668, SAFE STEPS for Veterans Act of 2025

While reducing fall-related injuries among veterans is an important goal, the VFW does not believe that establishing a new Office of Falls Prevention at the Department of Veterans Affairs (VA) would be the most effective or efficient approach. The Veterans Health Administration (VHA) currently has multiple offices and teams dedicated to safety, risk prevention, and rehabilitation. Strengthening these existing programs, such as those within the prosthetics department and physical or occupational therapy, would be a more practical solution. These teams currently conduct home evaluations for adaptation programs, provide mobility and balance training, and engage directly with veterans in fall prevention efforts.

Establishing a new office could add layers of bureaucracy, increase administrative costs, and create confusion regarding roles and responsibilities across VA services. Additionally, it is unclear how many veterans would voluntarily allow home fall-risk evaluations unless they specifically request home adaptations.

Before creating a new office, the VFW recommends that Congress and VA conduct a comprehensive evaluation of current resources, staffing, and interdepartmental coordination within VHA. This would help identify gaps and strengthen collaboration within existing structures. Enhancing and integrating current efforts would improve outcomes without creating unnecessary administrative hurdles.

S.926, Saving Our Veterans Lives Act of 2025

The VFW supports this legislation to authorize VA to establish a program providing veterans with access to free lockboxes for the secure storage of firearms. According to VA's *2024 National Veteran Suicide Prevention Annual Report*, in 2022 firearms were the means in nearly 75 percent of male veteran suicides and 45 percent of female veteran suicides. The same report found that male and female veterans die by suicide at rates 70 percent and 144 percent higher, respectively, than their civilian counterparts. These data highlight the elevated risk of suicide among veterans, particularly involving firearms, which have a 90 percent fatality rate compared to less lethal means. The report also notes that many suicides result from impulsive decisions that occur in less than ten minutes. Providing a physical barrier between at-risk veterans and their firearms, such as this lockbox, would create a critical pause that could allow time for the suicidal impulse to subside without irreversible action.

The VFW appreciates the provisions that would enhance efficient, effective outreach and program implementation by authorizing VA to partner with organizations experienced in firearm safety and secure storage devices. We also strongly agree with the guardrails that would ensure the program is fully voluntary and would not impede lawful firearm ownership. The program would not require firearm registration, collect or track personally identifiable firearm-related data, or create any list of participating veterans. It would also prohibit resale of the VA-furnished lockboxes. We believe the annual congressional reporting requirement would strengthen oversight and accountability by documenting program utilization, outreach effectiveness, obstacles to participation, and recommendations for improvement.

S.1116, Ensuring Veterans' Final Resting Place Act of 2025

The VFW supports this proposal to authorize VA to provide an urn or commemorative plaque as personal property to the next of kin of a decedent who dies on or after January 5, 2021, but who is not interred in either a private cemetery or in a national, state, tribal, or county veterans cemetery. Current law prohibits additional burial benefits, including interment in a VA cemetery, for a veteran decedent after the next of kin chooses the urn or commemorative plaque option. However, qualified family members retain eligibility for burial in a VA national cemetery, which creates a situation in which the entire family would not be interred together. We agree that future interment of an urn alongside eligible family members is an appropriate option for VA to provide so survivors may choose how to best memorialize their loved ones.

S.1657, Review Every Veteran's Claim Act of 2025

The VFW supports this legislation to amend Title 38, United States Code, Section 5103A(d) to prevent VA from denying a disability claim solely based on missing a compensation and pension (C&P) examination. Veterans miss appointments for many reasons and would benefit from flexibility in the process. This proposal would be a positive development and should facilitate continued improvements. However, we suggest modifying the text to clarify that VA must adjudicate the claim using the evidence of record when the available information clearly establishes the existence and severity of the claimed disability and would result in a favorable outcome for the claimant. Conversely, when the existing evidence does not adequately demonstrate the claimed disability, a C&P examination must remain mandatory to ensure a fully informed decision.

The VFW has assisted countless veterans who had to reapply for benefits because they missed examination appointments. Restarting a disability claim solely for this reason is burdensome and unnecessary. In such a case, we recommend returning the claim file to the work queue with a specific flag denoting "missed medical examination." This method would enable the veteran to resume processing the claim at the point of the missed appointment instead of starting over from the beginning.

S.1665, OATH Act of 2025

The VFW supports this legislation to ensure that veterans who participated in secrecy oath programs receive their full earned VA benefits. These veterans were prohibited under penalty of court-martial or civilian prosecution from disclosing details about their service, such as locations, assignment dates, or duties. This restriction has historically prevented them from filing claims for VA disability compensation and health care for service-connected conditions, effectively excluding them from the claims process. The legislation would define the term "secrecy oath program" in United States Code for clarity, and require VA to identify affected individuals within 90 days of their release from such program and inform them of all benefits to which they are entitled. However, to ensure appropriate transparency, the legislation should provide an unclassified description of the methodology VA would use to identify the affected veterans.

Additionally, we recommend clarifying Section 4 regarding effective dates. Current language could unintentionally assign retroactive effective dates to claims, including secondary conditions, even if the condition did not exist at the time of the claimed earlier date. The legislation should explicitly address how effective dates are applied to initial and secondary claims to prevent misinterpretation.

S.1868, Critical Access for Veterans Care Act

The VFW supports this legislation to expand access to veterans to Critical Access Hospitals (CAHs) and affiliated clinics under the Veterans Community Care Program (VCCP). This legislation resolves a significant gap in the VCCP that currently places unnecessary financial and administrative burdens on veterans. Currently, when a veteran is referred to an approved Community Care Network (CCN) provider that performs procedures at an affiliated hospital not listed in the VA referral, VA often denies payment for facility charges. This legislation would

ensure that if the provider is VA-approved, the location where care is delivered is also covered. This is an essential improvement for veterans in rural and underserved areas who rely on these hospitals for procedures their clinics cannot perform. CAHs are small rural facilities certified by the Centers for Medicare and Medicaid Services that provide vital local access to care. For many veterans, these hospitals are the only accessible medical settings. Allowing these hospitals to deliver authorized services under the VCCP would expand timely access, reduce travel burdens, and strengthen continuity of care.

At the same time, the VFW would like to stress that expanded access must not come at the cost of quality control or erosion of VA's core capacity to deliver comprehensive, veteran-centered care. This legislation would improve flexibility where authorized care can be delivered while maintaining VA's oversight role. By closing administrative gaps that lead to denied claims and unexpected veteran expenses, this legislation would protect veterans from financial harm and ensure that referrals function as intended.

S.1992, Veterans Appeals Efficiency Act of 2025

The VFW supports this legislation to expand the authority of the Board of Veterans' Appeals (BVA) to improve the efficiency of the appeals process, reduce the backlog of appeals at BVA, and allow appellants to receive quicker decisions. Veterans can wait as long as two years for an appeal decision, depending on the docket, and some veterans wait significantly longer if they request a hearing. Unfortunately, BVA cannot reduce or eliminate its current appeals inventory of approximately 200,000 cases (as indicated in the BVA fiscal year 2024 annual report), by operating at its current rate. With a projected 100,000 new cases for 2025, faster yet accurate decisions are not possible without streamlining BVA policies and procedures. This legislation would allow for aggregation of claims enabling BVA to decide multiple claims simultaneously, accelerating the decision process. Since BVA does not currently have express authority in statute to aggregate similar claims from multiple veterans, it does not presently use this method.

This legislation would direct VA to enter into an agreement with a federally funded research and development center to assess the feasibility of giving BVA precedential authority. If supportable, this authority would reduce repetitive litigation over the same legal issues and help streamline the appeals process. Regarding the United States Court of Appeals for Veterans Claims, the legislation would expand its authority to certify class action. This expansion could systematically resolve widespread issues rather than addressing them on a case-by-case basis, providing another mechanism to streamline appeals processes and accelerate adjudication.

Furthermore, there is a lack of specific guidance when a veteran's appeal is not only eligible to advance on the docket but also when it is likely to be decided, which leads to an inconsistent appeals process. This legislation would remedy that situation by directing VA to prescribe guidelines for the advancement of a case on the docket including the type of evidence a veteran may submit with a motion to advance the case. However, the VFW recommends that any collection of data for advancement on the docket include the effect of natural disasters, as they may substantially delay the process. Recent natural disasters that resulted in BVA invoking emergency authorities caused significant delay for long docketed appeals.

The legislation's reporting regimen would enhance oversight of VA's appeals process and increase transparency. Better data tracking as described in the legislation would standardize how VA monitors its claims, which could help identify and remedy information bottlenecks. In addition, to ensure the accuracy of the data, the VFW suggests adding a subparagraph (F) to the proposed Title 38, section 5109C, to track instances in which an eligible person requests to be a substitute for a deceased claimant for the purpose of processing the claim to completion.

Lastly, this legislation would codify the Court's authority to issue limited remands to BVA and require the Court to issue procedural rules. In previous testimony, the VFW expressed that there has been a problem with too much overdevelopment of claims. In fiscal year 2024, the Court remanded 83 percent of appeals back to BVA because of legal errors in BVA-issued decisions. Limited remands occur when the Court orders BVA to address specific issues on which it erred without requiring BVA to issue a new decision on the entire, perhaps lengthy and multi-issue appeal. Limited remands increase efficiency by eliminating the need to review a second time those issues on which BVA did not previously err. Though the Court has the authority to issue limited remands, it has not codified the process in which a veteran can request a limited remand and when the Court should issue one. As a result, such actions are rare.

S.2061, Molly R. Loomis Research for Descendants of Toxic Exposed Veterans Act of 2025

The VFW supports this legislation to initiate comprehensive research into birth defects in the descendants of toxic-exposed veterans. While VA currently presumes a connection between certain toxic exposures and adverse health conditions among veterans and active duty service members, the intergenerational effects of these exposures remain largely unknown.

This proposal would build upon the foundation of the Interagency Working Group on Toxic Exposure (known hereafter as the "Working Group") established in Section 501 of the *Honoring our PACT Act of 2022* (Public Law 117-168). The Working Group would further establish task forces to collaboratively research the diagnoses and treatment of health conditions affecting the descendants of veterans exposed to toxic substances during military service.

The VFW appreciates the provisions that would enhance transparency, accountability, and oversight. In coordination with the Agency for Toxic Substances and Disease Registry, the Working Group would create and maintain a publicly accessible website detailing the agency's activities, findings, and data reviews assessing the strength of evidence linking eligible health conditions to toxic exposure activities. Furthermore, the legislation would require regular reporting to the Senate and House Committees on Veterans' Affairs, ensuring robust congressional oversight of the Working Group and its research task forces. These measures would strengthen public trust, promote scientific integrity, and help advance understanding of the long-term generational health impacts of toxic exposure in military service.

S.2220, FORGOTTEN Veterans Act of 2025

The VFW supports this legislation to recognize service members who served at classified locations within the Nevada Test and Training Range (NTTR) as having participated in a

radiation risk activity qualifying them for VA health care and benefits. Because the NTTR is a classified location, affected veterans have been unable to substantiate their service or exposure history.

The VFW appreciates the provision to expand the Individual Longitudinal Exposure Record to include domestic occupational and environmental hazard data. This expansion would improve claims processing related to domestic toxic exposures and research capabilities while also maintaining appropriate safeguards for classified information.

Furthermore, this legislation would establish a presumption of service connection for Department of Defense (DOD) personnel who served at shared DOD and Department of Energy (DOE) facilities, aligning their eligibility for VA benefits with those of DOE employees already covered under the *Energy Employees Occupational Illness Compensation Program Act* of 2000.

S.2264, AVERT Crises Act of 2025

The VFW supports this legislation to improve VA's emergency management capabilities. This legislation seeks to enhance VA's readiness for natural disasters, pandemics, and large-scale emergencies, as well as its role in national emergency response, known as its "Fourth Mission." Focusing on foundational groundwork for future reforms centered on analysis and reporting rather than immediate sweeping changes, the short-term costs are minimal. However, the potential long-term benefits include significant improvements in efficiency, readiness, and the continuity of care for veterans.

This legislation would require VA to compile a series of reports that would codify the roles and responsibilities of VA offices involved in emergency management; assess and document the current capabilities of VA Regional Readiness Centers to respond to various emergencies; and identify limitations in fuel and other resource-sharing agreements between VA and the Federal Emergency Management Agency. The VFW appreciates these reporting requirements and the resulting assessment of VA's emergency response capabilities. Understanding and addressing the gaps in preparedness will ensure that VA could effectively fulfill its Fourth Mission responsibilities when necessary, while simultaneously supporting veterans.

S.2309, Veteran Burial Timeliness and Death Certificate Accountability Act

The VFW supports this legislation to require the timely certification of deaths, mandating that death certificates be completed no later than 48 hours after the veteran's physician or nurse practitioner is notified. In cases in which the physician or nurse practitioner cannot comply with this requirement, the coroner or medical examiner in the jurisdiction of the death may do the certification. This legislation would remedy excessive delays, sometimes as long as eight weeks, by VA physicians signing death certificates. Survivors depend on these certifications to arrange burials and apply for survivor benefits. Delays in issuing death certificates can cause significant financial and emotional hardship for these grieving families. Additionally, we recommend including a provision that would direct the certifying official to consider the veteran's service-connected conditions when determining the cause of death. Eligibility for survivor benefits is predicated on the service-connected condition contributing to the death so this information is critical to making that determination.

To maximize the effectiveness of the new VA initiative, Congress should mandate a clearly defined project scope that specifies the target veteran population, participating sites, and anticipated outcomes. VA should also be required to collect comprehensive data from veterans and caregivers to evaluate satisfaction, access, and safety. Additionally, robust reporting and evaluation provisions in the legislation would enable Congress to monitor the program, determine its effectiveness, and make evidence-based decisions regarding its expansion or modification.

Veterans have earned their burial benefits, and this legislation aims to fulfill the promise made to them and their families. Individuals who served our country deserve to have their final rites conducted with dignity, promptness, and accuracy. The importance of this cannot be overstated. By strengthening public trust in VA, we demonstrate that the system effectively supports veterans when it matters most.

S.2328, Military Learning for Credit Act of 2025

The VFW supports this legislation to allow veterans to use their education benefits to pay for examinations and assessments that convert military experience into college credit. These include College-Level Examination Program tests, DANTES Subject Standardized Tests, the National Career Readiness Certificate, and portfolio assessments by colleges that evaluate military training or experience, in addition to similar examinations approved by VA.

Veterans bring valuable skills and knowledge from their military service. This proposal recognizes that the unique experience obtained through defending our nation should equate to transferable credits or advanced standing credits in the pursuit of higher education. This legislation would serve as a means to accelerate academic progress, reduce out-of-pocket costs, and transition more efficiently into civilian careers. This coincides with the VFW's goal of expanding use of GI Bill benefits and improved access to academic credit for prior learning.

S.2333, Health Records Enhancement Act

The VFW supports this legislation to permit a designated individual to add supplementary information to a decedent's medical record. Under this legislation, the Secretaries of Defense and Veterans Affairs would jointly develop a process to identify this individual—an immediate family member or another adult specifically authorized for this purpose. This person would be permitted to add information to the medical record but not delete or alter existing information.

Allowing these contributions would help complete the medical record with first-hand observations of the veteran's condition and response to treatment during the final days. A more comprehensive record would enhance understanding of patient outcomes, support research, and help identify trends that could improve future health care delivery.

S.2397, CARING for Our Veterans Health Act of 2025

The VFW supports this legislation to implement improvements to health care delivery through

VA's community care providers. It would direct VA to develop guidelines to help its medical centers obtain final medical documentation after veterans receive services from community providers following a referral. This legislation would also mandate the establishment of clear goals and performance metrics to ensure the collection of both initial and final medical documentation from these providers.

Overall, this legislation represents a positive and necessary step toward improving the quality of care for veterans. Enhancing the coordination and accuracy of medical documentation would support better continuity of care. By including measurable goals and mandatory training, the legislation would promote accountability and consistency among care providers, reducing variability in service quality. Additionally, the requirement for regular reporting to Congress introduces transparency, allowing for oversight and fostering public trust. If implemented effectively, the legislation could significantly enhance the experience and outcomes for veterans receiving health care within the VA system and through community providers.

S.2683, VSAFE Act of 2025

The VFW supports this legislation to require VA to establish a Veterans Scam and Fraud Evasion Officer position. Scammers frequently target veterans due to their presumed benefits, service history, and public recognition. The August 2023 *VA Fraud Prevention Kit* cited a 2021 American Association of Retired Persons study that found 78 percent of veterans were targeted by scams exploiting their military service. The scope of the problem is significant. According to the *Consumer Sentinel Network Data Book 2023*, published by the Federal Trade Commission in February 2024, more than 150,000 veterans and military retirees reported fraud in 2023 with losses exceeding $350 million.

In response, VA launched its VSAFE webpage and a companion fraud hotline in 2024. This legislation would codify these initiatives and consolidate all VA fraud prevention efforts under the Veterans Scam and Fraud Evasion Officer. This person would serve as the central point of contact for fraud prevention, information sharing, and response coordination, while collaborating with other federal agencies to advance a whole-of-government strategy against veteran-targeted fraud. Additionally, this person would engage with Veterans Service Organizations and government partners to identify emerging scam risks and strengthen protections for veterans.

S.2737, Veterans National Traumatic Brain Injury Treatment Act

The VFW supports this legislation to improve access to care for veterans with complex traumatic brain injury (TBI) through a pilot program offering hyperbaric oxygen therapy (HBOT). Our organization remains committed to exploring alternative treatments for post-traumatic stress disorder (PTSD) and TBI, especially for veterans who have not had success with standard therapies. We further acknowledge that VA continues to lead in adopting emerging technologies and innovative care models.

We also emphasize the importance of such a program being implemented responsibly. Clear, evidence-based clinical standards and strong VA oversight are necessary to ensure that alternative therapies such as HBOT are safe, effective, and well-coordinated within a veteran's broader treatment plan.

S.2807, RESPECT Act of 2025

The VFW supports this legislation to close a gap in current law preventing the disinterment of certain sex offenders interred before 2013. This legislation would authorize federal officials to reconsider interment decisions made on or after June 18, 1973, for individuals credibly accused of sex offenses buried in cemeteries managed by the National Cemetery Administration or at Arlington National Cemetery.

Under current law, reconsideration is limited to interments after December 2013. This legislation would ensure consistent policy irrespective of the interment date. It would also address survivors' concerns about their loved ones resting alongside individuals who would otherwise be disinterred if not for the pre-2013 technicality.

Draft Legislation, Fisher House Availability Act

The VFW supports this legislation to require VA to expand eligibility for use of temporary lodging facilities, such as Fisher Houses, on a space-available basis to certain TRICARE beneficiaries. Fisher Houses provide no-cost temporary lodging for families of veterans receiving treatment at VA medical centers. This expansion is needed because many service members and military families lack affordable lodging when they must travel long distances for specialized medical care. VA Fisher Houses mainly serve veterans and their families. However, active duty personnel, especially National Guard and Reserve members or those treated at VA facilities due to proximity, often cannot access this support.

We ask lawmakers to support this effort by ensuring service members, their families, and active duty individuals can use these facilities when space is available. This would reduce financial hardship, support care continuity, improve readiness, and strengthen family support, especially in rural areas where medical services are far and lodging is the main barrier.

Draft Legislation, Leveraging Integrated Networks in Communities for Veterans Act

The VFW supports this proposed legislation to require VA to establish a community integration network pilot program to provide a coordinated, holistic suite of services for veterans. Instead of researching separate, stove-piped programs, veterans would be able to access the network and build a package of services in one stop tailored to the veteran's needs. Under the pilot, VA would select at least one facility in each Veterans Integrated Service Network in which to implement an interoperable technology network to connect public and private service providers. Services could include housing, health care, nutritional support, job training, transportation, child care, caregiving, disability claims assistance, suicide prevention, sexual assault treatment, legal services, and other veteran-centered support.

The program would ensure compliance with federal and state privacy laws, effectively manage referrals and outcomes, integrate standardized social determinant risk assessments into routine VA care, and coordinate with existing community networks and Medicaid programs. Reporting and oversight provisions would track improvements or deterioration in veterans' health outcomes and access to services. Assuming timely and effective implementation, the VFW believes this

coordinated approach would benefit veterans by informing them of what is available and providing easy access to a variety of services.

Draft Legislation, SERVE Act

The VFW supports this legislation to improve collaboration and resource sharing between DOD and VA to expand health care access for veterans, particularly those living near military medical treatment facilities. This initiative would enable veterans, especially those in rural or underserved areas, to utilize nearby military medical facilities, which would help reduce travel time and minimize appointment delays. Leveraging DOD facilities with unused capacity would minimize waste and optimize government health care resources. This approach would encourage the integration of systems, cross-credentialing of staff, and joint training, ultimately promoting a continuity of care for both active duty personnel and veterans.

This legislation would enhance transparency by providing public reports on VA-DOD sharing agreements and establishing oversight through coordinated action plans and performance monitoring. Although successful implementation would require careful management of funding, staffing, and data integration, this proposal represents a significant step toward ensuring that no available federal health care capacity goes unused when it can be utilized to help veterans in need.

Draft Legislation, Improving Access to Care for Rural Veterans Act

The VFW supports this legislation to establish partnerships between VA medical facilities and rural hospitals to improve health care access for veterans residing in rural areas. The proposal would require each VA medical facility to establish a partnership with at least one hospital located in a designated rural area. We recommend that the term "rural" be clearly defined within the legislation to ensure that partnerships are formed with hospitals that genuinely serve rural or underserved veteran populations, aligning with the legislation's intent.

Furthermore, the current language states that each partnership "may include" activities such as shared telehealth services, co-located clinics, joint training, and coordinated emergency care. To ensure consistency and measurable outcomes across the VA system, we recommend this language be revised to state that each partnership "shall include" at least one of the following: agreements for telehealth service provision; co-location or leasing of space or equipment; training programs, care coordination, emergency services and transport; or other activities deemed appropriate to improve access and continuity of care for veterans.

The legislation's inclusion of clear timelines, oversight requirements, and biennial reporting would foster accountability and continuous improvement. However, successful implementation would require adequate funding, workforce capacity, and systemwide coordination to address infrastructure and resource challenges.

Draft Legislation, Commission on Equity and Reconciliation in the Uniformed Services Act

This proposal would establish a Commission on Equity and Reconciliation in the Uniformed

Services to investigate and address the impacts of DOD and VA policies affecting LGBTQ+ service members and veterans, recommend remedies, and educate the public on institutionalized discrimination. The VFW does not have a position on most provisions within Sections 2 through 7 of this proposed legislation, including the Commission's establishment and duties, membership, powers, administration, termination, and funding, as these topics fall outside the scope of the VFW's member-driven resolutions.

The VFW supports certain provisions within this proposal that address discharge upgrades and redress for denied health care and benefits. Specifically, the VFW supports Section 2[b][1][B] to direct the Commission to document how VA policies have affected eligibility for, and access to, benefits for service members discharged due to sexual orientation or gender identity, Section 2[b][9] to examine the impacts of denied medically necessary health care on service members and veterans, and Section 2[b][14] to recommend appropriate remedies to address the Commission's findings.

The VFW also supports specific remedies outlined in the proposal. This includes Section 2[14][C] to restore gender-affirming services and care within DOD and VA for service members, veterans, and other beneficiaries. These services had previously been provided by both departments, and we do not support reducing or eliminating the full suite of care for service members and veterans. For those who were actively receiving treatments, the elimination of their medical services has been detrimental to many, impacting their health, wellbeing, and ability to serve at their full potential.

The VFW also supports Section 2[14][D] to streamline discharge upgrades and amendments to military records, including improving transparency and accessibility for affected individuals. We support Section 2[14][G] to expand health care and other resources to meet the needs of LGBTQ+ patients, including improved data collection, mental health counseling, and other medical services; and Sec. 2[14][H] to review burial rights denied to service members and veterans prematurely discharged under prior DOD policies.

Draft, Get Justice Involved Veterans BACK HOME Act

The VFW supports the intent of this proposal to expand VA mental health services for incarcerated veterans. It would require VA to conduct a pilot program to provide mental health care in correctional facilities, prioritizing those with a service-connected disability for PTSD, TBI, or military sexual trauma (MST). It requires VA to deliver services through telemental health or mobile units, establish dedicated veteran housing units in federal prisons where feasible, and automatically resume compensation payments upon release. It would also amend section 10132 of Title 34 to collect data pertaining to incarcerated veterans for an annual report to Congress.

The VFW has concerns about two provisions. First, Section 2(e)(2), Treatment and Assessment, states that "a health care provider providing mental health care under the pilot program shall provide treatment and assessment of medical conditions and is not to provide assessment or evaluation of current or future disability claims." This conflicts with the VFW's long-standing position that VA health care providers should be allowed to provide medical nexus opinions and supporting documentation for disability claims, as they have direct contact with the veterans they

treat. As written, this provision could inadvertently discourage or prevent incarcerated veterans from filing disability compensation claims.

Second, the VFW recommends revising the language in Section 2(a) that would prioritize treatment for PTSD or MST. We recommend that the text refer more broadly to veterans with mental health conditions, since the Veterans Affairs Schedule for Rating Disabilities does not currently differentiate between types of mental health conditions, except for eating disorders. Moreover, MST is not itself a mental health condition, rather VA recognizes conditions that result from MST.

Chairman Moran and Ranking Member Blumenthal, this concludes my testimony. I am prepared to answer any questions you or members of the committee may have.

Senate Committee on Veterans' Affairs

Legislative Hearing on Pending Legislation

December 10, 2025

Statement for the Record of Bart Stichman, Co-Founder and Special Counsel for the National Veterans Legal Services Program (NVLSP)

Introduction

My name is Bart Stichman, and I am the co-founder of National Veterans Legal Services Program (NVLSP) and currently serve as NVLSP's Special Counsel. Established in 1981, NVLSP is an independent, nonprofit veterans service organization that is dedicated to ensuring that our government lives up to its obligations to provide our 18 million veterans and active service members the VA and military department benefits they have earned due to their military service to our country. At NVLSP, we have a uniform code: to serve those who have served us.

NVLSP would like to thank Chairman Moran, Ranking Member Blumenthal, and distinguished members of the Senate Committee on Veterans' Affairs for the opportunity to present our views regarding the pending legislation before the Committee.

NVLSP firmly supports the Veterans Appeals Efficiency Act of 2025, S.1992, which contains several concrete, practical reforms that would meaningfully improve the adjudication of benefit claims and appeals process of the Department of Veterans Affairs (VA) and the U.S. Court of Appeals for Veterans Claims (CAVC).

This bill proposes simple solutions to the infamous "hamster wheel" of never-ending claims that traps veterans in endless procedural loops, delaying relief and compounding frustration for veterans and their families. It does not attempt to reinvent the system; it simply clarifies the authority and judicial tools Congress has already provided to VA and the CAVC. These existing tools, when used responsibly, can break the hamster wheel cycle, streamline adjudication, and restore fairness and efficiency to a system designed to serve veterans, not exhaust them.

The reforms in this bill provide three critical clarifications to the veterans' benefits adjudication process: two at the CAVC and one at the Board of Veterans' Appeals (BVA). First, the Veterans Appeals Efficiency Act would restore the supplemental jurisdiction the CAVC had in cases in which a party denied benefits by the BVA seeks certification of their appeal to the CAVC as a class action on behalf of those with claims pending before the VA.[1] Second, the bill

[1] The CAVC's rules provide for certification of a class where: (1) the class is so numerous that consolidating individual actions is impracticable; (2) there are questions of law or fact common to the class; (3) the legal issue or issues being raised by representative parties are typical of the legal issues that could be raised by the class; (4) the representative parties will fairly and adequately protect the interests of the class; and (5) the VA has acted or failed to act on grounds that apply generally to the class. Vet. App. R. 23.

would clarify the Court's existing authority to issue limited remands without returning a veteran's claim to the hamster wheel of agency review. Finally, the bill would codify the authority of the BVA to aggregate claims in appropriate cases, a tool seventy other federal agencies possess and utilize to streamline agency adjudication.[2] NVLSP supports these common-sense clarifications of existing tools and authorities in the veterans' claims system, with limited amendments to the bill noted below.

NVLSP also strongly supports three additional pieces of legislation before the Committee today: the OATH Act, S.1665, the Molly Loomis Bill, S.2061, and the Get Justice-Involved Veterans BACK HOME Act, S.____. These bills provide critical safeguards to ensure veterans receive the benefits they have earned and make forward-looking investments in the health and wellbeing of their descendants.

S.1992, The Veterans Appeals Efficiency Act

i. CAVC Aggregation

NVLSP enthusiastically supports the reform set out in section 2(e) of the Veterans Appeals Efficiency Act, which restores the CAVC's supplemental jurisdiction over claims "for which the agency of original jurisdiction has issued a nonfinal decision and the claimant has filed a notice of disagreement," including those where the claimant has filed a supplemental claim within one year of a BVA decision.[3]

The U.S. Court of Appeals for the Federal Circuit and the CAVC have long held the CAVC has authority to aggregate claims through the mechanism of a class action.[4] Congress vested the CAVC with broad equitable powers to ensure the efficient and consistent application of its rulings, including bringing together similarly situated veterans facing common legal or factual issues.[5] The CAVC has exercised this authority responsibly, and tens of thousands of veterans have already benefited from class-wide remedies that ensure uniform outcomes. For example, in a class action lawsuit challenging VA's policy to deny veterans the right to BVA appeal of an adverse VA decision made under the Family Caregiver Program, NVLSP and its co-counsel persuaded the Federal Circuit to affirm the CAVC's class action order requiring VA to send notice to more than 400,000 veterans of their right to appeal to the BVA their adverse determinations under the Family Caregiver Program.[6] Similarly, the CAVC certified two class actions on behalf of two different sets of more than 10,000 veterans whose BVA appeals had

[2] Michael Sant'Ambrogio & Adam S. Zimmerman, *Inside the Agency Class Action*, 126 Yale L.J. 1634, 1658-59 (2017).
[3] S.1992, § 2(e)
[4] *Monk v. Shulkin*, 855 F.3d 1312, 1318-22 (Fed. Cir. 2017) (holding that the CAVC has authority to adjudicate class actions "under the All Writs Act, other statutory authority, and the [CAVC's] inherent powers").
[5] 38 U.S.C. § 7264 grants the CAVC broad authority to conduct its proceedings "in accordance with such rules of practice and procedure as the Court prescribes."
[6] *Beaudette v. McDonough*, 34 Vet. App. 95 (2021), *aff'd*, 93 F.4th 1361 (Fed. Cir. 2024).

been unreasonably delayed, and in each case, the CAVC ordered the VA to transfer the appeals of each certified class member to the BVA by a date certain.[7]

The barrier to meaningful collective resolution today is not that the CAVC lacks authority; it is that a recent Federal Circuit decision unnecessarily constricts who may count toward a prerequisite that every request for class certification must satisfy: the requirement that there be "numerous" putative class members, which generally means that there must be at least 40 putative class members.[8] The supplemental jurisdiction reform of the Appeals Efficiency Act addresses this structural problem.

In *Skaar v. McDonough*, 48 F.4th 1323 (Fed. Cir. 2022), the Federal Circuit held that only veterans whose claims have received a final BVA decision may be included when assessing numerosity for class certification. This rule announced in *Skaar* bars the large majority of veterans with pending claims at the BVA or regional office from being included in the class and counting towards the numerosity requirement. *Skaar* held that veterans raising the same issue may count towards numerosity only if the BVA had already decided their appeal and the case was within the 120-day window to appeal a BVA decision. The adoption in *Skaar* of such a narrow period to count as a putative class member makes it extremely difficult to satisfy numerosity in most class contexts.

Five of the twelve Federal Circuit judges dissented from the denial in *Skaar* of rehearing *en banc*, emphasizing the severe consequences of excluding veterans at earlier stages of the VA adjudicatory process.[9] Judge Dyk, writing for the dissenters, described the VA system as "inefficient and subject to substantial delays" and noted that aggregation at the CAVC "promised to help ameliorate these problems… enabling veterans in a single case to secure a ruling that would help resolve dozens if not hundreds of similar claims."[10] The problem is not whether the CAVC has the authority to certify class actions—it does. The problem is that *Skaar* defines the class universe of eligible claimants so narrowly that veterans cannot meet the numerosity threshold needed to certify one.

The *Skaar* approach is sharply out of step with how Article III courts handle class actions against the federal government in other benefits systems. In Social Security litigation, for instance, courts routinely certify classes that include claimants at different adjudicative stages. For instance, the Supreme Court in *Califano v. Yamasaki*, 442 U.S. 682 (1979) upheld a

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[7] *Gladney-Chase v. Collins*, 38 Vet. App. 216, 219-222 (2025); *Godsey v. Wilkie*, 31 Vet. App. 207, 220-225 (2019).
[8] *See Skaar v. Wilkie*, 32 Vet. App. 156, 190-91 (2019) (*en banc*) (finding that "[n]umerosity need not be proven exactly," and "'[c]ourts generally find that the numerosity factor is satisfied if the class comprises 40 or more members and will find that it has not been satisfied when the class comprises 21 or fewer.'" (*citing Celano v. Marriott Int'l, Inc.*, 242 F.R.D. 544, 549 (N.D. Cal. 2007))), *vacated on other grounds sub nom. Skaar v. McDonough*, 48 F.4th 1323 (Fed. Cir. 2022).
[9] *Skaar v. McDonough*, 57 F.4th 1015, 1016 (Fed. Cir. 2023) (Dyk, J., dissenting from denial of rehearing *en banc*).
[10] *Id.* at 1016-17.

nationwide class of beneficiaries challenging recoupment procedures, including individuals whose administrative claims had not yet reached final review. Such cases illustrate that, when a systemic legal issue drives inconsistent or delayed outcomes, courts do not artificially limit numerosity to a tiny fraction of fully appealed claims; they include those who are affected across the full administrative spectrum to ensure efficiency and fairness.

S.1992 does not expand the CAVC's powers beyond what they were pre-*Skaar*. Instead, it restores the Court's previously exercised authority to certify classes consistent with how Article III courts manage complex benefits disputes. Veterans with a final BVA decision, veterans with pending claims still before the BVA, and veterans whose remanded claims are being reprocessed at regional offices would all be recognized as part of the same class when they confront a shared legal or factual question. Reinstating workable numerosity will allow the Court to treat like veterans alike, prevent repetitive litigation across thousands of similar claims, ensure equity and uniformity across decisions, and meaningfully hold the VA accountable.

ii. Two Proposed Amendments to S.1992, Section 2(e), CAVC Aggregation

NVLSP proposes two important amendments to Section 2(e) of the Veterans Appeals Efficiency Act to ensure the bill fulfills its purpose of delivering efficient and fair adjudication for veterans.

First, language referencing "a request for a writ [of mandamus]" should be removed from Section 2(e). Currently, the bill defines "covered proceedings" over which S.1992's amendments to 38 U.S.C. § 7252 would apply to include both appeals and petitions for a writ of mandamus. But the injustice created by *Skaar* only has an impact on the CAVC's ability to aggregate cases in which the individual seeking class certification has appealed a BVA decision to the CAVC. *Skaar* did not involve, nor did it regulate, the numerosity requirement in cases in which the individual seeking class certification filed a writ of mandamus with the CAVC. The Court's authority to aggregate in writ of mandamus cases does not need to be, and should not be, addressed by Congress; it presently functions reasonably well.[11] The CAVC's writ authority derives from the All Writs Act, 28 U.S.C. § 1651(a), enacted in the First Judiciary Act of 1789 and made available to the CAVC as with other federal courts. By making the reforms in S.1992 applicable to class actions initiated by a writ of mandamus, the current language of S.1992 risks an inequitable result–narrowing the CAVC's robust existing authority to aggregate in appropriate writ cases and thus inadvertently undermining the broader purpose of this bill: to grant additional tools to veterans, the CAVC, and the BVA to manage their large dockets, reduce backlogs, and improve fairness and uniformity of decisions.

[11] *See, e.g.*, *Gladney-Chase v. Collins*, No. 24-4472, 2025 WL 1335465, at *6 (Vet. App. Apr. 24, 2025) (granting joint motion to certify class seeking mandamus relief in connection with failure of the BVA to timely docket appeals from Veterans Health Administration).

Second, references to opt-out procedures should be removed from section 2(e). The CAVC's existing rules for aggregate litigation do not contemplate a mechanism for veterans who fit within the class definition to opt out of the class, and for good reason: introducing statutory opt-out language makes no sense in a system that is different from the multi-forum environments where opt-outs are typically used. Most class actions that do not involve VA benefits are filed in one of the ninety-four U.S. district courts that exist in the U.S. states and territories. The decisions of these district courts are appealable to one of the eleven regional courts of appeals, plus the Federal Circuit. In some U.S. district court class actions, class members have a right to opt out of the class in order to preserve the individual's right to litigate his or her case in a different jurisdiction. For example, a putative class member who resides in Massachusetts may have the right in a national class action filed with a U.S. district court in Arizona to opt out of the Arizona district court class action in order to preserve his or her right to file and litigate the same legal issue before a local U.S. district court in Massachusetts whose decisions are appealable to the U.S. Court of Appeals for the First Circuit, rather than U.S. Court of Appeals for the Ninth Circuit, which hears appeals from the U.S. district court in Arizona.

But the opt-out mechanism makes no sense at the CAVC, because the CAVC is a national court for cases adjudicated by the VA, and the Federal Circuit has exclusive jurisdiction to hear all appeals filed from decisions of the CAVC. The language of S.1992 referring to a "claimant who has not opted out of an opportunity to be a member of a class" has no legal mooring, and a true opt-out mechanism is incompatible with the veterans' benefits system. The CAVC's rules have no provision authorizing VA claimants to opt out of a proposed class, and the CAVC has never offered a VA claimant such an opportunity. And even if a VA claimant were hypothetically allowed to opt out, there is no forum other than the CAVC and Federal Circuit to which such an opt-out could take their case. In other words, a veteran who hypothetically opted out would be forced to litigate their case before the exact same tribunals that would decide the class action with class members who did not opt out. Thus, the CAVC's class action ruling would continue to bind the agency and govern the disposition of any hypothetical opt-out veteran's claim.

iii. CAVC Limited Remands

NVLSP also supports the limited remand reform in section 2(e) of the Veterans Appeals Efficiency Act, which clarifies the CAVC's authority to issue limited remands to the BVA. Currently, when the CAVC encounters a procedural or substantive defect that requires agency action on one issue in an appeal involving multiple issues, the Court typically issues a full remand, sending the entire case back to the BVA for correction of one error without addressing any of the other issues. This piecemeal approach adds years to the adjudication process and results in substantial delays for veterans. Although the Court possesses the ability to issue limited remands while retaining jurisdiction over the rest of the case, it rarely does so because its

authority is not well-defined, and current precedent confines its use to exceptional circumstances.[12]

The Veterans Appeals Efficiency Act provides a targeted solution by codifying the Court's authority to order limited remands and instructing the CAVC to develop guidelines governing their use, including the authority to require the BVA to act within a specified timeframe, so that the case may expeditiously return to the Court for a final CAVC decision that disposes of the entire appeal after taking the results of the limited remand into account. By directing the Court to articulate transparent standards for when and how limited remands may be issued, this bill will enable all participants in the system, including the Court, veterans, and their representatives, to understand when limited remands are available, the proper process for requesting limited remands, and how they should operate. This reform turns an underused mechanism into a practical, accessible means of reducing delay and expediting relief.

iv. BVA Aggregation

In addition to its important reforms to the CAVC's supplemental jurisdiction and limited remand authority, NVLSP supports section 2(d)(1) of the Veterans Appeals Efficiency Act, which aims to reduce the backlog of veterans' benefits appeals by confirming the BVA's authority to aggregate appeals. This would relieve the burden on veterans, who currently must individually present arguments and submit evidence to the BVA on the same issues the BVA is considering in other cases. Many veterans do not have the resources to hire the counsel or experts necessary to argue or submit critical evidence on complex medical or legal issues central to their benefits determination. Where appropriate, aggregation would allow a veteran with such access to present a case on behalf of all similarly affected veterans.

While more than seventy other federal agencies have a class action, joinder, or consolidation practice that facilitates aggregation of administrative appeals, the BVA is an outlier in insisting that it lacks power ever to group together appeals raising the same question of law or fact for efficient adjudication.[13] But like other federal agencies, the BVA does have broad authority to prescribe rules to manage its docket of appeals.[14] Exercising this authority through agency aggregation will increase the efficiency of the appeals process, improve access for

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[12] *See Skaar v. Wilkie*, 32 Vet. App. 156, 201 (2019). 28 U.S.C. § 2106 provides that federal courts "may remand the cause and direct entry of such appropriate judgment, decree, or order, or require such further proceedings to be had as may be just under the circumstances"; *accord* 38 U.S.C. § 7252(a) (authorizing the CAVC to "remand [a] matter, as appropriate"). It is settled that the BVA is required to comply with CAVC remand orders. *Stegall v. West*, 11 Vet App. 268 (1998).

[13] Sant'Ambrogio & Zimmerman, *Inside the Agency Class Action*, 126 Yale L.J. at 1658–59.

[14] *See* 38 U.S.C. § 501(a) (2021) (providing that the Secretary has "authority to prescribe all rules and regulations which are necessary or appropriate to carry out the laws administered by the Department," including the manner and form of adjudication).

veterans who do not have the resources to argue the complex medical and legal issues central to their benefits determinations, and increase fairness by standardizing the BVA's findings.

According to the American Conference of the United States (ACUS), agencies that fail to aggregate claims "risk wasting resources in repetitive adjudication, reaching inconsistent outcomes for the same kinds of claims, and denying individuals access to the affordable representation that aggregate procedures promise."[15] This risk is already a reality at the BVA, where veterans face an average wait of 506 days on direct review, 713 on the evidence submission docket, and 927 on the hearing docket.[16] Consistent with the recommendations of ACUS, the BVA's organic statute, and the typical practice of federal agencies, Section 2(d)(1) of the Veterans Appeals Efficiency Act confirms that the BVA has authority to aggregate like claims in appropriate circumstances.

v. Conclusion

In sum, NVLSP urges the Committee to enact the Veterans Appeals Efficiency Act, particularly the reforms to codify the CAVC's authority to aggregate like claims and issue limited remands, as well as the BVA's authority to aggregate claims. Together, these measures will materially reduce the appeals backlog while advancing uniformity and consistency of decisions, fairness to veterans and families, and more equitable access to benefits they've been promised. There is no reason veterans seeking judicial review of benefits decisions should be denied access to the same procedural tools available to civilians challenging federal agency actions. Veterans deserve a fair and efficient judicial process, and this bill offers common-sense reforms that will help deliver it.

S.1665, OATH Act of 2025

NVLSP also supports the OATH Act of 2025. This bill will help to ensure that veterans who participated in secrecy oath programs receive the full benefits they earned. The bill requires VA to identify and notify impacted veterans, including those who served in the program at Edgewood Arsenal, where around 7,000 soldiers were used as test subjects in experiments to evaluate the impact of chemical warfare agents.[17] When these veterans left service, they were unable to seek VA disability benefits for injuries related to the program without violating their secrecy oaths. Although the Department of Defense lifted those oaths in 2006, existing veterans'

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[15] *See* Administrative Conference Recommendation 2016-2, *Aggregation of Similar Claims in Agency Adjudication* (2016), https://www.acus.gov/sites/default/files/documents/aggregate-agency-adjudication-final-recommendation_1.pdf.
[16] *See* Department of Veterans Affairs, *Veteran choices for type of Board appeal influences wait times: Appeal wait times* (2025), https://department.va.gov/board-of-veterans-appeals/decision-wait-times/veteran-choices-for-type-of-board-appeal-influences-wait-times/.
[17] U.S. Department of Veterans Affairs, "Edgewood/ Aberdeen Experiments," https://www.publichealth.va.gov/exposures/edgewood-aberdeen/index.asp.

benefits law allowed compensation only from the date of their post-2006 disability application, not from the earlier date of their discharge from military service, leaving them without decades of earned benefits. The bill remedies this injustice by setting the effective date for these disability awards at the time of the veteran's discharge or release, rather than the date they were finally permitted to apply. These changes restore fairness, correct decades-old oversights, and narrow the gap between entitlement and actual delivery of benefits for a segment of veterans who have long been overlooked due to the confidentiality of their service.

S.2061, Molly R. Loomis Research for Descendants of Toxic Exposed Veterans Act of 2025

NVLSP also strongly supports the Molly Loomis bill, which directs the Interagency Working Group on Toxic Exposure to launch targeted research on the diagnosis and treatment of health conditions affecting descendants of veterans who were exposed to toxic substances during their service. This research is essential to understanding the multigenerational health impacts borne by families whose loved ones served. By mandating research, requiring public disclosure of findings, and establishing firm reporting deadlines, the bill promotes transparency, scientific accountability, and long-overdue attention to families who are too often overlooked.

S. ____, The Get Justice-Involved Veterans BACK HOME Act

Finally, NVLSP strongly supports the Get Justice Involved Veterans BACK HOME Act. This bill focuses on the needs of incarcerated veterans. Among the most important sections of the bill is section 4, which provides for automatic resumption of the payment of compensation and Disability and Indemnity Compensation (DIC) to persons incarcerated for conviction of a felony after the period of incarceration ends. Although these veterans and survivors are not entitled during their incarceration to the full VA compensation they earned due to their or their family member's military service, their entitlement to such compensation should resume immediately after their incarceration ends. It is NVLSP's understanding that VA is sometimes unaware of the fact that the veteran or survivor has been released from incarceration or of that individual's post-incarceration address, and the veteran or survivor does not immediately inform the VA of this fact and his or her new address so that VA compensation payments can resume. Speedy resumption of these payments is often critical to the ability of the individual to successfully transition to life after incarceration. This bill would help reduce lag times between release from incarceration and resumption of payment of VA compensation.

Submissions for the Record

American Hospital Association™
Advancing Health in America

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December 9, 2025

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

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

Dear Senators Moran and Blumenthal,

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinician partners — including more than 270,000 affiliated physicians, 2 million nurses and other caregivers — and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) writes to express support for S. 1868, the Critical Access for Veterans Care Act.

The AHA believes a strong partnership between hospitals and health systems and the Department of Veterans Affairs (VA) is essential to ensure our nation's veterans receive the health care they need and deserve. Our member hospitals and health systems work with the VA to ensure veterans have access to the care they need, when they need it.

Many veterans live in rural communities and face challenges to accessing care, since some communities may lack a VA medical center or outpatient clinic. The AHA supported the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018 (VA MISSION Act of 2018), which provided options for veterans to access care through community providers in certain circumstances instead of exclusively at VA facilities. The VA MISSION Act of 2018 also decreased confusion about eligibility criteria and covered services[1]. The AHA is pleased to now support the Critical Access for Veterans Care Act, which would expand on the work of the VA

[1] https://www.aha.org/system/files/2018-05/180522-let-streamline-va-community-care-programs.pdf

MISSION Act of 2018 by creating a new pathway for veterans who live within 35 miles of a Critical Access Hospital (CAH) or Rural Health Clinic to access services from those community providers[2].

In addition, we are pleased that the legislation would address other barriers to access. Specifically, we support provisions of the legislation that would provide updates to payment methodology to mirror Medicare's cost-based reimbursement. This would ensure that CAHs are not reimbursed less to treat veterans than other patients and support streamlined processes since there would be consistency in the type of reimbursement that CAHs receive from Medicare and the VA. We also support that this legislation would remove some of the onerous administrative burdens such as prior authorizations, which can unnecessarily delay care delivery for veterans. Finally, we appreciate that the legislation would allow for referrals from CAHs and Rural Health Clinics to other providers in the same community. Ultimately, these provisions will support more timely access to care and greater choice for veterans in rural communities, as well as support rural providers by removing administrative burdens and providing consistent payment.

Our member hospitals and health systems stand ready to care for veterans who have sacrificed for our country and deserve the best possible timely care in their communities. If you have questions, please feel contact Kristin Horvath, senior associate director of government relations, at kschwartz@aha.org.

Sincerely,

Rick Pollack
President and Chief Executive Officer

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[2] https://www.cramer.senate.gov/news/press-releases/cramer-sheehy-introduce-bill-to-improve-veterans-access-to-timely-local-health-care

Marcus Lewis

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November 18, 2025

The Honorable Jerry Moran, Chairman
The Honorable Richard Blumenthal, Ranking Member
Senate Committee on Veterans' Affairs
418 Russell Senate Office Building
Washington, D.C. 20510

Chairman Moran and Ranking Member Blumenthal,

Thank you for the opportunity to submit this statement for the Committee's legislative hearing on S.1868, the Critical Access for Veterans Care Act. I offer my full support for this legislation as a veteran, as the Chief Executive Officer of First Care Health Center in Park River, North Dakota, and as someone who continues to navigate the complex process of securing care for service-connected conditions.

Since my honorable discharge in 2007, I have sought appropriate treatment for the injuries I sustained during my service. Like many veterans, I was encouraged by the introduction of the Veterans Choice Program in 2013. However, the program's promise was quickly overshadowed by significant challenges that continue under the Community Care Network. These issues include prolonged authorization delays, denials inconsistent with clinical need, and a credentialing process that is difficult for both veterans and community providers to navigate. The result is a system in which too many veterans are unable to access timely or effective care.

My circumstances reflect those of many rural veterans. I live more than three hours from the nearest VA hospital and work more than two hours from that facility. Yet within 50 miles of my home are three community healthcare facilities, including the one I lead. First Care Health Center is an award-winning organization providing primary care, therapy, diagnostic services, and participating in value-based care models known to improve outcomes and reduce overall

system costs. Despite the availability of this high-quality local care, I am currently paying out of pocket for needed therapy because accessing services through the Community Care Network has proven prohibitively difficult.

I am fortunate to have the financial means to do so. Many veterans are not. No one who has earned their benefits through service to our nation should face delays, denials, or personal financial hardship because a system designed to help them is unable to function effectively in rural environments.

S.1868, the Critical Access for Veterans Care Act, is an important and necessary step toward addressing these long-standing inequities. It acknowledges the unique realities faced by rural veterans and provides a practical pathway to expand access to timely, local, and reliable care. While it does not attempt to resolve every challenge within the broader VA system, it offers a focused and impactful solution that will immediately benefit rural veterans who have been underserved for far too long.

I commend the Committee for considering this legislation and appreciate your continued leadership in improving access to care for those who have served. I am proud to offer my strong support for S.1868 and respectfully urge its advancement.

Thank you for your attention to this critical issue and for your dedication to the well-being of our nation's veterans.

Respectfully,

Marcus R. Lewis

The North Dakota Rural Health Association's mission is to bring together diverse interests and provide a unified voice to promote and enhance the quality of rural health through leadership, advocacy, coalition building, education and communication.

November 25, 2025

The Honorable Jerry Moran, Chairman,
The Honorable Richard Blumenthal, Ranking Member
Senate Committee on Veterans' Affairs
418 Russell Senate Office Building
Washington, D.C. 20510

Chairman Moran and Ranking Member Blumenthal,

We write today in strong support of S.1868, the *Critical Access for Veterans Care Act*, introduced by Senators Cramer and Sheehy, which would update the VA MISSION Act of 2018 to streamline veterans access to care in their local communities.

Many of the men and women who have honorably served our country live in rural or highly rural areas face unnecessary, yet significant barriers to accessing timely, high-quality health care. The *Critical Access for Veterans Care Act* addresses three core challenges consistently impeding timely access under the Community Care Program:

- **Geographic Access:** Rural veterans often must travel long distances simply to receive care that could be delivered locally. The bill explicitly creates a new category of access for veterans residing within 35 miles of a Critical Access Hospital (CAH), ensuring the local rural hospital becomes a viable option. It utilizes the CAH designation, a widely recognized rural provider status, which is defined in federal law and provides a clear threshold for eligibility.
- **Administrative Hurdles**: Under the current community care framework, even though a rural facility may be the best local option, veterans face prior authorizations, referrals, and other requirements which unnecessarily delay care. This bill removes these impediments to receiving care at the local CAH, delivering simplified access without the box checking activities.
- **Veteran Choice**: Perhaps most importantly, the bill reinforces the longstanding bipartisan principle of veteran choice. It places decision making back in the hands of the veteran, empowering them to make decisions about their own care.

Far too long veterans have been stuck in a system where access has been overshadowed by bureaucratic procedure. This legislation offers a streamlined, practical approach which

The North Dakota Rural Health Association's mission is to bring together diverse interests and provide a unified voice to promote and enhance the quality of rural health through leadership, advocacy, coalition building, education and communication.

builds on existing infrastructure and recognized designations in rural health care to meaningfully improve veteran access to care.

Thank you for your leadership on behalf of the nation's veterans. We look forward to working with the Committee to advance this important legislation.

Sincerely,

Kylie Nissen
Executive Director
North Dakota Rural Health Association

December 4, 2025

The Honorable Jerry Moran, Chairman,
The Honorable Richard Blumenthal, Ranking Member
Senate Committee on Veterans' Affairs
418 Russell Senate Office Building
Washington, D.C. 20510

Chairman Moran and Ranking Member Blumenthal,
We write today in strong support of S.1868, the *Critical Access for Veterans Care Act*, introduced by Senators Cramer and Sheehy, which would update the VA MISSION Act of 2018 to streamline veterans access to care in their local communities.

Many of the men and women who have honorably served our country live in rural or highly rural areas face unnecessary, yet significant barriers to accessing timely, high-quality health care. The *Critical Access for Veterans Care Act* addresses three core challenges consistently impeding timely access under the Community Care Program:

- **Geographic Access:** Rural veterans often must travel long distances simply to receive care that could be delivered locally. The bill explicitly creates a new category of access for veterans residing within 35 miles of a Critical Access Hospital (CAH), ensuring the local rural hospital becomes a viable option. It utilizes the CAH designation, a widely recognized rural provider status, which is defined in federal law and provides a clear threshold for eligibility.
- **Administrative Hurdles**: Under the current community care framework, even though a rural facility may be the best local option, veterans face prior authorizations, referrals, and other requirements which unnecessarily delay care. This bill removes these impediments to receiving care at the local CAH, delivering simplified access without the box checking activities.
- **Veteran Choice**: Perhaps most importantly, the bill reinforces the longstanding bipartisan principle of veteran choice. It places decision making back in the hands of the veteran, empowering them to make decisions about their own care.

Far too long veterans have been stuck in a system where access has been overshadowed by bureaucratic procedure. This legislation offers a streamlined, practical approach which builds on existing infrastructure and recognized designations in rural health care to meaningfully improve veteran access to care.

Thank you for your leadership on behalf of the nation's veterans. We look forward to working with the Committee to advance this important legislation.

Sincerely,

Alan O'Neil
Chief Executive Officer
Unity Medical Center
Grafton, North Dakota 58237

Marcus Lewis
Chief Executive Officer
First Care Health Center
Park River, ND 58270

On behalf of:

Todd Forkel, CEO
Altru Health System
Grand Forks, ND

Eric Heupel, CEO
Ashley Medical Center
Ashley, ND

Nikki Lindsey, CEO
Dakota Regional Medical Center
Cooperstown, ND

Sam Harding, CEO
Nelson County Health System
McVille, ND

Erik Christenson, CEO
Heart of America Medical Center
Rugby, ND

Kristin Heid, CEO
Jacobson Memorial Hospital
Elgin, ND

Mike Delfs, CEO
Jamestown Regional Medical Center
Jamestown, ND

R. Wayne Reid, CEO
Langdon Prairie Health
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Lukas Fischer, CEO
Linton Hospital
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Pete Edis, CEO
McKenzie County Health
Watford City, ND

Brock Sherva, CEO
Northwood Deaconess Health Center
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Lisa LeTexier, CEO
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Ryan Mickelsen, CEO
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Chris Albertson, CEO
SMP - St. Andrews
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Chris Albertson, CEO
SMP - St. Kateri
Rolla, ND

Lukas Fischer, CEO
South Central Health
Wishek, ND

Dennis Goebel, CEO
Southwest Healthcare Services
Bowman, ND

Jody Nelson, CEO
St. Luke's Hospital
Crosby, ND

Jamie Eraas, CEO
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Ben Bucher, CEO
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June 13, 2025

The Honorable Angus King
U.S. Senate
133 Hart Senate Office Building
Washington, D.C. 20510

The Honorable Tim Sheehy
U.S. Senate
G55 Dirksen Senate Office Building
Washington, D.C. 20510

The Honorable Chris Deluzio
U.S. House of Representatives
1222 Longworth House Office Building
Washington, D.C. 20515

The Honorable Brian Fitzpatrick
U.S. House of Representatives
271 Cannon House Office Building
Washington, D.C. 20515

The Honorable Greg Landsman
U.S. House of Representatives
2244 Rayburn House Office Building
Washington, D.C. 20515

The Honorable John James
U.S. House of Representatives
1519 Longworth House Office Building
Washington, D.C. 20515

Dear Senators King and Sheehy, and Representatives Deluzio, Fitzpatrick, Landsman, and James:

On behalf of the American Academy of Pediatrics (AAP), a non-profit professional organization of 67,000 primary care pediatricians, pediatric medical sub-specialists, and pediatric surgical specialists dedicated to the health, safety and well-being of infants, children, adolescents, and young adults, I am writing to express our support for S.926/H.R. 1987, the *Saving Our Veterans Lives Act of 2025*, which would authorize a program for the Department of Veterans Affairs to provide free firearm lockboxes to veterans.

The AAP represents many members who are proud firearm owners, and we believe that the freedom of individuals to own firearms can and should be balanced with protecting children and their families from serious harm, and ensuring the health, security, and well-being of all people. This is why the AAP strongly supports efforts to promote safe storage of firearms.

Across this country, communities are suffering from preventable firearm-related injuries and deaths. Since 2017, firearm-related injuries have become the leading cause of death for children and youth. Exposure to firearm violence also contributes to trauma, and harms children's health and development. For these reasons and many more, pediatricians have long advocated for comprehensive policies to protect children from the dangers of firearm-related morbidity and mortality, including promoting safe firearm storage.

Furthermore, more than 2 million children in the United States live in military and veteran-related families and around 90,000 infants are born into these families each year.[1] Helping to reduce veteran suicide will support the health and well-being of infants and children in military and veteran households by ensuring these infants and children do not suffer the trauma of losing a parent or caregiver to firearm-related suicide. Promoting safe storage of firearms will also help reduce accidental shootings involving children.

The AAP supports the *Saving Our Veterans Lives Act of 2025*, which would authorize a program for the Department of Veterans Affairs to provide free firearm lockboxes to veterans and help prevent suicide deaths. This bill is a positive step forward in the work to reduce suicides though the secure storage of firearms.

Thank you for your bipartisan leadership in working to protect our nation's children from firearm-related injuries and deaths. If the AAP can be of any further assistance, please do not hesitate to contact Ami Gadhia in our Washington, D.C. office at agadhia@aap.org.

Sincerely,

Susan J. Kressly, MD, FAAP
President

SK/avg

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[i] Beth Ellen Davis, Gregory S. Blaschke, Elisabeth M. Stafford. "Military Children, Families, and Communities: Supporting Those Who Serve." *Pediatrics*. February 2012; 129 (Supplement_1): S3–S10. Available at: https://publications.aap.org/pediatrics/article/129/Supplement_1/S3/32015/Military-Children-Families-and-Communities

STATEMENT FOR THE RECORD

Senate Committee on Veterans' Affairs
Legislative Hearing

December 10, 2025

from

American Association for Marriage and Family Therapy
American Foundation for Suicide Prevention
American Psychiatric Association
American Psychological Association Services, Inc.
Centerstone
Maternal Mental Health Leadership Alliance
National Alliance on Mental Illness (NAMI)
Sandy Hook Promise
The Trevor Project

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

The coalition above of national organizations dedicated to behavioral health submit the following statement for the record in advance of the Senate Veterans Affairs Committee legislative hearing being held on December 10, 2025.

We collectively affirm our strong support of the Saving Our Veterans Lives Act of 2025 (S.926) and commend the bipartisan leadership of its sponsors, Senator King and Senator Sheehy. The large and diverse list of stakeholders supporting this practical legislation underscores its effective approach to preventing suicide and empowering our veterans to store their firearms in a secure manner. This bill is urgently needed, as an average of 17.6 veterans die by suicide on a daily basis.[i]

Research shows that firearms are used in most suicide deaths because of their high lethality.[ii] In fact, firearms were used in 72% of suicides among veterans in 2021.[iii] However, research also demonstrates that the high-risk, acute phase of suicidal crises is often fleeting. Therefore, putting time and distance between a person in crisis and their chosen method for suicide, such as by temporarily removing ready access to a firearm, has been shown to prevent suicide.[iv] Thus, the voluntary secure storage of firearms, particularly in lockboxes, is of utmost importance in helping individuals in crisis avoid tragic decisions.

We commend the legislation's support of the Department of Veterans Affairs' (VA) efforts to ensure our veterans have access to these life-saving apparatuses. This legislation will build upon important work already underway by the VA to provide secure firearm storage devices to veterans, helping to prevent suicide among veterans and their family members.

Importantly, research also demonstrates that if an individual's preferred, highly lethal method is unavailable, most people in a suicidal crisis do not simply find another way to die by suicide. Moreover, 90% of suicides attempted with a firearm are fatal[v], making it rare that individuals attempting suicide with a firearm will get a second chance to reconsider their decision, even as suicidal crises often represent a conflicting wish to live or die.[vi] Furthermore, two-thirds of those who survive a suicide attempt will never try again.[vii] These statistics emphasize the critical need for Congress to ensure that veterans experiencing thoughts of suicide have the capability and means to employ secure firearms storage strategies.

Thank you again for your focus on preventing suicide amongst our nation's veterans. We stand ready to work with the Committee to address this epidemic and save veterans' lives.

For more information, contact K. Conwell Smith, APA Deputy Chief for Military and Veteran Policy at csmith@apa.org or (301) 875-8923 | Bill White, American Foundation for Suicide Prevention at wwhite@afsp.org or (202)740-5967.

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[i] U.S. Veterans Administration (2024). 2024 National Veterans Suicide Prevention Annual Report. https://www.mentalhealth.va.gov/docs/data-sheets/2024/2024-Annual-Report-Part-2-of-2_508.pdf

[ii] CDC. (n.d.). Suicide data and statistics. CDC. https://www.cdc.gov/nchs/ fastats/suicide.htm

[iii] Office of Mental Health and Suicide Prevention. (2023, November). 2023 national veteran suicide prevention annual report. https://www. mentalhealth.va.gov/docs/data-sheets/2023/2023-NationalVeteran-Suicide-Prevention-Annual-Report-FINAL-508.pdf

[iv] Lubin G, Werbeloff N, Halperin D, Shmushkevitch M, Weiser M, Knobler HY. Decrease in suicide rates after a change of policy reducing access to firearms in adolescents: a naturalistic epidemiological study. Suicide Life Threat Behav 2010;40(5):421–4.

[v] Conner, A., Azrael, D., & Miller, M. (2019, December 17). Suicide case fatality rates in the United States, 2007 to 2014: A nationwide population-based study. Annals of Internal Medicine, 885–895. doi:10.7326/M19-1324

[vi] Bryan, C. J., Rudd, M. D., Peterson, A. L., Young-McCaughan, S., & Wertenberger, E. G. (2016). The ebb and flow of the wish to live and the wish to die among suicidal military personnel. Journal of Affective Disorders, 202, 58–66. https://doi.org/10.1016/j.jad.2016.05.049

[vii] Owens, D., Horrocks, J., & House, A. (2002). Fatal and non-fatal repetition of self-harm: Systematic review. 181, 193–199.

AMERICAN PSYCHIATRIC ASSOCIATION

800 Maine Avenue, S.W.
Suite 900
Washington, D.C. 20024

STATEMENT FOR THE RECORD

AMERICAN PSYCHIATRIC ASSOCIATION

FOR THE

SENATE COMMITTEE ON VETERANS' AFFAIRS

IN ADVANCE OF

DECEMBER 3, 2025

LEGISLATIVE HEARING

The American Psychiatric Association (APA), the national medical specialty society representing over 39,200 psychiatrists, appreciates the opportunity to submit this statement for the record to the Senate Committee on Veterans' Affairs. We commend the Committee's continued leadership in advancing policies that support timely, high-quality, and accessible mental health care for our nation's veterans, and respectfully offer the feedback below on the legislation set to be considered.

Protecting Veteran Access to Telemedicine Services Act

The APA strongly supports the Protecting Veteran Access to Telemedicine Services Act, legislation that would permanently extend a pandemic-related exemption to the Ryan Haight Act by allowing Department of Veterans Affairs (VA) clinicians to prescribe medically necessary controlled substances to veterans via telemedicine, even if an in-person examination has not occurred. Telehealth has proven to be an effective, evidence-based means of expanding access, improving continuity of treatment, and supporting timely interventions for those managing complex psychiatric and substance use conditions. As of 2024, 73 VA facilities faced a severe shortage of psychiatrists, highlighting the importance of the use of telemental health services. By ensuring that VA physicians, including psychiatrists, can deliver telehealth services without unnecessary restrictions, this legislation protects continuity of care and prevents treatment disruptions. The APA urges prompt support of this House passed legislation to preserve these essential flexibilities before they expire at the end of the year.

Saving Our Veterans' Lives Act

The APA also strongly supports the Saving Our Veterans' Lives Act, which seeks to establish a VA program to provide free firearm lockboxes to eligible veterans as a practical and effective means of reducing veteran suicide. This important legislation recognizes that firearms are the most common method used in veteran suicides, and that putting time and space between at-risk individuals and lethal means is one of the most evidence-based strategies for suicide prevention. Providing secure firearm storage options at no cost would empower veterans and their families to take proactive steps toward safety without stigma or intrusion into personal rights. Importantly, in addition to distributing lockboxes, the legislation would fund a public education campaign and require the development of an informational video on secure firearm storage, ensuring that suicide prevention messaging is consistent, accessible, and culturally sensitive to the veteran community. We urge the Committee to move swiftly on this measure and to continue supporting programs that expand access to mental health services and reduce suicide risk across the veteran population.

Written Informed Consent Act

The APA shares the Committee's commitment to ensuring that veterans are fully informed about their treatment options and appreciates the intent of the Written Informed Consent Act to enhance transparency and promote patient safety. However, as currently drafted, the legislation could have unintended consequences for both veterans and physicians. Additional written requirements may not enhance safety but could increase documentation burdens, discourage clinicians from treating complex patients, and heighten burnout among an already strained VA workforce. Moreover, an additional requirement of informed consent to access mental health medications could create a layer of stigma for patients and delay treatment. We welcome the opportunity to work with the Committee to identify

targeted approaches that balance patient autonomy with clinical efficiency, such as focusing written consent requirements on specific high-risk situations, while maintaining flexibility for physicians to exercise their best medical judgment. Mandating written consent for entire classes of medications, many of which are prescribed routinely for behavioral health conditions, risks creating administrative barriers that may delay timely treatment and divert valuable clinical time away from direct patient care. Informed consent should remain a clinical and patient-centered process, guided by professional judgment and existing VA protocols, which already require physicians to discuss the risks, benefits, and alternatives of treatment with their patients.

The APA thanks the Committee for its continued commitment to improving veterans' mental health care. We stand ready to collaborate and support the Committee's efforts to advance evidence-based solutions that strengthen access, quality, and safety in mental health services for all who have served.

STATEMENT FOR THE RECORD

Senate Committee on Veterans' Affairs

Legislative Hearing

December 10, 2025

from

Association of VA Hematology/Oncology
Association of VA Nurse Anesthetists
Association of VA Psychologist Leaders
Association of VA Social Workers
National Association of VA Physicians and Dentists
Nurses Organization of Veterans Affairs
Veterans Healthcare Policy Institute

(All are independent organizations, not representing the Department of Veterans Affairs)

Chairman Moran, Ranking Member Blumenthal, and distinguished members of the committee:

On behalf of our organizations, we thank you for inviting us to submit a statement for the record for today's Full Committee Legislative Hearing on improving the care and services for veterans. Members of our organization are veterans, have family members who are veterans, had long careers serving veterans, published papers on veterans' healthcare in peer-reviewed journals, presented testimony to your committee, and have served on President Trump's President's Roadmap to Empower Veterans and End a National Tragedy of Suicide (PREVENTS) task force.

In today's statement, we wish to convey our appreciation for your leadership and commitment to ensuring that veterans receive the highest level of health care within the Veterans Health Administration (VHA) and supplementary care in the private sector when it's both needed and authorized by the VHA.

While today's hearing considers 24 bills, we limit our comments to only three of them—S.926, "Saving Our Veterans Lives Act of 2025" and S.2397, The Coordinating and Aligning Records to Improve and Normalize Governance for Our Veterans Health Act of 2025 (CARING Act) both of which we enthusiastically support, and S.1868, "Critical Access for Veterans Care Act of 2025," for which we have grave concerns.

Saving Our Veterans Lives Act of 2025 (S. 926)

The transformative importance of this bill cannot be overstated. With veteran suicide rates—particularly from self-inflicted firearm injuries—remaining persistently high, fresh approaches like this one are urgently needed.

The suicide mortality rate for America's veterans is double that of their civilian counterparts. Firearms are by far the most common lethal means, accounting for 74.8% of male veteran suicide deaths and 45.4% of female veteran suicide deaths—rates that greatly exceed those of non-veterans. [1]

Survivors of firearm suicide attempts consistently report that having a gun readily available at home was the primary reason for their method choice. [2,3] Contrary to common misperception, people who survive or are prevented from attempting suicide don't inevitably keep trying until they die by suicide. Suicidal crises often represent a conflicting desire to both live and die, [4] and research shows that two-thirds of those who survive even highly lethal attempts—such as jumping in front of a subway—never try again. [5, 6, 7]

The acute, high-risk phase of suicidal crises often arises suddenly. Studies reveal that approximately half of suicide attempts begin less than 10 minutes after the decision is made, frequently occurring during a relationship quarrel. [8, 9, 10, 11, 12] Most people who attempt suicide with a firearm never get a chance to reconsider—90% of such acts are fatal. [13]

Secure storage saves lives. Reducing quick access to firearms during personal crises has proven effective in preventing suicide deaths. [14] Many suicide attempts stem from brief periods of feeling overwhelmed rather than meticulous planning. Helping someone navigate the highest-danger period without ready access to lethal means significantly decreases their suicide risk, both immediately and long-term.

Individuals residing in homes where firearms are kept loaded and unlocked face higher suicide risk compared to those where firearms are stored locked and unloaded. [15, 16, 17, 18]

Fifty one percent of veterans own one or more personal firearms, and over half of these owners store weapons loaded and unsecured. [19] A third of veterans who store firearms loaded and unlocked don't own a lockbox or safe. [20] For many veterans, cost remains the primary barrier to owning a lockbox. [21]

Since 2012, VA has distributed free cable gun locks to any veteran who requests one. While cable gun locks are versatile and low cost, they are shunned by many veterans (and other firearm owners), who overwhelmingly favor lockboxes and safes to secure their guns. [22, 23, 24]

A VA pilot program is currently offering free lockboxes to enrolled veterans assessed to have moderate to high risk for suicide who request that one be shipped to them. The program is grounded on clinician need and adheres to an accreditation requirement of The Joint Commission as well as a recommendation from VA's Office of Inspector General (OIG Report 21-00175-19 dated November 17, 2022). It also aligns with recommendations from President Trump's first term "Roadmap to Empower Veterans and End a National Tragedy of Suicide (PREVENTS)."

But the pilot program lacks committed, sustainable funds or systemwide propagation to ensure it can reach the large number of veterans who would benefit from it. The "Saving Our Veterans' Lives Act of 2025" would greatly strengthen the pilot in two crucial ways:

Issue	Current Pilot	S.926
Allocations needed for program staffing	No sustained, dedicated funds	Would cover funding for staff: program manager, statistician, evaluator, and prosthetics staff
Allocations needed for lockboxes	No sustained, dedicated funds	Assures sufficient funding for tens of thousands of lockboxes to be distributed to veterans

As drafted, S.926 applies to all veterans—regardless of identified risk level or VHA enrollment status—making it far more inclusive than the existing pilot program. However, beginning on a smaller scale may be a more prudent pathway to demonstrate the evidence-informed proof of concept before contemplating expansion to veterans at lower risk. Under such a circumscribed approach, the educational materials delineated in the bill should be tailored to this targeted subpopulation.

VA does not currently provide biometric fingerprint-enabled lockboxes, as they are appreciably more expensive and less suited to the bill's intended purpose. It would be prudent to limit distributed lockboxes to ones requiring a key or numeric combination to open.

Importantly, the "Saving Our Veterans Lives Act" ensures that nothing in the legislation could be construed to collect personally identifiable information of an individual who participates in the program under the proposed section 1720K for purposes of tracking firearm ownership; require any individual to register a firearm with VA; require mandatory firearm storage for any individual; prohibit any individual from purchasing, owning, or possessing a firearm under 18 U.S.C. § 922; discourage the lawful ownership of firearms; or create or maintain a repository of individuals participating in the program. This wisely crafted language ensures that **protecting 2nd Amendment rights and protecting lives are complementary – not opposing – goals.**

Personally identifiable information would be collected for the purpose of evaluating program impact but not for tracking firearm ownership. This data would allow an understanding of the demographics of participating veterans, their general locations, and the types of storage solutions they receive.

Critical Access for Veterans Care Act of 2025 (S.1868)

Despite its straightforward title, this bill will not improve healthcare access, expedite care delivery, reduce travel burdens, or enhance critical care capacity for rural veterans.

It would, however, undermine the carefully designed eligibility requirements that determine when veterans may receive services from Veterans Community Care Program (VCCP) providers under VA MISSION Act of 2018 provisions. That will ultimately diminish options and make it harder for many veterans to access needed care.

The legislation allows veterans living within 35 miles of designated Critical Access Hospitals (CAH) to bypass VA entirely and self-refer to these private facilities. The bill's authors claim that option will assure veterans quicker access to services, because rural veterans are being left, "without timely access to the high-quality care" and "offers veterans new options for health care in rural areas where there might not be a VA health facility nearby." [25] These "timely access," "new options," and "no facility nearby" assertions are untrue in two fundamental ways.

First, the VA MISSION Act of 2018 created the Veterans Community Care Program that guarantees veterans emergency medical and psychiatric care, as well as walk-in urgent care, anywhere. Veterans can also access private sector outpatient care if they would wait more than 20/28 days for an appointment at, or drive more than 30/60 minutes to, a VA medical center or clinic. Whenever that's the case, the VA offers the option for VCCP care, including at CAHs and their outpatient clinics.

Second, a vast number of CAHs are well within the 35-mile radius of VA facilities. For example, the full-service Grand Junction, Colorado VA Medical Center, serving 37,000 veterans, sits only 13 miles from Family Health West Hospital. The Altoona Pennsylvania VA Medical Center, serving 26,000 veterans, is 17 and 24 miles from Penn Highlands Healthcare and Conemaugh Miners Medical Center. White River Junction, Vermont's VA Medical Center is 5 miles from a Critical Access Hospital; Beckley, West Virginia's VA 14 miles away.

Add to that hundreds of Critical Access Hospitals that are located within the 35-mile radius from a VA Community Based Outpatient Clinic (CBOC). Ohio has 32 and Michigan has 28 Critical Access Hospitals near VA clinics. Eleven of Montana's 15 CBOCs are proximate to a CAH, eight of those less than three miles away. The VA clinics in Jamestown and Devils Lake, North Dakota and in Plentywood, Montana are in the same buildings as the local CAH.

The problem lies in how this legislation redirects veterans from VA CBOCs and rural VA hospitals to CAH care. When veterans shift their care elsewhere, VA funding follows them out the door. As patient volumes decline, VA facilities will face budget cuts that force reductions of programs or closures of clinics that other veterans prefer and rely on. What happens to the rural veterans who never wanted to go anywhere else? They'll face a private sector wasteland that can barely meet current demand, let alone absorb tens of thousands more patients

America's healthcare system—particularly in rural areas where a quarter of all veterans live [26]—is in crisis. Over 100 hospitals have closed in the past 15 years, while more than 700 rural hospitals are on the brink of bankruptcy and over 300 are at risk of immediate closure. [27] Closures force patients to travel longer distances for care, leading some to forgo treatment entirely. The consequences are especially severe for those with limited mobility and patients experiencing time-sensitive emergencies like heart attacks.

The situation will only worsen. Medicaid cuts over the next decade are projected to strip 10 million people of healthcare coverage. With fewer patients seeking treatment and more unable to pay for care in emergency departments, rural hospitals stand to lose $70 billion, [28] accelerating closures and service reductions.

The lack of healthcare providers compounds these problems. Eighty-six percent of U.S. counties are designated as primary care health professional shortage areas. [29] This scarcity can be deadly—insufficient primary care providers directly correlate with higher hospitalization rates and increased mortality. [29]

The mental health crisis is even more dire. One hundred sixty million Americans live in areas with mental health professional shortages; [31] 70-80 percent of rural counties have no psychiatrist at all; [32] 61% lack psychologists. This is particularly catastrophic for post-9/11 veterans, 58 percent [33] of whom have mental health conditions requiring specialized care.

The Critical Access for Veterans Care Act dismisses the critical importance of VA authorization, calling the role an "unnecessary roadblock" that should be abolished. This characterization fundamentally misrepresents both the function and value of the authorization process.

VA authorization and monitoring with the private sector was specifically mandated by the MISSION Act precisely because it is the only way, as a payor, VA can assure that taxpayer dollars are well spent and that veterans do not receive unnecessary, duplicative, or harmful treatment. This kind of utilization review is standard practice for third parties who pay for patient care and services. In this legislation eliminating pre-authorization, for example, it will be difficult for the VA to verify that a veteran treated by a CAH lives within the 35-mile radius.

Private doctors, regardless of their good intentions, lack the specialized training and integrated systems that make VA care uniquely effective for veterans with service-related conditions. Multiple studies [34] confirm that properly funded VA care delivers, on average, higher quality outcomes than private alternatives.

Veterans depend on the VA's integrated care, which are often unavailable in the private sector. Congress would be better focusing on strengthening and expanding these vital VA services.

We support one provision in the legislation: aligning CAH healthcare reimbursement for veterans with rates paid for non-veteran patients. Financial incentives should never create a system where certain patients receive priority based on reimbursement disparities.

CARING" (Coordinating and Aligning Records to Improve and Normalize Governance) for Our Veterans Health Act of 2025 (S.2397)

The "CARING for Our Veterans Health Act of 2025" directly addresses critical gaps in the Veterans Community Care Program (VCCP). By establishing rigorous monitoring protocols and mandatory performance benchmarks, the legislation tackles persistent deficiencies in training completion rates and documentation timeliness among community care providers.

The VA MISSION Act of 2018 fundamentally transformed veterans' healthcare delivery. This landmark legislation established the VCCP with two primary objectives: (a) reducing wait times and travel distances by expanding access to community providers, and (b) ensuring that

community-based care matched the quality delivered by the VA. The emphasis on quality was unmistakable—the word appeared 50 times throughout the bill.

Partnering with the private sector carries profound responsibility. The VA shoulders both legal and ethical obligations to ensure that contracted providers possess the specialized expertise necessary to treat conditions frequently resulting from military service.

The MISSION Act explicitly mandated that community mental health providers have competence equivalent to VA providers' "special expertise" in veteran-specific care. In response, the VA developed eight comprehensive training modules, each approximately one hour long, covering the mental health challenges most prevalent among veterans: posttraumatic stress, military sexual trauma, suicide prevention, and opioid safety, among others.

Recent findings from a Government Accounting Office (GAO) report [35] revealed that failure to set provider benchmarks has resulted in substantial deficiencies among non-VA mental health providers. These deficits are not merely concerning—they are inexcusable.

The GAO inquiry exposed a troubling pattern of indifference among VCCP providers towards these vital trainings. Between fiscal years 2021 and 2023, 22,725 community providers received mental health referrals, yet only 380—or roughly 2 percent—completed even one of the eight trainings. Those few who did participate averaged just 1.3 modules.

These deficiencies are particularly concerning when examining specific veteran populations. During the study period, more than 8,000 veterans with active suicide risk flags were referred to community providers, virtually none of whom had completed suicide prevention or lethal means safety training.

Similarly, while anxiety and stress-related disorders represented nearly half of patient's diagnoses, barely any community providers had taken posttraumatic stress disorder or military sexual trauma training.

The opioid crisis adds yet another layer of alarm. The GAO reported that a tiny fraction of community prescribers undertook the required brief opioid training—findings that mirror a 2021investigation from the VA Office of Inspector General.

Yet, even with these unambiguous warnings, VA has persistently turned a blind eye. As the GAO report reveals, VA leaders (under the last several Administrations) explicitly permitted network providers to disregard both recommended and mandated trainings, rationalizing that enforcing completion of trainings "could be problematic in ensuring network adequacy."

The same neglect pervades the VA's oversight of transmitting essential medical records. Community providers are contractually obligated to submit clinical documentation within 30 days of initial visit as well as within 30 days of final appointment. GAO discovered systematic failures in compliance. Initial visit records were missing for a third of referred veterans, and final visit documentation couldn't be found for any of them. Rather than addressing these gaping deficits, the VA again chose to emphasize "network adequacy" over record compliance,

significantly increasing the risks inherent in fragmented care, medication complications, and redundant testing.

The gap between patient needs and provider preparedness undermines the fundamental promise of the MISSION Act: that veterans would receive care in community settings that meets VA quality standards. Without adequate training in military-specific conditions and evidence-based interventions, community providers cannot deliver the specialized care that veterans require and deserve. Prioritizing provider quantity over quality translates to a glut of untrained providers rather than a smaller pool of well-trained ones.

The training gap between VA and private sector mental health providers is deeply concerning. A RAND Corporation study [36] comparing VA and community therapists reported that "a psychotherapist selected from the community is unlikely to have the skills necessary to deliver high-quality mental health care to service members or veterans." Private sector mental health providers in the VCCP have fewer years of clinical training [37] prior to licensure than those in the VA.

New research [38] provides even more evidence why S.2397 is necessary. The study tracked veterans with PTSD enrolled at the VA Southeast Louisiana Health Care System referred to the VCCP during 2021-2022. The quality gaps were stark:

- 25% of providers never sent records to the VA, preventing any care coordination
- Among those who did submit records, 56% failed to document suicide risk assessments
- 80% didn't use any of the six evidence-based first- or second-line PTSD treatments
- Fewer than 5% of patients showed symptom improvement
- Not one provider completed a diagnostic assessment

By contrast, every veteran seeking care for PTSD, depression, and other mental health conditions in the VA is offered evidence-based treatment options.

Veteran mental health screening and prevention also reveal stark differences between VA and community care. VA providers conduct annual screening for suicide [39]PTSD, substance use, military sexual trauma, and depression—protocols that don't occur in the VCCP. Additionally, 57% of private mental health providers reported they do not routinely screen [40] for problems common among veterans, such as mental health and substance use issues.

The quality of VCCP care is not comparable to the VA. Decades of research have established that the VA produces health care outcomes equal or superior to the private sector, across virtually every medical condition. A recent comprehensive summary of peer-reviewed studies [41] reinforces this conclusion. Moreover, the 2025 survey by Iraq and Afghanistan Veterans of America found [42] that only 31 percent of IAVA members with VCCP experience felt their community providers understand their medical needs.

The CARING Act directly responds to these documented failures. By mandating the establishment of clear performance benchmarks and requiring comprehensive monitoring

systems, the legislation seeks to transform the VCCP from a well-intentioned but poorly executed initiative into a rigorously accountable care coordination framework.

The Act's emphasis on documentation and record alignment serves dual strategic purposes. It establishes accountability mechanisms that incentivize community providers to meet training requirements. It also generates the data infrastructure necessary for ongoing quality assessment.

That said, third-party administrators overseeing community care networks should be held accountable for monitoring training completion and instructed to suspend providers who miss specified expectations. This legislation would be greatly strengthened by adding sanctions for TPA and provider failures.

Similarly, the VA should also establish enforceable standards for VCCP health record submission after initial and final visits, imposing meaningful penalties on those that fail to meet them.

After six years of VCCP operation, the evidence is clear: lax training and documentation standards have utterly failed to protect those who served. Until safeguards exist, expanded access to care in the community will only mean broader exposure to substandard care. It is time to fix that through rigorous documentation requirements, clear performance benchmarks, and comprehensive monitoring systems.

Thank you for the opportunity to offer our input on these important pieces of legislation.

References

1. US Department of Veterans Affairs. (2024). National veteran suicide prevention annual report. https://www.mentalhealth.va.gov/docs/data-sheets/2024/2024-Annual-Report-Part-2-of-2_508.pdf
2. de Moore, G. M., Plew, J. D., Bray, K. M., & Snars, J. N. (1994). Survivors of self-inflicted firearm injury: A liaison psychiatry perspective. Medical Journal of Australia, 160(7), 421–425. https://doi.org/10.5694/j.1326-5377.1994.tb138194.x
3. Peterson, L. G., Peterson, M., O'Shanick, G. J., & Swann, A. (1985). Self-inflicted gunshot wounds: Lethality of method versus intent. American Journal of Psychiatry, 142(2), 228–231. https://doi.org/10.1176/ajp.142.2.228
4. Bryan, C. J., Rudd, M. D., Peterson, A. L., Young-McCaughan, S., & Wertenberger, E. G. (2016). The ebb and flow of the wish to live and the wish to die among suicidal military personnel. Journal of Affective Disorders, 202, 58–66. https://doi.org/10.1016/j.jad.2016.05.049
5. O'Donnell, I., Arthur, A. J., & Farmer, R. D. (1994). A follow-up study of attempted railway suicides. Social Science & Medicine, 38(3), 437–442. https://doi.org/10.1016/0277-9536(94)90444-8
6. Owens, D., Horrocks, J., & House, A. (2002). Fatal and non-fatal repetition of self-harm: Systematic review. British Journal of Psychiatry, 181(3), 193–199. https://doi.org/10.1192/bjp.181.3.193
7. Seiden, R. H. (1978). Where are they now? A follow-up study of suicide attempters from the Golden Gate Bridge. Suicide and Life-Threatening Behavior, 8(4), 203–216. https://doi.org/10.1111/j.1943-278X.1978.tb00587.x
8. Deisenhammer, E. A., Ing, C. M., Strauss, R., Kemmler, G., Hinterhuber, H., & Weiss, E. M. (2009). The duration of the suicidal process: How much time is left for intervention between consideration and accomplishment of a suicide attempt? Journal of Clinical Psychiatry, 70(1), 19–24. https://doi.org/10.4088/JCP.07m03904

9. Simon, T. R., Swann, A. C., Powell, K. E., Potter, L. B., Kresnow, M., & O'Carroll, P. W. (2001). Characteristics of impulsive suicide attempts and attempters. Suicide and Life-Threatening Behavior, 32(Suppl 1), 49–59. https://doi.org/10.1521/suli.32.1.5.49.24212
10. Williams, C. L., Davidson, J. A., & Montgomery, I. (1980). Impulsive suicidal behavior. Journal of Clinical Psychology, 36(1), 90–94. https://doi.org/10.1002/1097-4679(198001)36:1<90:AID-JCLP2270360104>3.0.CO;2-F
11. Paashaus, L., Forkmann, T., Glaesmer, H., Juckel, G., Rath, D., Schönfelder, A., & Teismann, T. (2021). From decision to action: Suicidal history and time between decision to die and actual suicide attempt. Clinical Psychology & Psychotherapy, 28(6), 1427–1434. https://doi.org/10.1002/cpp.2580
12. Barber, C., Azrael, D., Berrigan, J., Miller, M., Sobelson, M., & Hemenway, D. (2018). Suicide and firearm injury in Utah. Linking data to save lives. Harvard T.H. Chan School of Public Health. https://www.hsph.harvard.edu/means-matter/suicide-and-firearm-injury-in-utah/
13. Conner, A., Azrael, D., & Miller, M. (2019). Suicide case fatality rates in the United States, 2007 to 2014: A nationwide population-based study. Annals of Internal Medicine, 171(12), 885–895. https://doi.org/10.7326/M19-1324
14. Lubin, G., Werbeloff, N., Halperin, D., Shmushkevitch, M., Weiser, M., & Knobler, H. Y. (2010). Decrease in suicide rates after a change of policy reducing access to firearms in adolescents: A naturalistic epidemiological study. Suicide and Life-Threatening Behavior, 40(5), 421–424. https://doi.org/10.1521/suli.2010.40.5.421
15. Conwell, Y., Duberstein, P. R., Connor, K., Eberly, S., Cox, C., & Caine, E. D. (2002). Access to firearms and risk for suicide in middle-aged and older adults. The American Journal of Geriatric Psychiatry, 10(4), 407–416. https://doi.org/10.1176/appi.ajgp.10.4.407
16. Dempsey, C. L., Benedek, D. M., Zuromski, K. L., Riggs-Donovan, C., Ng, T. H. H., Nock, M. K., Kessler, R. C., & Ursano, R. J. (2019). Association of firearm ownership, use, accessibility, and storage practices with suicide risk among US Army soldiers. JAMA Network Open, 2(6), Article e195383. https://doi.org/10.1001/jamanetworkopen.2019.5383
17. Grossman, D. C., Mueller, B. A., Riedy, C., Dowd, M. D., Villaveces, A., Prodzinski, J., Nakagawara, J., Howard, J., Thiersch, N., & Harruff, R. (2005). Gun storage practices and risk of youth suicide and unintentional firearm injuries. JAMA, 293(6), 707–714. https://doi.org/10.1001/jama.293.6.707
18. Shenassa, E. D., Rogers, M. L., Spalding, K. L., & Roberts, M. B. (2004). Safer storage of firearms at home and risk of suicide: A study of protective factors in a nationally representative sample. Journal of Epidemiology and Community Health, 58(10), 841–848. https://doi.org/10.1136/jech.2003.017343
19. Nichter, B., Hill, M. L., Fischer, I., Panza, K. E., Kline, A. C., Na, P. J., Norman, S. B., Rowcliffe, M., & Pietrzak, R. H. (2024). Firearm storage practices among military veterans in the United States: Findings from a nationally representative survey. *Journal of Affective Disorders*, *351*, 82–89. https://doi.org/10.1016/j.jad.2024.01.179
20. Simonetti, J. A., Azrael, D., Rowhani-Rahbar, A., & Miller, M. (2018). Firearm storage practices among American veterans. *American Journal of Preventive Medicine*, 55(4), 445-454. https://doi.org/10.1016/j.amepre.2018.04.014
21. Khazanov G, Spitzer E, Thomas S, et al (2025) Financial barriers and facilitators to secure firearm and medication storage among veterans with elevated suicide risk: a qualitative study Injury Prevention 2025;31:73-76.
22. Buck-Atkinson, J., McCarthy, M., Stanley, I. H., Harnke, B., Anestis, M. D., Bryan, C. J., Baker, J. C., & Betz, M. E. (2023). Firearm locking device preferences among firearm owners in the USA: A systematic review. *Injury Epidemiology*, *10*(1), Article 33. https://doi.org/10.1186/s40621-023-00436-7
23. Simonetti, J. A., Simeona, C., Gallagher, C., Hoffman, A., Eliassen, B., Chenoweth, J., & Villegas, C. (2019b). Preferences for firearm locking devices and device features among participants in a firearm safety event. *Western Journal of Emergency Medicine*, *20*(4), 552–556. https://doi.org/10.5811/westjem.2019.5.42727
24. Betz, M. E., Stanley, I. H., Buck-Atkinson, J., Johnson, R., Bryan, C. J., Baker, J. C., Bryan, A. O., Hunter, K., & Anestis, M. D. (2023). Firearm owners' preferences for locking devices: Results of a national survey. *Annals of Internal Medicine*, *176*(3), 329–336. https://doi.org/10.7326/M22-3113
25. Hersey, L. "Bill aims to ease access to medical care for rural veterans." Stars and Stripes. May 29, 2025. https://www.stripes.com/veterans/2025-05-29/veterans-rural-health-care-legislation-17952223.html
26. US Department of Veterans Affairs. (2024). Office of Research and Development. VA Research on Rural Health. https://www.research.va.gov/topics/rural_health.cfm

27. Center for Healthcare Policy & Patient Reform. Rural Hospitals at Risk of Closing. https://chqpr.org/downloads/Rural_Hospitals_at_Risk_of_Closing.pdf
28. National Rural Health Association. Federal Medicaid cuts imperil rural hospitals and residents. (June 23, 2025). https://www.ruralhealth.us/getmedia/c329578c-e029-4b0f-b3a7-89f6af8198ff/06-23-25-NRHA-Manatt-rural-Medicaid-cuts-report.pdf
29. Rural Health Information Hub. Health Professional Shortage Areas, Primary Care. (July 2025). https://www.ruralhealthinfo.org/charts/5
30. Schlak, A. E., Poghosyan, L., Liu, J., Kueakomoldej, S., Bilazarian, A., Rosa, W. E., & Martsolf, G. (2022). The Association between Health Professional Shortage Area (HPSA) Status, Work Environment, and Nurse Practitioner Burnout and Job Dissatisfaction. *Journal of health care for the poor and underserved*, *33*(2), 998–1016. https://doi.org/10.1353/hpu.2022.0077.
31. HRSA Health Workforce Shortage Areas https://data.hrsa.gov/topics/health-workforce/shortage-areas
32. Andrilla, C. Holly A. et al. Geographic Variation in the Supply of Selected Behavioral Health Providers. (2018) *American Journal of Preventive Medicine,* Volume 54, Issue 6, S199 - S207. https://www.ajpmonline.org/article/S0749-3797(18)30005-9/fulltext
33. National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Board on Health Care Services; Committee to Evaluate the Department of Veterans Affairs Mental Health Services. (2018) Evaluation of the Department of Veterans Affairs Mental Health Services. Washington (DC): National Academies Press (US)
34. Veterans Healthcare Policy Institute. Peer Reviewed Study Summaries on the VA's Superior Care. (2025) https://static1.squarespace.com/static/68a3a7a086f56252a95e0de0/t/68a62bb75b0dc83d0f81645a/1755720631084/Peer_Reviewed_Study.pdf
35. United States Government Accountability Office. VETERANS' COMMUNITY CARE: VA Needs Improved Oversight of Behavioral Health Medical Records and Provider Training. Report to Congressional Committees. May 2025. GAO-25-106910 https://files.gao.gov/reports/GAO-25-106910/index.html?_gl=1*so2aou*_ga*NjAzODEyODEzLjE3NDg2MTg1ODA.*_ga_V393SNS3SR*czE3NTA0NDg3MzQkbzUkZzAkdDE3NTA0NDg3MzQkajYwJGwwJGgw
36. Tanielian T, Farris C, Batka C, et al. "Ready to Serve: Community-based provider capacity to deliver culturally competent, quality mental health care to Veterans and their families." (RAND Corp. (2014) https://www.rand.org/pubs/research_reports/RR806.html
37. Vanneman, M. E., Rosen, A. K., Wagner, T. H., Shwartz, M., Gordon, S. H., Greenberg, G., Zheng, T., Cook, J., Beilstein-Wedel, E., Greene, T., & Kelley, A. T. (2023). Differences Between VHA-Delivered and VHA-Purchased Behavioral Health Care in Service and Patient Characteristics. *Psychiatric services (Washington, D.C.)*, *74*(2), 148–157. https://doi.org/10.1176/appi.ps.202100730
38. Franklin, C. L., Raines, A. M., Ennis, C. R., Boffa, J. W., Bender, A. M., Ferrie, M. L., Nocera, T. R., Dornbach-Bender, A., Seidler, D. A., Slaton, K. D., O'Malley, L., Shapiro, M. O., & Laborde, G. (2025). Evaluating coordination and quality of care among veterans receiving posttraumatic stress disorder care in the community. *Journal of traumatic stress*, 10.1002/jts.70012. Advance online publication. https://doi.org/10.1002/jts.70012
39. Gujral, K., Bahraini, N., Brenner, L. A., Van Campen, J., Zulman, D. M., Illarmo, S., & Wagner, T. H. (2023). VA's implementation of universal screening and evaluation for the suicide risk identification program in November 2020 -Implications for Veterans with prior mental health needs. *PloS one*, *18*(4), e0283633. https://doi.org/10.1371/journal.pone.0283633
40. RAND Corporation. "Improving the Quality of Mental Health Care for Veterans." August 13, 2019. https://www.rand.org/pubs/research_briefs/RB10087.html
41. Veterans Healthcare Policy Institute https://www.veteranspolicy.org/document-quality
42. Statement of Dr. Kyleanne Hunter Before the House Veterans Affairs Subcommittee on Health, July 15, 2025 https://docs.house.gov/meetings/VR/VR03/20250715/118495/HHRG-119-VR03-Wstate-HunterK-20250715.pdf

BRADY
UNITED AGAINST GUN VIOLENCE

December 7, 2025

Dear Members of the United States Senate Committee on Veterans' Affairs,

I am writing today in support of the bipartisan Saving Our Veterans Lives Act of 2025 (S.926). Previously serving as Executive Director and CEO of the American Association of Suicidology and now as Senior Director of End Family Fire, Brady's national secure gun storage campaign, I applaud this committee for taking such a strong proactive step forward in veteran suicide prevention.

Founded in 1974, Brady works across Congress, courts, and communities to end America's gun violence epidemic. Our organization carries the name of Jim Brady, who was shot and severely injured in the assassination attempt on President Reagan's life. Jim and his wife, Sarah, led the fight to pass the landmark Brady Bill 30 years ago.

The Department of Veterans Affairs' 2024 National Veteran Suicide Prevention Annual Report[1] revealed that suicide tragically claimed the lives of 6,407 of our nation's veterans in 2022. More than 17 veterans took their own life each day that year, and the large majority of those veteran deaths were by firearm.

In 2022, firearms remained the most prevalent method of suicide among veterans, with 73.5% of veteran suicides involving firearms, comparative to non-veteran deaths (52.2%). Additionally the percentage of veteran suicides involving firearms in 2022 marked a 7.1% increase in the percentage of firearm-related veteran suicides from 2001 to 2022, highlighting a startling upward trend over the past two decades.

Nearly half of all veterans own at least one firearm[2], and research shows that easy access to a gun in the home increases the risk of suicide death by 300%.[3] Simply put, the lethal nature of firearms greatly increases the risk of a fatal outcome in a suicide attempt. Reducing veteran

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[1] U.S. Department of Veterans Affairs, Office of Suicide Prevention. *2024 National Veteran Suicide Prevention Annual Report.* 2024. Retrieved {December 9, 2025}. https://www.mentalhealth.va.gov/docs/data-sheets/2024/2024-Annual-Report-Part-2-of-2_508.pdf

[2] Cleveland EC, Azrael D, Simonetti JA, Miller M. *Firearm ownership among American veterans: findings from the 2015 National Firearm Survey.* Inj Epidemiol. 2017 Dec 19. https://pmc.ncbi.nlm.nih.gov/articles/PMC5735043/.

[3] Andrew Anglemyer, Tara Horvath, George Rutherford. *The Accessibility of Firearms and Risk for Suicide and Homicide Victimization Among Household Members: A Systematic Review and Meta-analysis.* Ann Intern Med.2014;160:101-110. [Epub 21 January 2014]. https://www.acpjournals.org/doi/10.7326/M13-1301.

suicide deaths starts with acknowledging the role that firearms play and taking action to combat it.

The Saving Our Veterans Lives Act of 2025 will help reverse that deadly trend and save countless veteran lives across this country. Secure storage saves lives: many suicide attempts are undertaken impulsively during moments of temporary crisis, and delaying someone's access to a firearm by even a few moments offers them an opportunity to reconsider making a tragic and irreversible decision. This Act, which will direct the Department of Veterans Affairs to give a free lockbox to any veteran who requests one, will provide that critical time and space between a veteran in crisis and their firearm — helping save their life.

These secure storage practices are how we best address all forms of "family fire," a general term for gun violence that results from improperly stored or misused guns found in the home. Brady, in collaboration with The Ad Council, introduced this term with a national PSA campaign in 2018. The campaign's results consistently show that simply being aware of this issue prompts people to look into new firearm storage practices, talk to loved ones about the issue, and change and improve their current secure gun storage practices.

Providing free gun lockboxes to any veteran who requests one and providing them with secure gun storage information not only increases the likelihood of secure storage practices within that veteran's home, it helps save lives.

It is imperative the Committee support this bipartisan bill and help make the Saving Our Veterans Lives Act of 2025 law. We owe it to our nation's veterans who have sacrificed so much for us and this country.

Sincerely,

Colleen Creighton

Colleen Creighton
Sr. Director, End Family Fire
Brady

EVERYTOWN
FOR GUN SAFETY

December 10, 2025

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

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

Dear Chairman Moran and Ranking Member Blumenthal:

Everytown for Gun Safety, the largest gun violence prevention organization in the nation, writes to express our strong support of S. 926, the Saving Our Veterans Lives Act. We thank Senators King and Sheehy for their bipartisan leadership on this commonsense legislation that would empower the Department of Veterans Affairs (VA) to build upon the VA's life-saving work to reduce veteran suicide, providing veterans with more opportunities to store their firearms securely and safely. This work is more important now than ever as the proportion of veteran suicide deaths involving a firearm is the highest it has been in decades.[1] **We can—and must—do more to protect the brave men and women who have served and sacrificed for our nation from this preventable epidemic, and that is exactly what the Saving Our Veterans Lives Act would help do.**

In 2022 alone, there were 6,407 veteran suicide deaths in the United States.[2] No state is immune to this crisis.[3] Firearms, as the VA has found and reported, are "the most prevalent method of suicide among veterans" with 73.5% of veteran suicide deaths in 2022 involving firearms.[4] In some states, like Kansas, that rate is even higher.[5] Over the last 20 years, the veteran firearm suicide rate has increased by 58%—and veteran firearm suicide has stolen the lives of more than 87,000 veterans.[6]

The VA has also found that "[f]irearms are the most lethal means of suicide, with a 90% fatality rate compared to other methods, which are far less likely to result in death."[7] In fact, "[n]ine in [10] of those who survive a suicide attempt do not go on to die by suicide."[8] To that end, the VA has called attention to the "critical role that firearm access plays in [v]eteran suicide rates." Because, in moments of crisis, "[a]ccess to a firearm . . . dramatically increases the likelihood of a fatal suicide attempt." These moments can be "impulsive, often lasting less than 10 minutes," which makes putting time and space between someone in crisis and a firearm all the more critical.[9]

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[1] *See* Dep't of Veterans Affairs, *2024 National Veteran Suicide Prevention Annual Report,* State Data Appendix (2024) at "Suicides by Method," *available at* https://www.mentalhealth.va.gov/suicide_prevention/data.asp.
[2] Dep't of Veterans Affairs, *2024 National Veteran Suicide Prevention Annual Report, Part 1 of 2: In-Depth Reviews* (Dec. 2024) at p. 4, *available at* https://www.mentalhealth.va.gov/docs/data-sheets/2024/2024-Annual-Report-Part-1-of-2_508.pdf.
[3] *See State Data Appendix*, *supra* note 1, at "Veteran Suicides by State."
[4] *See 2024 Report*, *supra* note 2, at p. 6.
[5] *See* Dep't of Veterans Affairs, *Kansas: Veteran Suicide Data Sheet 2022*, available at https://www.mentalhealth.va.gov/docs/data-sheets/2022/2022_State_Data_Sheets_Kansas_508.pdf.
[6] *See* Everytown Research & Policy, *Those Who Serve: Addressing Firearm Suicide Among Military Veterans* (Feb. 24, 2025), *available at* https://everytownresearch.org/report/those-who-serve/ (analyzing data included in *State Data Appendix*, *supra* note 1).
[7] *See 2024 Report*, *supra* note 2, at p. 7.
[8] *See* Dep't of Veterans Affairs, *Lethal Means Safety Evidence* (last updated Dec. 2023), *available at* https://www.mirecc.va.gov/visn19/lethalmeanssafety/evidence/.
[9] *See 2024 Report*, *supra* note 2, at pp. 6-7.

That is why secure firearm storage is so important: it reduces immediate access to a firearm in these moments, providing the proven time and space "needed for the crisis to pass or for intervention to occur."[10] That is why secure firearm storage has long been a cornerstone of the VA's efforts to prevent veteran suicide, and that has been the case under administrations of both political parties, including in President Trump's first term. For example, in 2020, President Trump released a toolkit[11] on secure firearm storage for veterans, which, among other things, acknowledged that "environmental factors such as lethal means increase the risk for suicide."[12]

While the VA has "implemented a number of initiatives . . . to promote secure firearm storage," including offering information on secure firearm storage, distributing free cable locks to veterans, and training health care providers to implement lethal means safety counseling, among other efforts,[13] the ongoing crisis of veteran suicide and the proportion of those deaths that involve firearms necessitates that the VA's secure firearm storage initiatives be expanded. That's where the bipartisan Saving Our Veterans Lives Act comes in.

The Saving Our Veterans Lives Act would direct the VA to build on the VA's existing work—creating a program to provide lockboxes to veterans who request them. It would also require the VA to provide veterans, upon request, information about the proven benefits of and options for secure firearm storage. This legislation further includes a provision that would ensure all veterans—from rural communities to cities to everywhere in between—know about the VA's lockbox program and the importance of secure firearm storage through a robust public education campaign. If enacted and if fully implemented in partnership with the same veterans services, mental health, and suicide prevention organizations who also support this legislation, the Saving Our Veterans Lives Act will help do just that: save veterans' lives.[14]

We have a solemn duty to protect those who have protected us, and, with this legislation, we have a commonsense, bipartisan chance to provide the VA with another critical tool to help prevent more veteran suicides. For all of these reasons, we urge you, this Committee, and the United States Senate to pass the Saving Our Veterans Lives Act.

Sincerely,

Monisha Henley

Monisha Henley
Senior Vice President for Government Affairs
Everytown for Gun Safety

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[10] *Id.* at p. 7.
[11] *See* Press Release, Dep't of Veterans Affairs, *VA Releases Safe Firearm Storage Toolkit in Suicide Prevention Effort* (Apr. 20, 2020), *available at* https://news.va.gov/73736/va-releases-safe-firearm-storage-toolkit-suicide- prevention-effort/.
[12] Dep't of Veterans Affairs, *Suicide Prevention is Everyone's Business: A Toolkit for Safe Firearm Storage in Your Community* (2020) at p. 2, *available at* https://www.mentalhealth.va.gov/suicide_prevention/docs/Toolkit_Safe_Firearm_Storage_CLEARED_508_2-24-20.pdf.
[13] *See 2024 Report*, *supra* note 2, at pp. 7-9.
[14] Press Release, Sen. King, *King, Sheehy Lead Bipartisan Legislation to Combat Veteran Suicide* (Mar. 14, 2025), *available at* https://www.king.senate.gov/newsroom/press-releases/king-sheehy-lead-bipartisan-legislation-to-combat- veteran-suicide (listing endorsements from Disabled American Veterans, National Alliance on Mental Illness, American Psychiatric Association, American Psychological Association, and the American Foundation for Suicide Prevention).

December 10, 2025

The Honorable Jerry Moran
Chairman
U.S. Senate Committee on Veterans' Affairs
Washington, DC 20515

The Honorable Richard Blumenthal
Ranking Member
U.S. Senate Committee on Veterans' Affairs
Washington, DC 20515

Dear Chairman Moran and Ranking Member Blumenthal,

I am writing on behalf of GIFFORDS, the gun safety organization founded and led by former Congresswoman Gabrielle Giffords, to share our endorsement of S. 926, the Saving Our Veterans Lives Act, led by Senator Angus King and Senator Tim Sheehy.

The suicide crisis in America disproportionately impacts veterans, with, on average, more than 6,400 veterans dying by suicide each year,[1] a number which overwhelmingly involves firearms. Since 2015, the veteran suicide rate has been higher than the suicide rate among non-veterans.[2] In fact, the 2022 veteran suicide rate was more than double the rate among non-veterans.[3] Additionally, having access to firearms in the home triples the risk of firearm suicide death,[4] with nearly 3 in 4 veteran suicide deaths involving a firearm.[5] In comparison, only about half of all suicides in the US involve a firearm.[6] With more than half of all veterans owning a firearm,[7] and a steady rise in veteran firearm suicide rates,[8] we must do more to prevent these rates from climbing even further.

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[1] "2024 National Veteran Suicide Prevention ANNUAL REPORT Part 2 of 2: Report Findings" US Department of Veterans Affairs, Office of Mental Health and Suicide Prevention, https://www.mentalhealth.va.gov/suicide_prevention/data.asp.
Note: based on the last 5 years of available data: 2018 to 2022
[2] "2024 National Veteran Suicide Prevention ANNUAL REPORT Part 2 of 2: Report Findings" US Department of Veterans Affairs, Office of Mental Health and Suicide Prevention, https://www.mentalhealth.va.gov/suicide_prevention/data.asp.
[3] "2024 National Veteran Suicide Prevention ANNUAL REPORT Part 2 of 2: Report Findings" US Department of Veterans Affairs, Office of Mental Health and Suicide Prevention, https://www.mentalhealth.va.gov/suicide_prevention/data.asp.
[4] Andrew Anglemyer, Tara Horvath, and George Rutherford, "The Accessibility of Firearms and Risk for Suicide and Homicide Victimization Among Household Members: a Systematic Review and Meta-analysis," *Annals of Internal Medicine* 160, no. 2 (2014): 101–110.
[5] "2024 National Veteran Suicide Prevention ANNUAL REPORT Part 2 of 2: Report Findings" US Department of Veterans Affairs, Office of Mental Health and Suicide Prevention, https://www.mentalhealth.va.gov/suicide_prevention/data.asp.
[6] Centers for Disease Control and Prevention, Wide-ranging Online Data for Epidemiologic Research (WONDER), "Fatal Injury Data," last accessed December 8, 2025, https://wonder.cdc.gov/Deaths-by-Underlying-Cause.html.
[7] Ian C. Fischer, et al., "Firearm Ownership Among a Nationally Representative Sample of U.S. Veterans," *American Journal of Preventive Medicine* 65, no. 6 (2023): 1129-1133.
[8] "2024 National Veteran Suicide Prevention ANNUAL REPORT Part 2 of 2: Report Findings" US Department of Veterans Affairs, Office of Mental Health and Suicide Prevention, https://www.mentalhealth.va.gov/suicide_prevention/data.asp.

Laws that incentivize and promote secure storage practices can help prevent suicide. One study found that states with a law in place that required handguns to be locked in certain circumstances experienced reduced rates of firearm suicide generally.[9] Another study found that veterans who used a firearm for suicide were more likely to have a documented unsecured firearm in their home at the time of their death.[10] Taken together, this underscores the need for promoting secure storage of lethal means, especially firearms, as an important part of the Department of Veterans Affairs (VA) suicide prevention effort.

The Saving Our Veterans Lives Act expands the Department of Veterans Affairs's suicide prevention work by authorizing a program to provide free firearm lockboxes to veterans upon request. Current programs require a veteran to be enrolled in the Veterans Health Administration (VHA) and have qualifying characteristics—such as having been deemed to be at an elevated risk for suicide or self-harm—to obtain a free lockbox.[11] Year after year, statistics show that veterans as a group are already at a heightened risk of dying by suicide. This legislation provides lockboxes to veterans, regardless of their enrollment in the VHA or the obtainment of an at-risk mental health diagnosis. By encouraging secure storage practices for all veterans, we can save thousands of lives every year.

Our nation's veterans bravely volunteered to fight for our country, risking their lives; we owe them and their families meaningful actions to address the veteran suicide crisis. We urge you to pass this lifesaving legislation without delay.

Vanessa Gonzalez
Director of Government and Political Affairs GIFFORDS

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[9] Michael D. Anestis and Joye C. Anestis, "Suicide Rates and State Laws Regulating Access and Exposure to Handguns," *American Journal of Public Health* 105, no. 10 (2015): 2049–2058.
[10] Brooke A. Ammerman and Mark A. Reger, "Evaluation of Prevention Efforts and Risk Factors Among Veteran Suicide Decedents who Died by Firearm," *Suicide and Life-Threatening Behavior* 50, no. 3 (2020): 679–687.
[11] *See* Erica Sprey, "VA Firearm Lockbox Program: Providing more options for at-risk Veterans to secure firearms," Office of Research & Development, US Department of Veterans Affairs, (Sept. 9, 2024), https://www.research.va.gov/currents/0924-VA-Firearm-Lockbox-Program.cfm.

November 4, 2025

The Honorable Angus King
U.S. Senate
133 Hart Senate Office Building
Washington, DC 20510

The Honorable Tim Sheehy
U.S. Senate
124 Russell Senate Office Building
Washington, DC 20510

Dear Senator King & Senator Sheehy:

We are writing in strong support of your legislation, the *Saving Our Veterans Lives Act*, S.926, which would direct the Secretary of Veterans Affairs to establish a program to provide certain veterans with items used for the secure storage of firearms, and for other purposes. We thank you for your leadership on this critical bill and appreciate your continued leadership on behalf of veterans across the nation.

The mass shooting at Sandy Hook Elementary School took the lives of 20 precious first graders and 6 of their dedicated educators on December 14, 2012. Sandy Hook Promise is national nonprofit committed to educating and empowering youth and adults to keep children safe from all forms of violence. Through evidence-based violence-prevention programs, Sandy Hook Promise teaches students and adults how to recognize, intervene, and get help for individuals who may be socially isolated and/or at risk of hurting themselves or others. Sandy Hook Promise programs have reached 38 million youth and adults and averted multiple school shootings, suicides, and other violent threats across all 50 states.

Suicide is the 2nd leading cause of death for veterans under the age of 45.[1] From 2003 to 2022, over 87,00 veterans died by firearm suicide, making up three-quarters of all veteran suicides.[2] Veteran suicide by firearm is the highest it has been in over 20 years, and evidence shows that veterans are three times more likely to die by firearm suicide than non-veterans.[3] There is a deep need to put time and space between an at-risk person, including veterans, and access to their firearm to allow the suicidal ideation to pass and time for them to get help. Research has shown that by reducing access to lethal means, the risk of suicide is reduced by 95 percent.[4] The lockboxes provided through the *Saving Our Veterans Lives Act* will prevent suicides.

Additionally, the secure storage of firearms protects young people from both accidental and intentional gun violence. Further, a 2018 survey of veterans, put the number of children living in a home with an unsecured, loaded firearm to one in three.[5] When both firearms and ammunition are stored securely, children have a 78% lower risk of self-inflicted firearm injuries and an 85% lower risk of unintentional firearm injuries.[6] Similarly, research has found that more than 66% of school shooters acquire[7] and more than 75% of firearms used in youth suicide attempts and unintentional firearm injuries came from the residence of the victim, a relative, or a friend.[8] All of these risks can be mitigated through storage practices outlined and supported in the *Saving Our Veterans Lives Act* (S.926).

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[1] 2024 National Veteran Suicide Prevention Annual Report
[2] A Practical Review of Suicide Among Veterans: Preventive and Proactive Measures for Health Care Institutions and Providers - PMC
[3] Suicide Prevention - Mental Health - Mental Health
[4] https://pubmed.ncbi.nlm.nih.gov/26409438/
[5] J.A. Simonetti et al., "Firearm Storage Practices Among American Veterans," *American Journal of Preventative Medicine* 55 (2018): 445-54
[6] Gun Storage Practices and Risk of Youth Suicide and Unintentional Firearm Injuries | Adolescent Medicine | JAMA | JAMA Network
[7] The Final Report and Findings of the Safe School Initiative: Implications for the Prevention of School Attacks in the US (PDF)
[8] Self-inflicted and Unintentional Firearm Injuries Among Children and Adolescents: The Source of the Firearm | Adolescent Medicine | JAMA Pediatrics | JAMA Network

Sandy Hook Promise is proud to support this life-saving legislation. Thank you for your commitment to protecting our children, veterans, their families, and our communities. Together, we can prevent violence and save lives.

Sincerely,

Mark Barden

Mark Barden, Daniel's father
Co-Founder, Sandy Hook Promise

Nicole Hockley, Dylan's mother
Co-Founder & CEO, Sandy Hook Promise

CC: Senator Moran

Senator Blumenthal

UNITED STEELWORKERS
USW
UNITY AND STRENGTH FOR WORKERS

December 10, 2025

Via Email
Committee on Veterans Affairs
U.S. Senate
Washington, D.C. 20510

RE: United Steelworkers letter of support for S. 926, the Saving Our Veterans Lives Act.

Dear Chair Moran, Ranking Member Blumenthal, and members of the Committee:

On behalf of the 850,000 members of the United Steelworkers (USW), I write to thank you for holding this hearing on pending legislation, including S. 926, the Saving Our Veterans Live Act of 2025. We urge you to support this legislation.

USW represents members across nearly every sector in the American economy. In addition to being the largest industrial union, we also represent tens of thousands of veterans who work in every sector of our union. In 2022, delegates to the USW Constitutional Convention voted to change the USW Constitution and require every local union to form, support, and maintain a Veterans of Steel committee to better serve the veterans in their workplaces and communities.

According to the U.S. Department of Veterans Affairs (VA), more than 17 veterans die by suicide every day.[1] This tragic statistic underscores the urgent need for comprehensive mental health resources and support systems tailored to the unique challenges faced by those who have served our country.

The 2024 National Veteran Suicide Prevention Annual Report highlights that suicide rates among veterans remain significantly higher than those of the general population. Factors such as post-traumatic stress disorder (PTSD), difficulty transitioning to civilian life, and limited access to mental healthcare contribute to this crisis.[2]

[1] U.S. Department of Veterans Affairs, "2024 National Veteran Suicide Prevention Annual Report – Part 2 of 2: Report Findings", December 2024.
[2] Ibid.

United Steel, Paper and Forestry, Rubber, Manufacturing, Energy, Allied Industrial and Service Workers International Union
Legislative and Policy Department, 1155 Connecticut Ave, N.W. 5th Floor, Washington, D.C. 20036
202-778-4384 • 202-293-5308 (Fax) • www.usw.org

One critical aspect of suicide prevention is the safe storage of firearms. Nearly 70 percent of veteran suicides involve firearms, making secure storage practices a vital component for reducing risk.[3] Research shows that suicidal crises are often brief, with many individuals acting on their decision within minutes.[4] By increasing the time and distance between a person in crisis and access to lethal means, such as the use of gun safes or locks, we can create a crucial barrier that saves lives.

Since 2012, VA's Suicide Prevention Program has distributed free firearm cable locks to any veteran who requests one. A program is currently offering free lockboxes to Veterans Health Administration (VHA) enrolled veterans with elevated risk for suicide who request that one be mailed to them. The Saving Our Veterans Lives Act of 2025 improves upon this current VA program in the following ways:

- Applies to all veterans, with or without identified risk and VHA enrollment;
- Assures sufficient funding for thousands of lockboxes to be distributed to veterans;
- Expands distribution avenues, allowing greater access for all veterans; and
- Promotes public education campaigns, including through trusted allies.

By supporting this legislation, you have the opportunity to honor the sacrifices of our veterans and ensure that they receive the care and support they deserve.

On behalf of the United Steelworkers, we believe in standing together to protect and uplift those who have given so much for our nation. Therefore, we again urge you to prioritize the well-being of our nation's heroes by supporting the Saving Our Veterans Lives Act of 2025.

Sincerely,

Roy Houseman Jr.
Legislative Director
Assistant to the International President

[3] U.S. Department of Veterans Affairs, "Suicide Prevention is Everyone's Business: A Toolkit for Safe Firearm Storage in Your Community", February 27, 2020.
[4] U.S. Department of Veterans Affairs, "Keep It Secure – Secure Your Firearms", Accessed December 8, 2025.

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WTTA
WALK THE TALK AMERICA

Walk the Talk America
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The Honorable Angus King
U.S. Senate
133 Hart Senate Office Building
Washington, D.C. 20510

The Honorable Tim Sheehy
U.S. Senate
G55 Dirksen Senate Office Building
Washington, D.C. 20510

The Honorable Chris Deluzio
U.S. House of Representatives
1222 Longworth House Office Building
Washington, D.C. 20515

The Honorable Brian Fitzpatrick
U.S. House of Representatives
271 Cannon House Office Building
Washington, D.C. 20515

The Honorable Greg Landsman
U.S. House of Representatives
2244 Rayburn House Office Building
Washington, D.C. 20515

The Honorable John James
U.S. House of Representatives
1519 Longworth House Office Building
Washington, D.C. 20515

October 29, 2025

Dear Senators King and Sheehy, and Representatives Deluzio, Fitzpatrick, Landsman, and James:

On behalf of Walk the Talk America (WTTA), a nonprofit organization founded within the firearms industry to bridge the gap between mental health and responsible gun ownership, we are writing to express our support for the intent of the Saving Our Veterans Lives Act of 2025. This bipartisan legislation promotes access to firearm storage solutions for veterans, which aligns directly with our mission to reduce suicide and negative outcomes through education, awareness, and voluntary secure storage initiatives.

WTTA's work is rooted in the belief that firearm safety and mental health care are not opposing forces, but essential partners. We work to reduce gun-related deaths through education, advocacy, and community engagement while fully respecting Second Amendment rights. By bringing together gun owners, mental health professionals, and suicide prevention advocates, we bridge the often-polarized gun debate to find common ground on reducing preventable deaths. Our programs include educational initiatives, partnerships with shooting ranges and gun stores, and efforts to destigmatize mental health conversations within gun-owning communities.

Our programs have reached tens of thousands of gun owners and mental health professionals nationwide, emphasizing cultural competence, voluntary means safety, and early intervention.

I also had the privilege of serving on President Trump's President's Roadmap to Empower Veterans and End a National Tragedy of Suicide (PREVENTS) task force, which emphatically concluded that "a key component of effective suicide prevention is voluntary reduction in the ability to access lethal means with respect to time, distance, and convenience, particularly during acute suicidal crises." The task force recommended increasing implementation of programs for veterans focused on lethal means safety.

Walk the Talk America emphatically endorses firearm owners taking steps to temporarily and voluntarily reduce access to firearms during challenging moments. The evidence is unassailable. Access to lethal means for an individual at risk of suicide heightens that risk significantly. The deadly, impulsive phase of many suicidal crises is fleeting, and the vast majority of people who are intent on suicide but are thwarted or survive an attempt never attempt again. Research shows that temporary barriers between a person and their firearm during a suicidal crisis can significantly reduce suicide deaths. By providing storage devices and education through trusted channels like the VA, this bill would help ensure veterans receive the tools and resources they deserve to stay safe.

An expanding number of initiatives from within the firearms community now support voluntarily reducing access to firearms as a means to reduce suicide. The NSSF supports temporarily restricting access to firearms for those at risk of suicide, and their materials provide numerous examples of preventive secure storage options for gun owners and their families. I've attended three innovative VA-National Shooting Sports Foundation (NSSF) Roundtables with firearm manufacturers and other industry leaders, and the collaboration has been both productive and encouraging.

The Department of Veterans Affairs has demonstrated outstanding leadership in this area through provider training implemented over the past eight years and a pilot program offering free lock boxes to enrolled veterans assessed to be at moderate to high risk of suicide. The Saving Our Veterans Lives Act represents an important opportunity to build upon this progress and solidify these efforts as a Departmental priority.

Lethal means safety isn't a partisan issue. There is room for—indeed, urgent need for—suicide prevention strategies that promote counseling and safe storage while honoring responsible gun ownership rights. Protecting Second Amendment rights and protecting lives are complementary, not opposing, actions.

WTTA commends the collaborative leadership behind this effort and stands ready to assist in expanding its reach to ensure it remains inclusive of the full range of secure storage options available today.

Thank you for your continued commitment to addressing suicide prevention in a way that brings people together instead of driving them apart. If Walk the Talk America can be of further assistance or provide insight from our experience within both the mental health and firearms communities, please contact us at info@walkthetalkamerica.org.

Sincerely,

Michael Sodini
Founder & President
Walk the Talk America

URBAN INSTITUTE

Over 600,000 Nonelderly Veterans Would Have Subsidized Marketplace Coverage in 2026 under Enhanced Premium Tax Credits

Matthew Buettgens, Jennifer M. Haley, and Michael Simpson

September 2025

Many veterans receive care through the US Department of Veterans Affairs (VA). However, eligibility is limited to certain priority groups, including veterans with low incomes or who have service-connected disabilities, and VA services can be inaccessible for those who do not live near VA facilities. As a result, subsidized coverage through Medicaid and Marketplaces plays an important role in coverage for nonelderly veterans (Banthin, Haley, and Simpson 2025). The American Rescue Plan Act of 2021 enhanced premium tax credits (PTCs), making Marketplace plans more affordable, and Congress is currently considering whether to extend these enhancements after their planned expiration in December 2025. A recent brief found that 4.8 million people would lose coverage if the enhanced PTCs were to expire (Buettgens et al. 2025). In this analysis, we provide new information on the number of nonelderly veterans who would receive Marketplace PTCs in 2026 with and without the enhancements, using data from the Health Insurance Policy Simulation Model.[1]

We found that the expiration of enhanced PTCs would lead to lower enrollment in subsidized Marketplace coverage among veterans. Under enhanced subsidies, an estimated 623,000 veterans would have Marketplace coverage with PTCs in 2026. If enhanced subsidies expire, this number would fall to 356,000—reducing the number of veterans with subsidized Marketplace coverage by 267,000 or 43 percent. Many of those losing coverage would become uninsured, while others would enroll in more expensive employer coverage or nongroup coverage without PTCs, which would have higher premiums. Moreover, premiums would be higher for those who do maintain subsidized Marketplace coverage.

TABLE 1

Subsidized Marketplace Coverage among Nonelderly Veterans under Enhanced and Standard Marketplace PTCs, 2026

	Enhanced PTCs		Standard PTCs		Difference	
	Number (thousands)	%	Number (thousands)	%	Number (thousands)	%
Number and share of nonelderly veterans with Marketplace coverage with PTCs	623	7.3%	356	4.4%	−267	−43%

Source: The Urban Institute, Health Insurance Policy Simulation Model (HIPSM).
Notes: PTC = premium tax credit.

[1] We used the Health Insurance Policy Simulation Model to estimate the share of nonelderly veterans who would be enrolled in Marketplace coverage with PTCs or uninsured in 2026 with and without enhanced PTCs, as described in Buettgens et al. (2025). To obtain the numbers of nonelderly veterans corresponding to these shares, we used the latest available total number of nonelderly veterans (younger than age 65) from the 2024 American Community Survey, see "B21001: Sex by Age by Veteran Status for the Civilian Population 18 Years and Over," US Census Bureau, accessed September 29, 2025, https://data.census.gov/table/ACSDT1Y2024.B21001?q=veterans+in+2024+by+age.

References

Banthin, Jessica, Jennifer M. Haley, and Michael Simpson. 2023. "Uninsured Veterans in the US: Greater Expansion and Take-Up of Medicaid and Marketplace Coverage Has the Potential for Coverage Gains." Washington, DC: Urban Institute.

Buettgens, Matthew, Michael Simpson, Jason Levitis, Fernando Hernandez-Lepe, and Jessica Banthin. 2025. "4.8 Million People Will Lose Coverage in 2026 If Enhanced Premium Tax Credits Expire." Washington, DC: Urban Institute.

Matthew Buettgens is a senior fellow, Jennifer M. Haley is a principal research associate, and Michael Simpson is a principal research associate in the Health Policy Division at the Urban Institute.

Statements for the Record

TESTIMONY
OF
COLE T. LYLE
DIRECTOR
VETERANS' AFFAIRS AND REHABILITATION DIVISION
THE AMERICAN LEGION
BEFORE THE
SENATE COMMITTEE ON VETERANS' AFFAIRS
LEGISLATIVE HEARING
ON
"PENDING LEGISLATION"

DECEMBER 10, 2025

EXECUTIVE SUMMARY

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Senate Discussion Draft, the Commission on Equity and Reconciliation in the Uniformed Services Act (Blumenthal) *Pg. 22*	Support
Senate Discussion Draft, the Get Justice Involved Veterans BACK HOME Act (King) *Pg. 23*	Support with Amendments

The provisions of the following legislation on the agenda fall outside the scope of established resolutions of The American Legion. As a member-driven and resolution-based organization, The American Legion takes positions on legislation based on resolutions passed by membership. Therefore, we have no position on the following:

LEGISLATION	POSITION
S. 342, the Purple Heart Veterans Education Act (Murray)	No position
S. 668, the SAFE STEPS for Veterans Act (King)	No position
S. 2333, the Health Records Enhancement Act (Welch)	No Position
S. 2807, Restoring Eligibility Standards for Placement in Eligible Cemeteries and Tombs (RESPECT) Act (Cornyn/Hirono/Murkowski/Fettman/R. Scott/Schiff)	No Position

TESTIMONY
OF
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Chairman Moran, Ranking Member Blumenthal and distinguished members of the Committee, on behalf of National Commander Dan Wiley, and more than 1.5 million dues-paying members of The American Legion, we thank you for the opportunity to offer our written testimony regarding proposed legislation.

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

S. 926, the Saving Our Veterans Lives Act of 2025 (King/Sheehy)
To amend title 38, United States Code, to direct the Secretary of Veterans Affairs to establish a program to furnish to certain veterans items used for the secure storage of firearms, and for other purposes.

The *Saving Our Veterans Lives Act of 2025* would establish a program at the Department of Veterans Affairs (VA) to provide vouchers for firearm storage devices to veterans upon request. The current pilot program to provide firearm storage is offered only to Veteran Health Administration (VHA)-enrolled veterans who are determined to be at moderate to high risk of suicide. Unfortunately, the lockboxes are currently only available through VA Prosthetic and Sensory Aids Service, and there is no dedicated funding for the program.[1]

The proposed legislation extends eligibility to all veterans and provides lockboxes widely at VA and through firearm retailers, dramatically increasing availability. This legislation will also provide funding for a public education campaign to make veterans aware of the resources and where to find these lockboxes, and why it is so important in reducing veteran suicide.

[1] U.S. Department of Veterans Affairs. "VA Firearm Lockbox Program." VA Research Currents, September 9, 2024. Accessed November 24, 2025. https://www.research.va.gov/currents/0924-VA-Firearm-Lockbox-Program.cfm

Making this simple voucher widely available to more veterans demonstrates that suicide prevention is priority for VA and for our nation broadly, and that we are prepared to invest in programs and tools that have proven positive outcomes. The simple act of acknowledging the potential crisis that too many veterans may still face and offering a rapid solution to disrupt a critical chain of events, will definitely save lives.

Preventing veteran suicide is The American Legion's top priority. By providing veterans with an avenue for safely storing their firearms when they are in crisis, this legislation will have a direct and significant impact in preventing tragedy. The American Legion can support this bill through Resolution No: 11: *Lethal Means and Suicide Prevention*. This resolution expresses The American Legion's support of suicide prevention initiatives that do not encroach on Constitutional rights, such as voluntary firearm storage.

The American Legion supports S. 926 as currently written.

S. 1116, the Ensuring Veterans' Final Resting Place Act of 2025 (Banks/Collins/Rosen)

To amend title 38, United States Code, to authorize the provision of certain additional burial benefits for individuals for whom an urn or plaque is furnished, and for other purposes.

The *Johnny Isakson and David P. Roe, M.D. Veterans Health Care and Benefits Improvement Act of 2020* authorized the Secretary of Veterans Affairs (SECVA) to reimburse the costs of commemorative plaques and urns for veterans whose cremated remains were not interred at a cemetery federally managed by VA's National Cemetery Administration (NCA). However, as currently written, if furnished with an urn or commemorative plaque, the VA is barred from later providing a headstone or gravesite marker and certain other types of burial benefits.[2]

Uninformed surviving families will not realize that, under current law, choosing a VA-reimbursed commemorative plaque and urn will later prohibit the VA from providing a government headstone or gravesite marker if ever the veteran's remains are relocated.

Proposed legislation provides the technical fix and flexibility to truly honor a surviving family's final/reunification wishes, as the family may have originally opted not to inter the remains at one of our nation's most solemn burial grounds. Surviving family members deserve to be afforded the flexibility in keeping their VA-burial and reunification options open.

Notably, as currently written, the Senate version appears to be the obsolete companion version of the House's 118th iteration. The House's 119th iteration has added additional bill language to remove the language "who dies on or after November 11, 1998" in section 2306 of title 38 USC. The American Legion recommends adopting this bill language to remove this arbitrary death date restriction so that all military families may qualify for the additional VA-covered burial options

[2] P.L. 116-315 (January 5, 2021) Johnny Isakson and David P. Roe, M.D. Veterans Health Care and Benefits Improvement Act of 2020, section. 2207 - Provision of Urns and Commemorative Plaques for Remains of Certain Veterans Whose Cremated Remains Are Not Interred in Certain Cemeteries at: https://www.congress.gov/116/plaws/publ315/PLAW-116publ315.pdf.

authorized under recent passage of the *Johnny Isakson and David P. Roe, M.D. Veterans Health Care and Benefits Improvement Act of 2020.*

The American Legion supports S. 1116 with amendments.

S. 1657, the Review Every Veteran's Claim Act (Banks/King)

To amend title 38, United States Code, to limit the authority of the Secretary of Veterans Affairs to deny the claim of a veteran for benefits under the laws administered by such Secretary on the sole basis that such veteran failed to appear for a medical examination associated with such claim, and for other purposes.

VA's duty to assist is described most simply as the Department's legal obligation to help gather evidence to support a veteran's claim for VA benefits.[3] This includes service treatment records, federal records, private medical records, lay evidence, compensation exams, and even first-hand servicemember accounts related to supporting submitted claims for benefits. Duty to assist or *The Veterans Claims Assistance Act of 2000* was signed into public law on November 9, 2000, to clarify and reaffirm the responsibility of the Secretary, and ultimately VA to make reasonable efforts to obtain medical evidence.[4]

Current law, under 38 C.F.R. § 3.655 states that if a veteran misses an examination appointment without good cause or due to illness, hospitalization, or death of an immediate family member, the claim shall be denied.[5] The narrow structure of the law does not consider the logistical challenges and complexities veterans must navigate to maintain compensation exam appointments. Veterans do not control their compensation exam schedules; the schedule is dependent on medical provider availability and overall distance from the veterans' home. Some veterans living in rural areas travel long distances to scheduled exam locations. Veterans may experience mental health conditions such as Post Traumatic Stress (PTS) or Military Sexual Trauma (MST), along with chronic pain, which can create physical challenges that make it difficult to honor appointments forcing them to cancel or miss them entirely.

A veteran's claim should not be automatically denied due to a missed compensation exam appointment. The decision to deny a claim should be based on the evaluation of all evidence gathered during development, which includes all necessary appointments and medical opinions. A rescheduled appointment is much more efficient, cost effective, and less harmful to the veteran than a reordered exam that could be scheduled out months later. This ensures timely decisions, avoids rework, and reduces opportunities for vendor overpayment. The American Legion supports

[3] U.S. Department of Veterans Affairs. "VA's Duty to Assist." VA.gov, last updated July 31, 2025. Accessed November 24, 2025. https://www.va.gov/resources/vas-duty-to-assist/
[4] United States, "Veterans Claims Assistance Act of 2000," Public Law 106-475, 106th Congress, November 9, 2000, 114 Stat. 2096 https://uscode.house.gov/statutes/pl/106/475.pdf
[5] U.S. Department of Veterans Affairs. 38 C.F.R. § 3.655 — Failure to report for Department of Veterans Affairs examination. Electronic Code of Federal Regulations, Title 38, Chapter I, Part 3, Subpart A. Accessed November 21, 2025 https://www.ecfr.gov/current/title-38/chapter-I/part-3/subpart-A/subject-group-ECFR24d035b1eee2d6f/section-3.655

the Legislation using Resolution No. 11: *Oversight of Medical Disability Examination Contract Providers.*[6]

The American Legion Supports S. 1657 as currently written.

S. 1665, the Obligations to Aberdeen's Trusted Heroes (OATH) Act of 2025 (Blumenthal)
To amend title 38, United States Code, to ensure veterans of secrecy oath programs receive the full benefits they have earned, and for other purposes.

The U.S. Army Chemical Corps conducted a classified Cold War program at Edgewood Arsenal primarily to research chemical warfare agents, defenses (such as protective military clothing and equipment), and pharmaceuticals.[7] After the military devised its first policies on human experiments in 1953, requiring test subjects to be provided informed consent, veterans volunteered to participate in classified studies starting in 1956.[8] By the time this program was disbanded in 1975, nearly 7,000 military personnel had been subjugated to nerve agents (including sarin, VX), tear gas, mustard gas, ketamine, hallucinogens such as LSD, and highly toxic concoctions to test various forms of a "truth serum."[9]

Fifty years later, veterans disclosed believing they were volunteering to test military equipment but "were directed instead to military research labs for human trials using chemical substances they received in gas chambers, by injection and other means."[10] Some veterans stated feeling deceived by the military, as they "thought that the Army had sent them to test equipment to better the forces."[11] This deception brings into question the validity of the informed consent claimed by the military. Veterans who developed cancer, paralysis, depression, and PTSD, have had their VA claims denied as the government never acknowledged their participation in a classified program, and are held to secrecy through a signed nondisclosure agreement (NDA).[12] Thankfully, a recent 2023 Appeals hearing found that those who participated in secrecy oath programs had their due process violated and their ability to timely file for entitled VA disability claims (in accordance with 38 USC § 5110 - VA's claims filing effective date limitations) hindered.[13]

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[6] The American Legion. Resolution No. 11 Oversight of Medical Disability Examination Contract Providers, Accessed November 21, 2025. https://archive.legion.org/node/17155
[7] Almanza, Rikki. "Vietnam-Era Veterans Seek Retroactive Benefits for Exposure to Nerve Agents and Hallucinogens in Secret Military Tests." American Legion Department of California, October 11, 2024. https://calegion.org/vietnam-era-veterans-seek-retroactive-benefits-for-exposure-to-nerve-agents-and-hallucinogens-in-secret-military-tests/; and Hersey, Linda F. "Vietnam-Era Veterans Exposed to Nerve Agents and Hallucinogens in Secret Military Tests Seek Years of Back Benefits." Stars and Stripes, October 4, 2024. https://www.stripes.com/theaters/us/2024-10-04/veterans-human-testing-disability-benefits-15404186.html.
[8] Kime, Patricia. "Vets Used in Secret Tests Make Progress in Court." Military Times, August 18, 2022. https://www.militarytimes.com/pay-benefits/military-benefits/health-care/2015/07/11/vets-used-in-secret-tests-make-progress-in-court/; and "Public Health: Edgewood/Aberdeen Experiments." U.S. Department of Veterans Affairs, Last updated April 16, 2025. https://www.publichealth.va.gov/exposures/edgewood-aberdeen/index.asp.
[9] Ibid
[10] Ibid
[11] Ibid
[12] Ibid
[13] *Taylor v. McDonough* (2023). United States Court of Appeals for Veterans Claims (CAVC) https://www.cafc.uscourts.gov/opinions-orders/19-2211.OPINION.6-15-2023_2143076.pdf

The proposed legislation would mandate SECVA notify all former participants of these classified studies of their entitled VA Benefits and services they may be eligible for. It would also codify the recent *Taylor v. McDonough* decision by establishing that, for any claim involving an NDA or secrecy oath, the effective award date must begin on the day following the veteran's discharge or separation. Veterans should never have been trapped in such a dilemma due to the classified nature of their mission or job. Servicemembers entrusted with safeguarding our military secrets must have confidence that our nation will do its utmost to remove the burden of proof to qualify for their VA entitlement programs and compensation benefits.

The American Legion can support through Resolution No. 22: *Classified Incidents for Department of Veterans Affairs Claims Purposes,* which urges the Department of Defense to confirm incidents, without disclosing their classified nature, including injuries, illnesses, toxic exposures, and other activities claimed by veterans in VA disability claims, and for VA to aggressively request such confirmations, as part of its duty to assist veterans and their dependents.

The American Legion supports S. 1665 as currently written.

S.1868, the Critical Access for Veterans Care Act (Cramer/Sheehy)

To amend title 38, United States Code, to expand access by veterans to critical access hospitals and affiliated clinics under the Veterans Community Care Program, and for other purposes.

A large and growing number of American veterans live in rural or highly rural areas. According to VA statistics, 2.7 million rural veterans are enrolled in VHA, and a majority of them (54%) are age 65 and over.[14] These veterans face hurdles accessing medical care, including a lack of transportation and limited specialty care providers.

This legislation seeks to radically alter VA care for rural veterans. It proposes eliminating the VA referral for community care for veterans living in areas serviced by Critical Access Hospitals. These hospitals are defined by federal statute as being their area's only provider within a 35-mile radius, have 25 or less inpatient beds, provide 24-hour emergency services, and other requirements.[15] Instead of going through the VA's community care process, veterans living in the areas serviced by these hospitals would be able to automatically opt-in to receiving care there. The hospital would be able to refer these veterans to other providers and specialists without any review or oversight of the VA. The legislation would actually put restrictions on the VA from requiring referrals or prior authorization for community care services.

While The American Legion supports improving rural veteran health care and believes that VA-managed community care is VA care, this legislation would take a substantial number of veterans out of VA-supervised programs and services. By opting into community care without oversight

[14] "Rural Veterans." Department of Veterans Affairs, March 10, 2025. https://www.ruralhealth.va.gov/aboutus/ruralvets.asp.
[15] "Critical Access Hospitals." CMS.gov. Accessed November 23, 2025. https://www.cms.gov/medicare/health-safety-standards/certification-compliance/critical-access-hospitals.

from the VA, many veterans would lose the committed support of programs, resources, and caring staff that ensure our veterans, and not profits, are the focus.

In accordance with Resolution No. 7: *Ensuring VA Remain the Center of Care*, The American Legion cannot support this legislation. This resolution states unequivocally that it is the position of The American Legion that the Veterans Health Administration should remain the center of care for American veterans.

The American Legion opposes S. 1868 as currently written.

S. 1992, Veterans Appeals Efficiency Act of 2025 (Banks/Blumenthal)

To amend title 38, United States Code, to improve the efficiency of adjudications and appeals of claims for benefits under laws administered by Secretary of Veterans Affairs, and for other purposes.

The Board of Veterans Appeals (BVA or "the Board") reviews appeals filed by veterans and dependents with adverse decisions. Appeals filed regarding decisions made before the Appeals Modernization Act (AMA) effective date of February 19, 2019, are designated "legacy" appeals. Legacy appeals following a remand by the Court of Appeals for Veterans Claims (CAVC) are allowed to keep their original place in docket order. For both legacy and AMA claims, current law and regulations place priority on the docket for veterans who are aged 75 or older, those facing serious illness, or those under serious financial hardship.

The American Legion Service Officers (VSOs) have long reported issues with BVA being excessively stringent on the interpretation and application of 38 U.S.C. § 7107, where the VSO believes the legal standard of "good cause" was met by the client, yet priority placement on the docket was denied by BVA. For instance, VSOs report that clients who were temporarily staying with friends or family after an eviction or inability to pay rent being denied priority placement. While these veterans are technically not homeless, their circumstances fall squarely within the intent of § 71017(b)(3)(B) giving priority to appellants who are experiencing financial hardship. Other examples of veterans who were denied priority placement are those with accrued medical debt for treatment of primary/secondary conditions that have yet to be adjudicated as service-connected, pushing veterans further into dire financial distress. BVA's current strict interpretation of "seriously ill or financial hardship" category has missed its mark and ignored the original reasons for allowing advancement on the docket rules. A review of current practices is overdue and necessary.

To reduce BVA's appeals backlog, this proposed legislation would require an annual progress report be delivered to Congress with the following information:

- Cases in which an adjudicator failed to comply with a relevant decision of the Board
- Cases where an Agency of Original jurisdiction (AOJ) did not satisfy the Duty to Assist (DTA) guidelines
- Number of claims filed in the National Work Queue (NWQ) still pending office assignment for adjudication
- Number of cases pending before The Board
- Number of cases afforded expeditious treatment

- Number of cases were remanded by the Court of Appeals for Veterans Claims
- Number of cases are seeking continuous pursuit

Especially for the last metric, The American Legion and other Veteran Service Organizations have long called for the VBA to improve its process to assign correct effective dates. VBA's current computer code uses the same End Product (EP) for Supplemental Claims to reopen a decision and Supplemental Claims that are continuously pursued. As a result, VBA's computer system is unable to accurately track effective dates, resulting in individual VBA adjudicators having to manually fix the effective back date. Improved metrics on the frequency of this error may help prompt VBA to adopt technological solutions. The American Legion welcomes the reporting of these metrics, as it would provide more transparency and pinpoint VBA's workflow bottlenecks. The American Legion notes that the Social Security Administration (SSA) established data reporting and analysis for its disability adjudication process in the previous decade and has reported improved consistency and quality of its case reviews. Furthermore, SSA's data-informed decisions allowed training opportunities and staff feedback which resulted in improved accuracy and helped inform agencies with differences between agency and federal court interpretation of agency policies.[16] Moreover, The American Legion notes SSA's published report on the data analysis which drove conversations on how to create more effective, efficient policies at lower cost, and we believe that similar data analysis requirements for VBA's disability claims process could drive similar benefits.

Lastly, the proposed legislation would grant the Board Chairman authority to aggregate claims involving similar factual or legal issues for quicker resolution as a collective group, rather than adjudicate each similar case individually, as BVA currently does. BVA would also be authorized to request an opinion from the VA's Office of General Counsel if an appeal or group of appeals involves a question of law that would benefit from such an opinion.

We respectfully submit our recommendation to include the following amendment:

> *Section 7104(e) of title 38 is amended by inserting after paragraph (3) the following new paragraph: "(4) for aggregate appeals described in subsection (a), any nonprofit veteran organization chartered by Congress under subtitle II of title 36, United States Code, that has filed a request with the Board to receive such notices."*

When the Board Chairman aggregates common questions of law or fact, notice should be provided to Congressionally chartered VSOs for maxim participation. In ordinary civil litigation, when a Court certifies a class, some kind of notice is generally provided to others affected by the litigation so that they may protect their interests. Even with the best of intentions, it is quite possible that a group of cases aggregated by the Board will not be representative of all veterans affected by an issue, will not contain the most relevant medical or other evidence bearing on the issue, or will not

[16] Ray, Gerald K, and Jeffrey S. Lubbers. "A Government Success Story: How Data Analysis by the Social Security Appeals Council (with a Push from the Administrative Conference of the United States) Is Transforming Social Security Disability Adjudication." The George Washington Law Review, September 2015. https://www.gwlr.org/a-government-success-story-how-data-analysis-by-the-social-security-appeals-council-with-a-push-from-the-administrative-conference-of-the-united-states-is-transforming-social-security-disability-ad/.

consider all legal provisions bearing on the issue. Accordingly, VSOs must be provided with the basic elements of due process when the Board aggregates claims: notice and the opportunity to respond. This will ensure that the outcome of the aggregation is fully informed and as relevant as possible to meet the needs of the larger veteran benefits system.

Through Resolution No. 5: *Department of Veterans Affairs Appeals Process*, The American Legion supports any legislation that calls on VA to address all claims, to include its growing inventory of appeals in an expeditious and accurate manner. Furthermore, Resolution No. 5 resolves VA to create no program that diminishes a veteran's due process rights. The American Legion supports proposed legislation with the abovementioned recommended changes.

The American Legion supports S. 1992 with amendments.

S. 2061, the Molly R. Loomis Research for Descendants of Toxic Exposed Veterans Act of 2025 (Blumenthal/Murray)

To require the Interagency Working Group on Toxic Exposure to conduct research on the diagnosis and treatment of health conditions of descendants of individuals exposed to toxic substances while serving as members of the Armed Forces, and for other purposes.

The *Molly R. Loomis Research for Descendants of Toxic Exposed Veterans Act* would commission first-of-its-kind, landmark research on birth defects among descendants of toxic-exposed veterans, enabled by the PACT Act. Veterans exposed to toxins during their military service are more likely to develop certain medical conditions, such as rare cancers, heart conditions, and chronic lung ailments, as a direct result of their toxic exposure. Descendants of these toxic-exposed veterans are also likely to experience conditions, such as spina bifida, related to their parents' or grandparents' exposure to toxic chemicals. While there has been some research on the link between birth defects and generational exposure to toxins and chemicals, there has yet to be comprehensive government-led studies into the effects of toxic exposure on descendants of toxic-exposed veterans.

The congenital effects of toxic exposure on the descendants of service members were widely unknown until a 1979 congressional hearing before the House Committee on Interstate and Foreign Commerce.[17] Since then, military families who experience serious congenital conditions have been left with fear and uncertainty as to what the long-term impacts will be, and whether they will be provided with care. In 1997, the children of Vietnam veterans who suffer from spina bifida were authorized presumptive health care, and this was expanded in 2001 to include other conditions, but only for children of female Vietnam veterans. Toxic exposure coverage for the descendants of veterans has not been expanded since this 2001 provision, despite the implementation of the PACT Act and many other scientific and legislative advancements over the years.

[17] U.S. House of Representatives, Subcommittee on Oversight and Investigations, Committee on Interstate and Foreign Commerce. Involuntary Exposure to Agent Orange and Other Toxic Spraying: Hearings before the Subcommittee on Oversight and Investigations, Committee on Interstate and Foreign Commerce, House of Representatives, Ninety-Sixth Congress, First Session, June 26 and 27, 1979. Serial No. 96-139. Washington D.C.: U.S. Government Printing Office, 1980

Our knowledge of medicine and genetics has grown immensely in the last 24 years, particularly our understanding of transgenerational effects including epigenetics, or how gene expression can be affected by environmental factors.[18] The *Molly R. Loomis Research For Descendants of Toxic Exposed Veterans Act* would help offer insight into this issue by requiring the current interagency working group on toxic exposure to expand their research to include descendants of toxic exposed veterans. A study on the descendants of toxic exposure victims from our more recent conflicts would be a positive first step in extending benefits to those descendants who were affected by their parent servicemember's toxic exposure.

The American Legion Supports S. 2061 as currently written.

S. 2220, the Fighting for the Overlooked Recognition of Groups Operating in Toxic Test Environments in Nevada (FORGOTTEN) Veterans Act of 2025 (Rosen/Cortez Masto)
To expand presumptions of exposure by members of the Armed Forces to toxic substances, and for other purposes.

The *FORGOTTEN Veterans Act of 2025* expands presumptive radiation exposure to members of the Armed Forces who served in Nevada's Test and Training Range (NTTR) and nearby locations. Inexplicably, while former Department of Energy (DoE) employees are covered under the *Energy Employees Occupational Illness Compensation Program Act* (EEOCPA) for their radioactive exposure claims, former service members worked alongside DoE employees are left to fend for themselves. [19]

The *Radiation Exposure Compensation Act* (RECA) 42 U.S.C. § 2210 note and the EEOCPA only set aside trust funds to handle Department of Energy (DoE) employees' claims for the over 200 atmospheric nuclear weapons development tests as part of a Department of Labor's Office of Worker's Compensation program.[20] While monumental passage of the *Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics (PACT) Act of 2022* was an encouraging step in establishing three new radiation presumptive locations (i.e., Enewetak Atoll; Palomares, Spain; and Thule AFB, Greenland), they were all overseas cleanup sites, and domestic sites in Nevada were left out.

Nevadan legislators have introduced legislation over the years, such as the *Justice for Atomic Veterans Act of 1998* and *Recognition of Forgotten Atomic Veterans and their Surviving Spouses Act of 2005,* to address the servicemembers working at NTTR, a classified nuclear test range site. But this legislation has largely failed as veterans have faced difficulties accessing classified records to prove their presence at the site and their exposures.

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[18] Beck, D., Nilsson, E.E., Ben Maamar, M. et al. Environmental induced transgenerational inheritance impacts systems epigenetics in disease etiology. Sci Rep 12, 5452 (2022). https://doi.org/10.1038/s41598-022-09336-0
[19] U.S. Congress. Recognition of Forgotten Atomic Veterans and their Surviving Spouses Act of 2005, H.R. 4183, 109th Cong. (2005).; U.S. Congress Justice for Atomic Veterans Act of 1998, S.1385, 105th Cong. (1998)
[20] U.S. Department of Justice, Civil Division. "Radiation Exposure Compensation Act (RECA)." Last updated November 21, 2025. Accessed November 21, 2025. https://www.justice.gov/civil/reca.

The American Legion urges that new presumptive conditions and locations continue to be identified and included through the decision process established by The PACT Act. However, there are two situations where this process does not yield satisfactory results: Veteran's whose military locations and activities are classified, and exposures which affect such a small number of individuals that they are not good candidates for epidemiological research. The veterans who worked at NTTR meet both conditions, they are few and they conducted classified military activities. For this reason, bypassing the PACT Act presumptive decision process for these veterans is warranted.

A technical correction The American Legion would like addressed in markup is the removal of section 6 and 7 of S. 2220. While we fully support sections 1 to 5, sections 6 and 7 add the NTTR cohort to presumptive lists intended for post-Gulf War veterans who served overseas and were exposed to burn-pits. This cohort would be the only cohort included prior to 1990, and the only domestic cohort. In addition, Section 7 adds lipomas as service connected but only for this cohort. Cohort specific conditions are not present in either § 1119 presumptions of toxic exposure or § 1112(c)(3)(A) radiation-exposed veteran. The American Legion is supportive of adding lipoma to the radiation risk activity presumptive list under § 1112(c)(2)(V), and "Any other disease or condition for which the Secretary determines relevant" under § 1112(c)(2)(W) for continued flexibility anticipating emerging research.

Easing the burden of proof by establishing a presumptive radiation location for radiation-exposed veterans stationed at NTTR and ensuring that pertinent classified and medical information is properly tracked in ILER for VA disability claims and benefits purposes will remove the arduous appeals and litigation process. Broadening the definition of "radiation-risk activities" to beyond just "nuclear testing" by including activities such as the "development, construction, operation, or maintenance of military installations" will ensure justice for our atomic veterans and their families.

The American Legion can support through Resolution No. 41: *Radiation-Exposed Veterans* which urges Congress to designate these atomic veterans as "radiation-exposed veterans" and ensure that they are eligible for the same health care and other benefits as other servicemembers who were involved in active nuclear tests.

The American Legion supports S. 2220 with amendments.

S. 2264, the Advancing VA's Emergency Response to (AVERT) Crises Act of 2025 (Blumenthal)

To improve the emergency management capabilities of the Department of Veterans Affairs, and for other purposes.

This legislation would require the VA to produce comprehensive reports to Congress on VA's emergency management roles and the VA's regional readiness centers. It would also require the Secretary of the Department of Veterans Affairs to work with the Administrator of the Federal Emergency Management Agency (FEMA) to produce a plan on how to facilitate fuel sharing during times of emergency.

VA's Fourth Mission is to "improve the nation's preparedness for response to war, terrorism, national emergencies, and natural disasters by developing plans and taking actions to ensure continued service to Veterans, as well as to support national, state, and local emergency management, public health, safety and homeland security efforts."[21] This bill would directly help that effort by improving plans between VA and FEMA and helping Congress provide better oversight over VA's Fourth Mission.

The American Legion can support this resolution through Resolution No. 188: *Department of Veterans Affairs' Role in National Emergency Preparedness*. This resolution urges VA to continue taking an active role in emergency preparedness and ensure adequate funding for VA to carry out their Fourth Mission. Keeping Congress better appraised of the program will help to improve planning and funding.

The American Legion supports S. 2264 as currently written.

S. 2309, the Veteran Burial Timeliness and Death Certificate Accountability Act (Boozman/Hassan/Cornyn)

To direct a physician or nurse practitioner employed by the Secretary of Veterans Affairs to certify the death of a veteran not later than 48 hours after such physician or nurse practitioner learns of such death, and for other purposes.

During the COVID pandemic, VA doctors who were hesitant to sign off on death certificates for natural causes cited that they were either unqualified to do so or had only seen their patient virtually through telehealth rather than in-person.[22] Furthermore, when a family turns to a county or state coroner/medical examiner, those offices often cite unfamiliarity of the veteran's medical history or the time-consuming process of securing a veteran's pertinent medical records held by VA as impediments for a timely decision. Delays could range up to six weeks to certify a natural death cause.

Delays in securing a veteran's death certificate impedes the surviving family's ability to properly plan for burial. Moreover, survivors reported being locked out of the deceased veteran's checking or savings accounts, thus delaying the ability to settle a veteran's outstanding financial obligations. Legislation is needed to clearly define the VA's medical responsibility to better support families during end-of-life planning. Veterans and their surviving families expect and deserve a more expeditious means to procure a death certificates involving a natural cause.

Introduced legislation would direct VA physicians and nurse practitioners to task of certifying and signing off a death certificate no later than 48 hours of learning of, or being notified of, the veteran's death. By clarifying roles and setting a clear timeline for obtaining a signed death

[21] "VA's Fourth Mission." The Department of Veterans Affairs. Accessed November 19, 2025. https://www.va.gov/VHAEMERGENCYMANAGEMENT/docs/4TH-MISSION_FAQs_508.pdf.

[22] Anoka County Commissioners' letter to McDonough (Jun 24, 2024) https://kstp.com/wp-content/uploads/2024/10/Draft-letter-to-VA-Secretary.pdf ; Henry, Ben. "Some Veteran Families Delayed in Getting Death Certificate; Congress Working to Get Data from VA." KSTP (KSTP-TV), October 9, 2024. Accessed November 25, 2025. https://www.kstp.com/kstp-news/top-news/some-veteran-families-delayed-in-getting-death-certificate-congress-working-to-get-data-from-va

certificate, the proposed legislation helps families access VA burial and VA survivor benefits. The American Legion can support with amendments.

As currently written, proposed legislation restricts primary care provider to be either VA Physicians or Nurse Practitioners and omits VA Physician Assistants (PAs) when many states (such as Pennsylvania, North Carolina, and Colorado) grant PAs the ability to sign death certificates under certain circumstances. The American Legion proposes the including VA Physician Assistants to sec. 3(a)(1) increasing the number of available professions able to expedite the certification of a death of a natural cause.

The American Legion Supports S. 2309 with amendments.

S. 2328, the Military Learning for Credit Act of 2025 (Coons/Ernst)

To authorize the use of veterans educational assistance for examinations and assessments to receive credit toward degrees awarded by institutions of higher learning, and for other purposes.

The *Military Learning for Credit Act* will expand the use of VA education benefits by allowing student-veterans and eligible beneficiaries to use part of their education benefits for tests and exams that count toward a college degree. This change enables beneficiaries to conserve their entitlement when they can demonstrate competency in a subject through an approved test or exam. Whereas previously, a student would use an entire semester's worth of benefits for the same outcome. Now, students have greater flexibility to complete their degrees while preserving the benefits they have earned.

The American Legion supports this legislation through Resolution No. 338: *Support Licensure and Certification of Servicemembers, Veterans, and Spouses.*

The American Legion Supports S. 2328 as currently written.

S. 2397, the Caring for our Veterans Health Act of 2025 (Ricketts/King)

To require implementation by the Under Secretary for Health of the Department of Veterans Affairs of certain recommendations relating to the provision of health care through community care providers, and for other purposes.

The *CARING for Our Veterans Health Act of 2025* requires VA to implement new guidelines ensuring that medical documents are properly tracked after community care appointments and would also measure how long it takes for veterans to get community care records. It also requires the VA to report to Congress on steps it has taken to implement these changes. These changes would help ensure that VA's standard of care and record keeping is consistent across care in VA facilities and in the community.

The American Legion can support this legislation through Resolution No. 13: *Standards and Training for Community Care Providers.* This resolution urges VA to hold community care providers to the same standards of care as treatment at VA facilities. By ensuring proper record

keeping and access by community providers, this bill helps to achieve those consistent standards across veteran care.

The American Legion supports S. 2397 as currently written.

S. 2683, the VSAFE Act of 2025 (Cornyn/Hassan/Boozman/King)

To amend title 38, United States Code, to establish in the Department of Veterans Affairs a Veterans Scam and Fraud Evasion Officer, and for other purposes.

The Federal Trade Commission (FTC) has noted an uptick in identity theft and other forms of financial crimes in the military & veteran communities, where it has received a two-fold increase in fraudulent reports.[23] In 2021, the American Association of Retired Persons (AARP) noted that the military/veteran communities were 40% more likely to lose money to fraudsters than their civilian counterparts, and that four out of five military/veteran adults were targeted by scams tied to their unique military benefits.[24]

From complex student loan scams and scholarship scams to impersonating government officials from a beneficiary agency, scammers have used increasingly unscrupulous tactics to prey on our nation's veteran population.[25] These scams are often successful with service members and veterans dealing with mental health challenges or physical injuries which can diminish their capacity to manage day-to-day finances.[26] As financial scams and identity theft become increasingly sophisticated, The American Legion urges more to be done.

This proposed legislation would create a dedicated position in VA to oversee the necessary analytical monitoring, tracking, and coordination of scam and fraud prevention efforts with other federal agencies and Veterans Service Organizations in real time. This effort will improve the overall awareness of potential scams and create much-needed protection for vulnerable veterans. The American Legion strongly supports the proposal via Resolution No. 11: *Support Veteran and Reserve Servicemember Financial Protections*. This resolution calls for sound financial protection for veterans and reserve servicemembers against unscrupulous and predatory lenders.

The American Legion supports S. 2683 as currently written.

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[23] U.S. Congress, House, Protecting Military Servicemembers and Veterans from Financial Scams and Fraud: Prepared Statement of the Federal Trade Commission Before the House Subcommittee on National Security, 117th Cong., 2d sess., July 13, 2022

[24] AARP. "AARP Survey: Veterans More Likely to Lose Money to Scams Than Civilians." *AARP Press Center*, November 9, 2021. https://press.aarp.org/2021-11-9-AARP-Survey-Veterans-More-Likely-to-Lose-Money-to-Scams-Than-Civilians.

[25] U.S. Department of Veterans Affairs. "Fraud Prevention." Accessed June 2, 2025. https://benefits.va.gov/BENEFITS/fraud-prevention.asp.

[26] "Letter to U.S. Representative Julia Brownley in Support of the Protecting Our Veterans from Financial Fraud Act, July 13, 2015." The American Legion Digital Archive, July 13, 2015. https://archive.legion.org/node/15416.

Senate Discussion Draft, the Veterans National Traumatic Brain Injury Treatment Act (Tuberville)

To require the Secretary of Veterans Affairs to implement a pilot program to furnish hyperbaric oxygen therapy to certain veterans through community care providers, and for other purposes.

Hyperbaric oxygen therapy (HBOT) is a commonly used treatment for a variety of medical issues, including more than a dozen currently approved uses. However, there are alternative proposed uses that have significant implications among an active-duty military or veteran population as treatments for PTSD, mild traumatic brain injury (mTBI), and traumatic brain injury (TBI). These applications have seen a recent groundswell of support from the operator and veteran communities, raising the visibility of using HBOT for alternative applications.[27]

In multiple randomized and controlled clinical trials, HBOT demonstrated statistically significant symptomatic improvements, Reliable Changes, or Clinically Significant Changes in patients with PTSD symptoms or diagnosed PTSD across a wide range of pressure and oxygen doses. The highest doses were associated with a severe reversible exacerbation of emotional symptoms in 30-39% of subjects. Symptomatic improvements were supported by correlative functional and microstructural imaging changes in PTSD-affected brain regions. The imaging findings and hyperbaric oxygen therapy effects indicate that PTSD can no longer be considered strictly a psychiatric disease.[28]

This legislation seeks to provide veterans who rely on the VA for their healthcare needs access to HBOT as a treatment option for PTSD and TBI symptoms. It establishes a three-year pilot program, limited to two Veterans Integrated Service Networks (VISN) nationwide, to allow VA researchers to collect clinical data within VA facilities. The bill also mandates the Comptroller General of the United States to submit an update to the GAO's December 18, 2015 report (GAO-16-154) on HBOT for treating traumatic brain injury and post-traumatic stress disorder within a year. The report is a compilation of peer reviewed and published articles regarding research on the use of HBOT, and the update would incorporate the last 10 years of peer reviewed research identifying HBOT as a treatment for TBI and PTSD.

The requirement that participating facilities be accredited by the Joint Commission, the Undersea and Hyperbaric Medical Society, or a similar accrediting authority lends credibility to the program and ensures the research produced meets rigorous standards. Should the findings prove positive, the data will support potential expansion of HBOT services across the VA. Funding for this legislation would come from the VA HBOT Fund within the U.S. Treasury's General Fund, consisting solely of donations made to the Secretary for the explicit purpose of supporting these services.

Section 4 of this legislation provides an amendment to Section 5503(d)(7) of title 38, United States Code, extending this subsection from expiring on November 30, 2031, to October 30, 2034. If a veteran in this subsection has neither spouse nor child and has a Medicaid plan, or a State plan for

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[27] Biggs, Adam T., Lanny F. Littlejohn, and Hugh M. Dainer. "Alternative uses of hyperbaric oxygen therapy in military medicine: current positions and future directions." Military Medicine 187, no. 1-2 (2022): e40-e46.
[28] Andrews, Susan R., and Paul G. Harch. "Systematic review and dosage analysis: hyperbaric oxygen therapy efficacy in the treatment of posttraumatic stress disorder." Frontiers in Neurology 15 (2024): 1360311.

medical assistance and is receiving services from a state furnished nursing facility, then no pension in excess of $90 shall be paid to or for the veteran. The American Legion proposes the removal of this section is an unrelated issue to treating PTSD and TBI symptoms with HBOT.

For nearly a decade, The American Legion has advocated for the implementation of new and innovative treatments for TBI and PTSD. The American Legion strongly supports the main proposal within this legislation through Resolution No. 165: *Traumatic Brain Injury and Post Traumatic Stress Disorder Programs*. This resolution calls for oversight and funding for the innovative research of TBI and PTSD through HBOT.

The American Legion supports this draft with amendments.

Senate Discussion Draft, the Fisher House Availability Act (Moran)

To amend title 38, United States Code, to direct the Secretary of Veterans Affairs to make temporary lodging facilities of the Department of Veterans Affairs available for members of the Armed Forces, other individuals on active duty, and family members of such individuals on a space available basis, and for other purposes.

The Fisher House Foundation was created by Zachery and Elizabeth M. Fisher in 1990.[29] The original project cost 20 million dollars to provide temporary, comfortable homes for families of hospitalized military personnel, the most notable of which is at Walter Reed Medical Center in Bethesda, MD.[30] When one of these homes reaches capacity, the Fisher House Foundation has an additional resource called Hotels for Heroes, providing accommodations for service members, family, and close friends closer to a medical facility.[31] Taken together, these programs house 1,400 military and veteran families on a nightly basis in the U.S. and abroad.

This legislation seeks to expand this capability by making temporary lodging facilities on VA campuses available to members of the Armed Forces when the covered beneficiary must travel a significant distance to receive care at a non-VA facility. This will be given on a space-available basis. Military and veteran family members with patients that are being treated at a military or VA hospital are currently eligible to stay at a Fisher House or utilize the Hotels for Heroes program.[32]

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

The American Legion supports the draft legislation as currently written.

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[29] Zachary Fisher - Builder, Philanthropist, Patriot - Fisher House Foundation https://fisherhouse.org/about/our-history/zachary-fisher/.

[30] Fisher House Foundation, "Fisher House Foundation is On the Road to 100." Sept 28, 2022. https://fisherhouse.org/stories/articles/fisher-house-foundation-is-on-the-road-to-100/.

[31] Fisher House Foundation, Hotels for Heroes. https://fisherhouse.org/programs/hotel-for-heroes/.

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

Senate Discussion Draft, the Leveraging Integrated Networks in Communities for Veterans Act (Sullivan)

To require the Secretary of Veterans Affairs to carry out a pilot program to establish community integration network infrastructure for services for veterans, to require the collection from veterans of information related to social determinants of health, and for other purposes.

After leaving military service, veterans typically face a litany of issues in their lives as they attempt to reintegrate into the civilian population. The first issues faced after departure from active service are typically housing and employment. Veterans are often underemployed, leading to financial difficulties that result in issues with nutrition, transportation, childcare, and career development. Additionally, veterans begin to navigate a system of care to address their wounds of war, including disability assistance, treatment for MST or sexual assault, suicide prevention, medical and care needs, and legal aid. To resolve these difficulties and prevent as many of these issues from compounding as possible, a comprehensive integrated resource from VA would allow veterans to prepare for and resolve many of these issues with trusted sources of information and assistance.

This legislation seeks to establish a nationwide pilot program for an interoperable community integration network, connecting VA facilities with public-private partnerships to deliver health and social serves to veterans in need of assistance. The services would include the key social determinants of health (SDoH): nutritional assistance, housing, health care, transportation, job training, child development or care, caregiving or respite care, disability assistance, suicide prevention, sexual assault services, legal aid, transition services, and other services determined by SECVA. The intent is to leverage and enhance current technology networks, or create one through the VA's Center for Innovation for Care and Payment, to connect VA medical centers with community-based organizations, state and local agencies, health information exchanges, and housing authorities to serve veterans.

These network connections would include referral management support, capacity tracking, and outcome monitoring, while ensuring privacy protections for the veteran. The pilot program would be tested in a minimum of one facility in every VISN to ensure coverage nationwide while also coordinating with existing community networks and integrating with state Medicaid programs through guidance from the Department of Health and Human Services. A key component of this legislation is data collection, primarily through ICD-10 Z-codes and SDoH. By incorporating screening of veterans SDoH in routine medical care and tracking referral accuracy, provider response times, and initial encounter outcomes, the report to Congress three years after implementation will identify met and unmet needs and deliver the necessary information on how to improve this program. A year later, at the fourth-year mark, the GAO must conduct an independent evaluation of the program as well.

SECVA should work closely with VSOs to ensure this program can be successfully delivered to veterans. Receiving feedback throughout the pilot period and for the development of the 3-year report will ensure accurate and honest feedback from the veterans who participated. The Secretary should have the final approval authority regarding organizations involved with this program.

Our support for this legislation is provided by Resolution No. 8: *Implementation of the Assessing Circumstances and Offering Resources for Needs Program of the Department of Veterans Affairs*. The American Legion strongly urges Congress to implement the proposed legislation with appropriate guard rails to ensure that organizations listed and used through referral services do so in a manner that protects a veteran's privacy, security, and best interests. The added language should mirror a similar program that the VA already has in place that,

> "aims to: 1) systematically screen veterans for health-related social needs in nine domains (food, housing, utilities, transportation, education, employment, legal, social isolation/loneliness and digital needs); 2) provide clinical care teams real-time information about veterans' unmet needs; and 3) address identified needs through the provision of resources and referrals, including offering resource guides, support navigating resources, and/or referrals to social work or other relevant VHA and non-VHA services."[33]

The American Legion supports this draft with amendments.

Senate Discussion Draft, the SERVE Act (Moran)

To improve the availability of care for veterans from facilities and providers of the Department of Defense, and for other purposes

Since 1982, the DOD and the VA have been authorized to share resources.[34] Currently, the Departments have over 185 shared agreements.[35] One such agreement is that veterans may receive care at DOD facilities for the following specialties: surgery, orthopedics and mental health. The SERVE Act will provide additional access of care for veterans by mainstreaming other types of healthcare that may also be received at healthcare facilities run by DOD. This agreement offers significant cost savings and reduces the need for sending veterans into the community for care. Although these sharing agreements are in place, DOD and VA do not have a performance management system that would monitor the use of the agreements. It must be noted that a recent 2025 GAO report recommended a systemic process to implement new and expanded joint sharing agreements.[36]

Sharing agreements offer cost savings for both DOD and VA. Between 2020 and 2024, VA's healthcare budget increased by 50%; while during the same period, the DOD's healthcare budget increased by 17%. According to 38 U.S. Code 8111- Sharing of Department of Veterans Affairs and Department of Defense health care resources, the DOD-VA Health Care Sharing incentive

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[33] "Resolution No. 8: Implementation of the Assessing Circumstances and Offering Resources for Needs Program of the Department of Veterans Affairs." The American Legion Resolutions Archive, n.d. https://archive.legion.org/node/17152.

[34] U.S. Department of Defense, Department of Defense-Department of Veterans Affairs Health Care Collaboration (presentation, Health.mil, August 20,2015), https://health.mil/Reference-Center/Presentations/2-15/08/Department-of-Defence-Department-Of-Veteran--Affairs-Health-Care- Collaborations.

[35] Government Accountability Office. VA and DOD Health Care: Agreements to Share Services and Other Resources Should Be Evaluated. GAO-25-107497. Washington: Government Accountability Office, June 30,2025. GAO-25-107497, VA AND DOD HEALTH CARE: Agreements to Share Services and Other Resources Should be Evaluated, https://www.gao.gov/assets/gao-25-107497.pdf.

[36] Ibid

fund is jointly administered by the Secretary of Veteran's Affairs and the Secretary of Defense, and requires each department to contribute a minimum of $15,000,000 each.[37] However, this joint incentive program is scheduled to terminate on September 30, 2026, thus necessitating for more permanent legislative fixes.

There are many retired veterans who already qualify for care at both DOD and VA facilities. DOD facilities are geared towards maintaining military readiness, while VA's goal is to provide quality care for veterans.[38] Moreover, there are many medical specialties provided at VA which are often beneficial to medical retirees. The American Legion believes that sharing agreements between the VA and DOD increase access to specialized services for veterans. Support for this legislation is found in Resolution No. 14: *Access to Care*. Veterans deserve access to specialized care, and military installations are a perfect component of this care for the veteran community because they know the needs of people who have served.

The American Legion supports this draft as currently written.

Senate Discussion Draft, the Improving Access to Care for Rural Veterans Act (Duckworth/Blackburn)

To require the Secretary of Veterans Affairs to establish partnerships between medical facilities of the Department of Veterans Affairs and rural hospitals, and for other purposes.

There are more than 4.7 million veterans that live in rural areas across the country.[39] Rural veterans account for 35% of the veterans that are enrolled in the VA healthcare system.[40] Often, veterans living in rural areas are forced to drive hours just to get to their VA medical appointments. The time and distance to VA medical facilities leads to missed appointments, potentially undiagnosed conditions, and issues in treating chronic conditions that many veterans face while living in rural areas.

The American Legion developed the System Worth Saving Program in 2003 and made it a permanent program through resolution the following year. For the past two decades, The American Legion has conducted visits to VA medical centers and outpatient clinics to identify best practices and areas of improvement. According to a 2024 System Worth Savings Report from Raymond G. Murphy Veterans Hospital in Albuquerque, New Mexico, the executive leadership team on at least two occasions proposed initiatives to better support rural veterans in the hospital's catchment area, some of whom reside as far as seven to eight hours from the nearest VA Medical Center.

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[37] 38 U.S. Code 8111-Sharing of Department of Veterans Affairs and Department of Defense health care resources
[38] The American Legion, "Statement of Steve Robertson" Armed Services Subcommittee on Military Personnel. U.S. House of Representatives on VA-DOD Health Care Sharing". https://archive.legion.org/node/7417.
[39] Press Release, "Sen. Ossoff Leading Bipartisan Push to Strengthen Health Care Services for Veterans in Rural Georgia", June 22,2022, https://www.ossoff.senate.gov/press-releases/sen-ossoff-leading-bipartisan-push-to-strengthen-health-care-services-for-veterans-in-rural-georgia%EF%BF%BC/
[40] The American Legion, "$600,000 VA Transportation grant helps Legion Post serve rural veterans", November 10, 2020, https://www.legion.org/information-center/news/veterans-healthcare/2020/november/600000-va-transportation-grant-helps-legion-post-serve-rural-veterans

One proposal would use remote Community Based Outpatient Clinics for high need specialty care such as oncology, dermatology, pulmonology, and ophthalmology as these were identified as most in need for the veterans in rural areas. Additionally, the hospital has explored the possibility of standing up their own transportation program to take veterans to their specialty care appointments, but staffing shortages were a constant issue with the program.[41] However, without legislation authorizing appropriations for these services, the effort remains only a proposal. This legislation would help launch these programs and generate positive data needed to support potential expansion.

The draft legislation will establish partnerships between VA and rural hospitals, allowing for the rural sites to be designated as VA-authorized care sites. Their collaboration will allow VA's reach to be extended to the veterans under their care in rural and highly rural communities while also assisting with the capabilities and capacities of these medical facilities. Additionally, if a facility is unable to create a partnership or if it is simply not needed or necessary, the SECVA can establish a waiver for up to five years.

The American Legion strongly urges Congress to require the establishment of partnerships in these rural communities through the Department of Veterans Affairs. The American Legion supports programs that benefit rural populations through Resolution No. 22*: Public/Private Partnership with the Department of Veterans Affairs to Expand Reach with Local Hospitals* and Resolution No. 119: *Support More Service Programs Benefiting the Rural Veteran*. With the growing number of veterans using VA health care, we must ensure that all veterans have access to the medical care that they have earned.

The American Legion supports this draft as currently written.

Senate Discussion Draft, the Commission on Equity and Reconciliation in the Uniformed Services Act (Blumenthal)

To establish the Commission on Equity and Reconciliation in the Uniformed Services.

The proposed legislation will establish a commission tasked with the identification and compilation of DoD's historic policies concerning the policing of sexual orientation and gender identity within the uniformed services from World War II to present. Additionally, proposed legislation would require factsheets and examination of ramifications of such targeted policies onto the military LGBTQ+ community, such as the physical, mental, and financial tolls.

Members of the LGBTQ+ community have a long history of facing discrimination within the service. Famously, the Don't Ask Don't Tell (DADT) policy administratively service separated those 'outed' with an Other-than-Honorable (vs. Honorable) discharge.[42] Not only were their military careers abruptly cut short, but their discharge status barred them from obtaining VA benefits that they had earned.

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[41] System Worth Saving - Raymond G. Murphy VAMC, n.d. https://www.legion.org/systemworthsaving/reports.
[42] American Legion, National Headquarters (Washington, DC), Statement of Tiffany Ellett, Deputy Director of Health Policy, National Veterans Affairs and Rehabilitation Division, The American Legion before the Subcommittee on Oversight & Investigations, Committee on Veterans' Affairs, United States House of Representatives on "Legislative Hearing," March 30, 2022, https://archive.legion.org/node/14853.

While the veteran LGBTQ+ community has won some recent victories such as in 2021, where those discharged under DADT were made eligible for VA benefits, or the recent January 2025 class action to remove any reference of being discharged under DADT in official discharge papers, more is required to ensure servicemembers are made whole.[43] The proposed legislation will devise a 15-person commission, to be dissolved 90 days after delivering a report on recommendations to better streamline and make more transparent each service branch's Military Correction Review Boards (MCRBs), proposals to better compensate for lost time and lost professional opportunities, possible backpay, and means to reinstate gender affirming care at VA, among other matters.

Through the years, The American Legion has supported equity for all LGBTQ+ veterans. During the 2020 legislative address to Congress, then-National Commander Oxford affirmed VA's need to ensure equitable care for LGBTQ+ veterans.[44] As proposed legislation seeks to remedy past discriminatory policies onto the LGBTQ+ community, The American Legion can support through resolution No. 10: *Care for the Lesbian, Gay, Bisexual, Transgender, Queer+ (LGBTQ+) Veteran Community.*

The American Legion supports this draft as currently written.

Senate Discussion Draft, the Get Justice Involved Veterans BACK HOME Act (King)
To improve the provision of services from the Department of Veterans Affairs to incarcerated veterans, and for other purposes.

The proposed legislation seeks to address several issues facing justice-involved veterans: healthcare, disability compensation, and tracking veteran status in correctional facilities. As the law is currently written, VA is prohibited from providing medical services to incarcerated veterans, as they are considered to be under the primary custody of another governmental agency, such as the Bureau of Prisons (BOP). The combined effects of service-connected conditions like PTSD and traumatic conditions in prisons increase the need for reliable healthcare for incarcerated veterans, who are particularly vulnerable to suicide. Additionally, as housing, clothing, meals and healthcare are all provided through the Federal, state, or local penal institution or correctional facility while incarcerated, a veteran's monthly disability compensation undergoes apportionment, which creates financial stressors and additional barriers to being able to transition successfully post incarceration. Finally, there is no standard definition or process for identifying veterans in correctional facilities, which makes tracking veterans in need of assistance extremely difficult.

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[43] Wolf, Mackenzie. "A Victory for LGBTQ+ Veterans Discharged under 'Don't Ask, Don't Tell.'" The American Legion, September 13, 2021. https://www.legion.org/information-center/news/veterans-benefits/2021/september/a-victory-for-lgbtq-veterans-discharged-under-dont-ask-dont-tell; and Almanza, Rikki. "Pentagon Reaches Settlement That Could Restore Benefits to LGBTQ+ Veterans Discharged under 'Don't Ask, Don't Tell.'" American Legion Department of California, January 9, 2025. https://calegion.org/pentagon-settlement-could-restore-benefits-to-lgbtq-veterans-discharged-under-dont-ask-dont-tell/.

[44] Raughter, John. "Oxford Presents American Legion Legislative Agenda to Congress." The American Legion, March 12, 2020. https://www.legion.org/information-center/news/commander/2020/march/oxford-presents-american-legion-legislative-agenda-to-congress.

This legislation would mandate VA to provide mental healthcare to incarcerated veterans currently under the Federal, state, or local penal institution or correctional facility's purview, with an emphasis on those with a service-connected disability related to PTSD, TBI, or MST. Care would be administered through telehealth, mobile health units through the VA/Vet Centers, and through the VA directly. Additionally, the bill allows the Secretary of Veterans Affairs to make the determination regarding mental health services through other means.

The bill also proposes that veterans whose disability compensation payouts are reduced during incarceration have their original entitlements restored upon release. Apportionment (for felony convictions) is automatically reduced to the 10% or 5% monthly VA disability rating when disabled veterans are incarcerated for more than 60 days. Disability payments are not reduced for recipients participating in work release programs, residing in halfway houses (also known as "residential re-entry centers"), or under community control. Reinstating original benefits would ensure that no justice-involved veteran continues to pay for their offenses after their sentence ends.

There are currently 107,400 veterans incarcerated in a state or federal facility, with one in five federally incarcerated veterans having been exposed to combat.[45] Moreover, as veterans diagnosed with PTSD or TBI are 61% and 59% more likely, respectively, to have entanglements with the legal system and become justice-involved, ensuring access to VA-led mental health support in the earlier phase of incarceration is imperative more than ever.[46] As noted within a 2021 GAO report, veterans who are successfully linked with a VA Veteran Justice Officer (VJO) specialist for both VA and non-VA services (e.g., substance use treatment, mental health services, housing support) demonstrate better social and mental health outcomes, stable housing, and had lower recidivism rates.[47] This proposed legislation calls for better processes to identify veterans in correctional facilities, for earlier access to mental health support, and streamlining of follow-on support such as legal and housing.

The American Legion supports proposed legislation through Resolution No. 18: *Mental Health Programs for Justice-Involved Veterans*, which supports legislation that establishes or funds programs or initiatives directed at providing mental health services for justice-involved veterans.

The American Legion supports this draft as currently written.

CONCLUSION

Chairman Moran, Ranking Member Blumenthal, and distinguished members of the Committee, The American Legion thanks you for your leadership and for allowing us the opportunity to provide feedback on legislation.

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[45] "Fact Sheet: Access to Justice Is Access for Veterans." DOJ: Office for Access to Justice, February 22, 2025. https://www.justice.gov/atj/fact-sheet-access-justice-access-veterans.
[46] Ibid
[47] "Veterans Justice Outreach Program: Further Actions to Identify and Address Barriers to Participation Would Promote Access to Services," Government Accountability Office (GAO), Report #GAO-21-564 September 14, 2021. https://www.gao.gov/assets/d21564.pdf .

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

STATEMENT FOR THE RECORD

Senate Committee on Veterans' Affairs

Legislative Hearing

December 10, 2025

from

American Psychological Association Services, Inc.
Association of VA Hematology/Oncology
Association of VA Nurse Anesthetists
Association of VA Psychologist Leaders
Association of VA Social Workers
National Association of VA Physicians and Dentists
Nurses Organization of Veterans Affairs
Veterans Healthcare Policy Institute

(All are independent organizations, not representing the Department of Veterans Affairs)

Chairman Moran, Ranking Member Blumenthal, and distinguished members of the committee:

On behalf of our organizations, we thank you for inviting us to submit a statement for the record for today's Full Committee Legislative Hearing on improving the care and services for veterans. Members of our organization are veterans, have family members who are veterans, had long careers serving veterans, published papers on veterans' healthcare in peer-reviewed journals, presented testimony to your committee, and have served on President Trump's President's Roadmap to Empower Veterans and End a National Tragedy of Suicide (PREVENTS) task force.

In today's statement, we wish to convey our appreciation for your leadership and commitment to ensuring that veterans receive the highest level of health care within the Veterans Health Administration (VHA) and supplementary care in the private sector when it's both needed and authorized by the VHA.

While today's hearing considers 24 bills, we limit our comments to only three of them—S.926, "Saving Our Veterans Lives Act of 2025" and S.2397, The Coordinating and Aligning Records to Improve and Normalize Governance for Our Veterans Health Act of 2025 (CARING Act) both of which we enthusiastically support, and S.1868, "Critical Access for Veterans Care Act of 2025," for which we have grave concerns.

Saving Our Veterans Lives Act of 2025 (S. 926)

The transformative importance of this bill cannot be overstated. With veteran suicide rates—particularly from self-inflicted firearm injuries—remaining persistently high, fresh approaches like this one are urgently needed.

The suicide mortality rate for America's veterans is double that of their civilian counterparts. Firearms are by far the most common lethal means, accounting for 74.8% of male veteran suicide deaths and 45.4% of female veteran suicide deaths—rates that greatly exceed those of non-veterans. [1]

Survivors of firearm suicide attempts consistently report that having a gun readily available at home was the primary reason for their method choice. [2,3] Contrary to common misperception, people who survive or are prevented from attempting suicide don't inevitably keep trying until they die by suicide. Suicidal crises often represent a conflicting desire to both live and die, [4] and research shows that two-thirds of those who survive even highly lethal attempts—such as jumping in front of a subway—never try again. [5, 6, 7]

The acute, high-risk phase of suicidal crises often arises suddenly. Studies reveal that approximately half of suicide attempts begin less than 10 minutes after the decision is made, frequently occurring during a relationship quarrel. [8, 9, 10, 11, 12] Most people who attempt suicide with a firearm never get a chance to reconsider—90% of such acts are fatal. [13]

Secure storage saves lives. Reducing quick access to firearms during personal crises has proven effective in preventing suicide deaths. [14] Many suicide attempts stem from brief periods of feeling overwhelmed rather than meticulous planning. Helping someone navigate the highest-danger period without ready access to lethal means significantly decreases their suicide risk, both immediately and long-term.

Individuals residing in homes where firearms are kept loaded and unlocked face higher suicide risk compared to those where firearms are stored locked and unloaded. [15, 16, 17, 18]

Fifty one percent of veterans own one or more personal firearms, and over half of these owners store weapons loaded and unsecured. [19] A third of veterans who store firearms loaded and unlocked don't own a lockbox or safe. [20] For many veterans, cost remains the primary barrier to owning a lockbox. [21]

Since 2012, VA has distributed free cable gun locks to any veteran who requests one. While cable gun locks are versatile and low cost, they are shunned by many veterans (and other firearm owners), who overwhelmingly favor lockboxes and safes to secure their guns. [22, 23, 24]

A VA pilot program is currently offering free lockboxes to enrolled veterans assessed to have moderate to high risk for suicide who request that one be shipped to them. The program is grounded on clinician need and adheres to an accreditation requirement of The Joint Commission as well as a recommendation from VA's Office of Inspector General (OIG Report 21-00175-19 dated November 17, 2022). It also aligns with recommendations from President Trump's first term "Roadmap to Empower Veterans and End a National Tragedy of Suicide (PREVENTS)."

But the pilot program lacks committed, sustainable funds or systemwide propagation to ensure it can reach the large number of veterans who would benefit from it. The "Saving Our Veterans' Lives Act of 2025" would greatly strengthen the pilot in two crucial ways:

Issue	Current Pilot	S.926
Allocations needed for program staffing	No sustained, dedicated funds	Would cover funding for staff: program manager, statistician, evaluator, and prosthetics staff
Allocations needed for lockboxes	No sustained, dedicated funds	Assures sufficient funding for tens of thousands of lockboxes to be distributed to veterans

As drafted, S.926 applies to all veterans—regardless of identified risk level or VHA enrollment status—making it far more inclusive than the existing pilot program. However, beginning on a smaller scale may be a more prudent pathway to demonstrate the evidence-informed proof of concept before contemplating expansion to veterans at lower risk. Under such a circumscribed approach, the educational materials delineated in the bill should be tailored to this targeted subpopulation.

VA does not currently provide biometric fingerprint-enabled lockboxes, as they are appreciably more expensive and less suited to the bill's intended purpose. It would be prudent to limit distributed lockboxes to ones requiring a key or numeric combination to open.

Importantly, the "Saving Our Veterans Lives Act" ensures that nothing in the legislation could be construed to collect personally identifiable information of an individual who participates in the program under the proposed section 1720K for purposes of tracking firearm ownership; require any individual to register a firearm with VA; require mandatory firearm storage for any individual; prohibit any individual from purchasing, owning, or possessing a firearm under 18 U.S.C. § 922; discourage the lawful ownership of firearms; or create or maintain a repository of individuals participating in the program. This wisely crafted language ensures that **protecting 2nd Amendment rights and protecting lives are complementary – not opposing – goals.**

Personally identifiable information would be collected for the purpose of evaluating program impact but not for tracking firearm ownership. This data would allow an understanding of the demographics of participating veterans, their general locations, and the types of storage solutions they receive.

Critical Access for Veterans Care Act of 2025 (S.1868)

Despite its straightforward title, this bill will not improve healthcare access, expedite care delivery, reduce travel burdens, or enhance critical care capacity for rural veterans.

It would, however, undermine the carefully designed eligibility requirements that determine when veterans may receive services from Veterans Community Care Program (VCCP) providers

under VA MISSION Act of 2018 provisions. That will ultimately diminish options and make it harder for many veterans to access needed care.

The legislation allows veterans living within 35 miles of designated Critical Access Hospitals (CAH) to bypass VA entirely and self-refer to these private facilities. The bill's authors claim that option will assure veterans quicker access to services, because rural veterans are being left, "without timely access to the high-quality care" and "offers veterans new options for health care in rural areas where there might not be a VA health facility nearby." [25] These "timely access," "new options," and "no facility nearby" assertions are untrue in two fundamental ways.

First, the VA MISSION Act of 2018 created the Veterans Community Care Program that guarantees veterans emergency medical and psychiatric care, as well as walk-in urgent care, anywhere. Veterans can also access private sector outpatient care if they would wait more than 20/28 days for an appointment at, or drive more than 30/60 minutes to, a VA medical center or clinic. Whenever that's the case, the VA offers the option for VCCP care, including at CAHs and their outpatient clinics.

Second, a vast number of CAHs are well within the 35-mile radius of VA facilities. For example, the full-service Grand Junction, Colorado VA Medical Center, serving 37,000 veterans, sits only 13 miles from Family Health West Hospital. The Altoona Pennsylvania VA Medical Center, serving 26,000 veterans, is 17 and 24 miles from Penn Highlands Healthcare and Conemaugh Miners Medical Center. White River Junction, Vermont's VA Medical Center is 5 miles from a Critical Access Hospital; Beckley, West Virginia's VA 14 miles away.

Add to that hundreds of Critical Access Hospitals that are located within the 35-mile radius from a VA Community-Based Outpatient Clinic (CBOC). Ohio has 32 and Michigan has 28 Critical Access Hospitals near VA clinics. Eleven of Montana's 15 CBOCs are proximate to a CAH, eight of those less than three miles away. The VA clinics in Jamestown and Devils Lake, North Dakota and in Plentywood, Montana are in the same buildings as the local CAH.

The problem lies in how this legislation redirects veterans from VA CBOCs and rural VA hospitals to CAH care. When veterans shift their care elsewhere, VA funding follows them out the door. As patient volumes decline, VA facilities will face budget cuts that force reductions of programs or closures of clinics that other veterans prefer and rely on. What happens to the rural veterans who never wanted to go anywhere else? They'll face a private sector desert that can barely meet current demand, let alone absorb tens of thousands more patients

America's healthcare system—particularly in rural areas where a quarter of all veterans live [26]—is in crisis. Over 100 hospitals have closed in the past 15 years, while more than 700 rural hospitals are on the brink of bankruptcy and over 300 are at risk of immediate closure. [27] Closures force patients to travel longer distances for care, leading some to forgo treatment entirely. The consequences are especially severe for those with limited mobility and patients experiencing time-sensitive emergencies like heart attacks.

The situation will only worsen. Medicaid cuts over the next decade are projected to strip 10 million people of healthcare coverage. With fewer patients seeking treatment and more unable to

pay for care in emergency departments, rural hospitals stand to lose $70 billion, [28] accelerating closures and service reductions.

The lack of healthcare providers compounds these problems. Eighty-six percent of U.S. counties are designated as primary care health professional shortage areas. [29] This scarcity can be deadly—insufficient primary care providers directly correlate with higher hospitalization rates and increased mortality. [29]

The mental health crisis is even more dire. One hundred sixty million Americans live in areas with mental health professional shortages; [31] 70-80 percent of rural counties have no psychiatrist at all; [32] 61% lack psychologists. This is particularly catastrophic for post-9/11 veterans, 58 percent [33] of whom have mental health conditions requiring specialized care.

The Critical Access for Veterans Care Act dismisses the critical importance of VA authorization, calling the role an "unnecessary roadblock" that should be abolished. This characterization fundamentally misrepresents both the function and value of the authorization process.

VA authorization and monitoring with the private sector was specifically mandated by the MISSION Act precisely because it is the only way, as a payor, VA can assure that taxpayer dollars are well spent and that veterans do not receive unnecessary, duplicative, or harmful treatment. This kind of utilization review is standard practice for third parties who pay for patient care and services. In this legislation eliminating pre-authorization, for example, it will be difficult for the VA to verify that a veteran treated by a CAH lives within the 35-mile radius.

Private doctors, regardless of their good intentions, lack the specialized training and integrated systems that make VA care uniquely effective for veterans with service-related conditions. Multiple studies [34] confirm that properly funded VA care delivers, on average, higher quality outcomes than private alternatives.

Veterans depend on the VA's integrated care, which are often unavailable in the private sector. Congress would be better focusing on strengthening and expanding these vital VA services.

We support one provision in the legislation: aligning CAH healthcare reimbursement for veterans with rates paid for non-veteran patients. Financial incentives should never create a system where certain patients receive priority based on reimbursement disparities.

CARING (Coordinating and Aligning Records to Improve and Normalize Governance) for Our Veterans Health Act of 2025 (S.2397)

The "CARING for Our Veterans Health Act of 2025" directly addresses critical gaps in the Veterans Community Care Program (VCCP). By establishing rigorous monitoring protocols and mandatory performance benchmarks, the legislation tackles persistent deficiencies in training completion rates and documentation timeliness among community care providers.

The VA MISSION Act of 2018 fundamentally transformed veterans' healthcare delivery. This landmark legislation established the VCCP with two primary objectives: (a) reducing wait times and travel distances by expanding access to community providers, and (b) ensuring that community-based care matched the quality delivered by the VA. The emphasis on quality was unmistakable—the word appeared 50 times throughout the bill.

Partnering with the private sector carries profound responsibility. The VA shoulders both legal and ethical obligations to ensure that contracted providers possess the specialized expertise necessary to treat conditions frequently resulting from military service.

The MISSION Act explicitly mandated that community mental health providers have competence equivalent to VA providers' "special expertise" in veteran-specific care. In response, the VA developed eight comprehensive training modules, each approximately one hour long, covering the mental health challenges most prevalent among veterans: posttraumatic stress, military sexual trauma, suicide prevention, and opioid safety, among others.

Recent findings from a Government Accounting Office (GAO) report [35] revealed that failure to set provider benchmarks has resulted in substantial deficiencies among non-VA mental health providers. These deficits are not merely concerning—they are inexcusable.

The GAO inquiry exposed a troubling pattern of indifference among VCCP providers towards these vital trainings. Between fiscal years 2021 and 2023, 22,725 community providers received mental health referrals, yet only 380—or roughly 2 percent—completed even one of the eight trainings. Those few who did participate averaged just 1.3 modules.

These deficiencies are particularly concerning when examining specific veteran populations. During the study period, more than 8,000 veterans with active suicide risk flags were referred to community providers, virtually none of whom had completed suicide prevention or lethal means safety training.

Similarly, while anxiety and stress-related disorders represented nearly half of patient's diagnoses, barely any community providers had taken posttraumatic stress disorder or military sexual trauma training.

The opioid crisis adds yet another layer of alarm. The GAO reported that a tiny fraction of community prescribers undertook the required brief opioid training—findings that mirror a 2021investigation from the VA Office of Inspector General.

Yet, even with these unambiguous warnings, VA has persistently turned a blind eye. As the GAO report reveals, VA leaders (under the last several Administrations) explicitly permitted network providers to disregard both recommended and mandated trainings, rationalizing that enforcing completion of trainings "could be problematic in ensuring network adequacy."

The same neglect pervades the VA's oversight of transmitting essential medical records. Community providers are contractually obligated to submit clinical documentation within 30 days of initial visit as well as within 30 days of final appointment. GAO discovered systematic

failures in compliance. Initial visit records were missing for a third of referred veterans, and final visit documentation couldn't be found for any of them. Rather than addressing these gaping deficits, the VA again chose to emphasize "network adequacy" over record compliance, significantly increasing the risks inherent in fragmented care, medication complications, and redundant testing.

The gap between patient needs and provider preparedness undermines the fundamental promise of the MISSION Act: that veterans would receive care in community settings that meets VA quality standards. Without adequate training in military-specific conditions and evidence-based interventions, community providers cannot deliver the specialized care that veterans require and deserve. Prioritizing provider quantity over quality translates to a glut of untrained providers rather than a smaller pool of well-trained ones.

The training gap between VA and private sector mental health providers is deeply concerning. A RAND Corporation study [36] comparing VA and community therapists reported that "a psychotherapist selected from the community is unlikely to have the skills necessary to deliver high-quality mental health care to service members or veterans." Private sector mental health providers in the VCCP have fewer years of clinical training [37] prior to licensure than those in the VA.

New research [38] provides even more evidence why S.2397 is necessary. The study tracked veterans with PTSD enrolled at the VA Southeast Louisiana Health Care System referred to the VCCP during 2021-2022. The quality gaps were stark:

- 25% of providers never sent records to the VA, preventing any care coordination
- Among those who did submit records, 56% failed to document suicide risk assessments
- 80% didn't use any of the six evidence-based first- or second-line PTSD treatments
- Fewer than 5% of patients showed symptom improvement
- Not one provider completed a diagnostic assessment

By contrast, every veteran seeking care for PTSD, depression, and other mental health conditions in the VA is offered evidence-based treatment options.

Veteran mental health screening and prevention also reveal stark differences between VA and community care. VA providers conduct annual screening for suicide [39]PTSD, substance use, military sexual trauma, and depression—protocols that don't occur in the VCCP. Additionally, 57% of private mental health providers reported they do not routinely screen [40] for problems common among veterans, such as mental health and substance use issues.

The quality of VCCP care is not comparable to the VA. Decades of research have established that the VA produces health care outcomes equal or superior to the private sector, across virtually every medical condition. A recent comprehensive summary of peer-reviewed studies [41] reinforces this conclusion. Moreover, the 2025 survey by Iraq and Afghanistan Veterans of America found [42] that only 31 percent of IAVA members with VCCP experience felt their community providers understand their medical needs.

The CARING Act directly responds to these documented failures. By mandating the establishment of clear performance benchmarks and requiring comprehensive monitoring systems, the legislation seeks to transform the VCCP from a well-intentioned but poorly executed initiative into a rigorously accountable care coordination framework.

The Act's emphasis on documentation and record alignment serves dual strategic purposes. It establishes accountability mechanisms that incentivize community providers to meet training requirements. It also generates the data infrastructure necessary for ongoing quality assessment.

That said, third-party administrators overseeing community care networks should be held accountable for monitoring training completion and instructed to suspend providers who miss specified expectations. This legislation would be greatly strengthened by adding sanctions for TPA and provider failures.

Similarly, the VA should also establish enforceable standards for VCCP health record submission after initial and final visits, imposing meaningful penalties on those that fail to meet them.

After six years of VCCP operation, the evidence is clear: lax training and documentation standards have utterly failed to protect those who served. Until safeguards exist, expanded access to care in the community will only mean broader exposure to substandard care. It is time to fix that through rigorous documentation requirements, clear performance benchmarks, and comprehensive monitoring systems.

Thank you for the opportunity to offer our input on these important pieces of legislation.

References

1. US Department of Veterans Affairs. (2024). National veteran suicide prevention annual report. https://www.mentalhealth.va.gov/docs/data-sheets/2024/2024-Annual-Report-Part-2-of-2_508.pdf
2. de Moore, G. M., Plew, J. D., Bray, K. M., & Snars, J. N. (1994). Survivors of self-inflicted firearm injury: A liaison psychiatry perspective. Medical Journal of Australia, 160(7), 421–425. https://doi.org/10.5694/j.1326-5377.1994.tb138194.x
3. Peterson, L. G., Peterson, M., O'Shanick, G. J., & Swann, A. (1985). Self-inflicted gunshot wounds: Lethality of method versus intent. American Journal of Psychiatry, 142(2), 228–231. https://doi.org/10.1176/ajp.142.2.228
4. Bryan, C. J., Rudd, M. D., Peterson, A. L., Young-McCaughan, S., & Wertenberger, E. G. (2016). The ebb and flow of the wish to live and the wish to die among suicidal military personnel. Journal of Affective Disorders, 202, 58–66. https://doi.org/10.1016/j.jad.2016.05.049
5. O'Donnell, I., Arthur, A. J., & Farmer, R. D. (1994). A follow-up study of attempted railway suicides. Social Science & Medicine, 38(3), 437–442. https://doi.org/10.1016/0277-9536(94)90444-8
6. Owens, D., Horrocks, J., & House, A. (2002). Fatal and non-fatal repetition of self-harm: Systematic review. British Journal of Psychiatry, 181(3), 193–199. https://doi.org/10.1192/bjp.181.3.193
7. Seiden, R. H. (1978). Where are they now? A follow-up study of suicide attempters from the Golden Gate Bridge. Suicide and Life-Threatening Behavior, 8(4), 203–216. https://doi.org/10.1111/j.1943-278X.1978.tb00587.x
8. Deisenhammer, E. A., Ing, C. M., Strauss, R., Kemmler, G., Hinterhuber, H., & Weiss, E. M. (2009). The duration of the suicidal process: How much time is left for intervention between consideration and

accomplishment of a suicide attempt? Journal of Clinical Psychiatry, 70(1), 19–24. https://doi.org/10.4088/JCP.07m03904

9. Simon, T. R., Swann, A. C., Powell, K. E., Potter, L. B., Kresnow, M., & O'Carroll, P. W. (2001). Characteristics of impulsive suicide attempts and attempters. Suicide and Life-Threatening Behavior, 32(Suppl 1), 49–59. https://doi.org/10.1521/suli.32.1.5.49.24212
10. Williams, C. L., Davidson, J. A., & Montgomery, I. (1980). Impulsive suicidal behavior. Journal of Clinical Psychology, 36(1), 90–94. https://doi.org/10.1002/1097-4679(198001)36:1<90:AID-JCLP2270360104>3.0.CO;2-F
11. Paashaus, L., Forkmann, T., Glaesmer, H., Juckel, G., Rath, D., Schönfelder, A., & Teismann, T. (2021). From decision to action: Suicidal history and time between decision to die and actual suicide attempt. Clinical Psychology & Psychotherapy, 28(6), 1427–1434. https://doi.org/10.1002/cpp.2580
12. Barber, C., Azrael, D., Berrigan, J., Miller, M., Sobelson, M., & Hemenway, D. (2018). Suicide and firearm injury in Utah. Linking data to save lives. Harvard T.H. Chan School of Public Health. https://www.hsph.harvard.edu/means-matter/suicide-and-firearm-injury-in-utah/
13. Conner, A., Azrael, D., & Miller, M. (2019). Suicide case fatality rates in the United States, 2007 to 2014: A nationwide population-based study. Annals of Internal Medicine, 171(12), 885–895. https://doi.org/10.7326/M19-1324
14. Lubin, G., Werbeloff, N., Halperin, D., Shmushkevitch, M., Weiser, M., & Knobler, H. Y. (2010). Decrease in suicide rates after a change of policy reducing access to firearms in adolescents: A naturalistic epidemiological study. Suicide and Life-Threatening Behavior, 40(5), 421–424. https://doi.org/10.1521/suli.2010.40.5.421
15. Conwell, Y., Duberstein, P. R., Connor, K., Eberly, S., Cox, C., & Caine, E. D. (2002). Access to firearms and risk for suicide in middle-aged and older adults. The American Journal of Geriatric Psychiatry, 10(4), 407–416. https://doi.org/10.1176/appi.ajgp.10.4.407
16. Dempsey, C. L., Benedek, D. M., Zuromski, K. L., Riggs-Donovan, C., Ng, T. H. H., Nock, M. K., Kessler, R. C., & Ursano, R. J. (2019). Association of firearm ownership, use, accessibility, and storage practices with suicide risk among US Army soldiers. JAMA Network Open, 2(6), Article e195383. https://doi.org/10.1001/jamanetworkopen.2019.5383
17. Grossman, D. C., Mueller, B. A., Riedy, C., Dowd, M. D., Villaveces, A., Prodzinski, J., Nakagawara, J., Howard, J., Thiersch, N., & Harruff, R. (2005). Gun storage practices and risk of youth suicide and unintentional firearm injuries. JAMA, 293(6), 707–714. https://doi.org/10.1001/jama.293.6.707
18. Shenassa, E. D., Rogers, M. L., Spalding, K. L., & Roberts, M. B. (2004). Safer storage of firearms at home and risk of suicide: A study of protective factors in a nationally representative sample. Journal of Epidemiology and Community Health, 58(10), 841–848. https://doi.org/10.1136/jech.2003.017343
19. Nichter, B., Hill, M. L., Fischer, I., Panza, K. E., Kline, A. C., Na, P. J., Norman, S. B., Rowcliffe, M., & Pietrzak, R. H. (2024). Firearm storage practices among military veterans in the United States: Findings from a nationally representative survey. *Journal of Affective Disorders*, *351*, 82–89. https://doi.org/10.1016/j.jad.2024.01.179
20. Simonetti, J. A., Azrael, D., Rowhani-Rahbar, A., & Miller, M. (2018). Firearm storage practices among American veterans. *American Journal of Preventive Medicine*, 55(4), 445-454. https://doi.org/10.1016/j.amepre.2018.04.014
21. Khazanov G, Spitzer E, Thomas S, et al (2025) Financial barriers and facilitators to secure firearm and medication storage among veterans with elevated suicide risk: a qualitative study Injury Prevention 2025;31:73-76.
22. Buck-Atkinson, J., McCarthy, M., Stanley, I. H., Harnke, B., Anestis, M. D., Bryan, C. J., Baker, J. C., & Betz, M. E. (2023). Firearm locking device preferences among firearm owners in the USA: A systematic review. *Injury Epidemiology*, *10*(1), Article 33. https://doi.org/10.1186/s40621-023-00436-7
23. Simonetti, J. A., Simeona, C., Gallagher, C., Hoffman, A., Eliassen, B., Chenoweth, J., & Villegas, C. (2019b). Preferences for firearm locking devices and device features among participants in a firearm safety event. *Western Journal of Emergency Medicine*, *20*(4), 552–556. https://doi.org/10.5811/westjem.2019.5.42727
24. Betz, M. E., Stanley, I. H., Buck-Atkinson, J., Johnson, R., Bryan, C. J., Baker, J. C., Bryan, A. O., Hunter, K., & Anestis, M. D. (2023). Firearm owners' preferences for locking devices: Results of a national survey. *Annals of Internal Medicine*, *176*(3), 329–336. https://doi.org/10.7326/M22-3113
25. Hersey, L. "Bill aims to ease access to medical care for rural veterans." Stars and Stripes. May 29, 2025. https://www.stripes.com/veterans/2025-05-29/veterans-rural-health-care-legislation-17952223.html

26. US Department of Veterans Affairs. (2024). Office of Research and Development. VA Research on Rural Health. https://www.research.va.gov/topics/rural_health.cfm
27. Center for Healthcare Policy & Patient Reform. Rural Hospitals at Risk of Closing. https://chqpr.org/downloads/Rural_Hospitals_at_Risk_of_Closing.pdf
28. National Rural Health Association. Federal Medicaid cuts imperil rural hospitals and residents. (June 23, 2025). https://www.ruralhealth.us/getmedia/c329578c-e029-4b0f-b3a7-89f6af8198ff/06-23-25-NRHA-Manatt-rural-Medicaid-cuts-report.pdf
29. Rural Health Information Hub. Health Professional Shortage Areas, Primary Care. (July 2025). https://www.ruralhealthinfo.org/charts/5
30. Schlak, A. E., Poghosyan, L., Liu, J., Kueakomoldej, S., Bilazarian, A., Rosa, W. E., & Martsolf, G. (2022). The Association between Health Professional Shortage Area (HPSA) Status, Work Environment, and Nurse Practitioner Burnout and Job Dissatisfaction. *Journal of health care for the poor and underserved*, *33*(2), 998–1016. https://doi.org/10.1353/hpu.2022.0077.
31. HRSA Health Workforce Shortage Areas https://data.hrsa.gov/topics/health-workforce/shortage-areas
32. Andrilla, C. Holly A. et al. Geographic Variation in the Supply of Selected Behavioral Health Providers. (2018) *American Journal of Preventive Medicine,* Volume 54, Issue 6, S199 - S207. https://www.ajpmonline.org/article/S0749-3797(18)30005-9/fulltext
33. National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Board on Health Care Services; Committee to Evaluate the Department of Veterans Affairs Mental Health Services. (2018) Evaluation of the Department of Veterans Affairs Mental Health Services. Washington (DC): National Academies Press (US)
34. Veterans Healthcare Policy Institute. Peer Reviewed Study Summaries on the VA's Superior Care. (2025) https://static1.squarespace.com/static/68a3a7a086f56252a95e0de0/t/68a62bb75b0dc83d0f81645a/1755720631084/Peer_Reviewed_Study.pdf
35. United States Government Accountability Office. VETERANS' COMMUNITY CARE: VA Needs Improved Oversight of Behavioral Health Medical Records and Provider Training. Report to Congressional Committees. May 2025. GAO-25-106910 https://files.gao.gov/reports/GAO-25-106910/index.html?_gl=1*so2aou*_ga*NjAzODEyODEzLjE3NDg2MTg1ODA.*_ga_V393SNS3SR*czE3NTA0NDg3MzQkbzUkZzAkdDE3NTA0NDg3MzQkajYwJGwwJGgw
36. Tanielian T, Farris C, Batka C, et al. "Ready to Serve: Community-based provider capacity to deliver culturally competent, quality mental health care to Veterans and their families." (RAND Corp. (2014) https://www.rand.org/pubs/research_reports/RR806.html
37. Vanneman, M. E., Rosen, A. K., Wagner, T. H., Shwartz, M., Gordon, S. H., Greenberg, G., Zheng, T., Cook, J., Beilstein-Wedel, E., Greene, T., & Kelley, A. T. (2023). Differences Between VHA-Delivered and VHA-Purchased Behavioral Health Care in Service and Patient Characteristics. *Psychiatric services (Washington, D.C.)*, *74*(2), 148–157. https://doi.org/10.1176/appi.ps.202100730
38. Franklin, C. L., Raines, A. M., Ennis, C. R., Boffa, J. W., Bender, A. M., Ferrie, M. L., Nocera, T. R., Dornbach-Bender, A., Seidler, D. A., Slaton, K. D., O'Malley, L., Shapiro, M. O., & Laborde, G. (2025). Evaluating coordination and quality of care among veterans receiving posttraumatic stress disorder care in the community. *Journal of traumatic stress*, 10.1002/jts.70012. Advance online publication. https://doi.org/10.1002/jts.70012
39. Gujral, K., Bahraini, N., Brenner, L. A., Van Campen, J., Zulman, D. M., Illarmo, S., & Wagner, T. H. (2023). VA's implementation of universal screening and evaluation for the suicide risk identification program in November 2020 -Implications for Veterans with prior mental health needs. *PloS one*, *18*(4), e0283633. https://doi.org/10.1371/journal.pone.0283633
40. RAND Corporation. "Improving the Quality of Mental Health Care for Veterans." August 13, 2019. https://www.rand.org/pubs/research_briefs/RB10087.html
41. Veterans Healthcare Policy Institute https://www.veteranspolicy.org/document-quality
42. Statement of Dr. Kyleanne Hunter Before the House Veterans Affairs Subcommittee on Health, July 15, 2025 https://docs.house.gov/meetings/VR/VR03/20250715/118495/HHRG-119-VR03-Wstate-HunterK-20250715.pdf

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December 3, 2025

The Honorable Jerry Moran
Chairman
Committee on Veterans' Affairs
United States Senate
Washington, DC 20010

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

Dear Chairman Moran and Ranking Member Blumenthal:

From the Anoka County Board of Commissioners, we submit this letter in strong support of S. 2309, the Veteran Burial Timeliness and Death Certificate Accountability Act. We are grateful to you both for holding this important hearing and for your continued bipartisan leadership in support of our nation's veterans and their families. A special thanks needs to go to Senator John Boozman (R-AR) and Senator Margaret Hassan (D-NH) for their continued support of veterans. Without them we are not here today.

From the moment a servicemember raises their right hand and swears an oath to defend the United States, this nation incurs a solemn and lifelong debt. It is a debt that does not end when their service concludes—but extends to the moment we lay them to rest with dignity, honor, and the respect they have earned. Unfortunately, that fundamental promise is being undermined by avoidable delays that place significant and unnecessary strain on grieving families.

Across Minnesota and throughout the country, families routinely face **4–8-week delays** in securing the documentation and certifications required for veterans' burials. For grieving families, these delays deepen trauma at an already painful moment. Instead of focusing on honoring their loved one, they are forced to navigate a confusing system, experiencing uncertainty, stress, and emotional strain. No family should have to wait months to bury a veteran who served this nation with honor.

The solution presented in S. 2309 is common-sense, achievable, and urgently needed. This legislation establishes clear timeliness standards and enhances accountability to ensure veterans' families receive the swift, respectful service they deserve. These changes are not complicated to implement—indeed, they represent basic improvements that should have been standard long ago.

For five years, Anoka County and many partners across the country have worked to highlight this problem and push for action. We are grateful that Congress has now elevated this issue to where it belongs—with strong bipartisan support and a real opportunity to fix a system that has caused families needless hardship for far too long. We urge Congress to act before the end of the year to finally deliver the relief veterans' families need and deserve.

Passing S. 2309 would send a powerful message to veterans: that their nation honors their service not only in life, but in death; that their sacrifice matters; and that their families will be treated with dignity and compassion during their most difficult moments. By acting now, Congress can make this holiday season a time of relief, healing, and closure for families who have been waiting too long for the respect their loved ones earned.

Thank you again, Chairman Moran and Ranking Member Blumenthal, for your bipartisan leadership and your unwavering support for veterans and their families. We urge swift passage of this important legislation.

Respectfully submitted,

Mike Gamache, Chair, District 5

John Heinrich, District 1

Julie Braastad, District 2

Jeff Reinert, District 3

Scott Schulte, District 4

Julie Jeppson, District 6

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KEEPING OUR PROMISE TO AMERICA'S VETERANS

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STATEMENT OF
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DEPUTY NATIONAL LEGISLATIVE DIRECTOR
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE
LEGISLATIVE HEARING
DECEMBER 10, 2025

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

DAV (Disabled American Veterans) is pleased to provide testimony for the record for this legislative hearing concerning pending legislation. DAV is a congressionally chartered and Department of Veterans Affairs (VA) accredited veterans service organization (VSO) dedicated to ensuring our promise is kept to America's veterans.

S. 342, the Purple Heart Veterans Education Act of 2025

Current law requires service members to complete at least six years of service and commit to an additional four years in order to transfer Post-9/11 GI Bill educational benefits to their dependents. This requirement effectively excludes many Purple Heart recipients whose service may have ended before reaching the necessary time-in-service threshold.

S. 342, the Purple Heart GI Bill Transfer Fairness Act, would remove this barrier by allowing Purple Heart recipients to transfer their unused Post-9/11 GI Bill educational benefits to their dependents, regardless of the length of their military service.

Purple Heart recipients have already made extraordinary sacrifices in service to our country. Denying them the ability to transfer earned education benefits to their spouses or children is inconsistent with the intent of the Post-9/11 GI Bill and fails to recognize the sacrifices endured by their families.

We support S. 342 in accordance with DAV Resolution No. 416, which calls for removing time restrictions to transfer Post-9/11 GI Bill benefits to eligible dependents. Passage of this legislation would honor our nation's Purple Heart recipients and ensure that their families receive the educational benefits they have rightfully earned.

S. 668, the Supporting Access to Falls Education and Prevention and Strengthening Training Efforts and Promoting Safety Initiatives (SAFE STEPS) for Veterans Act of 2025

Falls are the leading cause of fatal and nonfatal injuries for older Americans; every 19 minutes an older adult dies from a fall. Veterans often have challenges that increase their risk—such as physical disabilities, chronic health conditions, medication use, limb loss and traumatic brain injury. Through evidence-based lifestyle and clinical interventions, falls prevention programs, and clinical-community partnerships, the number of falls among veterans may be reduced.

This legislation creates an Office of Falls Prevention within the Veterans Health Administration (VHA), responsible for developing, coordinating, and overseeing evidence-based programs aimed at reducing fall-related injuries among veterans, particularly older adults, and those with mobility challenges.

This bill directs the VA to implement standardized prevention strategies across VA medical centers and community providers, collect and report data on fall incidents and provide targeted education and training for staff, caregivers and veterans themselves. It also calls for public education campaigns and the development of recommendations of best practices to prevent falls.

DAV supports S. 668 in accordance with DAV Resolution No. 653, which calls for strengthening the VA health care system and its specialized services. By focusing on proactive, preventive care, the SAFE STEPS for Veterans Act aims to improve veterans' quality of life and long-term health outcomes.

S. 926, the Saving Our Veterans Lives Act of 2025

By offering secure firearm storage options, this legislation reduces access to lethal means during moments of crisis, creating a critical time delay that can help save lives. This delay provides veterans with an opportunity to reconsider their actions, reach out for support or contact crisis resources during periods of acute risk.

The Saving Our Veterans Lives Act of 2025 aims to reduce veteran suicide by providing eligible veterans with secure firearm storage items, such as lockboxes or vouchers for lockboxes, upon request through a VA program. The high rates of veteran suicide—highlighted by the *2024 VA National Veteran Suicide Prevention Annual Report*, which reported 6,407 suicides among veterans in 2022, with firearms involved in 72% of these cases—underscores the urgent need for comprehensive mitigation measures.

The bill also includes a robust educational component, requiring the VA to distribute information and develop materials, such as information videos, on the benefits of secure firearm storage as a suicide prevention strategy. These efforts are designed to promote responsible firearm handling and storage practices, protect veterans and

their families from accidental discharges or unauthorized access and foster culture of safety within the veteran's community. Participation in the program is voluntary and should not infringe upon veterans' privacy and second amendment rights.

The Saving Our Veterans Lives Act of 2025 takes a proactive, evidence-based approach to suicide prevention by providing secure firearm storage resources, together with additional education and support to veterans, with the goal of reducing suicide risk and promoting safety for veterans and their families.

We support this commonsense bill in accordance with DAV Resolution No. 311, which calls for mental health and suicide prevention program improvements.

S. 1116, the Ensuring Veterans' Final Resting Place Act of 2025

Currently, veterans are eligible for VA burial benefits such as headstones, markers, urns or plaques, but they cannot receive both an urn or plaque and a headstone or marker for the same burial—only one form of recognition is allowed.

The Ensuring Veterans' Final Resting Place Act addresses this limitation by eliminating restrictions on receiving duplicate benefits, allowing veterans to receive both an urn or plaque and a headstone or marker. The bill applies retroactively to deaths occurring on or after January 5, 2021. This change honors their service and sacrifice while reducing the financial, emotional and logistical burdens faced by surviving families.

We support the Ensuring Veterans' Final Resting Place Act in accordance with DAV Resolution No. 631, which affirms our commitment to ensuring that every veteran receives the dignified final resting place they have earned in service to our nation.

S. 1657, the Review Every Veteran's Claim Act

This legislation addresses a significant concern in the adjudication of veterans' benefits by prohibiting the denial of claims solely because a veteran failed to attend a scheduled medical examination. Currently, under VA's duty to assist (38 U.S.C. § 5103A), the law states that VA "...shall treat an examination or opinion as being necessary to make a decision on a claim..." when the full evidentiary record "...does not contain sufficient medical evidence...to make a decision on the claim" In practice, this language often results in the Veterans Benefits Administration (VBA) denying claims when a veteran misses an examination—even when substantial supporting evidence, such as service medical records, private treatment records or lay statements, is already part of the record.

S. 1657, the Review Every Veteran's Claim Act, would amend this provision to clarify by inserting a new subsection clarifying that:

> "If a veteran fails to appear for a medical examination provided by the Secretary in conjunction with a claim for a benefit under a law administered by the Secretary, the Secretary may not deny such claim on the sole basis that such veteran failed to appear for such medical examination."

This reform would prevent automatic denials based solely on a missed examination and require the VA to evaluate all available evidence before rendering a decision.

Veterans may face unique challenges, including medical limitations, transportation barriers or unforeseen personal circumstances, that can make attending examinations difficult. Denying benefits solely for this reason undermines the fairness and compassion that should guide the VA claims process. This legislation would ensure that VA fully considers all relevant evidence—service medical records, private treatment documentation and lay statements—before making a benefits determination, helping to prevent unjust claim denials and uphold the principles of fairness, equity and respect owed to every veteran.

In alignment with DAV Resolution No. 240, we support the Review Every Veteran's Claim Act as a meaningful and necessary reform.

S. 1665, the Obligations to Aberdeen's Trusted Heroes (OATH) Act of 2025

Military members who participated in chemical weapons testing programs at the Edgewood Arsenal facility in Aberdeen, Maryland, as well as other secrecy oath programs, did so under difficult, dangerous and highly classified conditions. Due to the secrecy involved, these veterans often have a difficult time establishing service connection for VA benefits, particularly for injuries and illnesses related to toxic exposures. S. 1665, the OATH Act of 2025, would help to ensure they receive full access to all the benefits they have earned, including health care for conditions potentially related to hazardous or toxic exposures.

This legislation would assist veterans of the Edgewood Arsenal Program and other secrecy oath programs to access their earned benefits by requiring the VA to notify them of eligibility and provide clear guidance on how to claim those benefits, including information on available resources and programs. The bill's provisions would apply to all veterans who have completed or been released from secrecy oath programs and ensure that the effective date for disability compensation claims is preserved as the date of discharge or release from service.

The need for this legislation is underscored by the precedent established in *Taylor v. McDonough (64 F. 4th 1349, Fed. Cir. 2023)*, where a veteran's participation in a classified testing program at Edgewood Arsenal and resulting secrecy oath prevented them from filing for benefits for decades. The Federal Circuit ultimately held that equitable relief may apply when government actions, such as a secrecy oath, prevent a veteran from timely filing a claim.

In accordance with DAV Resolution No. 239, which calls for legislation to make it easier to establish service connection for conditions related to toxic and environmental exposures, we support S. 1665. This legislation would help ensure veterans who served under secrecy oaths, especially those potentially exposed to hazardous substances, have equal access to the benefits, health care and recognition afforded to all other veterans.

S. 1868, the Critical Access for Veterans Care Act

S. 1868, the Critical Access for Veterans Care Act of 2025, seeks to expand health care access for rural veterans by allowing them to receive care from critical access hospitals and affiliated rural health clinics without the need for prior VA authorization or referral. Unlike other parts of VA's community care program, this legislation would allow veterans to receive medical care services paid for by VA without VA's knowledge, authorization or coordination.

The bill would also create different reimbursement rates for these rural hospitals and providers compared to other community care providers. It would also establish a separate requirement that these reimbursements be paid within 60 days.

While we certainly understand and agree with the intention of the bill to expand access for veterans who live in rural areas, we have concerns about whether this legislation would achieve that purpose and how it would impact veterans who choose and rely on VA for their care. In many rural communities, VA is the only significant health care provider, particularly for specialized services, and any erosion of support for such VA facilities could reduce access for some rural veterans. Further, we are concerned about the dangers of increased fragmentation of care that could result from veterans going to both VA and non-VA providers without any coordination of their care. We also know that, on average, VA often provides higher quality care than private providers and believe that VA should be the primary provider and coordinator of care wherever feasible.

As the Committee considers S. 1868 and other legislation to expand access to care, particularly in rural areas, it is imperative that VA remain central to that strategy. The focus must always remain on providing timely, high-quality, veteran-centric, coordinated care, regardless of where veterans live.

S. 1992, the Veterans Appeals Efficiency Act of 2025

The Veterans Appeals Efficiency Act of 2025 proposes significant changes to the Board of Veterans' Appeals ("Board"), the Veterans Benefits Administration (VBA), and the Court of Appeals for Veterans Claims (CAVC). While DAV agrees with the bill's intent to modernize and improve appeals efficiency, several provisions raise concerns that could compromise veterans' rights and due process if not amended.

We strongly support the bill's emphasis on transparency and accountability. Requiring annual reports on remand processing times, motions to advance appeals and dismissals, including those resulting from suicide, will provide critical oversight and highlight inefficiencies within the system. We also support the provisions to improve claims tracking at various stages, including remanded, unassigned, expedited and supplemental claims, which could help develop a more data-driven and accountable appeals process.

However, the provision authorizing the Board Chairman to aggregate appeals with common legal or factual issues is problematic without explicit opt-out protections. While aggregation may promote consistency and reduce redundancy, veterans must retain the right to proceed independently. Without opt-out rights, claimants risk losing autonomy over their appeals, facing delays from collective proceedings, or having weaker cases undermine stronger ones. Preserving claimant choice is essential to safeguarding due process.

The bill's expansion of CAVC jurisdiction to include class certification motions prior to final agency decisions, and its codification of limited remands, also raise concerns. These changes could disrupt the administrative process, draw veterans into class actions without informed consent, and reduce the Court's flexibility to tailor justice to individual circumstances. Clear guardrails are needed to ensure that jurisdictional expansion does not compromise fairness or efficiency.

We are further concerned by the requirement that VA contract with a Federally Funded Research and Development Center (FFRDC) to study precedential authority and aggregation rules, develop recommendations to change those rules and then rapidly implement those recommendations without regular congressional review and approval. This delegation of legislative authority to a non-governmental entity without congressional oversight, which also limits any meaningful stakeholder input from VSOs, is both unnecessary and unwise. Congress can and should make these determinations in an open and transparent manner. Further, if precedential authority is granted, there must be safeguards included, such as multi-member panels, similar to the CAVC's three-judge requirement, for better accuracy and fairness.

To ensure this legislation fulfills its purpose without harming veterans' rights, DAV recommends that Congress include explicit opt-out provisions for claim aggregation, establish clear guardrails on expanded CAVC jurisdiction, require congressional review and approval of FFRDC recommendations before implementation, mandate multi-member panels for Board precedential decisions, and assess workload and staffing impacts on both the Board and the Court to prevent exacerbating existing backlogs.

Although S. 1992 advances transparency and modernization in the appeals process in some respects, without revisions to protect due process and claimant autonomy, it risks undermining the very efficiencies it seeks to create. DAV cannot

support the bill in its current form, but we stand ready to work with Congress to amend it in ways that protect veterans' rights while advancing meaningful reform.

S. 2061, the Molly R. Loomis Research for Descendants of Toxic Exposed Veterans Act of 2025

For decades, countless service members have endured toxic exposures during military service, from burn pits and chemical agents to industrial contaminants. While federal research has primarily focused on the health consequences for veterans themselves, emerging scientific evidence suggests these exposures may also have intergenerational impacts, affecting the health of their descendants. Yet, the children and families of toxic-exposed veterans remain largely unstudied, without access to formal health monitoring or specialized care.

S. 2061, the Molly R. Loomis Research for Descendants of Toxic Exposed Veterans Act of 2025, seeks to close this critical gap by requiring the Interagency Working Group on Toxic Exposure that was established by the PACT Act to study, track and report on health outcomes among descendants of toxic-exposed veterans. The legislation would also establish federal task forces to foster collaboration across agencies and ensure that findings and recommendations are publicly accessible. In addition, it advances comprehensive research into generational effects, building the evidence base needed to inform care, policy and prevention strategies.

Veterans and their dependents have consistently voiced the need for these actions. Veterans want assurance that the sacrifices they made in service will not leave their children and grandchildren vulnerable to unrecognized health risks. Dependents of toxic-exposed veterans, some of whom already struggle with unexplained medical challenges, seek acknowledgement, answers and access to care informed by rigorous research. Their lived experiences highlight the urgency of expanding federal efforts beyond the individual veteran to encompass the family unit, ensuring that no generation is left behind.

We support S. 2061 in accordance with DAV Resolution No. 84, which calls for expanding research into the generational consequences of toxic exposure to understand the full scope of how these exposures affect veterans, their families, and descendants. By investing in this work, Congress can help ensure that future generations are not left without recognition, resources and hope.

S. 2220, the Fighting for the Overlooked Recognition of Groups Operating in Toxic Test Environments in Nevada (FORGOTTEN) Veterans Act of 2025

S. 2220, the FORGOTTEN Veterans Act, addresses the long-standing inequities faced by veterans who served at the Nevada Test and Training Range (NTTR) and other Department of Energy (DOE) facilities. Although exposed DOE civilian employees can already receive both free health care and financial compensation under the Energy Employees Occupational Illness Compensation Program Act (EEOICPA), the similar

exposures of service members who were stationed at NTTR have not even been formally acknowledged by VA or the Department of Defense (DOD). For decades, these service members have been denied recognition and benefits for toxic and radiological exposures sustained during their service. This legislation would correct that inequity and reflects several core recommendations outlined in the DAV–MOAA *Ending the Wait for Toxic-Exposed Veterans* report, particularly those focused on tracking and conceding toxic exposures.

The bill requires the Secretary of Defense to classify the Nevada Test and Training Range and other similar locations as toxic exposure sites and that service members stationed there had been exposed to radiation-risk activities, thereby opening the door to receive health care and benefits under VA's "Atomic veterans" programs.

Consistent with our *Ending the Wait* report recommendations, the bill also directs the DOD to enhance the Individual Longitudinal Exposure Record (ILER) to better document all toxic exposures encountered by service members, including those occurring within the United States. By doing so, comprehensive exposure information will be accessible to both DOD and VA health care providers and disability evaluators. This will strengthen continuity of care and improve claims accuracy, ensuring that service members are not left to prove individual exposures decades after their service.

In addition, the bill creates a new presumption of service connection for these veterans for lipomas and tumor related conditions, thereby streamlining the process for receiving VA benefits and health care services for affected veterans.

In alignment with DAV Resolution No. 239 and the DAV–MOAA *Ending the Wait for Toxic-Exposed Veterans* report, DAV strongly supports S. 2220. By improving the ILER program, establishing concessions of exposure, and recognizing radiation-risk activities and related health impacts, this legislation will correct longstanding inequities and honor the service of these veterans.

S. 2264, the Advancing VA's Emergency Response to (AVERT) Crises Act of 2025

The COVID-19 pandemic and recent natural disasters highlight the critical importance of VA's emergency response capabilities, particularly communication infrastructure and continuity of care protocols. It is imperative that VA is prepared to fulfill its Fourth Mission to improve the nation's preparedness for response to war, terrorism, national emergencies and natural disasters while simultaneously maintaining seamless delivery of medical services and benefits that our veterans depend on.

S. 2264 would require the VA to assess and report on its emergency management roles, Regional Readiness Centers and coordination with FEMA, in order to determine ways to make them more effective and efficient. By helping to improve plans for streamlining VA's emergency response capabilities, the AVERT Crises Act could better prepare the Department to protect veterans' health and safety during future emergencies while maintaining its readiness to serve the broader national interest.

In accordance with DAV Resolution No. 653, which calls for the strengthening and protection of the VA health care system, we support this legislation to reinforce VA's Fourth Mission and ensure that they are ready to step up again and answer the nation's call for help.

S. 2309, the Veteran Burial Timeliness and Death Certificate Accountability Act

Some families of deceased veterans have experienced delays in the certification of death, which can postpone burial services, impede access to survivor benefits, and add unnecessary stress. There have been reports indicating that in some cases, VA-employed physicians and nurse practitioners have faced procedural or workload barriers that have extended certification timelines, sometimes for weeks.

Recognizing these challenges, the VA issued VHA Notice 2025-03, an interim policy establishing a 48-hour certification timeline for VA-employed physicians and nurse practitioners. This policy is set to expire on June 30, 2026.

S. 2309, the Veteran Burial Timeliness and Death Certificate Accountability Act, would codify the requirement that VA primary care providers certify the deaths of veterans within 48 hours from the time they become aware of their death. If they are unable to do so, the bill authorizes a local coroner or medical examiner in the jurisdiction where the veteran died to make the death certification.

While promoting timeliness is essential, equal attention must be given to accuracy in determining cause of death. For survivors of disabled veterans who will seek to receive Dependency and Indemnity Compensation (DIC) benefits based on the veteran dying from a service-connected condition, it is of paramount importance that all contributing factors be included as a cause of death. The failure to include a service-connected condition on a death certificate can make it an immensely more challenging and time-consuming process to receive survivor benefits.

While DAV does not have a resolution specific to this proposal, and takes no position on the legislation, we urge the Committee to ensure that any efforts to speed up the process of certifying veterans' deaths do not lead to unintended consequences that instead delay the award of survivor benefits due to inaccurate or incomplete death certificates.

S. 2328, the Military Learning for Credit Act of 2025

The transition from military to civilian life often presents significant challenges, particularly in pursuing higher education and meaningful employment. Too often, veterans encounter unnecessary barriers in accessing these benefits they have earned or in receiving proper recognition of their military learning. By covering the costs of examinations such as the College Level Examination Program (CLEP), DANTES Subject Standardized Tests (DSST), the National Career Readiness Certificate (NCRC),

and institution-based portfolio assessments, this bill ensures that financial obstacles do not prevent veterans from converting their military experience into academic progress.

Under S. 2328, veterans could apply their educational assistance toward the cost of these exams, up to $500 per test. This provision would reduce both the time and expense required to complete a degree, accelerate entry into the civilian workforce, and strengthen long-term economic stability for veterans and their families. In practical terms, it means veterans can move more quickly from the classroom to careers, maximizing the return on their earned benefits.

We support this legislation in accordance with DAV Resolution No. 428, which calls for programs, policies and legislation that identify and remove barriers to employment and education for service members and veterans.

S. 2333, the Health Records Enhancement Act

Typically, when a veteran dies, their health record is considered closed and is not usually amended, even when newly discovered toxic exposures or medical conditions are identified after death, which can sometimes negatively impact the award of survivor benefits for lack of proof of service connection. S. 2333, the Health Records Enhancement Act, seeks to address this issue by requiring the DOD and the VA to permit the supplementation of deceased veterans' health records. This approach could help improve the ability of veterans' survivors to provide verified medical evidence that strengthens service-connected claims. It could also improve epidemiological research by helping to identify long-term health trends on the impact of toxic exposures across generations of veterans, as well as guide VA and the DOD in shaping future health care policy and resource allocation.

While we appreciate the intent of the legislation, DAV does not have a specific resolution related to supplementing medical records and takes no position on the legislation. We also note that if the Committee moves such legislation, it must ensure that there are adequate controls to protect the privacy and usage of veterans' medical information. These considerations will be critical to ensuring that the process is transparent, consistent, and beneficial to veterans' families and the broader veteran community.

S. 2397, the Coordinating and Aligning Records to Improve and Normalize Governance (CARING) for our Veterans Health Act of 2025

As more veterans receive care through the Veterans Community Care Program (VCCP), a persistent challenge remains: inconsistent and delayed transfer of medical records between community care providers and VA. This gap puts veterans at risk, as VA providers often lack the timely information needed for informed decisions—leading to duplicative tests, medication errors and disrupted continuity of care.

S. 2397, the CARING for Our Veterans Health Act, could help address these critical deficiencies by requiring the VA to develop standardized guidance and reporting requirements for obtaining medical documentation from community care providers after veterans receive referred services. The bill would also require VA to set and monitor training goals for community care providers to help ensure completion of all required courses.

In line with DAV Resolution No. 5, which calls for seamless access to veterans' medical records between VA, DOD and community care through full implementation of a secure, interoperable electronic health record system, DAV supports this legislation that could help ensure better care coordination for veterans using VA and community care providers.

S. 2683, the Veterans Scam and Fraud Evasion (VSAFE) Act

Veterans are frequent targets of scams and fraud by criminals going after their earned benefits, financial resources and personal information. According to consumer complaints reported to the Federal Trade Commission (FTC) and published in the 2024 *Consumer Sentinel Network Data Book*, veterans suffered an estimated $419 million in fraud-related losses in 2024 alone.

While multiple agencies, including the VA, currently work to address fraud, these efforts are often fragmented and lack centralized coordination. S. 2683, the VSAFE Act, seeks to change that by establishing a Veterans Scam and Fraud Evasion Officer within the VA. This new position would lead all fraud prevention initiatives, ensuring a cohesive strategy and providing veterans with consistent, reliable guidance on how to identify, report and avoid scams. The Officer's responsibilities would also coordinate closely with the Inspector General and other federal agencies to ensure a unified federal approach to fraud prevention for veterans.

Consistent with DAV Resolution No. 632, we strongly support Section 2 of S. 2683 to help to defend veterans and their benefits from those who seek to exploit them. Section 3 would extend the reduction of VA pension payments for veterans in nursing homes, presumably to achieve savings and comply with congressional "pay-as-you-go" (PAYGO) rules and statutes. DAV has a resolution calling for all VA health care services, benefits and programs to be exempt from PAYGO and we do not support this provision.

S.2737, the Veterans National Traumatic Brain Injury Treatment Act

S. 2737, the Veterans National Traumatic Brain Injury Treatment Act, proposes a pilot program offering hyperbaric oxygen therapy (HBOT) to veterans with traumatic brain injury (TBI) or post-traumatic stress disorder (PTSD) through approved community providers. The program would operate in two Veterans Integrated Service Networks (VISNs) but would be funded solely by private donations. HBOT facilities participating in the pilot would need to meet recognized accreditation standards, such as those of the

Joint Commission or the Undersea and Hyperbaric Medical Society, ensuring veterans receive this care in safe, clinically validated settings. The bill also requires the Government Accountability Office (GAO) to review and reassess HBOT based on new HBOT trials conducted by VA, DOD and private entities since publication of GAO's 2015 HBOT report.

VA's mental health care guidelines currently prioritize psychotherapy and rehabilitation as first-line treatments for TBI and PTSD, yet many veterans continue to experience persistent symptoms despite standard care. However, a randomized, clinical trial involving veterans with treatment-resistant PTSD found that HBOT significantly reduced PTSD symptoms and improved brain connectivity on functional MRI, with a substantial portion of participants achieving remission, representing the most rigorous and promising evidence to date supporting HBOT as a potential non-pharmacological treatment for PTSD.

DAV Resolution No. 93 calls on VA conduct robust research to evaluate the effectiveness of HBOT for treatment resistant TBI and PTSD. While we appreciate the intention of this legislation to offer additional treatment options for veterans suffering from TBI and PTSD, we continue to believe that HBOT, like every treatment and therapy that VA provides, should have conclusive evidence of its safety and efficacy for each usage based on thorough research. We also have questions about whether VA should rely on private funding sources for specific treatments or medicines and the precedent this could set. For these reasons, we do not support the legislation as drafted.

S. 2807, the Restoring Eligibility Standards for Placement in Eligible Cemeteries and Tombs (RESPECT) Act

National cemeteries are sacred grounds where veterans and their families rightly expect dignity, honor and respect for their service to our nation. S. 2807, the RESPECT Act, would amend current statutory language about how certain interment restrictions apply to veterans convicted of sex offenses by changing the applicability date for VA to reconsider such decisions from December 20, 2013, to on or after June 18, 1973.

DAV has no resolution specific to S. 2807 and does not take a position on this legislation.

S. 3033, the Improving Access to Care for Rural Veterans Act

S. 3033, the Improving Access to Care for Rural Veterans Act, would require VA health care facilities in rural areas to expand the number of partnerships they have with non-VA medical facilities. These partnerships could include agreements for telehealth, co-location or leasing of space and equipment, training, care coordination, emergency services—including transportation—and other services deemed appropriate. The legislation requires all existing and new VA facilities to have at least one partnership within three years of enactment of the law unless granted a waiver. The intent of this

legislation is clear: to expand access to care for veterans in rural communities while potentially reducing costs and strengthening local health care infrastructure.

Rural veterans face unique and persistent barriers to care. Long travel distances, limited provider availability and fewer specialty services often result in delayed treatment, poorer health outcomes and increased isolation. These challenges can also disproportionately affect tribal communities, women veterans and other underserved populations. By leveraging local resources and minimizing duplication, this bill would help ensure that veterans in remote and medically underserved areas receive the timely equitable, and veteran-centered care they have earned.

We support this bill in line with DAV Resolution No. 129, which calls for stronger access to care for veterans in rural and underserved communities. By fostering local partnerships, expanding telehealth and improving coordination, this legislation could help reduce barriers and ensure more timely care.

S. 3119, the Fisher House Availability Act

S. 3119 would expand eligibility to permit active-duty service members, other individuals on active duty and their family members to stay in VA temporary lodging facilities—particularly Fisher Houses—on a space-available basis when they must travel significant distances to receive medical care. The Fisher House program's core mission is to provide free, temporary lodging for the families and caregivers of veterans receiving medical care at VA or DOD medical facilities. This mission is vital to ensuring that veterans and their loved ones have the support they need during treatment and recovery.

Although we have no resolution related to this proposal, and take no position on the legislation, DAV supports the intent of expanding lodging support to active-duty service members and their families while maintaining veterans and their caregivers as the primary beneficiaries of the Fisher House program.

Draft bill, Leveraging Integrated Networks in Communities (LINC) for Veterans Act

The draft bill, Leveraging Integrated Networks in Communities (LINC) for Veterans Act, would require VA to establish a pilot program at one VA health care facility in each Veterans Integrated Service Network (VISN) to build interoperable community integration networks that connect veterans to non-VA health and social services—including housing, transportation, mental health care, job training and legal aid—through coordinated public-private partnerships. Additionally, it would mandate routine screening for social determinants of health using standardized tools, track referral outcomes and promote collaboration with Medicaid and existing networks.

DAV has no resolution specific to this proposal and takes no position on the legislation. We appreciate the bill's intent to expand access for veterans to a full spectrum of health, economic, and social services, however we have questions about

whether this proposal is the most efficient and effective way to use VA's limited resources to achieve this goal. Veterans who are enrolled in the VA health care system already have integrated access to a host of additional VA services and benefits that can improve their physical, mental, social, and economic health. These "wrap-around" services are a cornerstone of VA's holistic approach to improving the lives of the men and women who served, as well as their families, caregivers, and survivors. The Committee should consider whether requiring VA to take on the additional responsibility of re-creating its integrated programs, services, and benefits outside of VA could potentially detract from VA's core missions, and whether the time and resources required would be better invested in expanding VA's own programs, especially in rural and frontier communities.

Draft bill, the Sharing Essential Resources for Veterans Everywhere (SERVE) Act

The draft bill, Sharing Essential Resources for Veterans Everywhere (SERVE) Act, seeks to improve veterans' access to health care by better utilizing military medical treatment facilities (MTFs) with excess capacity and strengthening coordination between the VA and the DOD. This proposed legislation would require the development and implementation of action plans for DOD MTFs and nearby VA medical facilities to allow enrolled veterans to receive care at MTFs. The action plans would include cross-credentialing of providers, expedited base access for VA beneficiaries, integrated IT systems, and designated coordinators to manage implementation. The bill would designate DOD providers as preferred providers within the VA community care network. It also calls on VA to allow veterans to receive certain medical services at MTFs without any VA referral or preauthorization, although it provides no specific language about what services would be included.

DAV supports most provisions of the SERVE Act as it aligns with DAV Resolution No. 650 and others that seek to expand access, timeliness and quality of VA health care, including non-VA options when VA care is not accessible. We particularly support the bill's designation of DOD providers as "preferred providers" in VA's community care program, because they will generally have greater expertise and cultural competency treating former service members. We do have concerns about removing VA's role in referring and pre-authorizing enrolled veterans care at DOD and other non-VA facilities and recommend that the Committee further refine and clarify that provision. While VA has sensibly begun to allow veterans to schedule certain routine medical services, such as vision or hearing exams, without a primary care provider referral or pre-authorization, VA must remain the overall coordinator of an enrolled veteran's care to avoid negative health outcomes that result from fragmented care.

The bill also includes a provision in subsection 2(i) that would extend the reduction of VA pension payments for veterans in nursing homes, presumably to achieve savings and comply with congressional "pay-as-you-go" (PAYGO) rules and statutes. DAV has a resolution calling for all VA health care services, benefits and programs to be exempt from PAYGO and we do not support this provision.

Draft bill, the Commission on Equity and Reconciliation in the Uniformed Services Act

This draft bill, the Commission on Equity and Reconciliation in the Uniformed Services Act, would create an independent Commission on Equity and Reconciliation in the Uniformed Services tasked with documenting historical discriminatory practices and holding public hearings. The Commission would gather testimony from affected service members, veterans, their families and subject-matter experts, with particular attention to veteran services, health care access and benefits for those impacted by past discriminatory policies.

DAV has no resolution specific to this proposal and takes no position on the legislation. However, we do recognize that there have been disparities in access and outcomes for historically under-represented and underserved subgroups of veterans, including racial and ethnic minorities; LGBTQ+ individuals; women; and those living in rural, remote or medically underserved communities. We continue to call on VA to support efforts to develop and implement sustainable programs and accountability measures aimed at eliminating health and service inequities to ensure equitable access, treatment and outcomes for all veterans.

Draft Bill, the Get Justice-Involved Veterans BACK HOME Act

The draft bill, Get Justice-Involved Veterans Behavioral Assistance and Care for Key Health Outcomes to Maintain Empowerment (BACK HOME) Act, would authorize a pilot program to deliver tele-mental health services or mobile mental health units to veterans in correctional facilities, prioritizing veterans with service-connected PTSD, TBI or military sexual trauma. Additionally, the bill would require VA coordination with federal and state agencies, establish dedicated provider hubs, prohibit disability claims evaluations during treatment, mandate separate housing units for veterans in federal prisons to support rehabilitation and peer connection and ensure automatic resumption of VA benefits post-incarceration.

Although DAV does not have a resolution specific to this proposal, and takes no position on the bill, we support the intent of the legislation. VA research indicates that veterans with PTSD are approximately 60% more likely to experience justice-system involvement compared to their peers without the condition. Similarly, veterans with traumatic brain injuries—one of the signature wounds of the post-9/11 conflicts—face an elevated risk of criminal justice involvement, underscoring the complex intersection between combat-related injuries and post-service legal challenges. Despite their service, justice-involved veterans often lack access to coordinated care, benefits and reentry support, contributing to higher rates of recidivism and poorer health outcomes.

As the Committee considers this legislation, it will be important to consider the administrative and logistical challenges of having VA provide services at state and federal prisons, including the overlapping authorities and responsibilities. In this regard,

leveraging the use of advance communications technologies could be critical to expanding access to VA mental health services for veterans during incarceration.

In closing, Mr. Chairman, we thank you for the opportunity to submit a statement for the record on the bills being considered by the Committee.

Military-Veterans Advocacy

Written Testimony/Statement in Support of S 2737 *Veterans National Traumatic Brain Injury Treatment Act*

Submitted to the United States Senate Veterans Affairs Committee
December 10, 2025

Commander John B. Wells, USN (Ret)
Chairman

Introduction

Distinguished Chairman Jerry Moran and Ranking Member Richard Blumenthal and other members of the Committee, thank you for the opportunity to present the views of Military-Veterans Advocacy® (MVA™) on S 2737.

The number of veterans personnel suffering from service-connected Traumatic Brain Injury (TBI) has ballooned, in part because of a realization that the disability exists as well as improved diagnostic capabilities has increased awareness. Unlike Post Traumatic Stress (PTS), which is a psychological injury, TBI represents physical damage to the brain. Unfortunately, the Department of Veterans Affairs has turned to numbing and often dangerous opioids for treatment. This problem is complicated by the lack of understanding of the physiological effects of TBI.

About Military-Veterans Advocacy®

Military-Veterans Advocacy Inc.® (MVA™) is a tax-exempt IRC 501[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 1100 proud members. In 2022, our volunteer board of directors donated almost 9500 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.

Military-Veterans Advocacy's® 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. His curriculum-vitae is attached.

S 2737

Veterans National Traumatic Brain Injury Treatment Act

MVA™ has long supported the use of HBOT to treat Traumatic Brain Injury. There is an increasing body of evidence that show HBOT is an effective HR 3649 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 MVA™ 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.

As the VA possesses this equipment for wound and burn treatment cost should be negligible. The HBOT process has been very successful in treating wounds, amputations and burns. TBI is just another wound – in this case to the brain, The brain is another organ susceptible to this type of treatment.

Granted some studies claim there is not sufficient evidence to confirm the effectiveness of HBOT for TBI. The VA, as they do with anything they do not want to do, embraced the "not sufficient evidence" argument. Additionally, many of the lukewarm studies have ties to "Big Pharma "who profit from the sale of the opioids.

Always mendacious, the VA has opposed this program claiming there is not sufficient evidence and that the oxygen treatment may not accomplish its goal. What could be better than the pilot program required by S 2737 to settle the question Yet VA continues to oppose this beneficial treatment regimen. At best, MVA believes that the VA's rejection of this treatment protocol is negligent and constitutes malpractice. Our veterans deserve better.

Take the case of Sgt. Major Jim Kuiken, USMC (retired). Jim was involved in several explosive injuries and was diagnosed with TBI by private medical groups. The VA, despite Jim's 8 months of rehabilitation in in a military hospital, and his purple heart, termed his TBI not service connected. Jim sought assistance from a private non-profit who referred him for HBOT treatment. Despite receiving only 20 of the 60 prescribed treatments, Jim noted major improvements in his memory and other cognitive abilities.

HBOT calls for the application of 100% pure oxygen at 1½ atmospheric pressure. The treatment oxygenates the cells and regenerates them is the same way cells are regenerated to repair wounds and amputations. The question that must be raised is "Why not require a pilot program to use a proven treatment method to heal a wounded organ?" In other words, what harm can come of this? It is well settled that oxygen is good for the human body. Let's make this treatment available to our national heroes.

MVA™ urges the SVAC to favorably mark-up S- 2737.

Conclusion

On behalf of our membership, we would like to extend our thanks to the Chairwoman Ranking Members, and remaining Committee members for the opportunity to present our view.

Respectfully Submitted,

John B. Wells
Commander USN (retired)
Executive Director

MILITARY, VETERAN & FAMILY
CENTER OF EXCELLENCE

STATEMENT FOR THE RECORD

Senate Committee on Veterans' Affairs

Legislative Hearing

December 10, 2025

from

A-G Associates' Military Veteran and Family Center of Excellence

on

Saving Our Veterans Lives Act of 2025 (S. 926)

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

We are grateful for the opportunity to submit a Statement for the Record for today's full committee legislative hearing in support of the bipartisan *Saving Our Veterans Lives Act of 2025*. This legislation represents a meaningful investment in the well-being and safety of our nation's veterans.

We represent a cross-functional team of experts who have dedicated our careers to analyzing, designing, and transforming systems of care for veterans by uniting researchers, strategists, clinicians, and change leaders with one purpose: to strengthen the ecosystem that supports service members, veterans, families, and caregivers. Our investment in the military and veteran community extends beyond our expertise. We are veterans and family members who have experienced and navigated the complex realities that can follow separation from service. We have also seen firsthand how the gaps in our current system can have devastating consequences. The result is an ongoing loss of life that can be prevented through expanding access to lethal means safety resources.

The rate of suicide among veterans continues to exceed that of the civilian population. In 2022, firearms were involved in 73.5% of veteran suicide deaths compared to 52.2% among non-veterans.[1] However, numerous initiatives, targeted interventions, and financial investments across the public and private sectors are laying the groundwork for progress and continue to improve

[1] U.S. Department of Veterans Affairs, Office of Suicide Prevention. 2024 National Veteran Suicide Prevention Annual Report. 2024.

outcomes over time with sustained execution. Addressing this crisis requires innovative, multifaceted, and evidence-based solutions that intervene before a crisis becomes fatal.

Lethal means safety strategies are recognized as a cornerstone of effective suicide prevention because they address two critical facts:

1) Many suicidal crises are often short-lived and impulsive, with half of all suicide attempts initiated less than 10 minutes after the thought arises.[2]

2) Evidence shows that creating time and distance between a person experiencing suicidal thoughts and a lethal means of suicide saves lives.[3]

For people who experience thoughts of suicide, means matter. Ninety percent of firearm-related suicide attempts are fatal, virtually eliminating any chance for intervention or reconsideration once the means are accessed.[4]

As presently written, the scope of S.926 extends lethal means safety materials to all veterans, regardless of their current enrollment or risk level, which is an ambitious and commendable goal. A more strategic initial approach would be to first focus implementation on the highest-risk veteran subpopulations. By tailoring the bill's educational materials and outreach to these targeted groups, VA can produce evidence-informed proof of concept regarding efficacy and resource management. This would establish a data-driven foundation before expanding the program to the full veteran population.

To ensure accountability and transparency, VA will be required to submit annual reports to Congress detailing the execution of the secure storage program. These reports must include specific metrics to evaluate the program's reach and effectiveness, such as tracking the number of items distributed through the Veterans Health Administration (VHA) channels and external partners. The VA report should also include an assessment of the efforts made and the obstacles encountered in reaching eligible veterans who are not currently enrolled in VA care. Our team understands that meaningful evaluation must go beyond simply counting distributions and instead focus on key public health outcomes:

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[2] Deisenhammer, E. A., Ing, C. M., Strauss, R., Kemmler, G., Hinterhuber, H., & Weiss, E. M. (2009). The duration of the suicidal process: How much time is left for intervention between consideration and accomplishment of a suicide attempt? Journal of Clinical Psychiatry, 70(1), 19–24. https://doi.org/10.4088/JCP.07m03904

[3] Simon OR, Swann AC, Powell KE, Potter LB, Kresnow MJ, O'Carroll PW. Characteristics of impulsive suicide attempts and attempters. Suicide Life Threat Behav. 2001;32(1 Suppl):49-59. doi: 10.1521/suli.32.1.5.49.24212. PMID: 11924695.

[4] Ziyi Cai, Alvin Junus, Qingsong Chang, Paul S.F. Yip (2022). The lethality of suicide methods: A systematic review and meta-analysis.
Journal of Affective Disorders,Volume 300.
https://doi.org/10.1016/j.jad.2021.12.054.

1) Change in Self-Reported Secure Storage Practices: Tracking the increase in veterans who report storing their firearms securely, such as locking them at home or using out-of-home storage programs, is a key indicator of success. This shows whether the intervention effectively encourages secure storage habits to become a normal and routine part of firearm ownership, thereby shaping how the community discusses and manages storage by extending core military weapons-handling principles of maintaining control, accountability, and disciplined access.

2) Uptake in Out-of-Home Storage Programs: Monitoring the growth and utilization of partnered programs that offer temporary, secure out-of-home storage for at-risk veterans will demonstrate acceptance of the most comprehensive safety measure during a crisis.

Adding a third-party evaluator to the implementation of the Saving Our Veterans Lives Act would significantly improve the bill's impact and long-term success. An independent evaluator provides objectivity and specialized knowledge in suicide prevention research, ensuring that program results are accurately assessed and free from internal bias. This helps policymakers determine not only if the distribution of secure storage equipment is reaching veterans but also if it is genuinely reducing risk during crises. Program evaluation should also identify gaps, disparities, and unintended consequences early on, allowing for quick adjustments and ongoing improvements. Additionally, robust program evaluation provides the essential foundation for accurately assessing return on investment. By producing transparent, trustworthy, and practical findings, independent evaluation gives Congress and the VA the evidence needed to improve the program, expand effective measures, and ultimately save more lives.

A major policy challenge in promoting secure firearm storage is the concern that it infringes on lawful firearm ownership. The proposed legislation includes a detailed Rule of Construction that explicitly protects lawful ownership of firearms, reassuring veterans that participation in the program will not lead to the collection of personally identifiable information for firearm tracking, will not require firearm registration with any government agency, will not mandate firearm storage, and cannot be interpreted as discouraging lawful ownership or possession of a firearm. This language ensures that the policy effectively balances Second Amendment rights with life-saving suicide prevention efforts, emphasizing that these goals are mutually supportive rather than conflicting.

We urge the Committee to advance the *Saving Our Veterans Lives Act of 2025.* Passing this legislation would be a significant step toward fulfilling the promise to provide veterans with comprehensive care systems that support them throughout every stage of their lives.

Thank you to the Committee for your leadership and ongoing dedication to those who have served.

NATIONAL ORGANIZATION OF VETERANS' ADVOCATES, INC.

Statement for the Record

Before the

Senate Committee on Veterans' Affairs

Concerning

Pending Legislation

December 10, 2025

Chairman Moran, Ranking Member Blumenthal, and members of the Committee, the National Organization of Veterans' Advocates (NOVA) thanks you for the opportunity to offer our views on pending legislation.

NOVA is a not-for-profit 501(c)(6) educational membership organization incorporated in the District of Columbia in 1993. NOVA represents approximately 900 accredited attorneys, agents, and qualified members assisting tens of thousands of our nation's military veterans, survivors, family members, and caregivers seeking to obtain their earned benefits from VA. NOVA members represent veterans before all levels of VA's disability claims process, and handle appeals before the U.S. Court of Appeals for Veterans Claims (CAVC), U.S. Court of Appeals for the Federal Circuit, and U.S. Supreme Court.

NOVA works to develop and encourage high standards of service and representation for persons seeking VA benefits. A critical part of NOVA's mission is to educate advocates. NOVA currently conducts two conferences per year, each offering approximately 15 hours of continuing legal education (CLE) credit for attendees. Experts from within and outside the membership present and train on the latest developments and best practices in veterans law and policy. NOVA sustaining members must participate in at least one conference every 24 months to maintain eligibility to appear in our public-facing advocate directory. In addition to conferences, NOVA offers webinars, online support, peer-to-peer mentorship, and other guidance to its members to enhance their advocacy skills.

NOVA advocates for laws and policies that advance the rights of veterans. For example, NOVA collaborated with Veteran Service Organizations (VSOs) and other accredited representatives, VA, and Congress on appeals modernization reform. Those efforts resulted in passage of the *Veterans Appeals Improvement and Modernization Act* (AMA), P.L. 115-55, 131 Stat. 1105, which was signed into law by President Trump in 2017.

NOVA also advances important cases and files amicus briefs in others. *See, e.g., NOVA v. Secretary of Veterans Affairs*, 710 F.3d 1328 (Fed. Cir. 2013) (addressing VA's failure to honor its commitment to stop applying an invalid rule); *Procopio v. Wilkie*, 913 F.3d 1371 (Fed. Cir. 2019) (amicus); *NOVA v. Secretary of Veterans Affairs*, 981 F.3d 1360 (Fed. Cir. 2020) (M21-1 rule was interpretive rule of general applicability and agency action subject to judicial review); *National Organization of Veterans' Advocates, Inc., et al., v. Secretary of Veterans Affairs*, 981 F.3d 1360 (2022) (Federal Circuit invalidated knee replacement rule); *Arellano v. McDonough*, 598 U.S. 1 (2023) (amicus); *Terry v. McDonough,* 37 Vet.App. 1 (2023) (amicus); *Bufkin v. Collins*, 604 U.S. ___ (2025) (amicus).

NOVA offers its views on the following bills:

S. 1657, Review Every Veterans Claim Act of 2025

NOVA supports S. 1657, Review Every Veterans Claim Act of 2025. This bill would amend current 38 U.S.C. § 5103A to provide that, "[i]f a veteran fails to appear for a medical examination provided by the Secretary in conjunction with a claim for a benefit under a law administered by the Secretary, the Secretary may not deny such claim on the sole basis that such veteran failed to appear for such medical examination."

By eliminating denials based solely on the failure to appear for an examination, veterans will stop being unfairly penalized for situations often beyond their control. NOVA members frequently report instances where a veteran tries to communicate an inability to attend an examination for a host of reasons: conflict with work schedules, illness, family responsibilities, a lack of transportation, etc. Sometimes they are unable to reach someone to reschedule or that request is not honored. In other cases, the veteran never receives notice of the examination. Veterans who are homeless or at risk of homelessness are particularly vulnerable. Amending this provision reflects a veteran-friendly policy.

Furthermore, VA often schedules unnecessary examinations and reexaminations for veterans, which has been frequently reported by NOVA (most recently to this committee just a few weeks ago). *See* National Organization of Veterans' Advocates, *Statement for the Record Before the Senate Committee on Veterans' Affairs*, "Putting the Veterans First: Is the Current VA Disability System Keeping Its Promise?" 4-5 (October 29, 2025). Unnecessary examinations are particularly troublesome considering the statutory requirement for VA to consider private medical evidence. *See* 38 U.S.C. § 5125 ("a report of a medical examination administered by a private physician that is provided by a claimant in support of a claim for benefits under that chapter may be accepted without a requirement for confirmation by an examination by a physician employed by the Veterans Health Administration if the report is sufficiently complete to be adequate for the purpose of adjudicating such claim"). By amending 38 U.S.C. § 5103A and prohibiting VA from denying a claim solely because of a missed examination, VA will be required to conduct a more fulsome review of the record to consider private evidence or ongoing VA treatment before ordering more examinations in a system that is already overloaded with requests.

We have one minor suggestion for clarification. The current bill would strike "COMPENSATION CLAIMS" and replace it with "CLAIMS FOR BENEFITS." This change appears overly broad as VA "claims for benefits" encompass a broad range of services and awards that do not require an examination as a condition for a grant. By contrast, a heading such as "CLAIMS FOR VA DISABILITY BENEFITS" would be clearer and ensure that this prohibition against denials solely because of a missed examination would extend to all VA disability benefit claims and appeals.

S. 1665, Obligations to Aberdeen's Trusted Heroes (OATH) Act of 2025

NOVA supports S. 1665, OATH Act of 2025. In 2022, NOVA joined other veterans' organizations in an amicus brief supporting Edgewood veterans. *Arellano v. McDonough*, 598 U.S. 1 (2023). That brief details the dilemma faced by veterans who were subjected to unethical chemical testing at the Edgewood Arsenal and were then prevented from applying for benefits due to the secrecy oath they swore. Having sworn this oath, they were robbed of years of compensation benefits for the conditions caused by this testing. Unfortunately, the Supreme Court held that equitable tolling did not apply to the effective date provisions of 38 U.S.C. § 5110(b)(1), which prevented these veterans from obtaining their just compensation. While no bill can fully alleviate the suffering of these veterans, section 4 of S. 1665 allows for the earliest possible effective date. In addition, this bill sets forth a process that will allow for veterans who have participated or will participate in secrecy oath programs to receive equitable treatment in applying for disability benefits. We urge the committee to quickly move this bill forward and for Congress to pass it.

S. 1992, Veterans Appeals Efficiency Act

NOVA does not support S. 1992 in its entirety as currently drafted.

Reporting Requirements. NOVA generally supports the provisions that require the Secretary to report on the length of adjudication (Section 2(b)) and information on certain claims/notice of certain assignments (Section 2(c)). Congress, however, must ensure that VA has the necessary resources to collect and report such data so as to not interfere with the Board's primary mission as articulated at 38 C.F.R. § 20.103: "The principal functions of the Board are to make determinations of appellate jurisdiction, consider all applications on appeal properly before it, conduct hearings on appeal, evaluate the evidence of record, and enter decisions in writing on the questions presented on appeal."

Advancement on the Docket. NOVA supports the prescription of guidelines for advancement on the docket at the Board, primarily to ensure consistency in how such rules are applied. Presently, the Board considers 75 years to be the age for automatic advancement on the docket; however, the VA Regional Offices apply the rule at age 85. Congress should institute a set age of 75 for all claimants.

Board Aggregation/Precedential Decisions. NOVA does not support the aggregation provisions as currently written. This bill needs to provide more clarity on the role of the study prior to implementation of actual aggregation. Section 2(d)(1)(A) would amend 38 U.S.C. § 7104(a) to add the following new sentence: "If the Chairman of the Board determines that more than one appeal involves common questions of law or fact, the Chairman may aggregate such appeals to decide such questions of law or fact." That provision takes "effect on the date of the enactment of this Act" but will "apply beginning

on the date on which the Secretary of Veterans Affairs completes the developments of policies and procedures required under subsection (g)(4)(A)(ii)." Subsection (g)(4)(A)(ii) provides for the development of policies and procedures to implement the recommendations in FFRDC assessment with respect to the authority of the Board. The language is confusing and the authority bestowed under Section 2(d)(1)(A) appears to put the cart before the horse.

This bill correctly identifies problems with inconsistent Board decisions that hinder efficient and accurate appeals processing. Aggregate action is a powerful tool that, used well, may address these problems. As currently drafted, however, the bill is too broad, provides too much unilateral authority to the Board Chairman, and risks introducing further systemic inefficiency.

Specifically, the only additional guidance regarding aggregation that the bill provides is at section 2(d)(3), defining "aggregate" to encompass "any practice or procedure to collect common issues, claims, or appeals by multiple parties for the purposes of resolving such issues, claims, or appeals," including "the use of joinder, consolidation, intervention, class actions, and any other multiparty proceedings." This broad language allows for the Secretary, acting through the Board Chairman, to unilaterally convene a class of unrepresented claimants and decide—without mention of any right of notice or opportunity to opt out—one or more common questions of law or fact adversely and in binding fashion across the entire class. Statutory restrictions upon VA's ability to provide information regarding a claimant or claim to third parties (intended to protect veterans' privacy) would also pose potentially substantial obstacles against providing notice to claimants whom the Board Chairman's aggregate action might adversely affect.

Furthermore, the bill, as drafted, leaves in question whether adversely affected claimants even could appeal any such action. The Federal Circuit has ruled that the CAVC has no jurisdiction to review a decision of the Board's Chairman. *See Mayer v. Brown*, 37 F.3d 618 (1994). Based on that precedent, adverse aggregate action by the Chairman could stand absolute, immune to appeal. The bill's commission of such unilateral power and discretion to the Chairman also would be at odds with 38 U.S.C. § 7102(b), which instructs that "[a] proceeding may not be assigned to the Chairman as an individual member," subject to section 7103(a)'s provision that the Chairman may "order[] reconsideration of the decision" and then, pursuant to section 7102(b), participate among a multi-judge panel in that reconsideration.

At this time, NOVA recommends proceeding with the FFRDC assessment that will provide for a broader debate about the potential role of aggregation or other related policies at the Board, to include consideration of use of precedential decisions at the Board.

Ensuring Compliance with Board Remands. It is critically important that the Board ensure substantial compliance with a decision to remand, even though the Board does not maintain jurisdiction in the AMA system upon a remand. This language of this section, however, is confusing as to the role of the agency of original jurisdiction in this process. Specifically, under (f)(2)(B), it is unclear how a determination of "such decision was unnecessary" would be made. This section needs more clarification.

CAVC Jurisdiction. NOVA supports the expansion of the CAVC's class action jurisdiction in the amendments proposed for 38 U.S.C. § 7252(b).

NOVA does not support the amendments proposed for 38 U.S.C. § 7252(c). Existing law permits the CAVC to exercise limited remand authority, which it has done since its earliest decisions. *See, e.g., Gilbert v. Derwinski*, 1 Vet.App. 49, 59 (1990) (Court retained jurisdiction and remanded for the Board to provide adequate reasons or bases for its determinations). This language as drafted seems too rigid. For example, it should not require the CAVC to make a rule defining the amount of time to allow for **every** limited remand because each case is different. Any such "guidelines" can be included in the CAVC's Internal Operating Procedures, but should not be in the Rules of Practice and Procedure.

S. 2683, Veterans Scam and Fraud Evasion (VSAFE) Act of 2025

NOVA supports the intent of the S. 2683. Unfortunately, veterans are the targets of many kinds of fraud and scams, facing efforts by individuals and groups to fraudulently obtain or deprive veterans, family members, survivors, and caregivers of the compensation and benefits they deserve. However, while NOVA supports the intent of the bill and the interest in providing veterans with a focused plan for preventing and reporting fraud and scams, this Committee should address the ongoing problem of unaccredited claims consultants, who violate VA standards and charge veterans predatory fees outside the statutory scheme. This problem has been allowed to grow unchecked for too long and, as a result, there is a patchwork of state legislation further confusing veterans. Federal action is required.

CONCLUSION

Thank you for the opportunity to provide our views on this legislation. If you have questions or would like to request additional information, please feel free to contact:

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STATEMENT OF

STUDENT VETERANS OF AMERICA

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS

U.S. SENATE

HEARING ON THE TOPIC OF:

PENDING LEGISLATION

December 10, 2025

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studentveterans.org

SVA

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S. 2328, the Military Learning for Credit Act of 2025 2

SVA

Chairman Moran, Ranking Member Blumenthal, and Members of the Committee: Thank you for inviting Student Veterans of America (SVA) to submit a statement for the record on the legislation pending before you today.

With a mission focused on empowering student veterans, SVA is committed to providing an educational experience that goes beyond the classroom. Through a dedicated and expansive network of on-campus chapters across the country, SVA aims to inspire yesterday's warriors by connecting student veterans with a community of like-minded chapter leaders. Every day these passionate leaders work to provide the necessary resources, network support, and advocacy to ensure student veterans, military-connected students, their families and survivors can effectively connect, expand their skills, and ultimately achieve their greatest potential.

SVA thanks the Committee for considering this legislation that would impact student veterans, military-connected students, their families, caregivers, and survivors in higher education.

S. 2328, the Military Learning for Credit Act of 2025

SVA supports S. 2328, *the Military Learning for Credit Act of 2025*, which would direct the Department of Veterans' Affairs to use veterans' educational assistance to cover those examination and assessment fees, cutting education costs, shortening time to degree and helping veterans bring proven skills to high-demand jobs faster.

There is no question that today's veterans take diverse and nonlinear paths through higher education. Increased access to college courses before, during, and after military service has changed the way veterans engage with education. [1] SVA has also found that many service members are implicitly discouraged from pursuing higher education.[2] From high school guidance counselors to leadership within the military, there is often an unspoken message that service members are not "college material."[3] It is only after separating from the military and seeing other veterans succeed in higher education that many recognize their own potential and enroll.[4]

SVA's NVEST (2017) data show that veterans graduate at higher rates than traditional students but struggle with underemployment after graduation.[5] Despite their strong academic performance, veterans are less likely to take advantage of internships and externships – key experiences that provide professional networking opportunities and industry exposure. This is not due to a lack of interest or awareness, but rather financial pressures.[6] Many veterans juggle school, work, and family responsibilities, making unpaid or low-paid internships an unfeasible option. There,

[1] Kinch, A. K., & Cate, C. A. (ongoing). Life Cycle Atlas. Student Veterans of America. https://studentveterans.org/research/life-cycle-atlas/
[2] Id.
[3] Id.
[4] Id.
[5] Cate, C. A., Lyon, J. S., Schmeling, J., & Bogue, B. Y. (2017). National Veteran Education Success Tracker: A report on the academic success of student veterans using the Post-9/11 GI Bill. Student Veterans of America. https://studentveterans.org/wpcontent/uploads/2020/08/NVEST-Report_FINAL.pdf.
[6] Preliminary findings from SVA's Career Services Needs Assessment (2022).

it is not in the best interest of the student veteran to have them pay out-of-pocket to take classes for college credit, when it may be equally satisfied with their prior military training and experience. This bill would be one step towards eliminating a financial hurdle that only delays graduation and slows their transition into the civilian workforce.

SVA would like to thank Senator Coons and Senator Ernst for their leadership in advancing this important legislation to ensure more student veterans are recognized and credited for their military experience in the classroom towards their employment.

○

The continued success of veterans in higher education in the Post-9/11 era is no mistake or coincidence. In our Nation's history, educated veterans have always been the best of a generation and the key to solving our most complex challenges. Today's student veterans carry this legacy forward.

We thank the Chairman, Ranking Member, and the Committee Members for your time, attention, and devotion to the cause of veterans, military-connected students, their families, caregivers and survivors.

STATEMENT OF
TRAGEDY ASSISTANCE PROGRAM FOR SURVIVORS (TAPS)
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

LEGISLATIVE HEARING

DECEMBER 10, 2025

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 2024 alone, 8,911 newly bereaved military and veteran survivors connected to TAPS for care and services, the most in our 30-year history. This is an average of 24 new survivors coming to TAPS each and every day. Of the survivors seeking our care in 2024, 37 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 only 3 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.

Chairman Moran and Ranking Member Blumenthal, and distinguished members of the Senate Committee 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 to 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 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.

SAVING OUR VETERANS LIVES ACT OF 2025 (S. 926)

TAPS Strongly Supports

TAPS thanks Senators Angus King (I-ME) and Tim Sheehy (R-MT) for introducing critical legislation to reduce the risk of veteran suicide. The ***Saving Our Veterans Lives Act* (S. 926)** would authorize a program through the Department of Veterans Affairs (VA) to provide free firearm lockboxes to veterans to put time and space between at-risk individuals and lethal means, such as firearms.

TAPS has supported more than 27,000 bereaved survivors of military or veteran suicide loss. We know from thousands of cases how serious the issue of lethal means safety is to addressing military and veteran suicide.

Carla Stumpf Patton, Surviving Spouse of Marine Corps Drill Instructor Sgt Richard Stumpf

"My husband, Richard Stumpf, an active-duty U.S. Marine drill instructor, died by suicide in 1994 with his service-issued weapon in the workplace. My life and the lives of all those exposed to his death irrevocably changed that day. I was pregnant, full-term, at the time of my loss and gave birth several days later after being rushed to the hospital at the same time as his funeral.

"As a young military spouse, I did not have the resources or situational awareness to navigate a suicide intervention, let alone a discussion about lethal means safety. However, 26 years later, I have devoted my professional life and career to suicide prevention and caring for survivors of suicide loss. As with most devastating experiences, we usually do not learn the valuable lessons until long after we have had time to reflect upon what might have changed things or made for a different outcome.

"One of the many things I have learned through my experiences in terms of preventing suicide, which research supports, is that lethal means safety, particularly with safe use and safe storage of firearms, is as critically important today as it was when I lost my husband in 1994, given the exponential lethality and high rates of firearm-related suicides in the military and veteran communities."

Many TAPS survivors wish they had been provided proactive counseling on lethal means safety planning before their loved one died. The time for learning about these issues is *right now*, not in a moment of crisis. Prior education and awareness, during and post service, especially during transition to veteran status, make everyone better prepared to respond when faced with a situation requiring a potential intervention.

Discussions on lethal means safety and safe storage of firearms can be challenging when firearms are a large part of military and veteran identity, but these critical conversations must happen because they have the potential to save lives.

ENSURING VETERANS' FINAL RESTING PLACE ACT OF 2025 (S. 1116)

TAPS Strongly Supports

TAPS is grateful to Senators Jim Banks (R-IN), Susan Collins (R-ME), and Jacky Rosen (D-NV) for introducing the ***Ensuring Veterans' Final Resting Place Act of 2025 (S. 1116).*** This important legislation would authorize the provision of certain additional burial benefits for individuals for whom an urn or plaque is furnished, if the cost of the urn or plaque is reimbursed by a non-department entity.

We have heard from surviving families who initially elected to receive an urn or plaque in honor of their deceased veteran that they were unaware this election would forfeit burial benefits going forward. This legislation would allow surviving families to reimburse the VA for the cost of the urn or plaque if they later elect to inter their veteran in a VA national cemetery. Under current law, surviving families are not allowed to elect both. Unfortunately, this has caused additional emotional and financial burdens on military and veteran surviving families.

REVIEW EVERY VETERAN'S CLAIM ACT of 2025 (S. 1657)

TAPS Supports

TAPS appreciates Senators Jim Banks (R-IN) and Angus King (I-ME) for introducing the ***Review Every Veteran's Claim Act of 2025*** **(S. 1657).** This important legislation would preclude the Department of Veterans Affairs (VA) from denying a claim based solely on the veteran's failure to appear for a VA examination, scheduled in conjunction with a claim. It would also require the VA to consider the evidence already in the veteran's claims file when making a decision on their claim.

Requiring the VA to consider all available evidence, including service or private medical records, as well as lay statements, before rendering its claims decision, will allow veterans to have a fair and complete review of their claims. This common-sense legislation will improve the claims process for veterans and their families, and TAPS looks forward to its swift passage.

VETERANS APPEALS EFFICIENCY ACT OF 2025 (S. 1992)

TAPS Supports

TAPS thanks Senator Jim Banks (R-IN) and Ranking Member Richard Blumenthal (D-CT) for introducing the ***Veterans Appeals Efficiency Act of 2025*** **(S. 1992)**, which aims to improve how the Department of Veterans Affairs (VA) handles benefits claims and appeals — making the process faster, more transparent, and easier to track for veterans and their families.

This important legislation would direct the VA to report on how long remanded claims are pending, how many cases have been expedited, and how many appeals have been dismissed — including those due to a veteran's death or suicide. The VA would also be required to define what qualifies a veteran's appeal for faster review, and track the progress and delays of the claims process to improve outcomes and ensure fair and timely consideration.

The ***Veterans Appeals Efficiency Act of 2025*** builds upon Ranking Member Blumenthal's ***Veterans Appeals Improvement and Modernization Act of 2017*** **(Public Law 115-55)** by granting the U.S. Court of Appeals for Veterans Claims expanded authority to send cases back for focused review and oversee class actions involving similar claims. This important legislation will help empower veterans to resolve shared legal challenges.

MOLLY R. LOOMIS RESEARCH FOR DESCENDANTS OF TOXIC EXPOSED VETERANS ACT OF 2025 (S. 2061)

TAPS Strongly Supports

TAPS greatly appreciates Ranking Member Richard Blumenthal (D-CT) and Senator Patty Murray (D-WA) for introducing the ***Molly R. Loomis Research for Descendants of Toxic Exposed Veterans Act*** **(S. 2061).** This important legislation will expand critical research on the diagnosis and treatment of health conditions of descendants of veterans who were exposed to toxic substances during their military service.

S. 2016 would amend the ***Sergeant First Class Heath Robinson Honoring Our Promise to Address Comprehensive Toxics Act of 2022*** **(Public Law 117–168)**, to include the establishment of a federal interagency "working group" task force to conduct collaborative research activities over a five-year period, and make recommended legislative or administrative actions.

As a founding member and co-chair of the Toxic Exposure in the American Military (TEAM) Coalition — a group of 30 military and veteran service organizations and experts — TAPS was honored to invite Molly Loomis to address our group. This legislation is named in her honor. She is the daughter of Richard Loomis, a Vietnam War veteran who was exposed to Agent Orange during his military service and died in 2013 from bladder cancer. Molly was born with spina bifida, a condition that has been diagnosed in the biological children of Vietnam War veterans.

According to research from the Environmental Working Group, "The impact of toxic chemicals on generations of offspring with no direct exposure to the contaminant is known as a transgenerational effect." This groundbreaking legislation will help us understand the magnitude of transgenerational effects of toxic exposure on veterans' families and help provide a pathway to earlier detection and treatment.

Our nation's toxic-exposed veterans and their families deserve answers, decisive action, and essential life-saving care and support. TAPS strongly urges the passage of the ***Molly R. Loomis Research for Descendants of Toxic Exposed Veterans Act*** **(S. 2061)** without delay.

FIGHTING FOR THE OVERLOOKED RECOGNITION OF GROUPS OPERATING IN TOXIC TEST ENVIRONMENTS IN NEVADA (FORGOTTEN) VETERANS ACT OF 2025 (S. 2220)

TAPS Strongly Supports

TAPS is extremely grateful to Senators Jacky Rosen (D-NV) and Catherine Cortez Masto (D-NV) for introducing the ***Fighting for the Overlooked Recognition of Groups Operating in Toxic Test Environments in Nevada (FORGOTTEN) Veterans Act of 2025*** **(S. 2220).** This long-overdue legislation will ensure veterans who were exposed to toxic radiation within the Nevada Test and Training Range (NTTR) from the 1950s through the 1990s receive the health care and benefits they have earned and deserve.

Veterans who served at the NTTR are currently unable to receive VA care and benefits for radiation and toxic exposure. This is due to the classified nature of their location during service, which prevents them from providing the required proof of service at the NTTR to the VA. Unfortunately, many of these veterans are dying in rapid numbers.

This critical legislation will classify the NTTR as contaminated and require the Department of Defense (DoD) to document all exposures, including those that occur domestically, into the service member's Individual Longitudinal Exposure Record

(ILER). It will also require the Secretary of the Air Force to identify all those who served within the NTTR since January 27, 1951, and establish a process for service members and veterans to provide proof of their assignment within the NTTR.

Since this population was left out of the ***Sergeant First Class Heath Robinson Honoring Our Promise to Address Comprehensive Toxics Act of 2022*** **(Public Law 117–168),** S. 2220 will establish a presumption of toxic exposure for veterans who served on or above the NTTR, easing the burden of proof in VA claims. This bill will also expand presumptive conditions for service connection by adding lipomas and tumor-related conditions to the list of presumed service-connected illnesses.

TAPS is proud to stand with The Invisible Enemy, formed in 2023 by Air Force Sergeant Dave Crete to advocate for service members, veterans, and civilians who served within the NTTR. As the co-chair of the Toxic Exposure in the American Military (TEAM) Coalition, TAPS and our fellow TEAM members recently welcomed The Invisible Enemy as a new member of our coalition. Together, we are standing shoulder to shoulder in support of the ***FORGOTTEN Veterans Act of 2025.***

These "forgotten veterans" have waited decades for the care and benefits they have earned and deserve, and must not be made to wait any longer. TAPS urges Congress to act now and pass this critical, life-saving legislation!

VETERAN BURIAL TIMELINESS AND DEATH CERTIFICATE ACCOUNTABILITY ACT (S. 2309)

TAPS Strongly Supports

TAPS thanks Senators John Boozman (R-AR), Maggie Hassan (D-NH), and John Cornyn (R-TX) for introducing the ***Veteran Burial Timeliness and Death Certificate Accountability Act*** **(S. 2309).** This important legislation would require a physician or nurse practitioner employed by the Department of Veterans Affairs (VA) to certify the death certificate of a veteran no later than 48 hours after notification, regardless of where the veteran passes.

As the national organization providing comfort, care, and resources to all those grieving the death of a military or veteran loved one, TAPS knows firsthand that the timely issuance of a death certificate is vital for the emotional and financial well-being of our surviving families. Without a death certificate, surviving families cannot access their veteran's earned burial and survivor benefits, and find much-needed closure critical to their grieving process.

MILITARY LEARNING FOR CREDIT ACT OF 2025 (S. 2328)

TAPS Supports

TAPS thanks Senators Christopher Coons (D-DE) and Joni Ernst (R-IA) for introducing the ***Military Learning for Credit Act of 2025*** **(S. 2328),** and Representatives Maggie Goodlander (D-NH-2), Elise Stefanik (R-NY-21), Chris Papas (D-NH-1), and Juan Ciscomani (R-AZ-6) for introducing it in the House.

This bipartisan, bicameral legislation will enable veterans to use their educational assistance to cover the costs associated with examinations and assessments required to receive academic credit toward degrees from institutions of higher learning. These examinations and assessments include standardized tests like the DANTES Subject Standardized Test Program (DSST), College Level Examination Program (CLEP), National Career Readiness Certificate examination, and evaluations of military training or learning portfolios.

TAPS is proud to support this legislation, which formally acknowledges and assigns academic credit to a veteran's valuable experiential learning gained through military service. S. 2328 will further strengthen educational support for our veterans and their families, and TAPS looks forward to its passage.

HEALTH RECORDS ENHANCEMENT ACT (S. 2333)

TAPS Supports

As the leading voice for the families of those who died as a result of illnesses connected to toxic exposure and a founding member and co-chair of the Toxic Exposure in the American Military (TEAM) Coalition, TAPS is grateful to Senator Peter Welch (D-VT) for introducing the ***Health Records Enhancement Ac***t **(S. 2333)**.

This important legislation will improve data collection on burn pit and toxic exposures by authorizing a designated caregiver or immediate family members of deceased veterans to provide the Department of Veterans Affairs (VA) and the Department of Defense (DoD) with additional health data and observed health conditions.

The ability to add this critical information to a deceased veteran's health records will not only provide a more comprehensive health history, it will enable future research and informed preventative care for impacted veterans, helping save precious lives.

VETERANS SCAM AND FRAUD EVASION (VSAFE) ACT OF 2025 (S. 2683)

TAPS Strongly Supports

TAPS thanks Senators John Cornyn (R-TX), Maggie Hassan (D-NH), John Boozman (R-AR), and Angus King (I-ME) for introducing the ***Veterans Scam And Fraud Evasion (VSAFE) Act of 2025*** **(S. 2683).** This important bipartisan legislation takes crucial steps to rectify the increasingly sophisticated scams and fraudulent schemes targeted at many veterans, families, caregivers, and survivors. Veteran-targeted scams include identity theft, fraudulent benefit offers, predatory financial schemes, phishing attempts, and impersonation of VA personnel.

These schemes not only steal money, but dignity and peace of mind. This legislation creates a **Veterans Scam and Fraud Evasion Officer** within the Department of Veterans Affairs — finally establishing a single, accountable leader responsible for coordinating all fraud-prevention activities within the VA. Centralized coordination means fewer veterans fall through the cracks, and the VA can use its resources more effectively rather than duplicating efforts across siloed departments.

Many of these scams succeed because the criminals know veterans, families, caregivers, and survivors trust government institutions. That trust is being weaponized against them. The VSAFE Act is not just a bureaucratic fix — it is an important act of restoring that trust.

RESTORING THE SANCTITY OF PUBLIC ENTOMBMENTS, CEMETERIES, AND TRIBUTES ACT OF 2025 OR RESPECT ACT OF 2025 (S. 2807)

TAPS Supports

TAPS thanks Senators John Cornyn (R-TX), Mazie Hirono (D-HI), Lisa Murkowski (R-AK), John Fetterman (D-PA), Rick Scott (R-FL), and Adam Schiff (D-CA) for introducing the ***Restoring the Sanctity of Public Entombments, Cemeteries, and Tributes Act of 2025 or RESPECT Act of 2025*** **(S. 2807).**

This bipartisan legislation would allow for the reconsideration of decisions made on or after June 18, 1973, by modifying the applicability of the authority of the Secretary of Veterans Affairs or the Secretary of the Army to inter the remains or honor the memory of a person in a national cemetery. It also repeals a section of the ***Alicia Dawn Koehl Respect for National Cemeteries Act*** **(Public Law 113-65),** and would streamline the processes for interment and memorials within national cemeteries.

FISHER HOUSE AVAILABILITY ACT of 2025 (DISCUSSION DRAFT)

TAPS Strongly Supports

TAPS greatly appreciates Chairman Jerry Moran (R-KS) and Ranking Member Richard Blumenthal (D-CT) for introducing the ***Fisher House Availability Act of 2025,*** which takes a meaningful and overdue step to support the well-being of our service members, veterans, and their families during times of medical need.

For decades, Fisher Houses have stood as one of the most successful public–private partnerships serving the military and veteran community. These homes relieve the financial and emotional burden on families by providing no-cost lodging near VA and military medical centers. They allow loved ones to remain close at hand during treatment and recovery — something research consistently shows improves outcomes, strengthens resilience, and reduces stress on both patients and caregivers.

Service members and their families often travel great distances for specialized care, only to find they cannot use nearby Fisher House lodging purely because of statutory restrictions. This creates unnecessary financial strain, forces families to stay apart during moments of crisis, and leaves existing space in Fisher Houses underutilized.

The ***Fisher House Availability Act of 2025*** remedies this gap by expanding access without displacing veterans. This ensures veterans remain the priority while making practical use of vacant rooms that would otherwise go unused. It ensures that families can stay together during medical hardship while utilizing already existing infrastructure.

SHARING ESSENTIAL RESOURCES FOR VETERANS EVERYWHERE (SERVE) ACT (DISCUSSION DRAFT)

TAPS Supports

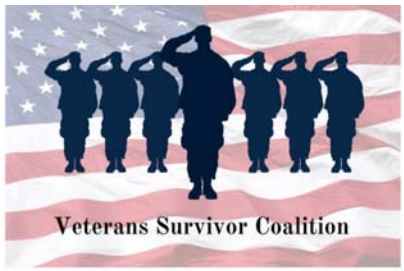
TAPS thanks Chairman Jerry Moran (R-KS) for introducing the ***Sharing Essential Resources for Veterans Everywhere Act*** or the ***SERVE Act***, which aims to improve the availability of care for veterans from facilities and providers of the Department of Defense (DoD).

This important legislation would require the Secretary of Veterans Affairs to ensure training for staff and contractors involved in or assisting with scheduling veteran appointments under the community care program to offer veterans the option of receiving care at military medical treatment facilities operated by the DoD.

The bill would also require cross-credentialing of health care providers, including nurses, medical technicians, and other support staff, to jointly care for beneficiaries in medical facilities of the VA and DoD. Expanding the partnership between the VA and DoD in areas where a military medical treatment facility has excess capacity will improve access to care for veterans and utilize essential shared resources.

CONCLUSION

TAPS appreciates the leadership of the Senate Committee on Veterans' Affairs, its distinguished members, and professional staff for holding this legislative hearing on strengthening veteran and survivor benefits. TAPS is honored to submit a statement for the record on behalf of the thousands of surviving military and veteran families we serve.



Supporting Signing Death Certificates Within 48-Hours

December 3, 2025

The Honorable Jerry Moran
Chairman
Committee on Veterans' Affairs
United States Senate
Washington, DC 20010

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

Dear Chairman Moran and Ranking Member Blumenthal:

On behalf of the Veterans' Survivor Coalition, which represents families across the country who have lost loved ones who served, we write in firm support of S. 2309, the Veteran Burial Timeliness and Death Certificate Accountability Act. We thank you for holding this hearing and for your consistent bipartisan commitment to veterans' issues. We also extend our deep appreciation to Senator John Boozman and Senator Margaret Hassan, whose persistent advocacy has kept this issue alive and moving forward.

For the families we represent, the days immediately following the loss of a veteran are some of the hardest they will ever face. Yet instead of being able to grieve, honor, and remember their loved one, many families are confronted with 4–8 week delays in obtaining the documentation required for burial. These delays stall every step of the process: funeral planning, military honors, burial at a veterans cemetery, and the ability to bring final peace to those who served our nation.

The impact is profound
Families are forced to wait, sometimes for months, unable to schedule a burial. Children are left confused as to why their parent cannot be laid to rest. Spouses are stuck in an emotional limbo, unable to move forward or find closure. Many families describe this experience as "a second loss"—a painful reminder that the very system meant to honor their veteran has instead left them in distress.

These delays occur for reasons that should not exist in a nation committed to honoring its veterans. The pain caused by these gaps is real, widespread, and entirely preventable.

Supporting Signing Death Certificates Within 48-Hours

S. 2309 addresses the problem head-on
It establishes clear expectations, enforces timely processing, and creates accountability structures that remove the uncertainty families now face. It takes a system that too often leaves families waiting in anguish and replaces it with one built on respect, reliability, and compassion. Most importantly, it ensures that when a veteran passes, their family is not forced to fight through red tape at the moment they are hurting most.

For years—five long years—families, county officials, advocates, and survivors have been working to bring attention to this issue. Today's hearing represents a crucial milestone in a journey that has been driven by heartbreak, determination, and the refusal to let any more families suffer through avoidable delays.

We urge the Senate to act swiftly and pass this legislation before the end of the year. Doing so would provide immediate relief to thousands of families and send a message that this country stands by its promise to care for those who served—and for the loved ones they leave behind.

Thank you again, Chairman Moran and Ranking Member Blumenthal, for your steadfast leadership and your commitment to veterans and their families. We urge Congress to seize this moment and deliver the respectful, timely process our veterans deserve.

Respectfully submitted,

The Veterans' Survivor Coalition

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