STATEMENT

of the

MILITARY OFFICERS ASSOCIATION OF AMERICA

LEGISLATIVE PRIORITIES

for

VETERANS' HEALTH CARE and BENEFITS

115th Congress

before the

SENATE and HOUSE VETERANS' AFFAIRS COMMITTEES

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EXECUTIVE SUMMARY

VETERANS' HEALTH CARE

- **Health Care System Reform —** Support and invest in modernizing the Veterans Affairs Health Administration, including reforming Veterans Choice and VA Community Care Programs, while preserving foundational programs and services unique to the VA to meet evolving veteran and health system requirements.
- **Program of Comprehensive Assistance for Family Caregivers —** Expand the Caregivers and Veterans Omnibus Health Services Act of 2010 (P.L. 111-163) to include full-time caregivers of catastrophically disabled veterans of conflicts before Sept. 11, 2001, and align the VA and DoD caregiver definitions and policies for support and services to help ease transition from military service into VA care.
- **Women Veterans' Health Care** — Aggressively invest and implement the six pillars of VHA's strategic priorities to provide comprehensive primary care, health education, reproductive health services, and women's health research; improve communication and partnerships; and increase access to gender-specific medical and mental health care to meet the unique needs of servicewomen and transitioning women veterans.
- **Suicide Prevention and Traumatic Injuries —** Implement and sustain an integrated, multidisciplinary, comprehensive behavioral health system to address the rising rates of suicides and veterans suffering from cognitive, mental health, and physical conditions resulting from traumatic exposure or injury, service or non-service connected.
- **Deployment-Related Illnesses and Toxic Exposures Research —** Invest and advance joint federal research on the effect on servicemembers of exposure to occupational, environmental, or hazardous toxins and contaminants resulting from their military service and ensure health care and benefits are established to appropriately compensate and support veterans, family members, and survivors.

VETERANS' BENEFITS

- **Develop a Framework to Address Future Toxic Exposures** — Institute a mechanism to not only address known toxic exposures but also to institute a framework to manage toxic exposures that might happen in the future.
- **Improve the Transition Assistance Program for Women Veterans** — Mandate improvements to the Transition Assistance Program to ensure women veterans are aware of and can access earned benefits.
- **Preserve the Integrity of Earned Veterans' Benefits** — Preserve the intended value of earned veterans' benefits, such as the Post-9/11 GI Bill, from being compromised through unscrupulous actions of those who seek to prey on veterans for financial gain.

- **Improve Legislation to Enable Military Spouse Employment** — The Military Spouse Residency Relief Act and Servicemember Civil Relief Act are within these committees' jurisdiction and improvements can be made that would dramatically impact military spouse employment and enable successful transition for military families to veteran status.

CHAIRMAN ISAKSON, CHAIRMAN ROE, RANKING MEMBERS TESTER AND WALZ, on behalf of the Military Officers Association of America (MOAA), I am grateful for the opportunity to present testimony on MOAA's major legislative priorities for veterans' health care and benefits for 2018.

MOAA does not receive any grants or contracts from the federal government.

The association is especially grateful for the committees' tenacious efforts and unfailing commitment to putting veterans first, particularly in light of the significant competing priorities and fiscal challenges facing our country today. MOAA appreciates your willingness to keep veterans and veterans' organizations engaged and informed in the policymaking process, thus honoring the service and sacrifice of uniformed servicemembers and veterans and their families in a meaningful and tangible way.

MOAA realizes the constraints of the Budget Control Act, and we are committed to assisting Congress in finding ways to provide veterans the care and benefits they have earned without cannibalizing those same benefits to pay for other earned benefits or to be used for other national economic priorities. We are not, however, opposed to responsible reform efforts that will yield greater efficiencies within VA, reduce wasteful spending and practices, and allow for the fulfillment of promises made to our veterans.

MOAA will focus our advocacy efforts this year on enacting legislation that ensures timely access to the best possible quality health care for veterans while also preserving the benefits they earned through their military service.

VETERANS' HEALTH CARE PRIORITIES

HEALTH CARE SYSTEM REFORM

While the all-volunteer force evolves over time, so does the Veterans Health Administration (VHA) as it struggles to keep pace with the ever-changing needs of multigenerational veterans who have served.

Veterans generally are older than their nonveteran counterparts. According to the National Center for Veterans Analysis and Statistics, Profile of Veterans: 2016 Data from the American Community Survey in February 2018, the median age of male veterans was 65, compared to 41 years old for their nonveteran peers. For females, the median age for veterans was 50, compared to 47 years old for nonveteran women.

The largest group of male veterans living today served during the Vietnam era (1964-75), while the largest group of women veterans served post-9/11 (September 2001 or later).

Nearly 6.7 million of the almost 22 million veterans in the U.S. receive their care in a VA medical facility. Veterans using VA health care often have some of the most complex health conditions, requiring specialized multidisciplinary care, including behavioral health services foundational to VHA.

Although the veteran population is expected to continue declining over the next few years, demand for VA health care steadily grows because of the aging and unique demographics of this population, preventing the department from meeting current capacity and capability demand. As such, MOAA continues to press for major VA health care system reform by supporting and investing in modernizing VHA technology, finance, infrastructure, electronic health records, and human resource systems, including reforming VA Community Care and Choice Programs to meet transformational goals and evolving veteran and health system requirements.

Critical elements to veterans' health care reform should include:

- VA act as the primary provider of care and maintain overall health care coordination and navigation support for veterans.
- Investment in foundational and specialty-care services paramount to VA, such as spinal cord injury, blind rehabilitation, mental health, prosthetics, and similar services.
- Delivery of core mission functions, such as clinical, education, research, and national emergency response to advance the health and well-being of veterans and the broader U.S. population health.
- High-performing, high-quality, integrated health care network, combining the best of VHA, and the best of private-sector community-based services.
- Option for veterans to have a choice to use network community providers when VA is unable to offer reasonable access to quality care.
- Highest priority in access to health care given to service-connected and low-income veterans.

MOAA and our veterans' service organization (VSO) partners worked tirelessly with VA and congressional leaders to protect, strengthen and reform VHA over the last several years, including replacing the Veterans Choice Program and consolidating the seven disparate and complex community-care programs VA manages today.

Efforts to reform VHA and integrate community-care programs require vigilance in striking the right balance of public and private care while ensuring VA maintains the ability to be the primary resource for delivering veterans' health care. No veterans should be left with the impression that VA isn't responsible for providing them the health care they require. Accordingly, MOAA is supportive of legislative solutions and funding scenarios that preserve foundational and specialty services inherently under the purview of VA, place VA as the primary provider of medical care and services, and provide for clinically appropriate solutions and patient outcomes across the system, leaving no veteran behind.

Nearly a year after his promotion to secretary of VA, Dr. Shulkin continues to be saddled with the Choice Program — a temporary program established through the Veterans Access, Choice and Accountability Act of 2014 (P.L. 113-146) to address massive wait times across the VA's health system brought to light by media reports of secret wait lists in the Phoenix VA medical center in Arizona. The program has been limping along on life support until Congress can pass broader measures to improve and fund the necessary reform for veterans' health care.

By all accounts, 2017 was an extremely productive year, with the president signing almost a dozen significant pieces of legislation aimed at improving the lives of veterans and their families, including the Harry W. Colmery Veterans Educational Assistance Act (P.L. 115-48), commonly referred to as the "Forever GI Bill;" the VA Accountability and Whistleblower Protection Act of 2017 (P.L. 115-41); and short-term extensions to Choice funding.

Yet another year slipped by without an agreement on legislation to move forward with replacing Choice and reforming community care, even after the thoughtful and collaborative work between VA and the committees to come up with their respective community-care bills — Secretary Shulkin's CARE (Community Access for Rewarding Experiences) draft bill; S. 2193, the Caring for our Veterans Act of 2017; and H.R. 4242, the VA Care in the Community Act.

While both the House and Senate bills have merit, MOAA and most all VSOs support S. 2193, as it also includes provisions to expand VA support and services for full-time caregivers of catastrophically disabled veterans of all eras, includes investments in VHA infrastructure, and builds upon Secretary Shulkin's CARE proposal.

MOAA believes the administration and Congress have never been closer to reconciling the differences between the bills, and we remain solidly determined in our advocacy efforts to get legislation signed and enacted this year to keep VA on a trajectory of providing veterans timely access to quality health care.

Concurrently, VA must have the necessary funding to implement the reform legislation, including a budget to sustain the integrated health care network over the longer term, both direct care and community care. Operating under a continuing resolution for the first six months of FY 2018 hinders VA's ability to implement any dramatic system improvements, much less conduct daily business operations, and potentially negatively impacts veterans' access to care.

As a strong proponent of our VSO partners (Disabled American Veterans, Paralyzed Veterans of America, and the Veterans of Foreign Wars) and coauthors of *The Independent Budget (IB): Veterans Agenda for the 115th Congress*, MOAA urges the committees to carefully consider the IB's recommendations in deliberating VA budget requirements. The IB, the independent assessments supporting the Commission on Care report address the problems associated with inadequate funding and the potential impact on delivering timely, quality health care when funding, resources, and demand are not in alignment.

Congress and the administration consistently have increased funding for VA health care since 2006. As in previous years, the president's budget proposal for FY 2019 builds on Secretary Shulkin's efforts to modernize the VA and rebuild trust between the agency and the veterans it serves. MOAA is encouraged by the administration's budget proposal and pleased it addresses many of our association's reform priorities.

VA has done an admirable job on its own to bring about system change, and MOAA commends Secretary Shulkin for reestablishing a strong partnership with DoD. This is an especially important time to develop strong relationships and learn from each other as both departments undergo massive transformation. MOAA believes successful transformation will only occur once VA and DoD have fully implemented and achieved an integrated, interoperable electronic health record system.

Finally, with assistance from Congress, VA must aggressively focus efforts this year to eliminate the 35,000 employee shortage in its health system and pursue workforce improvements needed to have a viable, talented, and stable workforce to meet the needs of veterans in the 21st century.

Workforce improvements should include:

- recruiting and retaining health care professionals in under resourced areas such as physicians, physician assistants, mental health providers, and nurses from other government and civilian sectors;
- implementing independent practice authority for advance practice nurses;
- growing the existing MOU between VHA and the Department of Health and Human Services from 30 to over 100 billets for members of the U.S. Public Health Service (USPHS) to serve in clinical and nonclinical roles; and
- establishing a memorandum of understanding between VHA and USPHS to create and fund 10 slots per year at the Uniformed Services University of the Health Sciences for medical students who agree to join the USPHS and then serve in VHA clinics and hospitals to repay the government for their medical education.

MOAA recommends the committees:

- ***strike a bipartisan, bicameral agreement on VA community-care reform legislation and associated funding to move community-care legislation quickly through Congress through enactment and***
- ***provide continuous, full level of funding for VHA, aligning funding and resources to meet veteran needs, which includes preserving foundational programs and services unique to VA to meet evolving veteran and health system requirements.***

PROGRAM OF COMPREHENSIVE ASSISTANCE FOR FAMILY CAREGIVERS (PCAFC)

The Caregivers and Veterans Omnibus Health Services Act of 2010 (P.L. 111-163) was enacted to provide comprehensive caregiver support and services to caregivers of veterans severely injured or disabled in the line of duty on or after Sept. 11, 2001.

VA has done a stellar job over these many years in implementing and fine-tuning the PCAFC — the only health system in the country to provide extensive wrap-around medical care and support services, such as a monthly stipend, travel expenses, health insurance, mental health services, and respite care specifically for caregivers.

Thousands of Post-9/11 veterans and their caregivers have benefited from the program by receiving comprehensive services in a home environment to help facilitate their health and well-being.

However, millions of veterans remain ineligible for this benefit because their service took place before Sept. 11, 2001. MOAA, The Military Coalition (TMC), VSOs, and other stakeholder organizations have pressed hard since the program was established to pass legislation to ensure veterans of all eras have access to the same level of comprehensive services as Post-9/11 veterans.

MOAA commends Secretary Shulkin for acknowledging and working toward a solution to care and support veterans and their caregivers of all eras.

> *"It is our intent to be able to bring this to pre-9/11 caregivers because, frankly, the most vulnerable group right now are elderly veterans," Shulkin said. "The worst situation is when nobody is in their home and they have to leave their home to go to an institution, a nursing home…Its cheaper to keep veterans in their homes with caregivers than it is to move them to an outside facility," he told lawmakers last May.*

Over the past year, VA conducted a strategic review of PCAFC and worked closely with stakeholders throughout the process. The review reveals a need for better communication between VA, caregivers, and veterans about eligibility determinations, discharges, and clinical appeals process, including significant inconsistency across the system in implementing the program.

Since the review, VA has taken a number of positive steps to improve communication and engagement with all stakeholders, such as redesigning the Caregiver Support Program website, publishing a new directive, and standardizing information materials for communicating with veterans and their caregivers in all VA medical facilities. The need is great among all generations of veterans. One veteran asked us to share his observations of VA and his needs:

"I am an 81-year-old, blind, 100-percent disabled veteran who uses VA for most all of my care. VA has saved my life on multiple occasions, for which I am eternally grateful. As wonderful as VA, and the Choice Program have been for me, it's my wife I worry about the most. She's been my caregiver for over 20 years, and the burden is wearing on her, but VA told me they don't have support services to help her. Please share this with whoever will listen, and let them know we need VA's help." U.S. Navy Retired, MOAA life member, Happy Valley, OR

MOAA is grateful to members in both committees for championing a number of significant bills over the years to expand eligibility and improve VA's Caregiver Support Program. While many of these bills have focused primarily on veterans and their caregivers, more needs to be done to help servicemembers and their caregivers as they transition from military service. VA and DoD definitions and policies for caregiver compensation and support services should mirror each other, and that support should be seamless from one system to the next to make it easier for servicemembers and their families as they transition during a devastating and extremely confusing time in their lives.

MOAA is confident VA will be able to expand caregiver support with the commitment and assistance from Congress, the administration, VSOs, and other stakeholders to find a common solution.

MOAA recommends:

Congress expand the Caregivers and Veterans Omnibus Health Services Act of 2010 (P.L. 111-163) to include full-time caregivers of catastrophically disabled veterans of conflicts before Sept. 11, 2001, as delineated in S. 2193, and align VA and DoD caregiver definitions and policies for support and services to help ease transition from military service into the VA.

WOMEN VETERANS' HEALTH CARE

Women continue entering military service in record numbers and remain the fastest growing population of veterans in VHA. In fact, the total population of women veterans is expected to grow at a rate of about 18,000 women per year over the next 10 years.

Today, about 2 million veterans in the U.S. and Puerto Rico are women, representing about 9.4 percent of the total veteran population.

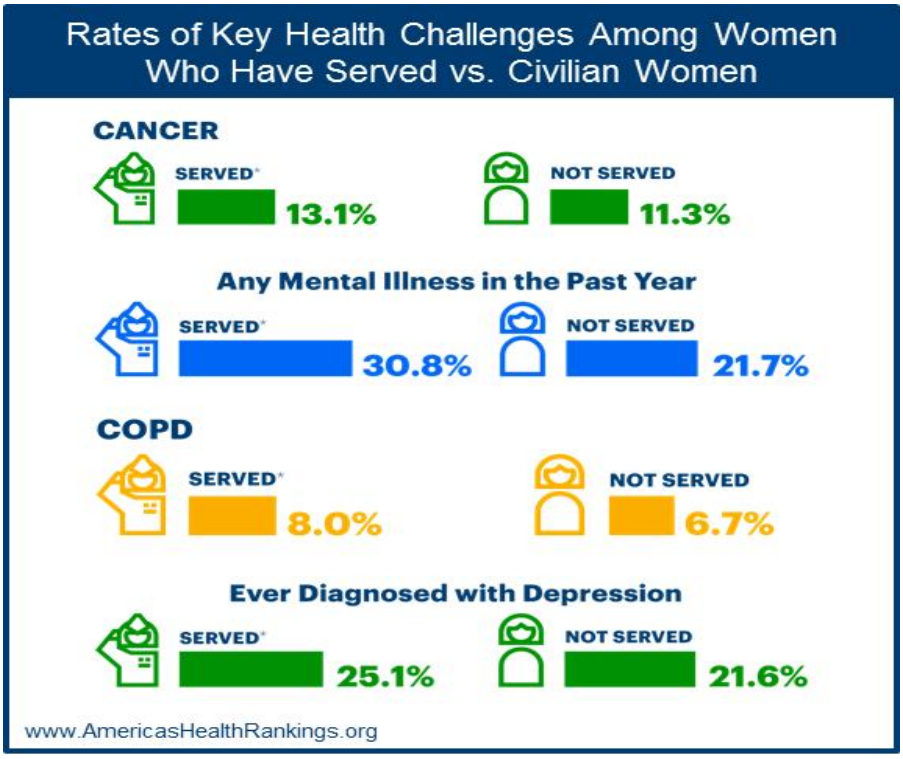
Since 2000, the number of women accessing VA health care has more than tripled, to about 700,000 enrolled in 2017.

With the lifting of the exclusion of women in combat in 2015, the roles of women in military service continue to change, presenting an opportunity for VA and DoD to collaborate on research and medical care in order to better understand the impact of military service on women's health. Both health systems must be prepared to address not only the most frequent medical conditions

and needs women face today but also the unique and evolving health issues associated with women in combat.

In November 2017, the United Health Foundation, in partnership with MOAA, released the *Health of Women Who Have Served Report* (an America's Health Rankings® Report). This distinctive study, developed in collaboration with an advisory steering group of leading military, veterans', and public health organizations, including VA, establishes a baseline portrait of the health of women who have served in the U.S. armed forces compared to the health of their civilian counterparts.

The study found women veterans reported higher rates of cancer, mental illness, chronic obstructive pulmonary disease (COPD), and depression.



More than 8 percent of the women surveyed over a four-year period reported having suicidal thoughts in the past year — twice that of their civilian counterparts. About a third reported arthritis, compared to about 26 percent of civilian women. Other findings include:

- About 13 percent of women who served had cancer, compared with roughly 11 percent of women who did not serve.
- Nearly 42 percent reported getting insufficient sleep, compared to 34 percent of civilian women.
- About a third of women veterans reported mental illness in the last year, compared to about 22 percent of women who didn't serve.

VA acknowledged the report findings were similar to what VA sees in this population. Despite facing some higher rates of health problems, women veterans show tremendous resilience, which is why more than 56 percent of respondents reported being in good or excellent health compared to about half of civilian women.

MOAA and United Health Foundation are especially grateful to Rep. Julia Brownley (D-Calif.) and Sen. Tammy Duckworth (D-Ill.) for their support of the report as expressed during a Capitol Hill event last fall:

"While we have made improvements, the VA remains ill-prepared to deal with growing number of women veterans whose mental and physical health care needs can be different from their male peers and from civilian women," Representative Brownley said.

"The focus of the study released today is so incredibly important and so needed," said Senator Duckworth. "That data is missing in the health care and scientific world in terms of the research and analysis of women veterans. People talk about it, but actual reports like this one are so rare."

While VA has done substantial work to get women "to choose VA" for their health needs by reducing gender gaps in clinical care and expanding services and care across the country, a number of significant barriers still linger as pointed out in recent Government Accountability Office (GAO) high risk studies and reports by VA's Advisory Committee on Women Veterans.

In February 2017, GAO reported challenges in VA addressing weaknesses in its oversight and accountability in providing health care services for women veterans in medical facilities. The report stated VA lacked reliable data to ensure medical center compliance with requirements related to the environment of care — standards for privacy at check-in and interview areas, location of exam rooms, and the presence of privacy curtains in exam and inpatient rooms.

Additionally, the VA Advisory Committee for Women Veterans continues to recommend VA across the agency "collect and report gender-specific demographic information about programs and services to better understand and respond to the unique needs of women veterans, and to identify opportunities and challenges in programming for women veterans" (September 2016 Report).

MOAA appreciates the committees' long-standing commitment to women veterans and is particularly grateful for your support in introducing the Deborah Sampson Act (S. 681 and H.R. 2452), which will go a long way in addressing gender disparities at VA to ensure women veterans are getting equitable care. This bill will provide for enhanced access to VA care and will ensure women veterans are getting the benefits they have earned through their service.

MOAA recommends:

- ***Ongoing congressional oversight and hearings to ensure VA aggressively invests and complies with requirements and standards outlined in the six pillars of VHA's Strategic Priorities to provide comprehensive primary care, health education, reproductive health services, women's health research; improve communication and partnerships; and increase access to gender-specific medical and mental health care to meet the unique needs of women servicemembers and transitioning women veterans. Ensure special emphasis on programs for women veterans with special needs, including rural, homeless or homebound, and aging veterans as well as women who have lost limbs.***
- ***Enactment of provisions in the Deborah Sampson Act to improve women veterans' access to health care and benefits.***

SUICIDE PREVENTION AND TRAUMATIC INJURIES

MOAA is pleased to see VA and DoD take a more unified strategy and joint approach to addressing suicides as we and TMC have pressed for in recent years.

Last September during Suicide Prevention Month, Shulkin said, "We know that in 2014, an average of 20 veterans a day died in this country from suicide, which is 20 too many."

"This is a national public health crisis requiring a national public health approach," Shulkin continued. "When it comes to preventing veteran suicide, VA can't — and should not — do this alone."

For several months, VA and DoD have pressed full speed ahead to address this national crisis by launching a number of campaigns and outreach events across the country, engaging federal, state, and community partners and veterans' organizations such as MOAA to promote solidarity by embracing a "no wrong door" philosophy to prevent veteran suicide.

MOAA is hopeful this synergy and cooperation will continue as both departments expand their efforts and resources to attack common health and wellness issues. Seventeen years of war continues to take a toll on our servicemembers and veterans and their families. Over the years, MOAA, TMC, and VSOs have seen a number of joint VA/DoD initiatives and programs come and go — attempting to once and for all eradicate suicides and address the multitude of psychological-cognitive health and traumatic injuries resulting from military service.

Additionally, MOAA is grateful to see VA taking steps to use innovative treatments to ease the lives of those living with post-traumatic stress disorder (PTSD) and traumatic brain injury (TBI). Recognizing some veterans don't respond or improve using traditional approaches to health care, VA is opening access to light emitting diode therapy (LED — uses a lightweight frame placed on the head and attached to the nose) for veterans with mild to moderate TBI to help improve brain function. For veterans with PTSD symptoms, VA is using stellate ganglion block (SGB—

involves an injection or shot of medication into the neck) to help ease feelings of anxiety and a constant state of alertness.

VA continues to expand outreach and health care services to help veterans with mental health conditions, including providing emergency care to veterans discharged under other than honorable conditions who normally are not eligible for VA benefits, expanding telemental health services, and advancing complementary and integrative health treatments to promote self-help healing and complement traditional medical approaches.

While promising, there is evidence VA has a lot more to do in outreach and educating veterans about the services available in VHA.

In January 2018, a congressionally mandated report by the National Academy of Sciences, Engineering and Medicine indicated a significant number of Iraq and Afghanistan veterans were unaware of the services in VHA or didn't know how to access the care. Further, the report found that *"approximately half of those who may have a need for mental health care do not use VA or non-VA services, indicating that a large proportion of veterans do not receive any treatment for conditions such as post-traumatic stress disorder, substance use disorder, or depression. In addition, more than half of veterans who screened positive in the survey for having a mental health care need do not perceive a need for mental health services."*

VA is working hard to hire additional providers, particularly in programs targeting high-risk veterans and those with debilitating issues associated with homelessness, chronic medical conditions, drug and alcohol abuse, brain or traumatic injuries, and suicide ideation. The VA also competes for the same limited quantity of quality providers and resources as private health systems at a time when demand is high and resources are limited. As such, VA must continue to aggressively improve the delivery of mental health services by leveraging public-private partnerships, increasing care to rural veterans, and expanding telehealth where possible. Special attention should be focused on seamless referral of high-risk active duty and reserve component servicemembers to the VA health system prior to discharge.

Finally, Congress, VA, and DoD must keep the spotlight on military sexual assault and military sexual trauma (MST). Stronger collaboration between the two agencies in reporting these cases, including policies for prevention, care, services, and benefits, will result in better treatment and support for survivors and improve system accountability.

MOAA and TMC recommends:
Congress ensure VA implement and sustain an integrated, multidisciplinary, comprehensive behavioral health system to address the rising rates of veterans suffering from traumatic injuries such as PTSD, TBI, and MST. Specifically:

- ***Invest in programs and research to identify at-risk populations, expand evidence-based treatment, and improve delivery of care and rehabilitative and preventive services.***
- ***Monitor the VA Suicide Prevention Office efforts to increase behavioral health staff, resources, and crisis line capacity, ensuring outreach efforts are expanded and***

synchronized with the DoD Suicide Prevention Office to address the high rates of suicide among servicemembers and veterans, assuring every call to the VA and military crisis lines are promptly answered.

- ***Amend 38 U.S. Code 1782, Counseling, Training, and Mental Health Services for immediate family members and caregivers to require VA to provide a full range of counseling and mental health services for families and caregivers of veterans participating in caregiving, rehabilitation, and medical care for service-connected and non-service-connected conditions, including veterans in crisis.***

DEPLOYMENT-RELATED ILLNESSES AND TOXIC EXPOSURES RESEARCH

Last year, MOAA and a group of key leaders in VA, DoD, and other governmental and nongovernmental organizations and individuals submitted a list of the top needs and potential solutions to the new administration and Congress for agencies and individuals to focus on in the next two to five years to better coordinate care for our nation's wounded, ill, and injured and their families and caregivers.

Combat casualty totals are much lower today due to medical advances on the battlefield, and there are no large-scale combat operations in Iraq and Afghanistan as in earlier years of war. And while military operations continue to change over time, so too do those wounded, ill, and injured as compared to even 10 years ago. There is a lower volume of combat casualties but, to a greater extent, more noncombat and training injuries, accidents, psychological and behavioral health conditions, and illnesses, particularly catastrophic cancers and diseases.

The group identified a critical need to have a coordinated government research effort targeting toxic exposure and other service-connected illnesses and diseases by establishing an intergovernmental agency partnership (i.e., VA, DoD, USPHS, CDC) to collaborate and implement a multigenerational longitudinal study for Post-9/11 veterans (similar to the National Vietnam Veterans' Readjustment Study), starting with research specific on moderate and severe traumatic brain injuries, comorbid mental health disorders, and organic mood disorders to learn more about how they interface.

With greater emphasis on psychological and physical health care, including veterans exposed to toxic substances and catastrophic injuries during military service, the need for long-term disability care and support services will rise with the aging veteran population.

The need for additional funding to support collaborative research between VA and DoD has never been greater, nor the timing better in light of VA's recent adoption of the same electronic health record as DoD, so ultimately patient data will reside in one common system. The departments have a unique opportunity to capture the experiences of servicemembers for research starting at the time members first enter the military. The lessons learned from earlier military conflicts and deployments can inform DoD on how best to investigate, document, and monitor servicemember exposure to occupational or environmental toxins and contaminants in a

more real-time manner rather than years later after the fact. These lessons learned also can inform the VA how best to prepare to meet the needs of these veterans and their families who will rely on health care and benefits long after military service.

Both the *Health of Women Who Have Served Report* and the precursor report released in 2016, called the *Health of Those Who Have Served Report*, also found those who have served are more likely to report being in very good or excellent health compared with civilians. Additionally, the 2016 report found that despite reporting better overall health, those who have served have higher rates of several chronic diseases than their civilian counterparts — including a 12-percent-higher rate of cancer, 38-percent-higher rate of coronary heart disease, and a 40-percent-higher rate of heart attacks.

These findings raise questions about what might be contributing to these key differences in the health of our servicemembers and veterans and point to areas where more research is needed on key health issues, such as the higher incidence of chronic disease risks and the impact of military service on the health of those who have served.

MOAA recommends:

- ***Invest and advance joint federal research on the effect on servicemembers of exposure to occupational, environmental, or hazardous toxins and contaminants resulting from their military service and ensure health care and benefits are established to appropriately compensate and support veterans, family members, and survivors.***
- ***The committees conduct a joint oversight hearing with the Armed Services Committees to review current data collection and information sharing between VA and DoD related to military service, including scope of medical conditions and discharges for disabilities, diseases, and illnesses. Identifying trends and opportunities to improve data management and medical and benefit programs for current and future exposures.***

VETERANS' BENEFITS PRIORITIES

DEVELOP A FRAMEWORK TO ADDRESS FUTURE TOXIC EXPOSURES

Military members have suffered toxic exposures for as long as the U.S. armed forces have existed. From mustard gas in World War I, radiation in World War II, herbicides during the Korea and Vietnam conflicts, burn pits and other toxins in Iraq and Afghanistan, chemical weapons in Syria, as well as those on our own bases such as at Camp Lejeune and Fort McClellan, it is clear toxic exposure is a regular occupational hazard of military service. In the past, those suffering the consequences of these exposures have been required to fight long battles to obtain the care and benefits they clearly deserved.

It is time for Congress to establish a standing procedure to address these and future toxic exposures such that our veterans no longer need to fight each battle individually. This can be accomplished through legislation that addresses current veterans who have suffered exposures to

provide the proper presumptions that would facilitate them being awarded disability compensation, as well as legislation that establishes a future process moving forward for those who might be exposed to toxins that are as of yet unknown.

As noted above, MOAA believes this effort must be a joint one with VA and DoD. It is essential VA and DoD work together to determine toxic exposures at the time they occur, document exposures in service, and begin studying their health impacts immediately, so that once these servicemembers become veterans, the care they will be needing already will be in place and resourced.

Congress must also require that VA use that information to establish benefits for those conditions that do not require each individual veteran to scientifically prove exposure-related nexus with each claim made. It is inefficient, ineffective, and unreasonable to place the burden on veterans to provide the scientific and medical evidence for each claim when that expertise necessarily resides within the government itself.

MOAA recommends:

- ***Pass legislation establishing a presumption of exposure to Agent Orange for Vietnam era veterans who served in the blue waters of Vietnam, as well as identified areas of Guam, Korea, and Thailand where Agent Orange was used.***
- ***Pass legislation to award disability compensation benefits to veterans who developed disabling conditions as a result of toxic exposures at Fort McClellan.***
- ***The committees conduct a joint oversight hearing with the Armed Services committees to review current data collection and information sharing between VA and DoD related to military service, including scope of medical conditions and discharges for disabilities, diseases, and illnesses. Identifying trends and opportunities to improve data management and medical and benefit programs for current and future exposures.***

IMPROVE THE TRANSITION ASSISTANCE PROGRAM FOR WOMEN VETERANS

As noted above, women are joining the services in steadily increasing numbers, and the corresponding number of women veterans will begin increasing dramatically. Although VA has made significant progress in resourcing women's health programs, more work needs to be done in the transition assistance program to ensure those who are leaving service actually know what benefits and services they can and should be using.

> *"Women veterans are still coming to us in the VA not even knowing how to apply for all the benefits they rate. They need to be educated prior to leaving service to ensure we can effectively assist them once they get here." Department of Veterans Affairs employee*

The joint efforts that VA and DoD have made in improving the transition assistance program have dramatically improved the program for those who are currently transitioning. Data and experience have identified areas where women veterans have unique experiences and needs following transition, yet women veterans still are bypassing VA or are arriving at VA unaware of what they should be doing to access the benefits and services available to them in the department. This indicates a failure in the agencies communicating about the benefits and resources for women veterans.

MOAA recommends:

- ***The committees direct VA to produce a report regarding disability compensation claims filed by women veterans compared to male veterans to determine whether there is a disparity between the disability ratings awarded to women versus men for the same conditions.***
- ***The committees conduct a joint oversight hearing with the Armed Services committees to review how the unique needs of women transitioning from active duty to veteran status are addressed and can be improved upon.***

PRESERVE THE INTEGRITY OF EARNED VETERANS' BENEFITS

Congress has recently implemented major improvements to certain veterans benefits, most notably the Post-9/11 GI Bill. MOAA is grateful for the committees' diligent and concerted efforts in ensuring veterans have an educational benefit that will prepare them for new and exciting challenges as they build new lives after military service.

There are, however, unscrupulous actors who see veterans as a dollar sign and seek to capitalize on their benefits without providing the valuable education Congress intended them to receive. MOAA would like to see better quality controls in the GI bill oversight because large amounts of GI bill funds keep flowing to institutions that do not provide the educational outcomes veterans need to embark on a new career. Even after some educational institutions have been sued by the Department of Justice and the states for defrauding students, they still remain eligible for GI bill funds.

"These colleges are approved by the government; you think they must be good, but they're not. Predatory colleges taking our GI bill and defrauding veterans? That has to be stopped. We need some help. I'm fighting for six years, and then I have to figure out if a college is any good?" Jamie Huebert, U.S. Navy veteran

MOAA recommends:

- ***Continue oversight efforts on VA's implementation of the Post-9/11 GI Bill to ensure Congress' intent is being met by the quality of educational institutions being funded by the GI Bill, including positive student veteran outcome measures.***
- ***The committees introduce and pass legislation to align VA protections for student-veterans with Department of Education and DoD protections.***

IMPROVE LEGISLATION TO ENABLE MILITARY SPOUSE EMPLOYMENT

Military spouse employment at the time of a servicemember's military-to-civilian transition positively correlates with better outcomes for the veteran. Yet, military spouse unemployment rates remain at least four times higher than civilian unemployment rates. While military spouse employment is not in the jurisdiction of this committee, military spouse residency is; expanding residency options for mobile military spouses could remove an additional barrier to maintaining a career.

Military spouses still lack the same legal residency protections that their servicemembers have. While some military spouses can avail themselves of the Military Spouse Residency Relief Act (MSRRA), these protections do not apply broadly enough and do not provide the same depth of protection servicemembers receive under the Servicemember Civil Relief Act. Currently, the MSRRA only provides residency protections to military spouses if they claim the same state of residency as the servicemember. However, many spouses and servicemembers meet and marry long after the servicemember has left their state of residency. Therefore, the military spouse lacks the required physical presence to gain residency in that state and be protected from many residency changes during the servicemembers multiple assignments.

Additionally, as licensure portability remains a state specific challenge, we look to innovation in reciprocal agreements and interstate compacts to offer more opportunity to our licensed and certified professionals, including military spouses. However, incomplete residency protections for military spouses can prevent them from participating in a compact. For example, 47 states have volunteered to become part of the Nurse Licensure Compact, and becoming a registered nurse is a top-three career field chosen by military spouses.

From the Nurse Licensure Compact FAQs[1]:

I live in a compact state and have a license from that state. What do I need to do to get a multistate license?

When you applied for that license, if you declared that state as your primary state of residence and met the licensure requirements of that state, the license you were issued should already be a multistate license, assuming you are currently in good standing.

[1] https://www.ncsbn.org/94.htm, National Council of State Boards of Nursing, NLC FAQ's page, accessed 2/21/2018.

We are grateful for the passage of H.R. 282, *The Military Residency Choice Act*, which would allow a military spouse to elect the same state of residency as the servicemember regardless of physical connection to that state. However, in the example above, this would only help a spouse if the servicemember's state of residency is a part of the compact.

We believe there must be enough protection in the MSRRA to allow military spouses to choose to maintain their residency, even if it is different from that of the servicemember, in order to preserve career portability.

MOAA recommends:

- ***The committees work with key stakeholders to draft legislative proposals expanding residency protections for military spouses.***

Conclusion

Veterans and their families sacrificed and gave so much during their service to our country. To ask them to continue giving after service by funding their earned benefits or cannibalizing benefits to pay for another veteran benefit or program is asking them to go above and beyond what we expect other citizens to do for their country who did not wear the uniform nor put their life on the line.

MOAA believes the members and their staffs have been outstanding partners with VSOs and their cooperation has been very valuable to the accomplishments for veterans in recent years. MOAA looks forward to working with the Congress, the administration, and stakeholders to achieve these legislative priorities — and fulfill our promises to our nation's finest men and women.

Biography of René Campos, CDR, USN (Ret.)
Senior Director, Government Relations for Veterans-Wounded Warrior Care

Commander René Campos rejoined the MOAA staff in February 2015, currently serving as the Senior Director of Government Relations, managing matters related to military and veterans' health care, wounded, ill and injured, and caregiver policy. Initially joining MOAA in October 2004, she helped establish a military family program working on defense and military quality of life programs and readiness issues. In September 2007, she joined the MOAA health care team, specializing in Veterans and Defense health care systems, as well as advocating for seamless transition and women in the military-veterans policies and programs.

She began her 30-year career as a photographer's mate, enlisting in 1973 and was later commissioned a naval officer in 1982. Her last assignment was at the Pentagon as the Associate Director, Office of Family Policy in the Office of the Deputy Under Secretary of Defense for Military Community and Family Policy.

Commander Campos serves as a member of The Military Coalition (TMC) — a consortium of nationally prominent uniformed services and veterans' organizations, representing approximately 5.5 million current and former members of the seven uniformed services, including their families and survivors, serving as the Co-Chair on the Veterans Committee and as a member of the Health Care; Morale, Welfare & Recreation and Military Construction, and Base Realignment & Closure; Guard and Reserve, and Personnel, Compensation and Commissary Committees.