



**TESTIMONY
OF
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NATIONAL COMMANDER
THE AMERICAN LEGION
BEFORE THE
JOINT HEARING
OF THE
COMMITTEES ON VETERANS' AFFAIRS
UNITED STATES SENATE AND UNITED STATES HOUSE
OF REPRESENTATIVES**

MARCH 4, 2026

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

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

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

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

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

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

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

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

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

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

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

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

We urge the committees to prioritize the following issues:

VETERANS AFFAIRS AND REHABILITATION

Winning the War Within

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

The veteran suicide epidemic continues to be the No. 1 concern of The American Legion. While the suicide rate for all Americans has risen since 2001, veteran rates have increased by 52%, now more than double that of civilians.¹ Suicide is the second leading cause of death among veterans under the age of 45,² and while the VA estimates 17.5 veterans die by suicide per day, other reliable sources suggest the number may be as high as 44.³

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

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

While the SFSPGP final report detailing the effectiveness of the program is not yet available as of January 2026, the interim report shows great promise. One promising metric is that 24% of program participants become new Veterans Health Administration (VHA) enrollees⁵ The partnership between VHA and SFSPGP grantees is vital because suicide rates among veterans who receive mental health treatment decrease by almost 40%.⁶

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

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

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

What Congress Can Do:

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

Enhance and Protect Earned VA Benefits

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

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

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

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

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

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

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

What Congress Can Do:

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

Improving the Claims and Appeals Process

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

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

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

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

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

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

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

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

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

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

What Congress Can Do:

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

Champion Women Veterans Health

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

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

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

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

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

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

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

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

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

What Congress Can Do:

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

Recognizing the Next Generation of Toxic Exposure

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

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

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

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

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

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

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

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

What Congress Can Do:

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

Healthcare Modernization

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

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

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

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

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

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

What Congress Can Do:

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

Balance Community Care with Veteran Needs

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

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

From a broad perspective, the integration of community care to supplement the VA direct-care system has been an important relief valve to ensure a tragedy like Phoenix never happens again and has played a large role in ensuring veterans get the care they need, when they need it. However, despite large increases in VA FTEs, disregard for the AIR Commission recommendations⁵² and the patchwork approach to VA's infrastructure needs, the budget for community care has ballooned. This has naturally resulted in debates on balancing funding for VA's direct-care system and adherence to eligibility requirements.

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

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

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

The FY2025 VA near-miss budget shortfall highlighted a significant concern with community care costs. Although The American Legion strongly supports community care as a vital service to veterans, over \$150 billion has been spent on community care providers since 2015.⁵³ Costs for care in the community have grown approximately 20% annually since 2019,⁵⁴ whereas internal VA costs have remained stable.⁵⁵ This increase is primarily due to expanded eligibility under legislation such as the MISSION Act, the Dole Act, the PACT Act, and the COMPACT Act. This legislation contributed to an increase of VA patients to roughly 8,346,327 in 2024 which includes Gulf War and Vietnam Era Veterans.⁵⁶ This influx of patients increased community care cost estimates to \$17.6 billion in 2021,⁵⁷ prompting discussions on how this negatively impacts resourcing the VA healthcare system overall.

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

The American Legion supports allowing VA providers to provide telehealth appointments to patients outside of the state they are licensed in. To help alleviate high demand, VA released a rule allowing this in 2018.⁶¹ An additional rule allowing physicians to prescribe across state lines was released in 2020 to offset the effects of the COVID-19 pandemic.⁶² However, these rules are not yet codified into law. The American Legion supports H.R. 1107, the Protecting Veteran Access to Telemedicine Services Act of 2025, which would permanently codify these rules.

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

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

What Congress Can Do:

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

Enhance Caregiver and Survivor Support

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

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

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

Lastly, section 123 mandates VA to address its Veteran Directed Care (VDC) staffing models and directs the Secretary of VA to ensure that VDC and the VA Homemaker and Home Health Aide programs are administered through each VA Medical Center within two years. The 21st Century Dole Act also requires the VDC program to be made as practically available in remote areas such as American Samoa, Guam, the Commonwealth of the Northern Mariana Islands, Puerto Rico, U.S. Virgin Islands, and any other U.S. territories; the same requirements are to be provided for Native American veterans receiving care and services furnished by the Indian Health Service. VA must fully implement these changes to ensure VDC is available at all VA Medical Centers, as the program is available at 95 VAMCs, as of spring 2025.⁷⁰

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

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

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

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

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

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

What Congress Can Do:

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

Underserved Veterans

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

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

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

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

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

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

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

What Congress Can Do:

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

VETERANS EMPLOYMENT & EDUCATION

End Veteran Homelessness

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

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

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

What Congress Can Do:

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

Pass Guard and Reserve GI Bill Parity

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

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

Under current law, National Guard and Reserve servicemembers accrue GI Bill entitlement only when activated under federal orders. When activated under state orders, they do not qualify for GI Bill benefits, creating a significant disparity in access to these crucial resources. This issue became particularly apparent during the COVID-19 pandemic when many National Guard units were activated in response to the public health emergency. Those called under federal orders to assist with pandemic relief were eligible for GI Bill benefits, but those activated under state orders, such as those supporting governors' declarations, were not. Similarly, National Guard members who helped construct the U.S.-Mexico border wall earned GI Bill benefits, but the thousands who responded to civil rights protests in 2020 did not.

The arbitrary distinction between federal and state orders in determining GI Bill eligibility is unjust and should be eliminated. The American Legion strongly believes that every day in uniform counts and that National Guard and Reserve servicemembers, who serve alongside their active-duty counterparts, should receive the same benefits. It is time for Congress to rectify this discrepancy and extend GI Bill eligibility to all National Guard and Reserve servicemembers, regardless of the nature of their activation.

What Congress Can Do:

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

Support Access to Capital for Veteran Owned Small Businesses

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

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

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

What Congress Can Do:

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

Prioritizing Veterans in Federal Contracting

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

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

What Congress Can Do:

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

Increase Military Tuition Assistance

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

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

today, TA covers up to \$250 per credit hour or \$166 per quarter hour, with a maximum annual limit of \$4,500.⁷⁵ In contrast, the average cost of college tuition has significantly increased. For instance, the average annual cost at private colleges is \$44,961, while out-of-state tuition at public universities averages \$25,415, and in-state tuition for public schools is typically \$11,371.⁷⁶

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

What Congress Can Do:

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

Support the Modernization and Adoption of Digital TAP

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

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

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

What Congress Can Do:

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

Fund The Armed Forces Retirement Home

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

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

What Congress Can Do:

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

NATIONAL SECURITY

Major Richard Star Act

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

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

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

What Congress Can Do:

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

Protect Coast Guard Pay and Entitlements

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

What Congress Can Do:

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

Deported Veterans

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

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

What Congress Can Do:

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

Citizenship for Military Service

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

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

What Congress Can Do:

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

Access to Quality Healthcare for Servicemembers and their Families

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

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

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

What Congress Can Do:

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

CONCLUSION

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

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