Minority Veterans of America
Written Testimony of Lindsay Church
for the Open Session Legislative Hearing covering
H.R. 291, H.R. 345, H.R. 1216, H.R. 1957, H.R. 6273, and H.R. 7589

Provided for:

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Subcommittee on Health

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Chairwoman Brownley, Ranking Member Bergman, and Members of the Subcommittee,

My name is Lindsay Church, and I am the Executive Director and co-founder of Minority Veterans of America (MVA). Our organization works to create belonging and advance equity for our nation's historically marginalized and underserved veterans—racial and ethnic minorities, women, LGBTQ-identifying, and (non)religious minorities. Our position affords us the honor of representing more than 10.2-million veterans and of directly serving thousands of veteran-members across 49 states, 3 territories, and 3 countries, many of whom have never been, and may never be, recognized or heard individually. We strive to be the most diverse, inclusive, and equitable veteran-serving organization in the country, and believe that through creating an intersectional movement of minority veterans, we can build a collective voice capable of influencing critical change.

Our works puts us in contact with many veterans of historically underserved populations whose healthcare needs are not being fully met by the Veterans Health Administration (VHA): racial and ethnic minority veterans, women and other individuals who can become pregnant, transgender and non-binary veterans, and lesbian, gay and bisexual veterans. The testimony below comes from the lived experiences of individuals in these populations, reflecting the historical exclusion from the institution designed to serve them and their loved ones. It is offered in the hope that it may inform and improve this subcommittee's work.

We are grateful for the opportunity to provide our community's perspective and concerns on these legislative matters. And we appreciate the efforts that this subcommittee continues to take in acknowledging and addressing the gaps and barriers that confront the underserved populations we represent.

Reproductive Health

H.R. 345 (*Reproductive Health Information for Veterans Act*)
H.R. 1957 (*Veterans Infertility Treatment Act of 2021*)

We support Chairwoman Brownley's proposals to improve and expand reproductive healthcare options for veterans and their families obtaining care through the VHA.

A. Background

The VA has declared a mission of "serv[ing] Veterans by providing the highest quality health care available anywhere in the world," because "America's Veterans deserve nothing less."[1] It is painfully clear, however, that the VA continues to fall short of its mission when it

[1] Department of Veterans Affairs. (n.d.). *The Affordable Care Act, VA, and you.* https://www.va.gov/health/aca/enrolledveterans.asp

comes to serving veterans in need of comprehensive reproductive health care and family planning services. The fault for this is not entirely the Department's, as regressive laws have continued to limit and restrict certain types of reproductive health care and family planning options to many minority veterans and their partners. These limitations include in vitro fertilization (IVF) and other assisted reproductive technologies, some pregnancy-related care, and medical interventions to terminate pregnancy.

Congressional restrictions on this type of care are widely felt by veteran communities that have limited or no options for family planning and that are unable to otherwise access care. Among veterans, those most in need of comprehensive reproductive health care are gender, sexual, racial, and ethnic minorities. According to the VA's own statistics, nearly 10% of our nation's veterans identify as women—representing the fastest growing demographic of veterans eligible for health care.[2] Currently numbering over two million, women are expected to make up 18% of the veteran population by 2040.[3] In addition, an estimated over one million veterans are lesbian, gay, or bisexual,[4] and about 134,000 veterans are transgender.[5] Collectively, millions of veterans and their family members find themselves unable to obtain critical reproductive health care from VHA.

Due to current restrictions, many veterans must seek alternative care for reproductive health care services and navigate additional medical systems. Requiring patients to navigate multiple healthcare systems is not ideal for health outcomes: Research shows that veterans who receive their healthcare exclusively through VA had better health profiles than their counterparts who received piecemeal care between two or more frameworks.[6] On top of this administrative burden is cost: many veterans don't have the means to pay for non-VA health care, especially services as expensive as reproductive healthcare services like IVF and abortion.

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[2] Office of Data Governance and Analytics. (2017, February). *America's women veterans: military service history and VA benefit utilization statistics*. National Center for Veterans Analysis and Statistics. Department of Veterans Affairs. https://www.va.gov/vetdata/docs/specialreports/women_veterans_2015_final.pdf

[3] Department of Veterans Affairs. (n.d.) *Women veterans in focus.* https://www.womenshealth.va.gov/WOMENSHEALTH/docs/VHA-WomensHealth-Focus-Infographic-v20-sm-508b.pdf

[4] Gates, G. (2010, May). *Lesbian, gay, and bisexual men and women in the US military: Updated estimates.* The Williams Institute. https://escholarship.org/uc/item/0gn4t6t3

[5] Gates, G.J., & Herman, J.L. (2014, May). *Transgender military service in the United States*. The Williams Institute. https://escholarship.org/uc/item/1t24j53h

[6] Vanderberg, P., Uppal, G., Barker, A., & Flemming, D. (2013, May). *The impact of the Affordable Care Act on VA's Dual Eligible Population*. Health Services Research & Development Service. Department of Veterans Affairs. https://www.hsrd.research.va.gov/publications/internal/forum04_13.pdf

These administrative and financial burdens disproportionately impact populations that already experience disparities. For example, the rate of unintended pregnancy for white women sits at 33%, while for Latina women it is 58% and Black women it is 79%.[7] Yet Black and Latina women face socioeconomic disparities, health inequities, and housing instability at a higher rate than white women,[8] as do unmarried women. This puts the out-of-pocket costs for some abortions, which can be up to $1,000 depending on how far along the patient is in the pregnancy, out of reach for many. Similarly, LGBTQ+ veterans face economic, housing, and health insecurities,[9] yet same-sex couples who want to build a family are excluded from accessing the VA programs and services that will help them afford that. One way to address these disparities is for Congress to remove barriers to VHA eligibility and eliminate restrictions on the care VA may provide.

B. Comprehensive reproductive health care, including abortion care, for veterans

Comprehensive reproductive health care, including abortion care, is a necessary aspect of the complete health of any individual who can become pregnant:

> Making health for all a reality, and moving towards the progressive realization of human rights, requires that all individuals have access to quality health care, including comprehensive abortion care services—which includes information, management of abortion, and post-abortion care. Lack of access to safe, timely, affordable and respectful abortion care poses a risk to not only the physical, but also the mental and social, well-being of women and girls [and others who can give birth].[10]

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[7] Taylor, J., & Mhatre, N. (2017, October 6). *Contraceptive coverage under the Affordable Care Act*. Center for American Progress. https://www.americanprogress.org/issues/news/2017/10/06/440492/contraceptive-coverage-affordable-care-act

[8] Office of Health Equity. (n.d.). *Racial and ethnic minority veterans.* Department of Veterans Affairs. https://www.va.gov/HEALTHEQUITY/Race_Ethnicity.asp

[9] Mahowald, L. (2022, April 28). *LGBTQ+ military members and veterans face economic, housing, and health insecurities.* Center for American Progress. https://www.americanprogress.org/article/lgbtq-military-members-and-veterans-face-economic-housing-and-health-insecurities/

[10] World Health Organization. (n.d.). *Abortion*. https://www.who.int/health-topics/abortion#tab=tab_1. *See also* American Public Health Association. (2015, November 3). *Restricted access to abortion violates human rights, precludes reproductive justice, and demands public health intervention*. https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2016/01/04/11/24/restricted-access-to-abortion-violates-human-rights ("access to the full range of reproductive health services, including abortion, is a fundamental right").

But complete reproductive health care is not available to U.S. veterans through the Department of Veterans Affairs. The Veterans Healthcare Act of 1992 carved out critical aspects of such care, stating that in furnishing health care to women, the VA may provide

> [g]eneral reproductive healthcare, including the management of menopause, but not including under this section infertility services, abortions, or pregnancy care (including prenatal and delivery care), except for such care related to a pregnancy that is complicated or in which the risks of complication are increased by a service-connected condition.[11]

While restrictions against the provision of infertility and pregnancy care have been loosened since 1992, the prohibition against abortion care remains unchanged: both abortion and pregnancy-options counseling are specifically excluded from the medical services package.[12] This prohibition by the Department of Veterans Affairs is inconsistent with the current offerings of the Department of Defense which covers abortion in the instance of rape, incest, and when it endangers the life of the mother. If a service member who was sexually assaulted left service while still pregnant, they would be unable to receive care through the Departments of Veterans Affairs or Defense nor would they be able to receive counseling on their options. This is a shameful reality for women veterans and survivors.

Infertility and reproductive assistance

Infertility is an issue for many Americans: approximately 10% of men[13] and the same percentage of women[14] experience infertility issues. Veterans experience infertility at a higher rate compared to their non-veteran counterparts: among veterans who served since 9/11, the prevalence of lifetime infertility for men was 13.8% and for women was from

[11] Veterans Healthcare Act of 1992, Pub. L. 102-585, § 106(a), 106 Stat. 4943, 4947 (codified at 38 U.S.C. § 1710 note).
[12] 38 C.F.R. § 17.38(c)(1) (excluding abortions and abortion counsel from veterans medical benefits package); 38 C.F.R. § 17.272(a)(67) (excluding abortion for survivors and dependents "except when a physician certifies that the life of the mother would be endangered if the fetus were carried to term"); 38 C.F.R. § 17.272(a)(68) (excluding abortion counseling for survivors and dependents).
[13] Cleveland Clinic. (n.d.). *Male Infertility*. https://my.clevelandclinic.org/health/diseases/17201-male-infertility
[14] Office on Women's Health. (n.d.). *Infertility*. https://www.womenshealth.gov/a-z-topics/infertility

15.8%,[15] and in some studies up to 18%.[16] The factors that contribute to this phenomenon are numerous: among veterans, infertility may be due to service-related physical injury, post-traumatic stress, military sexual trauma, traumatic brain injury, or age (since many serve during peak reproductive years), among other challenges.[17] For racial and ethnic minority women, the rates of reported infertility were as high as 24%.[18]

Despite the higher prevalence of infertility, veterans are comparatively less likely to receive infertility care,[19] according to some studies half as likely.[20] VA eligibility barriers significantly contribute to this disparity: to qualify for the benefit, (1) veterans must be legally married and (2) have a service-connected condition causing the infertility, and the veteran or spouse must (3) have an "intact uterus" and at least one functioning ovary or own cryopreserved eggs, and (4) be able to produce sperm or own cryopreserved sperm.[21] Surrogacy, donor eggs, donor sperm, and donor embryos are not covered.[22] As a result, the benefit is available almost exclusively to couples that are both cisgender and heterosexual.[23] Eligibility criteria categorically exclude same-sex and same-gender couples, unmarried women, and transgender men who want to conceive, even if their infertility is related to their service. It also excludes individuals and couples with non-service-connected infertility conditions, including some transgender and non-binary veterans. Some personal stories of

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[15] Katon, J., Cypel, Y., Raza, M., Zephyrin, L., Reiber, G., Yano, E. M., Barth, S., & Schneiderman, A. (2014, Feb. 4). Self-reported infertility among male and female veterans serving during Operation Enduring Freedom/Operation Iraqi Freedom. *J Women's Health (Larchmont)*, *23(2)*, 175-183. doi: 10.1089/jwh.2013.4468

[16] Mancuso, A. C., Summers, K. M., Mengeling, M. A., Torner, J. C., Ryan, G. L., & Sadler, A. G., (2020, Mar. 17). Infertility and health-related quality of life in United States women veterans. *J Women's Health*, *29(3)*. doi: 10.1089/jwh.2019.7798

[17] Coloske, M. (2021, July 22). The right to serve, but not to carry: Expanding access to infertility treatment for US veterans. *Health Affairs.* https://www.healthaffairs.org/do/10.1377/forefront.20210715.658223/full/

[18] Goossen, R. P., Summers, K. M., Ryan, G. L., Mengeling, M. A., Booth, B. M., Torner, J. C., Syrop, C. H., & Sadler, A. G. (2019, January 10). Ethnic minority status and experiences of infertility in female veterans. *J Women's Health*, *28(1)*, 63-68. doi: 10.1089/jwh.2017.6731

[19] *Ibid*.

[20] Katon, J. G., Cypel, Y. S. & Zephyrin, L. C. (2013, November). Serving during Operation Enduring Freedom/Operation Iraqi Freedom. *J Women's Health, 23(2)*, 1-9 (Table 2). doi:10.1089/jwh.2013.4468

[21] Office of Community Care. (2019, April 21). *VA infertility services can help veterans and their families.* https://blogs.va.gov/VAntage/59082/va-infertility-services-can-help-veterans-and-their-families/

[22] *Ibid.*

[23] A couple comprising a transgender man and transgender woman might qualify for the benefit, if neither has undergone a medical procedure that has rendered them incapable of producing their own sperm or egg. In many cases, however, gender-affirming medical treatment can cause infertility in transgender men and render them unable to carry a pregnancy full term.

how the eligibility restrictions have affected real veterans—gathered from public reports as well as recounted to us—are provided in the Appendix.

The current policies are not only prohibitive to historically marginalized, minority veterans, but restrictive for the entire veteran community. Only 567 eligible married couples have received IVF services from the Department of Veterans Affairs since 2016.[24]

C. Comments on the legislation

We strongly support both of Chairwoman Brownley's proposals to provide more complete and comprehensive reproductive health care for our nation's veterans. In addition to our endorsement, we offer the suggestions and recommendations below.

1. H.R. 345 (Reproductive Health Information for Veterans Act)

We applaud the proposal to eliminate the statutory prohibition against VA medical providers providing abortion counseling to pregnant veterans. According to the American College of Obstetricians and Gynecologists (AGOG), "[d]octors and clinicians must be able to provide unbiased, factual information to patients regarding reproductive health care options. And people must be able to use their expertise in their own lives to make decisions for themselves and their families."[25]

The current prohibition of abortion options counseling (and abortion care) endangers the lives of veterans. Allowing pregnancy options counseling will bring the VA in line with evidence-based health care being practiced in exam rooms across the nation. Options counseling provides evidenced-based health information to pregnant veterans and discusses continuation of pregnancy with intention to parent, continuation of pregnancy with intent to adopt, and pregnancy termination through abortion. Resources for care are provided based on the veteran's choice from these options.

We have several recommendations to further embolden this bill in providing evidence-based health care to veterans.

a. *Abortion services*. We strongly urge the Committee to expand the proposed legislation to reverse the ban on VA-provided abortion services, including both medical procedures to terminate a pregnancy and medication abortions. As abortion access

[24] Carr, J. (2019, July 24). Abortion arguments at play in limiting veterans' IVF benefit. *ABC News*. https://abcnews.go.com/Health/wireStory/abortion-arguments-play-limiting-veterans-ivf-benefit-64542147

[25] The American College of Obstetricians and Gynecologists. (2022, May 23). *Understanding ACOG's Policy on Abortion*. https://www.acog.org/news/news-articles/2022/05/understanding-acog-policy-on-abortion

continues to be further out of reach for many veterans, agencies such as the Department of Veterans Affairs can provide essential reproductive health services.

In the United States, an estimated 49% of pregnancies are unintended.[26] The rate is similar for veterans.[27] In addition, veterans share many risk factors for unintended pregnancy found in civilian populations and are also disproportionately affected by post-traumatic stress, depression, and other mental health issues that increase the risk of unintended pregnancy. Moreover, "despite widespread access to low-cost contraception, many women veterans experience barriers to accessing high-quality contraceptive care."[28]

b. *Language and word choice*.

- *Preamble*: To reflect the scope of the legislation (including our suggestions below) more fully, we suggest that the preamble be modified as follows: "To direct the Secretary of Veterans Affairs to provide evidence-based pregnancy options, including abortion counseling, to pregnant veterans."
- *"Unwanted pregnancy."* We suggest using the language "unintended pregnancy" or "unplanned pregnancy" instead.

c. *Guidance*. We recommend changes to reflect the evidence-based health care guidelines by ACOG for options counseling, and further recommend VA medical providers be trained on and follow ACOG guidance.

2. H.R. 1957 (Veterans Infertility Treatment Act of 2021)

We enthusiastically support the proposal to expand the scope of the VA's infertility benefit. We have several minor comments and recommendations.

a. *Clarification*. Although many, if not most, assisted reproductive technologies involve in vitro fertilization, some do not (e.g., gamete intrafallopian transfer and intrauterine insemination). We suggest using language "assisted reproductive technologies" in place of IVF:

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[26] Committee on Health Care for Underserved Women. (2019, December). *Access to contraception.* The American College of Obstetricians and Gynecologists. https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2015/01/access-to-contraception

[27] Schwarz, E. B., Sileanu, F. E., Zhao, X., Mor, M. K., Callegari, L. S., & Borrero, S. (2018, January). Induced abortion among women veterans: data from the ECUUN study. *Contraception, 97(1)*, 41-47. doi: 10.1016/j.contraception.2017.09.012

[28] Wolgemuth, T. E., Cuddeback, M., Callegari, L. S., Rodriquez, K. L., Zhao, X., & Borrero, S. (2020, Jan.-Feb.) Perceived barriers and facilitators to contraceptive use among women veterans in the ECUUN study. *Womens Health Issues, 30(1)*. 57-63. doi: 10.1016/j.whi.2019.08.005

- In § 1720K(a)(2), change the phrase "In the case of in vitro fertilization treatment furnished under paragraph (1)" to "In the case of assisted reproductive technology treatment furnished under paragraph (1)".
- Similarly, in § 1720K(a)(3), the term "in vitro fertilization" should be either "assisted reproductive technology".

b. *Mandatory vs. permissive language*. The bill's use of the word "may" in several places is permissive rather than mandatory, thus allowed the VA to decline treatments or services in certain instances. We suggest the use of language that does not permit such discretion.

- *§ 1720K(a)(3)*: Change "The Secretary may furnish in vitro fertilization treatment under paragraph (1) using donated gametes or embryos." to "The Secretary shall furnish treatment or services under paragraph (1) without regard to whether donated gametes or embryos are used."
- *Sec. 3(b)(1)*: Change "may" to "shall."
- *Sec*. *3(b)(2)*: Change "The Secretary may furnish such counseling and treatment using donated gametes or embryos." to "The Secretary shall furnish such counseling and treatment without regard to whether donated gametes or embryos are used."

c. *Use of surrogates*. We suggest that language to be added to make clear that covered veterans without an "intact uterus" (such as gay men, trans women, and cisgender women who have had their uterus removed) may still access the benefit. For example:

- *§ 1720K(a)(3)*: This provision may be modified as follows: "The Secretary shall furnish treatment or services under paragraph (1) without regard to whether donated gametes or embryos are used or a surrogate is involved."
- *Sec. 3(b)(2)*: This provision may be modified similarly: "The Secretary shall furnish such counseling and treatment without regard to whether donated gametes or embryos are used or a surrogate is involved."

d. *Single veterans*. We recommend some minor changes to § 1720K(a)(1) to ensure that single veterans may access this benefit:

> In furnishing medical services under this chapter, the Secretary shall furnish infertility treatments (including through the use of assisted reproductive technology), standard fertility preservation services, or both, to a covered veteran, ~~or~~ a partner of a covered veteran, ~~,~~ (if the veteran and the partner of

the veteran apply jointly for such treatments or services), or both, through a process prescribed by the Secretary.

H.R. 1216

Modernizing Veterans' Health Care Eligibility Act

We applaud Representative Bost's proposal to create a commission to study the important issue of veteran health-care eligibility. Eligibility for VA health care is governed by numerous statutes, each of which imposes different criteria and requirements, resulting in a complex and confusing system that is daunting for any veteran to understand and navigate. A commission may identify areas where existing law imposes unnecessary barriers to benefit access and can make recommendations for changes that improve, simplify, or streamline such access. We have no doubt that the commission's work, implemented by the President and Congress under this bill, will improve the lives of many veterans. We therefore enthusiastically support this bill.

H.R. 291

Department of Veterans Affairs Creation of On-Site Treatment Systems Affording Veterans Improvements and Numerous General Safety Enhancements Act or the VA COST SAVINGS Enhancements Act

We have no comments to provide on this legislation at this time.

H.R. 6273

VA Zero Suicide Demonstration Project Act of 2021

We applaud Congresswoman Lee for again introducing this crucial piece of legislation, which will help address and, we believe, reduce suicidality rates of our nation's veteran communities. Notably, in addition to providing extensive training to VA staff leaders, this program will collect important data on the program's efficacy through comparative analyses between sites and between suicide prevention programs.

We are proud to reiterate our endorsement for the Committee today, and provide the following recommendations to further strengthen this bill's goal:

A. Specialty Demographics

The bill would require the VA to implement the curriculum of the Zero Suicide Institute of the Education Development Center. Recent external evaluations of the Institute found that

it identified only two specialty demographic areas: "military veterans" and "American Indians/Alaska Natives."[29] No explicit references, and few tacit references, were found regarding the identification and inclusion of minority[30] communities within the larger veteran demographic. Additionally, VA researchers themselves have pointed to the lack of LGBTQ demographic information and the need for greater complexity of analysis to make meaningful progress in suicide prevention.[31]

> *Recommendation*: We recommend that explicit language requiring that the Institute's curriculum include culturally resilient training on suicide prevention education for all minority communities served through the program.

This is particularly important because minority veterans experience post-traumatic stress and depression at rates higher than their non-minority counterparts,[32] which are well-documented risk factors for suicidality,[33] and the rates of minority-identified individuals leaving service is at an all-time high.[34] If current demographic trends continue, this issue will

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[29] Committee to Evaluate the Department of Veterans Affairs Mental Health Services. (2018). Equitable Mental Health Care. In The National Academies of Sciences, Engineering, and Medicine (Ed.), *Evaluation of the Department of Veterans Affairs mental health services* (pp. 265-292). National Academies Press.

[30] Minority veterans include racial and ethnic minorities, women, LGBTQ+ people, and (non)religious minorities.

[31] Office of Mental Health and Suicide Prevention. (2021, September). *National veteran suicide prevention report annual report.* Department of Veterans Affairs. https://www.mentalhealth.va.gov/docs/data-sheets/2021/2021-National-Veteran-Suicide-Prevention-Annual-Report-FINAL-9-8-21.pdf.

[32] Office of Health Equity. (2020). Mental health disparities among LGBT Veterans. Washington, DC: US Department of Veterans Affairs. www.va.gov/HOMELESS/nchav/resources/docs/veteran-populations/lgbt/LGBT_Veterans_Disparities_Fact_Sheet-508.pdf. *See also* Office of Mental Health and Suicide Prevention. (2020). *National veteran suicide prevention annual report.* Department of Veterans Affairs. www.mentalhealth.va.gov/docs/data-sheets/2020/2020-National-Veteran-Suicide-Prevention-Annual-Report-11-2020-508.pdf. *See also* Lynch, K. E., Gatsy, E, Viernes, B, Schliep, K. C., Whitcomb, B. W., Alba, P. R., DuVall, S. L., & Blosnich, J. R. (2020, December 28). Evaluation of suicide mortality among sexual minority US Veterans from 2000 to 2017. *JAMA Netw Open, 3(12):e2031357*. doi: 10.1001/jamanetworkopen.2020.31357. *See also* Calhou, P.S., Wilson, S. M., Hicks, T. A., Thomas, S. P., Dedert, E. A., Hair, L. P., Bastian, L. A., & Beckham, J. C. (2017, October). Racial and sociodemographic disparities in internet access and eHealth intervention utilization among veteran smokers. *J of Racial and Ethnic Health Disparities, 4*, 846–853. doi: 10.1007/s40615-016-0287-z.

[33] Centers for Disease Control and Prevention (n.d.). *Risk and Protective Factors*. https://www.cdc.gov/violenceprevention/suicide/riskprotectivefactors.html

[34] According to Department statistics in 2017, racial and ethnic minorities made up 23.2% of the Veteran population (*see* A below). White women make up an additional 6.2% of the veteran population (*see* B below), and we estimate that approximately 3.8% of the veteran population is lesbian or gay (*see* C below) while 0.8% is transgender (*see* D below).

only increase in importance, as racial and ethnic minorities are projected to rise to 36.2% of the veteran population by 2045[35] and white women veterans are projected to rise to 10.6% of the veteran population by 2043[36]. While we do not yet have statistics on sexual orientation and transgender status among U.S. veterans, we believe it is reasonable to project that at least 50% of the veteran population will self-identify with one or more minority communities by 2045.

Finally, we emphasize how crucial it is that policy initiatives aimed at enacting changes within the Department extend to broader public policy changes in the U.S., and that they co-articulate with existing and proposed policies regarding mental health disparities and suicide among minorities in the broader civilian population. Many minority veterans do not identify with the term "veteran," and many have historically experienced, and continue to experience, marginalization in veteran-centric spaces. Taking such proactive measures will reduce the harm that these veterans have and continue to experience and rebuild much of the trust that these marginalized and underserved communities have lost in the Department.

B. Substance Use Disorders

The Department has been at the forefront of research and therapies at the intersection of posttraumatic stress disorder (PTSD) and substance-use disorders (SUDs), noting that more than 20% of veterans with PTSD also have an SUD and nearly 33% of veterans seeking treatment for an SUD also have PTSD.[37] Unfortunately, there is a glaring lack of data on SUDs among minority veterans,[38] further indicating the need for comprehensive data collection

A. Office of Data Governance. (2017, March). *Minority veterans report: Military service history and VA benefits utilization statistics*. Department of Veterans Affairs. https://www.va.gov/vetdata/docs/SpecialReports/Minority_Veterans_Report.pdf
B. Office of Data Governance. (2017, February). *Woman veterans report: The past, present and future of women veterans*. Department of Veterans Affairs. https://www.va.gov/vetdata/docs/SpecialReports/Women_Veterans_2015_Final.pdf
C. Gates, G. J. (2003). *Gay veterans top one million*. Urban Institute. www.urban.org/sites/default/files/publication/59711/900642-gay-veterans-top-one-million.pdf.
D. Gates, G. J., & Herman, J. L. (2014, May). *Transgender military service in the United States*. The Williams Institute. https://escholarship.org/uc/item/1t24j53h

[35] *See supra* note 34(A).

[36] This figure was calculated using data from the VA that projects that 16.3% of all veterans will be women in 2043, and that currently white women make up 65.9% of all women veterans. *See supra* note 34(B).

[37] National Center for PTSD. (n.d.). *PTSD and Substance Abuse in Veterans*. Department of Veterans Affairs. www.ptsd.va.gov/understand/related/substance_abuse_vet.asp

[38] The VA's online database for SUDs among veterans mention demographics only once in their summary of one study on illicit substance use among HIV-positive men: "The researchers do note that demographic factors—such as age, race, and education—seem to impact mortality risk more

among veterans. We do know, however, that racial and ethnic minority veterans have higher rates of PTSD than white veterans[39] (suggesting higher rates of SUDs as well), that women veterans are at a higher risk for SUDs than their non-veteran counterparts,[40] and that LGBTQ people overall are at higher risk for SUDs.[41]

> *Recommendation*: We therefore recommend that data collection activities include opportunities to collect information on histories of substance use disorders.

In addition to stigmatization and other aspects of minority stress, research shows that higher rates of substance use are associated with violent victimization,[42] echoing a need for social determinants of health approach. We urge the Committee to ensure that the Department engages in comprehensive data collection to report on the deaths and known substance use of veterans involved with Departmental services and that health care providers receive culturally competent and informed training to effectively update frameworks, services, and clinical practice guidelines.

C. Gun Violence and Access to Firearms

Given the high rates of death by suicide involving a firearm,[43] it is vital that we understand gun violence and access to firearms as interrelated. Recent research on veterans who died by suicide using a firearm shows that less than half of these veterans "received prevention services from the Department in the form of contact with the local Suicide Prevention Team, engagement in lethal means safety efforts, a documented safety plan, and/or the presence of a high risk for suicide flag in the medical record."[44]

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than alcohol, cannabis, or stimulus use." Office of Research & Development. (n.d.). *Substance use disorders*. Department of Veterans Affairs. www.research.va.gov/topics/sud.cfm.

[39] Spoont, M. & McClendon, J. (2002). Racial and ethnic disparities in PTSD. *PTSD Research Quarterly, 31(4)*. National Center for PTSD, Department of Veterans Affairs. https://www.ptsd.va.gov/publications/rq_docs/V31N4.pdf

[40] Cucciare, M. A., Simpson, T., Hoggatt, K. J., Gifford, E., & Timko, C. (2013). Substance use among women veterans: Epidemiology to evidence-based treatment. *J of Addictive Diseases, 32(2)*, 119–139. doi: 10.1080/10550887.2013.795465

[41] Kalin, N. H. (2020, November 1). Substance use disorders and addiction: Mechanisms, trends, and treatment implications. *Am J of Psychiatry, 177(11)*, 1015–1018. doi: 10.1176/appi.ajp.2020.20091382

[42] Sherman, A. D. F., Cimino, A. N., Mendoza, N. S, Noorani, T., & Febres-Cordero, S. (2021). Polyvictimization and substance use among sexual minority cisgender women. *Substance Use & Misuse, 56(1)*, 39–45. doi: 10.1080/10826084.2020.1833928

[43] Office of Mental Health and Suicide Prevention, *supra* note 32 ("In 2018, firearms were the method of suicide in 69.4% of male Veteran suicide deaths and 41.9% of female Veteran suicide deaths.").

[44] Ammerman, B. A., & Reger, M. A. (2020). Evaluation of prevention efforts and risk factors among veteran suicide decedents who died by firearm. *Suicide and Life-Threatening Behavior, 50(3)*, 679–687. doi: 10.1111/sltb.12618

Recommendation: We therefore urge the Committee to consider mechanisms through which to identify and provide suicide prevention training to veteran gun owners, especially for those that are involved with the Institute or this program, as well as mandating that suicide prevention training be included as a necessary certificatory component in regulations regarding access to firearms.

H.R. 7589

Reduce and Eliminate Mental Health Outpatient Veteran Copays Act or the REMOVE Copays Act

As set forth in our statement of support at the time Chairman Takano introduced this bill, we fully support the REMOVE Act and urge the Committee and the full Congress to pass it.

More than 3.7 million veterans are living with mental health conditions,[45] the vast majority of which are service-connected. While great strides have been successful in breaking down the social stigma tied to seeking help, financial burdens are often cited as a chief deterrent from receiving the life-changing and life-saving assistance that these former service members have earned and deserve.

This bill will be especially important to our nation's minority-identifying veterans who, according to the VA's own statistics, are not only more likely to develop service-connected mental health conditions but are also subjected to greater civilian mental health disparities than their dominant culture counterparts. For them, and many others, a copay can be the difference between receiving care and not.

No veteran should go without treatment for mental-health conditions because they can't afford it. If anything, we urge the Committee to consider eliminating copays for mental health visits of qualifying veterans, rather than merely the first three of a calendar year.

* * *

Our feedback on the proposed legislation discussed above is meant to help ensure this subcommittee, and Congress, continues to live up to the standards that they have been charged with in service to our veterans. Our comments reflect the experiences of the veterans serve—mostly from underserved communities—who have been excluded from the VA's programs and services. Working together, we can ensure that all veterans can benefit from the work this Committee is doing on their behalf.

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[45] Substance Abuse and Mental Health Services Administration. (2018). *2018 National Survey on Drug Use and Health: Veterans*. Department of Health and Human Services. https://www.samhsa.gov/data/sites/default/files/reports/rpt23251/6_Veteran_2020_01_14_508.pdf

Thank you again for the opportunity to submit this written testimony and to provide oral testimony at the hearing. My colleagues and I look forward to working with you and your offices, and to support your efforts in serving our nation's underserved veteran populations. If we can be of further assistance, please contact me directly. at lchurch@minorityvets.org.

Respectfully Submitted,

/s/
Lindsay Church
Executive Director & Co-Founder
Minority Veterans of America

APPENDIX – PERSONAL STORIES

Khris Goins (he/him)
U.S. Army veteran (2006-2009)
Columbus, Ohio

Khris Goins served in the U.S. Army from 2006 to 2009. He served during policies like "Don't Ask, Don't Tell" and the ban against transgender people serving openly. Now, Khris wants to start a family with his wife of over 12 years, but Khris does not qualify for IVF treatments from the VA.

Khris is denied the VA benefit because neither he nor his wife can provide their own sperm. Khris is a transgender man who was assigned female at birth, so he does not produce sperm. Khris wife is a cisgender female and does not either. In 2015, they sought IVF treatment from the VA using donated sperm. They were denied under the VA's current rules.[46]

Toni Hackney (she/her)
U.S. Army veteran (16 years)
Atlanta, Georgia

Toni Hackney served in the U.S. Army for 16 years before retiring with the hope of starting a family and becoming a mother. Toni developed a service-connected disability that eradicated her chances of conceiving naturally. Toni's VA doctor suggested IVF treatments; she quickly discovered, however, that she was ineligible because she is unmarried.

Toni devoted her life to serving her country. Putting country first came at great personal expense, as those years of service were also her prime reproductive years. Toni is now in her late 40s. Without IVF provided by the VA, and lacking the estimated $45,000 to pay for the treatments herself, she is rapidly running out of time to realize her life-long dream of having a child.[47]

[46] Sokolow, A. (2020, August 25). The VA doesn't cover fertility treatments for unmarried veterans or same-sex couples. Some want to change that. *Medill News Service*. https://dc.medill.northwestern.edu/blog/2020/08/25/the-va-doesnt-cover-fertility-treatments-for-unmarried-veterans-or-same-sex-couples-some-want-to-change-that/#sthash.iGlkh9m9.IQzv9TVW.dpbs

[47] *Ibid*. *See also* Grant, J. (2020, December 6). Veteran starts GoFundMe after being denied IVF treatment benefits because she's single. *Essence.* https://www.essence.com/love/black-female-veteran-denied-ivf-treatment-benefits-not-married/

L.R. (she/her)

L.R. is a veteran who has a 100% service-connected disability rating from the VA. Due to her conditions, she was medically advised not to carry a child. Her VA OB/GYN referred L.R. and her wife to a fertility doctor so they could pursue IVF. They were told repeatedly that they met all criteria, gathered letters of support and all necessary documentation. As they neared the end of the process, in March 2020 they were informed that the benefit was denied. The reason given was that L.R.'s spouse was not of the opposite sex and therefore could not provide their own sperm.

E.W (she/her)

U.S. Navy veteran (9 years)

E.W. served in the U.S. Navy for nine years, including two tours in Iraq (2005) and Afghanistan (2007). During her time in service, she eschewed relationships—"Don't Ask, Don't Tell" was in full force, and E.W. wanted to put her career first anyway. She was discharged in 2013 with an Honorable characterization.

In 2012, E.W. met her fiancée while finishing her degree. Together, they purchased a home in 2016 and decided to start a family. But she encountered complications from infertility. Her VA doctor diagnosed the condition and referred her to a fertility treatment facility, where E.W. attempted intrauterine insemination (IUI) treatments. After five IUI treatments, E.W. became pregnant. But E.W. lost her child because of an ectopic pregnancy requiring emergency surgery in December 2018. The loss was devastating. Nevertheless, E.W. resumed IUI treatments and became pregnant again a year later. On Mother's Day 2020, E.W. lost her second child due to a miscarriage.

E.W. and her fiancée still wanted to grow their family and were advised that IVF was the next step. When she contacted the VA, however, E.W. was told she did not qualify because she was unmarried. When she informed the VA that he wedding was happening soon, E.W. was then informed that she did not qualify because the VA would not treat any couple requiring donor sperm.