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STATEMENT OF
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SUBCOMMITTEE ON HEALTH
UNITED STATES HOUSE OF REPRESENTATIVES
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Chairwoman Brownley, Ranking Member Bergman and Members of the Subcommittee:

Thank you for inviting DAV (Disabled American Veterans) to testify at today's legislative hearing of the Subcommittee on Health to consider multiple bills important to our nation's service-disabled veterans.

H.R. 291, the VA COST SAVINGS Enhancement Act

H.R. 291—the VA COST SAVINGS Enhancement Act would require the Department of Veterans Affairs (VA) to perform a cost analysis on the purchase of an on-site regulated medical waste treatment system at each VA medical center. The legislation would require each VA medical center to project cost savings to purchase a regulated waste management system under a blanket agreement for the Department. VHA Directive 7707 dictates VA's policy for its Green Environmental Management System program and environmental compliance and performance practices and calls for VA to determine more efficient systems that operate in accordance with federal, state and local laws.

DAV appreciates the potential for VA to identify cost-savings for VA medical centers in an environmentally responsible way but has no resolution on VA's disposal of medical waste and takes no position on this bill.

H.R. 345, the Reproductive Health Information for Veterans Act

H.R. 345—the Reproductive Health Information for Veterans Act would require VHA providers to offer abortion counseling to veterans with unwanted pregnancies, to include health and provider information for such services. DAV does not have a resolution on this issue and takes no formal position on H.R. 345. However, we do offer the following comments.

The cornerstone of quality health care is trusted, open communication with one's health care providers. It is in a veteran's best interest to have candid dialogue with their VA medical providers pertaining to any condition, treatment or procedure that impacts their health, regardless of whether services are provided by VA or not.

This is especially important in the case of pregnancy, as it could have serious effects on the physical and mental health and overall wellness of veterans, particularly for those with disabilities.

H.R. 1216, the Modernizing Veterans' Health Care Eligibility Act

This legislation would establish a Commission on Eligibility to examine policies guiding veterans' health care eligibility and make recommendations, if feasible and advisable, to change them. The Commission would be composed of 15 members appointed by the President; Senate Majority Leader; Senate Minority Leader; House Speaker and House Minority Leader (three each, including at least one of whom would be a veteran). The President would designate the chair of the Commission and at least one member must be appointed from a veterans service organization; one member that has worked for a large private health care system; one representative with experience in a government health care system; and one individual familiar with the Veterans Health Administration (VHA), but not currently employed there.

The Commission would be required to hold its first meeting no later than 15 days after a majority of its members are appointed and issue a preliminary report with findings and recommendations no later than 90 days after its first meeting and a final report and recommendations no later than one year from its initial meeting. The President would then be required to submit a report to Congress on the advisability and feasibility of each recommendation, along with executive actions and legislation necessary to implement them. DAV believes these proposed timelines would not allow individuals selected for the Commission, who may have little familiarity with the VA, its mission, and the specialized programs it has created for the veterans it serves, enough time to understand the nuanced policy Congress has legislated since the establishment of a national veterans program.

Additionally, we do have concern about previous efforts proposing to diminish the size and scope of the veteran's health care system whether by proposing changes in eligibility to limit the number of veterans who may receive care or by pressing for privatization of VA medical services. However, Congressional support for such efforts has been negligible and repeatedly dismissed by outside experts and panels. Likewise, it is increasingly unclear if the private sector would have the ability to absorb veteran patients or desire to address veterans' often complex medical needs that would manifest if Congress acceded to drastic changes in eligibility or otherwise limited the availability of VHA services for veterans.

Veterans' health care eligibility and VA's medical benefits package for enrolled veterans are clearly defined in title 38, United States Code, and accompanying federal regulation and continue to be modified in accordance with the needs of veterans at Congress' and the Administration's discretion. Because Congress has full authority to modify eligibility requirements or VA's medical care benefits package through the legislative process, it is unclear why a special outside commission is necessary.

We believe that Congress, and specifically, this Subcommittee, should continue to make decisions in the best interest of veterans by conducting oversight of VA health care eligibility and legislating the changes it deems necessary itself and not discharge its duties to unelected and unaccountable members of a commission.

H.R. 1957, the Veterans Infertility Treatment Act of 2021

H.R. 1957—the Veterans Infertility Treatment Act of 2021 would require VA to furnish infertility treatments, including assisted reproductive technology services and standard fertility preservation services, to veterans or veterans' partners, if they jointly apply for such services. Services would be available to any veteran who fails to conceive or carry a pregnancy to term after one year, to a veteran or partner who is unable to reproduce or who is at risk of inability to conceive, carry a birth to term or reproduce due to medical, sexual, reproductive history, age, physical limitations or diagnoses.

VA provides access to fertility counseling and standard diagnosis and treatment for infertility including artificial insemination, and some hormonal and surgical interventions. However, current law only authorizes VA to provide assisted reproductive technology services, on a very restricted basis, to veterans or their legal spouses if the veteran has a grievous service-connected injury that affects his or her ability to procreate. It does not allow donated genetic material to be used, which means even veterans who are unable to provide their own gametes, same-sex spouses and single veterans who otherwise meet the eligibility criteria may not access this benefit.

DAV is aware that the VA's budget request includes a legislative proposal to correct some of the most serious inequities in the current law by expanding access to these services to veterans who are unable to provide their own gametes or require donated material including same-sex partners and unmarried veterans. Nonetheless, many veterans with conditions that are service connected, such as veterans with PTSD (related to military experiences, such as combat, or military sexual trauma), depression or anxiety or toxic exposures, which can potentially put a veteran at risk of infertility, would not be able to benefit from this proposal.

DAV supports H.R. 1957 in accordance with DAV Resolution No. 005, which calls for us to support legislation to improve veterans' access to assisted reproductive technology for all service-related conditions that affect procreation that were not present before military service regardless of marital status. We do encourage the Subcommittee to seek technical assistance from VA to ensure that the bill meets all of its intended purposes.

H.R. 6273, the VA Zero Suicide Demonstration Project Act of 2021

H.R. 6273 would require VA to establish a pilot program—the Zero Suicide Initiative—to assess the use of a behavioral mental health care model based on the

Henry Ford Zero Suicide program. The legislation would require the development of an educational curriculum and training institute to study the best practices for suicide care and prevention including screening practices, lethal means counseling, comprehensive assessment and individual risk management. It would then require extensive training of staff team leaders. VA, in consultation with other entities involved with the initiative, would select five sites at which the pilot would take place. VA would be required to assess the program on a number of measures in comparison with non-demonstration sites within the Department.

The model has a goal of eliminating suicide by changing and improving systems of care. Proponents of the prevention model report dramatic (75%) and sustained reductions in suicide among their patient population.[1] A key focus in the model includes viewing errors or near misses as system failures and learning from and developing a health care culture that seeks "… recovery, restoration, and improvement, not blame, punishment, or retribution."[2]

VA already incorporates many of the aspects of the zero suicide model in its care plans for veterans at risk for suicide and, as a learning organization, it endeavors to continually improve patient safety. VA has a comprehensive, integrated mental health program including clinical practice guidelines jointly developed with the Department of Defense for suicide prevention as well as conditions related to suicidal behavior including management of depression, post-traumatic stress disorder, substance use disorders and traumatic brain injury. These clinical practice guidelines take into account the full spectrum of services (and wrap-around services) available to veterans and service members in the systems that serve them in addition to educational resources on specific issues associated with military service that may impact mental health and behavior.

While there are some indications that VA is slowly turning the tide on this epidemic (the number of suicides decreased by 399 veterans or 7.2% when adjusted for age and sex between 2018 and 2019),[3] it is imperative for VA to continue to move forward in improving its suicide prevention efforts and to continually look for ways to reduce suicide in the veteran population.

This pilot offers an opportunity for VA to focus on addressing potential systemic gaps in care for veteran patients who are at risk for suicide and to compare differences between the prevention models, best practices and related health outcomes. For these reasons, DAV is pleased to support H.R. 6273, in accordance with DAV Resolution No. 118 which calls for improvements in VA mental health care programs and suicide prevention services.

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[1] Coffey, C.E., VISION ZERO: A Model for Eliminating Suicide and Transforming Health Care, Statement before the House Committee on Veterans' Affairs, January 29 2020.
[2] Ibid.
[3] U.S. Department of Veterans. Office of Mental Health and Suicide Prevention. National Veterans Suicide Prevention Annual Report. September 2021.

H.R. 7589, the Reduce and Eliminate Mental Health Outpatient Veteran (REMOVE) Copays Act

Seeking mental health treatment is a victory in itself for many of our nation's veterans who battle the stigma of doing so, and it is incumbent upon VA to reduce access barriers to make it easier to take that step toward healing. H.R. 7589 would eliminate copayments for 3 VA outpatient mental health appointments annually, thereby allowing veterans who need these critical services to be relieved of the associated financial burdens.

DAV believes eliminating copayments for these visits is an important part of a broader strategy to address mental health issues and bolster suicide prevention among veterans, especially as the compounding cost of care can incur undue financial hardships and can be a contributing factor for some veterans to not seek needed care and even suicide. Given the complex nature of mental health care, DAV would recommend not limiting the number of visits exempted from copayment, which is set at 3 per year under this legislation. In many cases, veterans may require additional follow-on care after those three visits have been exhausted but would still face cost-sharing requirements that could once again limit their ability to access needed care.

With the aforementioned recommendation and in keeping with DAV Resolution No. 019, which calls for elimination of health care copayments, DAV supports this legislation to help ensure at-risk veterans continue to seek the mental health treatment they have earned.

Chairwoman Brownley, this concludes my testimony. I am pleased to answer any questions you or Members of the Subcommittee may have.