Beyond Deborah Sampson: Improving Healthcare for America's Women Veterans in the 117th Congress

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MINORITY VETERANS OF AMERICA

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Chairwoman Brownley, Ranking Member Bergman, and Distinguished Members of the Committee,

My name is Lindsay Church, and I am proud to serve as the Executive Director and Co-Founder of the Minority Veterans of America. Our organization works to create belonging and to advance equity and justice for the minority veteran community, including veterans of color, women, LGBTQ veterans, and (non)religious minorities. Since our inception in 2017, we have grown to over 2,200 members across 48 states, 3 territories, and 4 countries, 44% of whom identify as women. Together, our members account for thousands of years of military service, some dating back to conflicts and eras that pre-dated when they were legally recognized as women veterans.[2] As a Navy veteran and 100% service-connected disabled veteran, I am here today to testify from both my own personal experience and on behalf of the countless women veterans who may never have the opportunity to be heard or accounted for. Thank you for that opportunity.

I would like to begin with recognition of and gratitude for the Committee Members that helped ensure passage of the *Deborah Sampson Act*. This landmark piece of legislation will have a lasting impact on the lives of women veterans for generations to come. As this unique constituency group remains the fastest growing demographic within the broader veteran community, the rapid evolution has left a lag in the institution of supportive frameworks and the facilitation of principles meant to support women after their service. The culture that we have created, or failed to create, in our existing military and veteran community has left many women veterans without a community to call home. We are grateful for this Committee's concurrence that we must continue to center and prioritize the needs of our women veteran communities in the 117th Congress.

Engrained within the very fabric of our military history is a culture of harassment and contemporarily-antithetical views that such bigotry is acceptable when directed and women and minorities. Even today, there are instances of institutionalized discrimination that have been held in place for decades before being addressed not by the Agency (the Department of Veterans Affairs, hereinafter "Department") itself, but through the actions of this legislative body. These harmful policies foster a toxic environment and inflicts lasting damage on the mental and emotional health of those that endure the behavior. As veterans, women fight to be seen as worthy of the validation that their male counterparts innately receive, only to be met with systemic limitations by an agency that, even at its most fundamental levels, forgets, marginalizes, and even excludes them.

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[2]An estimated 400 women fought in the Civil War, 35,000 in WWI, and 140,000 in WWII. Women were first entitled to Veterans' benefits in 1948 when Congress passed the Women's Armed Services Integration Act granting women permanent status in the military. *See* www.womenshealth.va.gov/WOMENSHEALTH/outreachmaterials/womenveteransmakehistory/campaigns_makehistory.asp.

More recently, pervasive issues that disproportionately impact our women veterans, like military sexual trauma (MST)[3], have become topics of national discourse. That discourse, however, has to date had no substantial impact on the prevalent and rampant pandemic that our communities are facing. Cases like the murder of Specialist Vanessa Guillen,[4] the needless and continued incarceration of Sergeant Thae Ohu,[5] and the recent death-by-suicide of Sergeant Elder Fernandes[6] illustrate the need for urgent cultural and structural changes across the Departments of Defense and Veterans Affairs.

Implementation of the *Deborah Sampson Act* was not the final step. There is more work that must be done if we are to provide the needed and due frameworks and systems that our women veteran communities deserve and that their male counterparts innately receive. As our suggested focus areas below are taken into consideration, we would like to highlight that they were developed with our most marginalized members in mind and would encourage that future legislation be done in a similar manner. We have found that where a system is designed to serve the most sidelined within the community, it will inherently be better situated to serve those that experience heightened privileges.

A. Changes to Departmental Motto and Facility Names

Emblazoned on plaques at VA facilities throughout the country are the words of President Lincoln, avowing the sacred duty the Department had been charged with -- "[t]o care for him who shall have borne the battle and for his widow, and his orphan."

Women largely did not receive public recognition of their veteran status until 1980,[7] though served as nurses, spies, and even battlefield soldiers as early as the era in which President Lincoln's

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[3] Further conversations have highlighted that women do not belong amongst service ranks or mack a mockery of the mission. *See* www.nbcnews.com/think/opinion/women-military-are-useless-fox-news-tucker-carlson-pentagon-wants-ncna1260958.

[4] Jones, K. & Sanchez, R. (2020). Pfc. Vanessa Guillen bludgenoned to death on Army base, family attorney says. *CNN*. Accessed on July 5, 2020, at www.cnn.com/2020/07/02/us/vanessa-guillen-fort-hood-disappearance/index.html

[5] Hafner, K. (2020). Marines charging Virginia Beach corporal with attempted murder; family says she has PTSD after sexual assault. *The Virginia Pilot*. Accessed on November 1, 2020, at www.pilotonline.com/military/vp-nw-thae-ohu-update-20201028-5czhod7xafeavb3wdntms5dcim-story.html.

[6] Kesslen, B. & Madani, D. (2020). Elder Dernandes, missing Fort Hood soldier, found dead. *NBC News*. Accessed on November 1, 2020, at www.nbcnews.com/news/us-news/elder-fernandes-missing-fort-hood-soldier-believed-found-dead-n1238160.

[7] The 1980 Census was the first time that American women were asked if they had ever served in the Armed Forces, and an astonishing 1.2 million said "yes." Because very few of these newly identified Veterans used VA services, Congress and VA began a concerted effort to recognize and inform them of their benefits and entitlements. Activities were initiated to increase public awareness about services for women in the military and women Veterans. Soon after the 1980 census, Congress granted veteran status to women who had served in the

Departmental charge was first spoken. When those words were formally adopted as the Department's motto in 1959, thousands of women were serving our nation through the Army's Nurse Corps. Women have always been amongst the ranks of our nation's most revered veterans, though have been shielded from public perception and disavowed basic knowledge to access the available benefits and services that their siblings-in-arms received.

The outcomes that women veterans are experiencing today - rise in suicide rates and mental health crises, homelessness, health disparities - are challenges that show the results of our inequitable access to care. The current Department motto is exclusionary, as it does not reflect the diversity of our veteran community, nor our country. With nearly 25% of the nation's veteran community identifying as other than a white, cisgender, heterosexual man, it is time the Department's motto makes clear that they serve all who have served. We urge the Committee to again consider an amendment to the Department's existing mission statement to include the verbiage "to fulfill President Lincoln's promise to care for those 'who shall have borne the battle' and for their families, caregivers, and survivors."

In addition to the Department motto, other cultural symbols such as VA facility naming contribute to the invisibility of women veterans. Currently, of the 1,255 health care facilities managed by the Department of Veterans Affairs, only two are named after women veterans.[8] The 2020 Report of the VA Advisory Committee on Women Veterans included a recommendation of inclusive naming for Department facilities. The Advisory Committee suggested that such a change would "demonstrate to women veterans that their service matters."[9] Under former Secretary Robert Wilkie's leadership, the Department indicated their agreement with the Advisory Committee's findings and insisted that Congress is charged with the naming of such facilities.

A review of the existing health care facilities and other military and veteran installations should take place, ensuring that facilities named after discriminatory and violent movement leaders are renamed.[10] Facilities hosting names like Hunter Holmes McGuire, a former Confederate surgeon; or Michael Debakey,[11] who participated with Nazi sterilizations during his medical training at Heidelberg University should be rebranded with names of women veterans that have positively

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Women's Army Auxiliary Corps (WAAC) during World War II. *See* www.va.gov/womenvet/docs/20yearshistoricalperspective.pdf.

[8] *See* www.va.gov/directory/guide/allstate.asp.

[9] *See* 2020 Report of the Department of Veterans Affairs Advisory Committee on Women Veterans, available at www.va.gov/womenvet/docs/acwv/acwvReport2020.pdf.

[10] It has been noted that Fort Rucker was named after a Confederate General; Fort Wayne was named after a General responsible for the indigenous genocide at the Three Rivers in Indiana; and Richmond, Virginia's VA medical center was named after a Confederate surgeon and eugenics movement leader.

[11] Miller, C. A. (2019). *A time for all things: The life of Michael E. Debakey*. Oxford University Press, p. 110.

contributed to our nation's military and veteran history, like—Vanessa Guillén, Harriet Tubman, and Maybelle Campbell. We would also urge this body to consider intersectional identities in such naming efforts, ensuring appropriate representation of sexual orientation, race and ethnicity, and differing abilities are present. These intentional efforts would directly address the past harms and injustices that have been glorified and celebrated, and signal a commitment to rebuilding the lost trust and confidence the Department must gain back from our community.

B. Sexual Assault and Harassment at the Department

Military Sexual Trauma (MST) has a well-studied track record of pervasiveness within our armed services[12] summarized by the Sexual Assault and Prevention and Response (SAPR) program within the Department of Defense. Within the VA, there has yet to be a program or center equivalent to understand, respond to, and prevent sexual assault at VA. In fact, across the Department, VHA facilities have only recently been mandated to have an established policy to address sexual assault and harassment that occurs on their campuses, a welcome change initiated after the passage of the *Deborah Sampson Act*.[13] In the 2019 Department of Defense Annual Report on Sexual Assault in the Military, of the 7,825 reports of sexual assault, only 3.3% of all perpetrators were held to account, and only 1.8% were required to register as sex offenders as a result of their crime.[14] These same perpetrators that were not held to account eventually become veterans and patrons of VA. The Department should take a proactive stance in their prevention efforts and establish a Center for Sexual Assault and Harassment Prevention responsible for playing a protective role of survivors who entrust them with their care.

We are grateful for the meticulous care and attention that has been given to the military sexual trauma pandemic, and for the frameworks that are being built and improved upon to address these personal and systemic harms. In discussions of the continuation of harm as veterans transition out of their military careers, the pervasiveness of similar assaults and instances of harassment targeting VA patrons and staff has only recently received similar recognition. Just last year, a staff member of this Committee was assaulted at the DC VA Medical Center and was subsequently

[12] 15.7% of all military personnel and veterans report MST (3.9% of men, 38.4% of women) when the measure includes both harassment and assault. Additionally, 13.9% report MST (1.9% of men, 23.6% of women) when the measure assesses only assault and 31.2% report MST (8.9% of men, 52.5% of women) when the measure assesses only harassment.

[13] *See Amendment in the Nature of a Substitute to* H.R. 3224, available at www.juliabrownley.house.gov/wp-content/uploads/2019/10/H3224_ANS_xml_10.25.2019.pdf.

[14] *See* 28 Apr 2020 Memo from Undersecretary of Defense for Personnel and Readiness, Matthew P. Donovan, available at www.sapr.mil/sites/default/files/1_Department_of_Defense_Fiscal_Year_2019_Annual_Report_on_Sexual_Assault_in_the_Military.pdf

disparaged and gaslit on a national stage by the then-sitting Department Secretary. In a vulnerable state, where she sought assistance, support, and accountability from the very frameworks that were created to provide and assure it, she was shamed and questioned. This behavior signaled to all patrons and staff members of the Department that this type of behavior is permitted and that survivors seeking assistance and sharing their stories as they sought accountability would receive similar treatment.

The Government Accountability Office reported in 2020 that 18-27% of all VA employees had experienced some form of sexual assault or harassment between 2014 and 2016.[15] The RAND military workplace study further shows that the risk of sexual assault increases 1.5-times when in an environment with rates of ambient sexual harassment, this toxic culture is best illustrated by what our community refers to as the 'DoD-VA continuum of harm.'[16] If the Department is unable to protect their own employees, how will they instill confidence among the growing community of survivors to both trust and use them for their own health-services related to MST? The simple answer is, they cannot.

Of women veterans who access VA health care facilities shows that one in four women veterans reported inappropriate and/or unwanted comments or behavior by male veterans while on VA grounds.[17] VA must be laser focused on prevention efforts for the foreseeable future that focus not on legal liability[18] but, instead, are developed out of a deep commitment to truly better outcomes for survivors and all women veterans. That necessary trust and required confidence of the community has been broken and our known and silent sexual assault and harassment survivors are suffering as a result.

In addition to not being able to access medical care from VA health care facilities due to MST-related trauma, veterans who are victimized at a VA health care facility after their service is completed are additionally not compensated or supported through an increased disability rating

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[15] United States Government Accountability Office. (2020). *GAO-20-387*, Sexual harassment: Inconsistent and incomplete policies and information hinder VA's efforts to protect employees. Report to Congressional Requesters. Accessed on March 12, 2021, at www.gao.gov/assets/gao-20-387.pdf.

[16] Schell, T.L., Cefalu, M., Farris, C., & Morral, A.R. (2021). The relationship between sexual assault and sexual harassment in the U.S. military: Findings from the RAND Military Workplace Study. *RAND Corporation*. Available at www.rand.org/pubs/research_reports/RR3162.html?utm_campaign=&utm_content=1614707955&utm_medium=rand_social&utm_source=twitter.

[17] U.S. Department of Veteran's Affairs. (2019). How stranger harassment of women veterans affects healthcare. *Veteran's Perspectives* Monthly Newsletter. *VA Health Services Research & Development*. Accessed on March 14, 2021, at www.hsrd.research.va.gov/publications/vets_perspectives/0419-How-Stranger-Harassment-of-Women-Veterans-Affects-Healthcare.cfm.

[18] Krause, B. (2018). Veterans Affairs has an $8 million sexual harassment program. *DisabledVeterans.org*. Accessed on March 14, 2021, at www.disabledveterans.org/2018/04/02/veterans-affairs-8-million-sexual-harassment/.

following the event, because the Department measures the type of compensation and services a veteran may qualify for only based on what occurred during their military service, not the continuation of harm or further injuries that occurred within their facilities.[19] The Department should extend the benefits availed to survivors of military sexual trauma (MST) to survivors of similar sexual trauma experienced when accessing due and necessary care and benefits through VA facilities and programs.

A demographic that is not mentioned in the studies of VA health care use or included in MST data collection in the DVA or DoD is sexual orientation and transgender identities. LGBTQ individuals face higher rates of sexual violence than their heterosexual and cisgender counterparts, with transgender and bisexual individuals at the greatest risk, facing the staggering probability of over a 50% chance of becoming a survivor of sexual assault at some point during their lifetimes.[20] During the eras of *Don't Ask, Don't Tell*, the recent ban on open and authentic transgender military service, and the numerous predecessor policies, thousands of servicemembers received less-than-honorable discharges for their actual or perceived sexual orientations and gender identities.[21] Service members during this timeframe also feared reporting instances of same-sex sexual violence because of the potential accusations the victim may face of consensual same-sex behavior that would result in less than honorable, and in some instances even dishonorable and bad conduct discharges.[22] The lack of honorably characterized periods of service prevent this population of survivors from accessing comprehensive medical services and due care should be given to ensure this constituency group is made aware of existing frameworks and structures to bring needed relief, and also that their identities and experiences are centered in the development and re-development of other frameworks.

The criminalization of survivors, most notably through lesser discharge characterizations, is unfortunately prevalent even beyond our LGBTQ siblings. Actions and behaviors that are subjectively perceived as 'contrary to good order' can be classified as misconduct or criminal in nature, without consideration of the impact that mental health issues and sexual trauma have on veterans and the coping mechanisms that they turn to while facing a broken system of support. While discharge

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[19] *See* www.va.gov/health-care/about-va-health-benefits/cost-of-care/.

[20] Human Rights Campaign. (n.d.). *Sexual assault and the LGBTQ community*. Accessed on March 14, 2021, at www.hrc.org/resources/sexual-assault-and-the-lgbt-community.

[21] Benyon, S. (2020). Thousands of veterans with bad paper discharges might not know they can upgrade. *Stars and Stripes*. Accessed on March 14, 2021, at www.stripes.com/news/veterans/thousands-of-veterans-with-bad-paper-discharges-might-not-know-they-can-upgrade-1.647817.

[22] Lofgree, A.M., Carroll, K.K., Dugan, S.A., & Karnik, N.S. (2017). An overview of sexual trauma in the U.S. *Focus, Am. Psychiatr. Publ.* 15(4), 411-419. doi.org/10.1176/aapi.focus.20170024.

characterizations and reviews do not fall under the purview of this Committee, the high prevalence of post-traumatic stress disorder (PTSD), difficulty with social functioning and maintaining professional relationships, and substance abuse disorder among service members (and veterans) who have faced MST should be further explored and documented to immediately address this growing trend and to provide needed assistance.[23]

We urge the Committee to examine the weaponizing of military discharges and applied categorizations, and to apply significant attention and resources towards revitalizing Department processes to ensure that current frameworks do not prevent veterans from accessing life-changing services, resources, and care. We would also urge the use of either executive or legislative action to clear the records of infractions for post-traumatic stress disorder, traumatic brain injuries, military sexual trauma, and administrative discharges conducted under now defunct laws, a precedent for which has been documented through the Johnson, Ford, and Carter Presidential Administrations.

C. Comprehensive Data Collection and Training Improvements

While studies of veterans increasingly include minority veterans, there remains a lack of issue- and identity-specific comprehensive studies. This lack of research-based data has translated into barriers to access, gaps in services, and an attitude of provisional credit toward the advocacy work being done by and for minority veterans, from the doctor's office to the floor of Congress. In order to more accurately understand the needs of minority veterans and more effectively advocate on their behalf, we need a wealth of data that can only come from comprehensive studies and additional data inclusion such as LGBTQ status. These studies must be structured to explicitly identify barriers that may exist between marginalized communities, within specific marginalized populations, and at the intersection of various facets of identity (e.g., race/ethnicity, class, gender identity, sexual orientation, religion, ability, rural vs. urban, etc.).

While there are many research areas that deserve attention, we recommend pursuing research and data analysis projects that address the following issues, paying unique attention to intersectionality and the considerations of women with marginalized identities:

- Benefit utilization by women veterans, particularly women of color and LGBTQ women
- Disability claim awards by gender, race/ethnicity, MST, and LGBTQ status
- LGBTQ status

[23] DAV. (n.d.). *Military sexual trauma: MST*. Accessed on March 14, 2021, at www.dav.org/veterans/resources/military-sexual-trauma-mst/.

- Rates of self-injury, suicidal ideation, and death by suicide
- Substance use treatment
- Women veterans discharged due to LGBTQ status, including character of service and narrative reason for separation, especially as it relates to benefit utilization and disability claims

In addition to improvements in research studies and data collection, training imperatives by the department must prioritize providing equitable services to minority veterans. Minority veterans have a long history of experiencing discrimination and stigmatization within veteran-centric spaces, resulting in effective exclusion from necessary social support and medical care. It is crucial that ignorance and misinformation about minority veterans be addressed through education initiatives. Most importantly, these educational initiatives must be accompanied by social, material, and policy changes to ensure that efforts to increase equity in serving minority veterans are not undermined by the perpetuation of representations, practices, and structures which result in harm and effective exclusion. Proper and ongoing training regarding best practices and cultural competency training on minority veterans should be mandatory for Department staff, Veteran Service Organizations (VSOs), and contractors.

We recommend implementing training initiatives that address the following issues, paying unique attention to intersectionality and the considerations of women with marginalized identities:

- Trauma-informed care training with an explicit recognition of identity-related and historical trauma
- LGBTQ-focused MST training and counseling, including those connected to DADT and transgender-related discharges

D. Comprehensive and Equitable Family Planning

All veterans deserve access to comprehensive and equitable family planning. These services are not only medically necessary, they are also fundamental to securing the human rights of those who have served our nation. Abortion, contraception, IVF, and surrogacy are crucial forms of health care that our veterans deserve, and we recognize an additional need to account for the intersections of various identities and experiences in order to ensure comprehensive access and equitable care.

a. Abortion and Contraception

The Veterans Health Care Act prohibits abortion services and counseling, even when the pregnancy endangers the Veteran's life, increasing vulnerable Veterans' out-of-pocket healthcare

costs and limiting veterans' reproductive freedom.[24] Compared to their civilian counterparts, women veterans are more likely to have an abortion, amounting to almost 1 in 5 women veterans.[25] Factors such as poverty, housing security, and marital status in veterans increase the likelihood of having had an abortion in the last five years.[26] Veterans who face financial hardships and are unable to use the VA health care facilities for their procedures, may attempt an unsafe abortion procedure not overseen by a medical professional due to inability to financially pay for outside services. Unsafe abortion procedures accounts for 14.5% of all maternal deaths globally, with the concentrated value in areas with restrictive abortion laws.[27] Studies show that the way to decrease maternal deaths is to make abortion legal and broadly accessible, which is the opposite of what the Veterans Health Care Act accomplishes.[28]

It is widely recognized that those who experience systemic biases, which have arguably been amplified by the present pandemic, have diminished access to adequate healthcare and experience increased obstacles to contraceptives and economic hardship. Historically, women who have less economic opportunity and stability are less likely to take contraception or continue usage due to out-of-pocket costs. The rate of unintended pregnancy for white women is 33%, which is deeply contrasted by that of Latinx women (58%) and Black women (79%). In addition to the expansion of these benefits for women veterans, expanding the definition and the range of studies for the beneficiaries of reproductive and infertility services, to include contraception and abortion access, has the potential to better serve intersex, transgender men, and veterans with other gender identities that have the reproductive capacity to become pregnant.[29] Women, transgender, and non-binary veterans lack basic access to abortion counseling and related healthcare services through their VA providers—which the Department states they are unable to provide as a matter of law.[30] This

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

[25] Ibid.

[26] Ibid.

[27] Faundes, A., & Shah, I. H. (2015). Evidence supporting broader access to safe legal abortion. *International Journal of Gynecology & Obstetrics*. 131(S1), S56-S59. doi.org/10.1016/j.ijgo.2015.03.018.

[28] Ibid.

[29] Amnesty International. (2018). *Body politics: A primer on criminalization of sexuality and reproduction.* Amnesty International, Ltd. Peter Benenson House. Accessed on March 12, 2021, at www.amnesty.org/download/Documents/POL4077632018ENGLISH.PDF.

[30] 38 CFR §§ 17.38, 17.272.

expansion will ensure that the populations who serve our nation at higher rates than the remainder of the US population receive the benefits they deserve.[31]

We support the efforts of Rep. Brownley to rectify this injustice through introducing HR 345 Reproductive Health Information for Veterans Act and HR 239 Equal Access to Contraception for Veterans Act. We would urge all members of this Committee to support these initiatives and allow for the provision of comprehensive abortion and contraceptive care for all veterans.

b. IVF and Surrogacy

The Deborah Sampson Act has begun the process for the Department of Veterans Affairs to begin research on reproductive and infertility services for Veterans who have a genitourinary service-connected disability or a condition that was incurred or aggravated in line of duty that affects the ability of the veteran to reproduce. However, the narrow scope of this act leaves out a large portion of the veteran population who require these services based on sexual orientation, gender identity, marital status, and Veterans whose non-Veteran partner requires these services. Additionally, many other medical conditions require traditional or gestational surrogacy services, such as those that do not allow veterans to carry children even if they do not have fertility issues.[32]

The requirement that veterans must have a service-connected disability to receive IVF services has additional implications for minority veterans. Women veterans are significantly more likely than their men counterparts to not be given their deserved disability rating.[33] If the veteran does not have an infertility causing disability recognized by the VA while filing for compensation, then they will be unable to receive the services despite losing their reproductive capabilities during their time in active military service. As referenced earlier in this testimony, low-income racial minorities are more likely to utilize VA health care than the rest of the Veteran community. This is due mostly to having no other option because of socioeconomic standings. These same Veterans will then be unable to afford paying for IVF or surrogacy procedures out of pocket, costing an upwards of $210,000,[34] limiting their family planning capabilities. Prior arguments by legislators state that the

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[31] National Center for Transgender Equality. (2015). Military service by transgender people: Data from the 2015 U.S. Transgender Survey. Accessed on March 14, 2021, at www.transequality.org/sites/default/files/docs/usts/USTS-VeteransDayReport.pdf

[32] Sahakian, V. (2020). Understanding surrogacy and IVF. *PCFLA*. Accessed on March 14, 2021, at www.pfcla.com/blog/ivf-and-surrogacy.

[33] Holder, K.A. (2016). The disability of veterans. *U.S. Census Bureau.* Social, Economic, and Housing Statistics Division. Accessed on March 12, 2021, at www.census.gov/content/dam/Census/library/working-papers/2016/demo/Holder-2016-01.pdf.

[34] Tinker, B. (2019). The top 10 questions about surrogacy for same-sex couples, answered. *CNN* Health. Accessed on March 16, 2021, at www.cnn.com/2019/06/14/health/same-sex-surrogacy-faq.

lump-sum payments to Veterans who have lost the use of their reproductive organs should be used to pay for outside fertility treatments; however, these payments do not come near the total cost of surrogacy and IVF.[35]

In addition to the above limitations, the Department also does not recognize domestic partnerships for providing health and benefit service to the veteran's partner.[36] This is due to the Department of Veterans' Affairs recognizing only marriages valid by state law, including certain civil unions.[37] Additionally, the VA has previously denied unmarried Veterans to access IVF treatments solely due to their marital status.[38] These practices greatly discriminate against lesbian, gay, bisexual, transgender, intersex, and asexual Veterans in our communities. We would urge the Committee to expand IVF and surrogacy coverage to cover all veterans in need, regardless of the source of that need, the marital status of the veteran, or if the individual in need is the veteran or their partner.

E. Economic Determinants of Health

a. Disability Compensation Impacting SNAP/WIC Eligibility and Other Benefits

"Nearly 1.5 million veterans in the US are living below the federal poverty level (FPL). An additional 2.4 million veterans are living paycheck to pay-check at < 200% of the FPL." [39] Information about food insecurity among veterans is less concrete, with estimates vary widely, ranging from 6% to 24%—nearly twice that of the general US population. Veterans living in poverty are at even higher risk than nonveterans for food insecurity, homelessness, and other material hardship. Higher rates of food insecurity have been reported among certain high-risk subgroups, including veterans who served in Iraq and Afghanistan (27%), female veterans (28%), homeless and formerly homeless veterans (49%), and veterans with serious mental illness (35%). Additional risk factors for food insecurity specific to veteran populations include younger age, having recently left active-duty military service, and lower final military paygrade. As in the general population, veteran food

[35] Tritten, T.J. (2016). Congress allows IVF coverage for wounded vets, with limits. *Stars and Stripes*. Accessed on March 14, 2021, at www.stripes.com/congress-allows-ivf-coverage-for-wounded-vets-with-limits-1.431674.
[36] *See* www.va.gov/opa/marriage/
[37] *See Reliance on state law to determine validity of same-sex marriage.* A memorandum from the Department of Veterans Affairs General Counsel. Accessed on March 14, 2021, at www.va.gov/OGC/docs/2014/VAOPGCPREC4-2014.pdf.
[38] Sokolow, A. (2020). The VA doesn't cover fertility treatments for unmarried veterans or same-sex couples. Some want to change that. *USA Today*. Accessed on March 14, 2021, at www.usatoday.com/story/news/nation/2020/08/21/veterans-groups-say-va-should-offer-ivf-unmarried-same-sex-couples/3371635001/.
[39] National Center for Biotechnology Information. (2020). Food insecurity among veterans: Resources to screen and intervene.

insecurity is associated with a range of adverse health outcomes, including poorer overall health status as well as increased probability of delayed or missed care.

Minority veterans experience poverty and food insecurity at higher rates than their non-minority counterparts. According to Military Service History and VA Benefit Utilization Statistics, the most recent report from Department of Veterans Affairs National Center for Veterans Analysis and Statistics, published in March 2017, recent studies have shown that Post 9/11 veterans have a higher risk of unemployment than prior generations, and that "Post-911 minority veterans in 2014 had 41 percent higher risk of unemployment than minorities that served in Pre-9/11, 76 percent more than minorities that served in the Vietnam Era and 20 percent higher than those that served during Peacetime only periods." Current estimates show that veterans belonging to minority groups have approximate 44% higher risk of experiencing unemployment and experience poverty rates nearly twice as often than their non-minority counterparts.

Food Insecurity can cause a host of problems not limited to poorer patient activation in clinical settings, underusing medications and delaying needed medical care, worsening health, lost wages, having to make choices of whether to eat, pay rent, or take medicine, and relying on less-nutritious and nutrient-dense foods for sustenance. Negative mental health outcomes in adults and children, including anxiety, aggression, suicide, and suicidal ideation along with the undermining of physical, emotional, social, and economic opportunities for the children of veterans experiencing food insecurity are additional consequences. Because of those issues, there is also the negative impact of increased costs incurred by the Department due to the inadequate systems and frameworks.

There are many current offerings that help veterans experiencing food insecurity, sponsored through the Department and within the broader community. It is worth noting that though the offerings may be available, they are not always accessible or effectively communicated to eligible veterans. In addition to eligibility-enrollment gaps that exist in high proportions, so too do problematic eligibility criteria that exclude veterans from receiving SNAP or WIC benefits due to receipt of VA disability income. Currently, veteran disability compensation is counted as income in calculating SNAP and WIC benefits, whereas many other assistance programs—to include social security, unemployment, and Medicaid/Medicare—exempt that same income from criteria in their income calculations. While we recognize that this Committee does not have the unilateral authority to make such changes on its own, we would request the Department engage in data collection to determine the number of veterans that would otherwise be eligible for such benefits despite their disability income to better inform future rulemaking processes and ensuing impacts.

b. **Expansion of Gender-Specific Housing Services**

This legislative body released a report in November 2020, which identified a strong correlation between coronavirus vulnerability and infection rates, and the rampant housing insecurity pandemic. Specific emphasis was placed on the need for governmental intervention. We applaud the Department for their work in ensuring VA Home Loan borrowers are sheltered from evictions and the moratorium the Biden-Harris Administration extended for renters, but also highlight that evictions continue to occur. The housing insecurity pandemic is not a new phenomenon within the veteran community, or even the civilian community at large. Congress has been attempting to directly address this pandemic for the past several decades, with 4,521 pieces of legislation having been introduced since 1973. Notably, only 434 of those Bills, less than 10% of what has been introduced, were signed into law. That percentage of passed legislation remains consistent in Bills that focused specifically on addressing homelessness in the veteran community, with 2,073 pieces of legislation being introduced since 1979, and only 293 of them being signed into law.

Still, approximately 3-million people experience a short- or long-term episode of homelessness or housing insecurity annually. Veterans already experience homelessness at a higher rate than their non-veteran counterparts, but that state of insecurity is further exacerbated in individuals with lower socioeconomic statuses which, as discussed above, occur disproportionately among minority communities when compared to their non-minority counterparts. Internally, our biannual community needs assessment and impact survey supports these claims.

Looking beyond an individual's socioeconomic status, the Department's own research division has additionally confirmed that lived experiences, such as Military Sexual Trauma (MST), further increase a veteran's propensity to be homeless or to experience housing instability. In fact, nearly 10% of all MST survivors experience housing insecurity within the first 5-years of leaving the military. The majority of our membership identify as women or veterans of color, communities which experience MST at higher rates than their non-minority veteran counterparts. This disparity indicates that our nation's most underserved veteran communities must deal with compounded systemic and personal conditions and traumas, pushing back against inequitable systems that were not built for them but are being bastardized to support them, as they work to ensure their families secure and retain stable housing.

Fortunately, recent studies have indicated that survivors of MST in receipt of disability compensation or associated veterans' benefits were less likely to experience a housing crisis. We acknowledge the existence of several programs, resources, and frameworks designed specifically for homeless veterans, but would impress that comprehensive data collection and additional internal

and external culturally competent trainings and frameworks, especially around compounded personal and systemic traumas and oppression, and especially with regards to survivors of MST, be facilitated to ensure that these programs are designed to serve the most marginalized of our veteran communities.

c. Expansion of Childcare Benefits

MVA applauds the childcare expansion provisions that were included in the Deborah Sampson Act[40]. The newest provisions and the future availability of childcare services are a welcome and wonderful change that has the potential to reduce the financial anxiety and burden of accessing available healthcare for millions receiving their care at VA through the years. Establishing and expanding childcare provisions to student veterans and to those who live at less than 80% AMI can provide meaningful impact in the lives and outcomes of women and minority veterans.[41]

In 2011, the Department of Veterans Affairs instituted a pilot program providing financial support for childcare while eligible veterans were undergoing medical treatment. A 2015 report on the pilot program outcomes determined that more than 10,000 children of veterans were able to take part in the program and that women, compared with the overall veteran population, used the program four times more often. In utilization surveys, veterans reported that had they not had childcare available as provided by the program, many would have had to forgo medical care or bring their children to their appointments.[42]

As parents across the country and on this Committee are aware, childcare costs throughout the country are unaffordable. A 2019 report from ChildCare Aware of America found that childcare costs for an infant in the U.S. can cost nearly 36% of a single-parent led family income. The organization also found that "[i]n all regions of the United States, average child care prices for an infant in a child care center exceeded the average amount that families spend on food and transportation combined."

MVA member and Navy veteran Cassie Gabelt, almost had to drop out of school and forgo using her GI Bill benefits in 2013 while pursuing her MPS due to childcare costs. At the time, Ms. Gabelt received $1,100 in BAH through her GI Bill stipend. Ms. Gabelt was paying $600 monthly for

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[40] *See* H.R. 3224

[41] Wentling, N. (2019). House passes bill to offer free child care at VA facilities nationwide. *Stars and Stripes*. Accessed on March 14, 2021, at www.stripes.com/news/us/house-passes-bill-to-offer-free-child-care-at-va-facilities-nationwide-1.567958.

[42] *See* Chairwoman Brownley Press Release: House passes Brownley bill to expand child care program to improve veterans' access to healthcare. Accessed on March 14, 2021, at www.juliabrownley.house.gov/house-passes-brownley-bill-to-expand-child-care-program-to-improve-veterans-access-to-healthcare.

childcare, the average cost for her area, leading to a $7,200 annual price tag. At one point, after paying her monthly bills and childcare costs, while skipping meals to make ends meet, she had less than $42 in her bank account. She has also taken her son to multiple appointments and canceled several additional appointments at her VA Medical Center and Outpatient Clinic due to lack of access to childcare.

> "I now have a master's degree thanks to the GI Bill, but it was almost not to be. I remember being in tears almost daily while working on my undergraduate degree. I was tired. I was hungry from skipping meals. Every time I drove to class, my fingers were crossed in the hopes I didn't run over a nail and get a flat tire. My financial situation after separation from the Navy was so dire that one flat tire would have thrown me into bankruptcy, my car would have been repossessed, and I likely would have been evicted from my apartment because I was always squeaking by. In addition to having left the service with mountains of debt, my mental health was a disaster from service-connected issues topped off with the anxiety from these unnecessary external stressors. Not only was I skipping mental health appointments, or taking a then 3-year-old to them, I was spending more than half of my BAH stipend on childcare while in class, I had to continue to pay for the care during breaks from class when the stipend was not provided to keep my son's spot [in the childcare program]. An allowance for childcare and break pay would have saved me from exacerbating my service-connected mental health conditions and delaying healing just so I didn't end up homeless while trying to get an education."

Chairwoman Brownley has previously said that "[t]he lack of child care shouldn't prevent veterans from receiving VA healthcare services[, and that e]nsuring veterans have access to childcare is especially important for our growing population of women veterans, who are more likely to be taking care of young children."[43] Just as childcare costs are a barrier for those who need to access medical care to improve the quality of their life, it is also a barrier for those who want to receive an education for similar reasons. We would encourage this Committee to explore the expansion of childcare assistance, stipends, or subsidies for those who live at less than 80% AMI and to those who are using GI Bill benefits.

F. Mental Health

Women veterans have unique needs when it comes to mental health. In addition to access to

[43] Ibid.

care and the provision of equitable care, there is also the manifestation of mental health issues within veterans as they relate to stigmatized and criminalized behaviors. Such actions and behaviors that are considered to be misconduct or criminal in nature, are often categorized without consideration of the impact that mental health issues and sexual trauma have on veterans. The high prevalence of post-traumatic stress disorder (PTSD), traumatic brain injuries (TBIs), and substance use disorders (SUDs) among veterans has been noted. Despite efforts to increase screening for mental health conditions, many veterans with PTSD symptoms do not seek mental health care due to widespread stigmatization and fear of socioeconomic impacts. In an effort to cope with the devastating symptoms of PTSD, including the traumatic effects of sexual trauma and harassment, many veterans self-medicate by using illicit substances and alcohol as a substitute for professional mental health care. The existence of other legal and cultural categories for understanding behaviors and actions additionally make their expressions illegible in the current understood and utilized framework of mental health and sexual trauma.

The social barriers created by the stigma against seeking mental health care disproportionately impact minority service members in various ways. For example, the powerful, historical association between LGBTQ+ identity and severe mental illness has discouraged many LGBTQ+ people from seeking mental health care. The same is true for women, as sexist attitudes about women's mental health and disturbingly commonplace practices such as forced institutionalization have prevented many women from seeking care and being honest with the mental health care providers that they have seen. Finally, structural racism and bias against women of color, such as racist ideas about pain tolerance among Black people, are prevalent in all aspects of American society and are powerful contributing factors for racial and ethnic minorities in seeking mental health care.

These pervasive ideologies and practices impress upon women veterans that we cannot expect safety in our interactions with individuals or institutions. This is seen most obviously for women veterans in the course of our daily lives, as we continue to be saturated with the violation of our boundaries. This burden makes us aware in the worst ways that our bodies are hyper-visible while our voices are invisible. In too many cases, our stories include assault, violence, and trauma. This harm is compounded by the justified expectation, evident in the experiences of too many women, that speaking the truth will lead to us being shunned and accused of exaggerating our lived experiences or putting our own self-protective interests before veteran tenets of community cohesion.

Sexual harassment and abuse that occurs through their connection with military and veteran communities severely impacts women veterans' mental health for years, sometimes decades, after the event(s) occur. The major roadblock to resolving these traumas arises from the fact that women veterans are made to feel as if our voices and experiences do not matter. This devaluation mimics but extends beyond the circumstances of sexual abuse. It is evident when women veterans seek health care, only to have their suffering dismissed and underrated by the perpetuation of misogynistic stereotypes about women's exaggeration. It is evident in too many situations, normalized by administrative processes and made invisible through a narrow view of what constitutes sex-based discrimination and harassment.

Bills such as HR 344 Women Veterans TRUST Act directly address the mental health needs of women veterans, while bills such as HR 365 Marijuana 1-to-3 Act of 2021 work to reduce the criminalization of self-treatment for women veterans who are not currently seeking care through the VA due to stigma, discrimination, or past experiences of harm. We would urge the Committee to support these Bills and pursue other initiatives to support the mental health needs of all women veterans.

G. 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 SUD and nearly 33% of veterans seeking treatment for a substance use disorder also have posttraumatic stress disorder.[44] Unfortunately, there is a glaring lack of data on SUDs among minority veterans, further indicating a need for holistic data collection among veterans. However, we do know that racial and ethnic minority veterans have higher rates of PTSD than white veterans (suggesting higher rates of SUDs as well), that women veterans are at a higher risk for SUDs than their non-veteran counterparts, and that LGBTQ people overall are at higher risk for 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, echoing a need for a social determinants of health approach.

We applaud the work of Representative Cisneros and Representative Brian Mast (FL-18), for their work in directly addressing these and other concerns associated with mental health disparities

[44] National Center for PTSD. (n.d.). PTSD and Substance Abuse in Veterans. US Department of Veterans Affairs. Accessed on February 28, 2021, at www.ptsd.va.gov/understand/related/substance_abuse_vet.asp.

and SUD within the veteran community.[45] We urge the Committees to ensure the Department engages in comprehensive data collection to report on the deaths and known substance use of veterans involved with Departmental services, and in ensuring that health care providers receive culturally competent and informed training to effectively update frameworks, services, and clinical practice guidelines.

Thank, you again, for the opportunity to submit this testimony and for inviting me to the table for this conversation. If I can be of further assistance, please feel free to contact our Acting Policy Director, Andy Blevins, via email at ablevins@minorityvets.org.

Respectfully Submitted,

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

[45] *See* STOP Veteran Suicide and Substance Abuse Act (H.R. 5867), which was passed as part of the Commander John Scott Hannon Veterans Mental Health Care Improvement Act, Pub. L. 116-171.