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113TH CONGRESS } SENATE { REPORT
1st Session } { 113–106

WOMEN VETERANS AND OTHER HEALTH CARE IMPROVEMENTS ACT OF 2013

SEPTEMBER 17, 2013.—Ordered to be printed

Mr. SANDERS, from the Committee on Veterans' Affairs, submitted the following

REPORT

together with

MINORITY VIEWS

[To accompany S. 131]

The Committee on Veterans' Affairs (hereinafter, "Committee"), to which was referred the bill (S. 131) to amend title 38, United States Code (hereinafter, "U.S.C."), to improve the reproductive assistance provided by the Department of Veterans Affairs (hereinafter, "VA" or "the Department") to severely wounded, ill, or injured veterans and their spouses, and for other purposes, having considered the same, reports favorably thereon with an amendment in the nature of a substitute, and recommends that the bill, as amended, do pass.

INTRODUCTION

On January 24, 2013, Senator Murray introduced S. 131, the proposed "Women Veterans and Other Health Care Improvements Act of 2013." Senators Begich and Tester were original cosponsors of the bill. Senator Blumenthal was later added as a cosponsor of the bill. The bill was referred to the Committee upon introduction.

COMMITTEE HEARING

On May 9, 2013, the Committee held a hearing on legislation pending before the Committee. Testimony on S. 131 was received from: Heather L. Ansley, Esq., M.S.W., Vice President of Veterans

29–010

Policy, VetsFirst; Richard F. Weidman, Executive Director for Policy and Government Affairs, Vietnam Veterans of America; and Robert L. Jesse, M.D., Ph.D., Principal Deputy Under Secretary for Health, U.S. Department of Veterans Affairs.

COMMITTEE MEETING

On July 24, 2013, the Committee met in open session to consider legislation pending before the Committee. Among the measures so considered was an amended version of S. 131. The Committee voted by voice vote, to report favorably S. 131 as amended (hereinafter, "the Committee bill") to the Senate. One Member was recorded as a no vote.

SUMMARY OF S. 131 AS REPORTED

Section 1 would provide a short title for the bill and would provide that certain references within the bill are references to title 38, U.S.C.

Section 2 would clarify that fertility counseling and treatment are medical services which the Secretary may furnish to veterans like other medical services.

Section 3 would authorize reproductive treatment and care for spouses and surrogates of veterans.

Section 4 would authorize adoption assistance for severely wounded veterans.

Section 5 would require the prescription of regulations on furnishing of fertility counseling and treatment and adoption assistance by VA.

Section 6 would provide for coordination between VA and Department of Defense (hereinafter, "DOD") on furnishing of fertility counseling and treatment.

Section 7 would facilitate research on reproduction and infertility.

Section 8 would require an annual report on provision of fertility counseling and treatment furnished by VA.

Section 9 would authorize a program on assistance for child care for certain veterans.

Section 10 would authorize a program on counseling in retreat settings for women veterans newly separated from service in the armed forces.

BACKGROUND AND DISCUSSION

Sec. 2. Clarification that fertility counseling and treatment are medical services which the Secretary may furnish to veterans like other medical services.

Section 2 of the Committee bill, which is derived from S. 131, as introduced, would clarify that fertility counseling and treatment are medical services which the Secretary may furnish to veterans like other medical services.

Background. The nature of the most recent conflicts and the increasing use of improvised explosive devices leave servicemembers far more susceptible to blast injuries, including spinal cord injury and trauma to the reproductive and urinary tracts. According to DOD data, between 2003 and June 2013, 2,320 servicemembers

suffered genitourinary or pelvic injuries while serving in Iraq or Afghanistan.

VA currently provides fertility counseling and treatment for all enrolled veterans, including to both service-connected and non-service-connected veterans, as described in the Medical Benefits Package contained in section 17.38 of title 38, Code of Federal Regulations (hereinafter, "C.F.R."). The services offered include genetic counseling and testing, laboratory tests, biopsies of reproductive organs, hormonal treatments, and intra-uterine insemination. However, VA explicitly prohibits certain types of assisted reproductive technology (hereinafter, "ART") in section 17.38(c) of title 38, C.F.R., such as in vitro fertilization (hereinafter, "IVF").

A March 2011 study by Mattocks, et al., entitled "Women veterans' reproductive health preferences and experiences: a focus group analysis," published in Women's Health Issues found that women veterans felt VA could improve fertility services offered by increasing the availability of more advanced procedures. Additionally, the study found: "[S]everal participants had utilized infertility services provided by the VA, including infertility medications and artificial insemination, yet were denied VA coverage for assisted reproductive technologies, including in vitro fertilization. Participants expressed beliefs that the VA should provide more extensive infertility coverage, including in vitro fertilization, to assist women who are having difficulties becoming pregnant."

According to testimony submitted by the Department for the Committee's May 9, 2013, hearing on pending legislation, providing reproductive treatment through ART is in line with VA's goals to provide restorative care to disabled veterans and improve their quality of life. Both male and female veterans experience service-related reproductive injuries or illnesses that interfere with their fertility and fecundity—ability to carry a pregnancy to full-term. Among these are: blast injuries that can damage the sexual organs, including testicular or uterine rupture, or their nerve and vascular supplies, and non-ballistic injuries, such as spinal cord or traumatic brain injury. For these veterans, the use of ART may be their only option for achieving a successful pregnancy.

On April 27, 2010, DOD authorized IVF services for severely wounded, ill, or injured servicemembers and their spouses. DOD issued guidance on the implementation of this benefit on April 3, 2012. This resulted in an inequity in the services provided by VA and DOD to assist severely wounded veterans or servicemembers in becoming parents. Some veterans have difficulty utilizing this coverage before they separate from active duty due to timing and after separation due to geographic constraints.

Committee Bill. Section 2 of the Committee bill would modify section 1701(6) of title 38, U.S.C., to clarify that fertility treatments, including treatments through ART, are authorized for veterans. It is the view of the Committee that veterans should be able to access the same level of fertility treatments whether they utilize VA or DOD health care.

Sec. 3. Reproductive treatment and care for spouses and surrogates of veterans.

Section 3 of the Committee bill, which is derived from S. 131, as introduced, would require VA to furnish reproductive treatment

and care to spouses or surrogates of severely wounded, ill, or injured veterans. It also authorizes VA to coordinate fertility counseling and treatments for spouses and surrogates of veterans whose infertility is not related to military service.

Background. In order to provide comprehensive fertility treatment to a veteran, it is imperative to provide treatment to the veteran's spouse or surrogate to ensure that treatment results in a successful pregnancy. This is particularly significant for wounded, ill, or injured veterans. Certain illnesses or injuries necessitate the use of ART among veterans who may be clinically unable to achieve a successful pregnancy. According to testimony submitted by Dr. Mark Edney, Member of the American Urological Association, for the Committee's June 27, 2012, hearing on pending legislation, blast or gunshot wounds to the male pelvis or spinal cord and traumatic brain injury may render male servicemembers and veterans incapable of intercourse to achieve a natural pregnancy.

For other veterans, surrogacy—the process by which a woman agrees to become pregnant and give birth to a child on behalf of another person—is their only option for having their own children. According to testimony submitted by Dr. Edney, "[b]last or gunshot wounds to the female pelvis can also result in a variety of fertility-impairing injuries * * *[;] penetrating schrapnel injury to the female pelvis can disrupt the ovaries, fallopian tubes, body of the uterus or the vaginal vault * * *[;] [u]terine injury can result in a uterus incapable of sustaining a pregnancy which then opens the issue of surrogacy."

Committee Bill. Section 3 of the Committee bill would amend title 38, U.S.C., by adding a new section 1788. Subsection (a) of this new section would require VA to furnish fertility counseling and treatment, including ART, to a spouse or surrogate of a severely wounded, ill, or injured veteran who has an infertility condition incurred or aggravated in the line of duty in the active military, naval, or air service. The spouse or surrogate and the veteran must apply jointly for such counseling and treatment through a process prescribed by VA, and the veteran must be enrolled in the health care system established under section 1705(a) of title 38, U.S.C.

While VA provides reproductive counseling and treatment for veterans, the Committee notes that infertility management is one of many family planning concerns that commonly involves treatment of both parents. The Committee intends that VA make these treatments and any necessary components, including those derived from third party donation, available to spouses and surrogates of severely injured veterans in order to restore their ability to create a family.

Subsection (b) of this new section would authorize VA to coordinate fertility counseling and treatment for spouses or surrogates with the veteran's, when the veteran's infertility is not related to their military service.

Subsection (c) of this new section would clarify that nothing in this section shall be construed to require VA to find or certify a surrogate for a veteran or to connect a surrogate with an injured veteran. Subsection (c) also clarifies that nothing in this section shall be construed to require VA to furnish maternity care to a

spouse or veteran who would not otherwise be eligible for VA to provide that care.

Sec. 4. Adoption assistance for severely wounded veterans.

Section 4 of the Committee bill, which is derived from S. 131, as introduced, would authorize VA to provide adoption assistance to severely wounded, ill, or injured veterans who have an infertility condition incurred or aggravated in the line of duty.

Background. In light of injuries sustained, servicemembers and veterans may need to rely on third-party donation or adoption to build their families. The 2002 National Survey of Family Growth, conducted by the Centers for Disease Control and Prevention, found that approximately three quarters of women who were seeking to adopt a child faced issues with fertility or maintaining a pregnancy.

Committee Bill. Section 4 of the Committee bill would further amend title 38, U.S.C., by adding a new section 1789. This new section would authorize VA to assist a covered veteran in the adoption of one or more children. Covered veterans would include severely wounded, ill, or injured veterans who are enrolled in the VA health care system and have an infertility condition incurred or aggravated in the line of duty. This section authorizes VA to set a limitation on the amount that is equal to the lesser of the cost of one cycle of fertility treatment through ART or the cost of three adoptions.

The intent of the Committee is to ensure that veterans, with infertility conditions connected to their military service, have flexibility and options to choose from when deciding how to build their families.

Sec. 5. Regulations on furnishing of fertility counseling and treatment and adoption assistance by Department of Veterans Affairs.

Section 5 of the Committee bill, which is derived from S. 131, as introduced, would require VA to promulgate regulations on the furnishing of fertility treatments via ART, prior to furnishing counseling or treatment, and on the furnishing of services described in sections 1788 and 1789 of title 38, as added by sections 3 and 4 of the Committee bill, notwithstanding any other provision of the law.

Committee Bill. Section 5 of the Committee bill would require VA to promulgate regulations in accordance with section 553 of title 5, U.S.C., on the furnishing of fertility treatments and adoptions, as added by the Committee bill, prior to furnishing such services. This section would require that VA, not later than 540 days after the date of the enactment of the Committee bill, prescribe regulations to provide fertility treatments to veterans via ART and to carry out sections 1788 and 1789 of title 38, U.S.C., as added by the Committee bill. The Committee expects that the regulations required by this section would encourage the development of common-sense clinical guidance and would allow for stakeholder involvement in the decisionmaking process on how best to administer fertility counseling and treatment to veterans and their spouses or surrogates. The Committee also intends these regulations allow for collaborative decisionmaking on how to best offer fertility treatment

to surrogates and spouses, and adoption assistance to eligible veterans. It is not the intent of the Committee to stop or slow any existing fertility services that VA currently offers.

Sec. 6. Coordination between Department of Veterans Affairs and Department of Defense on furnishing of fertility counseling and treatment.

Section 6 of the Committee bill, which is derived from S. 131, as introduced, would require VA to coordinate the furnishing of fertility counseling and treatment by VA with the furnishing of such counseling and treatment by DOD.

Background. DOD, in certain situations and at certain military treatment facilities (hereinafter, "MTFs"), provides IVF treatments to severely wounded, ill, and injured servicemembers and spouses. DOD also has several MTFs that offer fertility treatments through ART on a cost-sharing basis. Offering these services has resulted in an inequity in the extent to which VA and DOD are able to assist severely wounded veterans or servicemembers in becoming parents.

Committee Bill. Section 6 of the Committee bill would require VA to coordinate its fertility counseling and treatment with that provided by DOD.

It is the intent of the Committee that VA and DOD coordinate their services to address the needs of this unique population. In addition, the Committee encourages VA to work with DOD and understand key lessons learned in DOD's implementation of guidance and delivery of services. The Committee believes that coordination will allow both Departments to avoid duplicative efforts while expanding access to fertility counseling and treatment for servicemembers and veterans.

Sec. 7. Facilitation of reproduction and infertility research.

Section 7 of the Committee bill, which is derived from S. 131, as introduced, would require VA to collaborate with the DOD and the Department of Health and Human Services (hereinafter, "HHS") to facilitate research on the long-term reproductive needs of veterans. This section would also require VA to report to Congress on research activities conducted in response to this section.

Background. Occupational hazards, including environmental exposures, trauma, and military sexual trauma, can affect the reproductive health of servicemembers. Many serving in Operation Iraqi Freedom (hereinafter, "OIF"), Operation Enduring Freedom (hereinafter, "OEF"), and Operation New Dawn (hereinafter, "OND") are of childbearing age, and may have to deal with a lifetime of symptoms related to their military service. For example, according to data from DOD, 2,320 servicemembers have suffered reproductive and urinary tract trauma on the battlefield between 2003 and June 2013. These injuries may limit servicemembers' and veterans' abilities to reproduce for various reasons, including damage to reproductive organs, pelvic fractures, and others.

In June 2012, an editorial by Colonel Steve Waxman, M.D., U.S.A.R., entitled "Lower Urinary Tract Injuries in Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF)" was published in Military Medicine. Colonel Waxman found that the concurrence of bladder and urethral injuries, along with genital trau-

ma, suggests that many injured servicemembers may have long-term hormonal and fertility issues. Limited research is available on the reproductive health needs and treatment options available for servicemembers and veterans. In testimony submitted for the Committee's June 27, 2012, hearing on pending legislation, Dr. Mark Edney, an urologist and Army Reservist, highlighted the critical need for research in this area, including research on strategies for preventing reproductive and urinary tract trauma on the battlefield and the long-term effects of such trauma on reproductive health.

Currently, VA has limited ongoing research in this area, including studies on urogenital systems and Post Traumatic Stress Disorder (hereinafter, "PTSD"), availability and use of contraceptives, and the effects of male reproductive toxicants on the ability to reproduce. In addition to VA, other government research entities can play an important role in filling the gap in existing research on the long-term reproductive needs of veterans, including DOD, because of its role in facilitating research to inform health care services for servicemembers, and HHS, because of its role in setting a national agenda for detection, prevention, and management of infertility.

Committee Bill. Section 7 of the Committee bill would amend subchapter II of chapter 73 of title 38, U.S.C., to create a new section 7330B. Subsection (a) of this new section would require VA to collaborate with DOD and HHS to facilitate research to improve VA's ability to meet the long-term reproductive health needs of veterans. Subsection (b) of this new section would require VA to ensure that information produced by the research facilitated under this section is disseminated throughout the VA system.

Section 7 would also require VA to submit a report to Congress, not later than 3 years after the date of the enactment of the Committee bill, on the research activities conducted under new section 7330B of title 38, U.S.C.

Sec. 8. Annual report on provision of fertility counseling and treatment furnished by Department of Veterans Affairs.

Section 8 of the Committee bill, which is derived from S. 131, as introduced, would require VA to submit a report to Congress each year on the fertility counseling and treatments furnished by VA during the year preceding the submittal of the report.

Background. At present, VA provides limited fertility treatments for all enrolled veterans including both service-connected and non-service-connected veterans. The services available to male veterans include laboratory testing, semen analysis, evaluation and treatment of erectile dysfunction interfering with sperm delivery, surgical correction of structural pathology, hormone therapy, sperm cryopreservation for certain conditions, genetic testing and counseling, sperm retrieval, post-ejaculatory urinalysis, and transrectal or scrotal ultrasonography. The services available to female veterans include laboratory testing, pelvic or transvaginal ultrasound, hysterosalpingogram, post-coital testing, diagnostic laparoscopy or hysteroscopy, endometrial biopsy, hormone therapy, intrauterine insemination, saline infused sonohysterogram, surgical correction of structural pathology, and genetic testing and counseling. There is no data readily available on usage of these services.

Committee Bill. Subsection (a) of section 8 of the Committee bill would require VA to submit a report to the Committee on Veterans'

Affairs of the Senate and House of Representatives each year on the fertility counseling and treatments furnished by VA during the year preceding the submittal of the report.

Subsection (b) of section 8 of the Committee bill describes the information required in each report submitted under subsection (a), including the number of veterans and spouses or surrogates of veterans who received fertility counseling or treatments furnished by VA, disaggregated by era of military service of such veterans; the cost to VA of furnishing fertility counseling and treatment, disaggregated by cost of services and administration; the average cost to VA per recipient of such counseling and treatment; in cases in which the Department furnished IVF, the average number of cycles per person furnished; and a description of how VA fertility counseling and treatment services are coordinated with similar services provided by DOD. It is the Committee's view that it is critical to monitor these services to ensure that they are meeting the needs of those they are intended to assist.

Sec. 9. Program on assistance for child care for certain veterans.

Section 9 of the Committee bill, which is derived from S. 131, as introduced, would authorize a permanent program to provide assistance for child care to certain veterans receiving readjustment counseling and related mental health services.

Background. The Caregivers and Veterans Omnibus Health Services Act of 2010, enacted as Public Law (hereinafter, "P.L.") 111–163, authorized VA to create a pilot program to provide assistance to veterans for child care expenses incurred while receiving care at VA Medical Centers via stipend, direct provision of child care, interagency collaboration, or payment to private child care agency. The pilot was authorized to be carried out in no fewer than three Veterans Integrated Service Networks for 2 years, beginning on the date the first site began to operate. Subsidies for child care are only available during the time period that a veteran is actually receiving specified health care services at a VA Medical Center, and during the time required by the veteran to travel to and from the site of treatment. Veterans eligible for subsidies are those who are the primary caretaker of a child or children and who are receiving regular or intensive mental health care, or other intensive health care services determined by VA as ones for which access would be improved by payment of a subsidy for child care.

The first child care site opened in Buffalo, NY, on October 3, 2011. Sites in Northport, NY, and American Lake, WA, opened on April 30, 2012, and December 3, 2012, respectively. The Dallas VA Medical Center also opened a site on April 1, 2013. Between the inception of the pilot program and June 2013, the four sites have served 3,817 children.

Having access to quality and timely mental health care is vital. VA's Vet Centers play an integral role in providing readjustment counseling and mental health treatment to combat veterans. Committee oversight has found access to child care can complicate a veteran's ability to consistently adhere to a Vet Center counseling and treatment plan.

Committee Bill. The Committee has recognized the absence of adequate child care as a significant barrier to accessing health care for veterans who are also primary caretakers of children. This

problem is exacerbated for veterans who may need more intensive and long-term outpatient services, such as care for PTSD, mental health, and other therapeutic programs.

Section 9(a) of the Committee bill would make permanent the pilot program to provide child care subsidies to eligible veterans. Section 9(b) would require VA to create a program to offer child care assistance to those seeking readjustment counseling and associated mental health services through VA's network of Vet Centers. It is the intent of the Committee to ensure that identified barriers to mental health care access are removed.

Sec. 10. Counseling in retreat settings for women veterans newly separated from service in the Armed Forces.

Section 10 of the Committee bill, which is derived from S. 131, as introduced, would make permanent the pilot program on counseling in retreat settings for women veterans newly separated from service in the Armed Forces.

Background. P.L. 111–163, the Caregivers and Veterans Omnibus Health Services Act of 2010, authorized VA to establish a pilot program designed to evaluate the feasibility of providing reintegration and readjustment services in group retreat settings to recently separated women veterans, after a prolonged deployment.

Services provided under the pilot program include information and assistance on reintegration into family, employment, and community; financial and occupational counseling; information and counseling on stress reduction and conflict resolution; and any other counseling VA considers appropriate to assist the participants in reintegrating into their families and communities.

As required by P.L. 111–163, the Department submitted a report to the Committees on Veterans' Affairs on outcomes of the pilot program. According to this report, the total cost for both years of the pilot program was $398,376. Over the 2-year period, six retreats were held in California, Colorado, Washington, New Mexico, and Connecticut. These retreats were attended by 134 women from 37 States and Territories, and 85 percent of participants had statistically significant improvements in psychological well-being, with 71 percent of participants maintaining these improvements 2 months after participation in a retreat. Eighty-one percent of participants showed statistically significant decreases in stress symptoms, 82 percent of participants showed more frequent use of positive coping skills, and 78 percent of those who qualified for a PTSD diagnosis prior to participating no longer qualified for that diagnosis 2 months after attendance at a retreat.

Committee Bill. Section 10 of the Committee bill would make permanent the pilot program. Based on reports, this program is successful at improving the ability for women veterans to reintegrate and readjust to civilian life. It is the intent of the Committee that VA continue to offer this cost-effective program to more women veterans who can benefit from participation.

COMMITTEE BILL COST ESTIMATE

In compliance with paragraph 11(a) of rule XXVI of the Standing Rules of the Senate, the Committee, based on information supplied by the Congressional Budget Office (hereinafter, "CBO"), estimates that enactment of the Committee bill would, relative to current

law, have a discretionary cost of $578 million over the 2014–2018 period, assuming appropriation of the estimated amounts. S. 131, as amended, contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act.

The cost estimate provided by CBO, setting forth a detailed breakdown of costs, follows:

CONGRESSIONAL BUDGET OFFICE,
Washington, DC, August 21, 2013.

Hon. BERNARD SANDERS,
Chairman,
Committee on Veterans' Affairs,
U.S. Senate, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for S. 131, the Women Veterans and Other Health Care Improvements Act of 2013.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contact is Ann E. Futrell.

Sincerely,

DOUGLAS W. ELMENDORF,
Director.

Enclosure.

S. 131—Women Veterans and Other Health Care Improvements Act of 2013

Summary: S. 131 would expand the types and availability of infertility treatment provided by the Department of Veterans Affairs (VA). CBO estimates that implementing the bill would cost $578 million over the 2014–2018 period, assuming appropriation of the estimated amounts. Enacting S. 131 would not affect direct spending or revenues; therefore, pay-as-you go procedures do not apply.

S. 131 contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act (UMRA).

Estimated cost to the Federal Government: The estimated budgetary impact of S. 131 is shown in the following table. The costs of this legislation fall within budget function 700 (veterans benefits and services).

Basis of estimate: For this estimate, CBO assumes the legislation will be enacted early in fiscal year 2014, that the necessary amounts will be appropriated for each year, and that outlays will follow historical spending patterns for similar and existing programs.

Infertility Treatment for Veterans. Section 2 would expand the types of infertility treatments provided by VA to include assisted reproductive technology (ART) procedures, of which in vitro fertilization (IVF) is the most widely used. Under current policy, VA provides veterans with limited assistance for infertility treatments and covers the costs for delivery and newborn care for eligible veterans. CBO's estimate of the cost of this provision includes two components: the cost of providing the additional fertility services and the cost of providing additional delivery services for the resulting pregnancies.

	By fiscal year, in millions of dollars—					
	2014	2015	2016	2017	2018	2014-2018
CHANGES IN SPENDING SUBJECT TO APPROPRIATION						
Infertility Treatment for Veterans						
Estimated Authorization Level	1	30	95	100	105	331
Estimated Outlays	1	27	88	98	104	318
Infertility Treatment for Certain Spouses and Surrogates						
Estimated Authorization Level	1	18	58	61	64	202
Estimated Outlays	1	16	54	60	63	194
Adoption Assistance						
Estimated Authorization Level	*	4	12	13	14	43
Estimated Outlays	*	4	11	13	14	42
Child Care Programs						
Estimated Authorization Level	3	3	3	3	3	15
Estimated Outlays	3	3	3	3	3	15
Counseling for Women in Retreat Settings						
Estimated Authorization Level	1	1	2	2	2	8
Estimated Outlays	1	1	2	2	2	8
Reproduction and Infertility Research						
Estimated Authorization Level	*	*	*	*	0	1
Estimated Outlays	*	*	*	*	*	1
Total Changes						
Estimated Authorization Level	6	56	170	179	188	600
Estimated Outlays	6	51	158	176	186	578

Note: * = less than $500,000.

The inclusion of ART as a covered treatment option would affect federal health care spending for female veterans. To determine the number of female veterans that would use this new benefit, CBO examined the use of ART services among the general population, as reported by the Centers for Disease Control (CDC). Based on that data, and making adjustments for the age of the veteran population and the number of enrollees in the VA health care system (and assuming that additional veterans would enroll to take advantage of the new benefit), CBO estimates that about 3,500 female veterans would use this benefit a year.

CBO estimates that the cost of those services would be about $16,000 per user in 2014 or about $57 million once the program is fully implemented in 2016; that estimate is based on publicly available pricing information for ART procedures from several fertility clinics.

In addition to the cost of the procedures, VA would incur additional costs for some of the resulting pregnancies. Based on information from the CDC, CBO estimates that about a third of ART procedures result in a pregnancy. However, some VA enrollees are currently undergoing ART procedures outside of VA, and the department already covers the cost of roughly half of the pregnancies that would be covered under the bill's ART provision. Therefore, CBO estimates that about 550 additional pregnancies would be covered by the VA under the bill. Furthermore, CBO estimates the cost of each pregnancy would be about $55,000 in 2014, based on information from private-sector studies. This amount is significantly higher than the average cost of a pregnancy in the United States (about $16,000) because it takes into account the higher percentage of multiple births and pre-term deliveries associated with pregnancies that result from fertility treatments. The total cost of

those pregnancies would be about $31 million once the program is fully implemented in 2016.

After accounting for inflation, and assuming that it would take about three years to write regulations and fully implement the proposal, CBO estimates that, in total, implementing section 2 would increase costs to VA by $318 million over the 2014–2018 period, assuming appropriation of the necessary amounts.

Infertility Treatment for Certain Spouses and Surrogates. Section 3 would require VA to provide fertility assistance services to the spouses and surrogates of veterans who, as a result of a service-connected disability, have difficulty fathering children.[1] CBO's estimate of the cost of this provision includes the cost of providing the fertility services as well as additional child delivery services for the resulting pregnancies for individuals eligible for CHAMPVA (11 percent of the spouses). CHAMPVA is an insurance program run by the VA for dependents and survivors of certain disabled veterans.

To estimate the number of veterans that would use this new benefit, CBO examined the use of ART services as reported by the CDC. Based on those data, and making adjustments for the age of the veteran population, and for the fact that the veteran's infertility must be caused by a severe service-connected condition in order to receive this benefit, CBO estimates that about 3,000 veterans would use this benefit each year. Similar to our analysis for section 2, CBO estimates an average cost of $16,000 per user in 2014. In addition to the cost of the fertility assistance procedures, CBO also estimates that VA would incur additional costs of roughly $3 million per year, once the program is fully implemented in 2016, to cover the cost of additional pregnancies.

In total, CBO estimates that implementing section 3 would increase costs to VA by $194 million over the 2014–2018 period. The bill would require VA to establish the rules and regulations to implement section 3 within 18 months of the bill's enactment; therefore, the costs for treatments would begin in late 2015.

Adoption Assistance. Section 4 would allow VA to pay for adoption costs for severely wounded veterans with infertility conditions related to their service-connected disability. Such payments would be limited to the lesser of the cost of one cycle of fertility treatment and the costs associated with three adoptions.

Using data from the CDC on adoption rates, adjusted for the number of veterans eligible for the new benefit, CBO estimates that about 700 veterans each year would decide to adopt with VA's assistance. Based on information about adoption costs from the Department of Health and Human Services, CBO assumes that the cost of three adoptions would be higher than the cost for one cycle of IVF (the most commonly used fertility treatment). CBO estimates that implementing this provision would cost $42 million over the 2014–2018 period, assuming appropriation of the necessary amounts.

Child Care Programs. Section 9 would allow VA to permanently extend existing pilot programs that provide child care for certain

[1] This section also would provide VA with the authority to coordinate infertility counseling and treatment for the spouses and surrogates of the broader veteran population. However, absent further detail, VA cannot provide information on how they would implement the provision; therefore, CBO cannot estimate a cost for that additional authority.

veterans who use VA medical facilities in no fewer than three Veteran Integrated Service Networks. Based on the authorization levels for the existing pilot programs, CBO estimates that implementing this program would cost $15 million over the 2014–2018 period.

Counseling for Women in Retreat Settings. Section 10 would direct VA to establish a program that provides counseling in group retreat settings to certain female veterans who have recently separated from military service. VA recently reported on a completed pilot program with similar requirements. Roughly 130 women veterans participated in the program in six retreats over a two-year period. Based on the reported spending for the pilot program and assuming an increase in participation—to 650 participants in 15 retreat settings in 2014, and a doubling of the number of participants by 2018—CBO estimates that implementing this program would cost $8 million over the 2014–2018 period.

Reproduction and Infertility Research. Section 7 would require the VA to conduct a research study on women's reproductive health in collaboration with the Department of Defense and the National Institutes of Health. Based on information from VA on the cost and duration of similar studies, CBO estimates the research study would run for about three years and cost $1 million over the 2014–2018 period.

Pay-As-You-Go Considerations: None.

Intergovernmental and private-sector impact: S. 131 contains no intergovernmental or private-sector mandates as defined in UMRA and would impose no costs on state, local, or tribal governments.

Estimate prepared by: Federal Costs: Ann E. Futrell; Impact on State, Local, and Tribal Governments: Lisa Ramirez-Branum; Impact on the Private Sector: Elizabeth Bass.

Estimate approved by: Peter H. Fontaine, Assistant Director for Budget Analysis.

Regulatory Impact Statement

In compliance with paragraph 11(b) of rule XXVI of the Standing Rules of the Senate, the Committee on Veterans' Affairs has made an evaluation of the regulatory impact that would be incurred in carrying out the Committee bill. The Committee finds that S. 131, as amended, would not entail any regulation of individuals or businesses or result in any impact on the personal privacy of any individuals and that the paperwork resulting from enactment would be minimal.

Tabulation of Votes Cast in Committee

In compliance with paragraph 7(b) of rule XXVI of the Standing Rules of the Senate, the following is a tabulation of votes cast in person or by proxy by members of the Committee on Veterans' Affairs at its July 24, 2013, meeting. On that date, the Committee voted, by voice vote, to order reported S. 131, as amended, to the Senate. Senator Moran was recorded as a no vote.

AGENCY REPORT

On May 9, 2013, Robert L. Jesse, M.D., Ph.D., Principal Deputy Under Secretary for Health, Department of Veterans Affairs, appeared before the Committee on Veterans' Affairs and submitted testimony on, among other things, S. 131. In addition, on September 11, 2013, VA provided views on S. 131. Excerpts from both the testimony and Department views are reprinted below:

STATEMENT OF ROBERT L. JESSE, M.D., PH.D., PRINCIPAL DEPUTY UNDER SECRETARY FOR HEALTH, U.S. DEPARTMENT OF VETERANS AFFAIRS

Good Morning Chairman Sanders, Ranking Member Burr, and Members of the Committee. Thank you for inviting me here today to present our views on several bills that would affect Department of Veterans Affairs (VA) benefits programs and services. Joining me today is Susan Blauert, Deputy Assistant General Counsel.

We do not yet have cleared views on sections 4, 10, 11, or 12 of S. 131, S. 287, section 3 of S. 522, S. 800, S. 832, S. 845, S. 851, S. 852, or the draft bill described as "The Veterans Affairs Research Transparency Act of 2013." Also, we do not have estimated costs associated with implementing S. 131, S, 422, S. 455, or S. 825. We will forward the views and estimated costs to you as soon as they are available.

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S. 131, WOMAN VETERANS AND OTHER HEALTH CARE IMPROVEMENTS ACT OF 2013

Section 2 of S. 131 would amend 38 U.S.C. section 1701(6) to include fertility counseling and treatment, including treatment using assisted reproductive technology, among those things that are considered to be "medical services" under chapter 17 of title 38, U.S.C.

VA supports section 2 of the bill, but must condition this support on assurance of the additional resources that would be required were this provision enacted. The provision of Assisted Reproductive Technologies (including any existing or future reproductive technology that involves the handling of eggs or sperm) is consistent with VA's goal to restore to the greatest extent possible the physical and mental capabilities of Veterans and improve the quality of their lives. For many, having children is an important and essential aspect of life. Those who desire but are unable to have children of their own commonly experience feelings of depression, grief, inadequacy, poor adjustment, and poor quality of life.

Section 3 of the bill would add a new section 1788 to title 38, U.S.C., that would require VA to furnish fertility counseling and treatment, including through the use of assisted reproductive technology, to a spouse or surrogate of a severely wounded, ill, or injured enrolled Veteran who has an infertility condition incurred or aggravated in the line of duty, if the spouse or surrogate and the Veteran apply jointly for such counseling and treatment through a process prescribed by VA. This section would authorize VA to "coordinate fertility counseling and treatment" for other spouses and surrogates of other Veterans who are seeking fertility counseling and treatment. Section 1788 would not be construed to require VA to furnish maternity care to a spouse or surrogate of a Veteran, or

to require VA to find or certify a surrogate for or connect a surrogate with a Veteran. Subsection (d) of proposed section 1788 would define the term "assisted reproductive technology" to include "in vitro fertilization and other fertility treatments in which both eggs and sperm are handled when clinically appropriate."

VA supports section 3 in part, but must condition this support on assurance of the additional resources that would be required were this provision enacted. VA supports providing infertility services including assisted reproductive technology to severely wounded, ill, or injured enrolled Veterans described in section 3, and their spouses or partners. VA does not, however, support coverage of such services for surrogates at this time. The complex legal, medical, and policy arrangements of surrogacy vary from state to state due to inconsistent regulations between States, and we believe would prove to be very difficult to implement in practice. Moreover, the additional coverage of surrogates is inconsistent with coverage provided by the Department of Defense (DOD), Medicaid, Medicare, and several private insurers and health systems. Current DOD policy addressing assisted reproductive services for severely injured Servicemembers specifically excludes coverage of surrogates. VA acknowledges that surrogacy may offer the only opportunity for Veterans and their spouses or partners to have a biological child. However, there may be other options to consider when exploring how best to compensate these Veterans for their loss and to facilitate procreation.

VA recommends the language of the bill be modified to account for different types of family arrangements, so that benefits are not limited to only spouses of Veterans described in proposed section 1788; VA recommends that section 1788 be revised to refer to a "spouse or partner" of a specified Veteran. In addition, the meaning and scope of the coordination contemplated under proposed section 1788(b) (which would authorize VA to "coordinate fertility counseling and treatment" for the spouses and surrogates of other Veterans not described in section 1788(a)) is unclear, and could potentially account for spouses and surrogates of all other Veterans. VA recommends that this be clarified.

Section 5 of the bill would require VA to report annually to the Committees on Veterans' Affairs of the Senate and House of Representatives on the fertility counseling and treatment furnished by VA during the preceding year. The first report would be required no later than 1 year after enactment. Each report submitted under section 5 would be required to contain specified information, including the number of Veterans, spouses, and surrogates who received fertility counseling and treatment furnished by VA; the costs of furnishing such counseling and treatment; and coordination of such counseling and treatment with similar services of DOD. VA does not object to such reporting.

Section 6(a) would require VA, no later than 540 days after enactment, to prescribe regulations to carry out proposed sections 1788 and 1789, and on fertility treatment to Veterans using assisted reproductive technology. Section 6(b) would prohibit VA from providing, until regulations are prescribed, fertility counseling and treatment under 1788, assistance under 1789, and to a Veteran "any fertility treatment that uses an assisted reproductive tech-

nology that the Secretary has not used in the provision of a fertility treatment to a veteran before the date of the enactment." The term "assisted reproductive technology" under section 6 would have the same meaning given to the term in proposed section 1788 of section 3.

VA does not support Section 6(a). While 540 days accorded for the drafting of regulations may seem like a long period of time, given the complexities of the issues involved, VA estimates that amount of time could be insufficient.

Section 7 of S. 131 would require the Secretary of VA and the Secretary of Defense to share best practices and facilitate referrals, as they consider appropriate, on the furnishing of fertility counseling and treatment. VA does not object to this requirement.

Section 8 of the bill would add a new section 7330B to title 38, U.S.C., entitled "Facilitation of reproduction and infertility research." This new section would require the Secretary of VA to "facilitate research conducted collaboratively by the Secretary of Defense and the Secretary of Health and Human Services" to improve VA's ability to meet the long-term reproductive health care needs of Veterans with service-connected genitourinary disabilities or conditions incurred or aggravated in the line of duty that affect the Veterans' ability to reproduce, such as spinal cord injury. The Secretary of VA would be required to ensure that information produced by research facilitated under section 7330B that may be useful for other activities of the Veterans Health Administration (VHA) is disseminated throughout VHA. No later than 3 years after enactment, VA would be required to report to Congress on the research activities conducted under section 7330B.

VA supports section 8 of S. 131. Generally, VA supports implementing research findings that are scientifically sound and that would benefit Veterans and improve health care delivery to Veterans. VA's goal is to restore the capabilities of Veterans with disabilities to the greatest extent possible. We utilize new research into various conditions to improve the quality of care we provide. Of note, rather than requiring VA to conduct research, this section would require VA to facilitate research that is conducted collaboratively by the Secretary of Defense and the Secretary of Health and Human Services. It is not clear how the term "facilitate" would be defined, which could raise privacy and security issues with respect to identifiable Veteran information. Given the ambiguity over the meaning of this term, VA is unable to provide a cost estimate at this time. If facilitation requires fairly minor involvement (coordination, distribution, etc.), VA expects the costs of this provision would be nominal; however, if facilitation is intended to mean direct funding, proposal reviews, and additional staff, costs would be greater.

Section 9 of S. 131 would require VA to enhance the capabilities of the VA Women Veterans Call Center (WVCC) in responding to requests by women Veterans for assistance with accessing VA health care and benefits, as well as in referring such Veterans to community resources to obtain assistance with services not furnished by VA.

VA supports section 9 and has established an inbound calling system specifically for women Veterans. By building on capabilities

within WVCC, the incoming call center allows women Veterans to call WVCC to connect them to resources, assist with specific concerns, and provide information on services and benefits. Many of the Veterans are calling VA daily requesting more details on how to enroll, how to find their DD–214, and what benefits they have earned. WVCC can directly connect women Veterans to Health Eligibility Center employees for enrollment information and to discuss the benefits that might be available to them. The call could also be transferred to the appropriate medical center to assist eligible Veterans with obtaining a health care appointment. Once the woman Veteran is connected to VA health care services, the Women Veterans Program Manager can also assist her in finding community resources that may not be provided by VA.

VA is unable to provide views on sections 4, 10, 11, and 12 at this time, but will provide views on those provisions in a later submission to the Committee.

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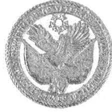

THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

September 11, 2013

The Honorable Bernie Sanders
Chairman
Senate Committee on Veterans' Affairs
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

The agenda for the Senate Committee on Veterans Affairs' May 9, 2013, legislative hearing included a number of bills that the Department of Veterans Affairs was unable to address in our testimony. We are aware of the Committee's interest in receiving our views and cost estimates for those bills. By this letter, we are providing views and cost estimates on section 4 and sections 10-12 of S. 131; S. 287; section 3 of S. 522; S. 800; sections 2-3 and 5-10 of S. 825; S. 832; S. 845; S. 851; and S. 877. We are also providing views for S. 852. In addition, we are providing cost estimates for sections 2 and 3 of S. 131; S. 422; section 2 of S. 522; and sections 6 and 7 of S. 852.

We appreciate this opportunity to comment on this legislation and look forward to working with you and the other Committee Members on these important legislative issues.

Sincerely,

Eric K. Shinseki

Enclosure

ENCLOSURE:
VA VIEWS

S. 131, WOMAN VETERANS AND OTHER HEALTH CARE IMPROVEMENT ACT OF 2013

Section 2 of S. 131 would amend 38 U.S.C. § 1701(6) to include fertility counseling and treatment, including assisted reproductive technology, among those things that are considered "medical services" under chapter 17 of title 38, U.S.C. As discussed in VA's May 9, 2013 testimony, VA supports section 2 of the bill, conditioned on the availability of the additional resources needed to implement this provision.

VA estimates that section 2 would cost $81.5 million in fiscal year (FY) 2015; $296 million over 5 years; and $652 million over 10 years. These estimates reflect the costs of new services that are not included currently in the medical benefits package and costs associated with maternity services for additional pregnancies that

may result from the use of assisted reproductive technology. These estimates do not reflect potential costs associated with additional enrollment or utilization of currently covered services that may result if the bill is enacted.

Among other things, section 3 of S. 131 would add a new section 1788 to title 38, U.S.C., that would require VA to furnish fertility counseling and treatment, including assisted reproductive technology, to a spouse or surrogate of a severely wounded, ill or injured enrolled Veteran who has an infertility condition that was incurred or aggravated in the line of duty, if the spouse or surrogate and Veteran apply jointly through a process prescribed by VA. As discussed in VA's May 9, 2013 testimony, VA supports section 3 of the bill in part, conditioned on the availability of the additional resources that would be required to implement this provision.

VA estimates that section 3 would cost $102 million in FY 2015; $319 million over 5 years; and $717 million over 10 years. These estimates include coverage of spouses and partners of covered Veterans. These estimates do not include costs associated with coverage of surrogates; as discussed in VA's May 9, 2013 testimony, VA does not support coverage of surrogates at this time.

Section 4 of S. 131 would authorize the Secretary to provide adoption assistance to severely wounded, ill, or injured Veterans who suffer from infertility conditions incurred or aggravated in the line of duty. VA understands the intent of this provision but has numerous concerns that merit further consideration. VA would need to consider the possible associated responsibilities that could go along with monetary adoption support, including adequate oversight of the agencies or entities that would receive the funds and potential issues of State law. VA also must carefully consider additional demands on its resources that would not be directed at core medical services for Veterans.

VA estimates that section 4 would cost $96.27 million in FY 2015; $521.46 million over 5 years; and $1.16 billion over 10 years.

Section 10 of S. 131 would expand the locations and duration of the pilot program required by section 203 of Public Law 111–163. Section 203 required VA to carry out a pilot program to evaluate the feasibility and advisability of providing reintegration and readjustment services in group retreat settings to women Veterans recently separated from service after a prolonged deployment. Section 10(a) would increase the number of locations at which VA is required to carry out the pilot program from three to fourteen. Section 10(b) would extend the duration of the pilot from 2 to 4 years. Section 10(c) would amend section 203(f) to authorize the appropriation of $400,000 for each of FY 2013 and FY 2014 to carry out the pilot program.

VA supports section 10 of S. 131. VA has completed the final year of the original 2-year pilot program, and the report required by section 203 was submitted to Congress on May 9, 2013. Initial reports show favorable results, indicating that the retreats, which focus on building trust and developing peer support in a therapeutic environment, supply participants with tools needed for successful reintegration into civilian life. Additional retreats would generate more data to inform a comprehensive assessment of the program during the new final reporting phase under section 10.

Although VA supports section 10, there may not be fourteen distinct geographic locations that satisfy the retreat requirements, such as the need for specialized locations for outdoor team-building exercises. VA would continue to look for new locations, but recommends that section 10(a) be amended to require VA to carry out the pilot program in up to fourteen locations, some of which may be repeat locations from the original pilot program.

In addition, VA recommends that section 10(b) be amended to require the pilot program be "carried out through September 30, 2015," rather than requiring that it be "carried out during the 4-year period beginning on the date of the commencement of the pilot program." This would ensure that VA has a sufficient period of time to carry out additional retreats for eligible women Veterans and generate data for analysis. For the same reason, we recommend section 10(c) be amended to authorize the appropriation of $400,000 "for each of fiscal years 2013 through 2015" to carry out the pilot program.

VA estimates section 10 would cost $337,320 in FY 2014 and, if the pilot extends through FY 2015, $350,520 in FY 2015, for a total cost of $687,840.

Section 11(a) of S. 131 would add a new section 1709B to title 38, U.S.C. that would make permanent VA's authority to provide assistance to qualified Veterans to obtain child care so that such Veterans can receive certain health care services. VA would be required to carry out the program in no fewer than three Veterans Integrated Service Networks. This section would also identify certain forms of assistance that may be provided. VA's pilot program providing such services under section 205 of Public Law 111–163 would expire upon enactment of section 11(a).

VA does not support a permanent mandatory authority to provide child care assistance. VA has four operational pilot locations where child care assistance is provided pursuant to section 205 of Public Law 111–163. The first pilot began operation in October 2011. The remaining pilots were set up in a staggered fashion with the most recent pilot not beginning until 2013. Under current law, all pilots are scheduled to end on October 2, 2013, therefore, not affording three pilots the benefit of 2 full years of operation.

Without 2 full years of operational data from each pilot, VA is not able to adequately assess long-term utilization needs and cost implications of the program. In light of this longer term analysis that includes an evaluation of resources, VA believes permissive authority to allow expansion of the program would be preferable to a permanent mandatory authority to provide child care assistance. Permissive authority would allow facilities at the local level to make a determination based on need and utilize resources, space and security as necessary.

VA is unable to provide an accurate cost estimate for a permanent mandatory child care program, in part, because of the lack of data on the existing pilots that have run for less than 2 years, but also because such an estimate would be dependent on location of the sites, the ability to contract in the area of the designated sites, and the utilization of services.

Section 11(b) of S. 131 would add a new section 1709C to title 38, U.S.C. that would require VA to carry out a program to provide as-

sistance to qualified Veterans to obtain child care so that such Veterans can receive readjustment counseling and related mental health services. The program would be carried out in at least three Readjustment Counseling Service Regions selected by VA. This section would identify certain forms of child care assistance that may be provided, and it would define "Vet Center" as "a center for readjustment counseling and related mental health services for veterans under section 1712A of [title 38, U.S.C.]."

VA supports section 11(b) in principle. Some Veterans who use Vet Center services, especially those who have served in Iraq or Afghanistan, have voiced concern that a lack of child care has impacted their ability to use Vet Center services consistently. Although Vet Center staff are always searching for new initiatives to increase Veteran access to services, VA has concerns about implementing child care assistance under section 11(b) without the opportunity to pilot this type of benefit. A pilot program is needed because VA currently is unable to predict utilization of this type of assistance. Comparisons to medical center pilots are not useful because Vet Centers provide services during non-traditional hours, including after normal business hours and on weekends when requested by the Veteran. This inability to predict utilization affects VA's ability to budget the program appropriately. VA recommends that section 11(b) be modified to authorize a pilot program to determine the feasibility, advisability, and costs of providing child care assistance to Veterans who utilize Vet Center services.

VA is not able to provide an accurate cost estimate for section 11(b) because VA lacks child-care experience for the special Vet Center context as described above and comparable models.

Section 12 of S. 131 would add a new section 323 to title 38, U.S.C., entitled "Contractor user fees." Under proposed section 323(a), VA would be required to impose a fee on each person with whom the Secretary engages in a contract for a good or service as a condition of the contract. The fee amount would be the lesser of: (1) seven percent of the total value of the contract, and (2) the total value of the contract multiplied by an applicable percentage calculated for the fiscal year. Before each fiscal year, VA would be required to establish an annual estimate of the total value of contracts for the next fiscal year and an annual estimate of the total cost of furnishing fertility counseling and treatment—including the use of assisted reproductive technology—and payments under proposed section 1789 (under section 4 of S. 131) for the next fiscal year, both of which would be used in estimating the applicable percentage for the fiscal year (the percentage by which the former exceeds the latter). The Secretary would have discretion to waive the fee for a person as the Secretary considers appropriate if the person is an individual or "small business concern" (as defined in section 3 of the Small Business Act). Fees could not be collected under proposed section 323(a) unless the expenditure of the fee is provided for in advance in an appropriations Act.

Proposed section 323(e) would establish a fund in the Treasury to be known as the "Department of Veterans Affairs Fertility Counseling and Treatment Fund," and all amounts received under proposed section 323(a) would be deposited in the fund. Subject to the provisions of appropriations Acts, amounts in the fund would be

made available, without fiscal year limitation, to VA to furnish fertility counseling and treatment—including the use of assisted reproductive technology—to eligible individuals and to make payments under proposed section 1789 (under section 4 of S. 131). Amounts received by VA under proposed section 323(a) would be treated for the purposes of sections 251 and 252 of the Balanced Budget and Emergency Deficit Control Act of 1985 as offsets to discretionary appropriations (rather than as offsets to direct spending), to the extent that such amounts are made available for expenditure in appropriations Acts for the purposes specified.

VA does not support section 12, which VA estimates could result in up to 7 percent less money available for contract actions. That is because contractors could be expected to pass this cost back to VA in the form of higher contract prices. Applying the proposed fee to “a contract for a good or service” without limitation would subject VA Administrations’ and Offices’ (e.g., Veterans Benefits Administration, National Cemetery Administration, Office of Human Resources and Administration, and Office of General Counsel) budget dollars for contracts to funding health care services. This would impact these entities’ budgets, particularly in smaller offices, for a purpose that is wholly unrelated to their primary functions. In this difficult time of budget limitations, this is impractical and could negatively impact overall VA performance. In addition, determining a percentage and implementing it for the beginning of each fiscal year would be difficult administratively, as would the process of collecting and accounting for these funds. (As a technical matter, the word “person” should be replaced with “contractor” throughout this provision.)

In many industries and for many contractors, the existing profit margins would not tolerate a 7 percent cut.

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MINORITY VIEWS OF RANKING MEMBER HON. RICHARD BURR

On July 24, 2013, the Senate Committee on Veterans' Affairs (hereinafter, "the Committee") voted, by voice vote, to approve en bloc five legislative items and three separate legislative items on the Committee's agenda. One item the Committee voted on individually was S. 131, as amended. In principal, I support several provisions of this legislation, which would improve the care of women veterans and reduce barriers to services. However, I was unable to support this legislation in Committee. At the time of the Committee meeting, I expressed concerns regarding: How would the Committee pay for any increased costs associated with the legislation? Will all of the provisions address real problems in a way that will actually help to improve the lives of military personnel, veterans, and their families? Last, the Administration had not yet provided complete views on this legislation.

Unfortunately, the Committee members were unable to adequately address the concerns of the Administration regarding this legislation before, during, or after the July 2013 meeting. My hope is that, on all matters before the Committee, the Committee will proceed in a more deliberate, informed manner.

CHANGES IN EXISTING LAW

In compliance with paragraph 12 of Rule XXVI of the Standing Rules of the Senate, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman).

Title 38. Veterans' Benefits

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Part II. General Benefits

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Chapter 17. Hospital, Nursing Home, Domiciliary, and Medical Care

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Sec.

SUBCHAPTER I. GENERAL

1701. Definitions.

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1709B. Assistance for child care for certain veterans receiving health care.

1709C. Assistance for child care for individuals receiving readjustment counseling and related mental health services.

SUBCHAPTER II. HOSPITAL, NURSING HOME, OR DOMICILIARY CARE AND MEDICAL TREATMENT

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1720H. Counseling in retreat settings for women veterans newly separated from service in the Armed Forces.

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SUBCHAPTER VIII. HEALTH CARE OF PERSONS OTHER THAN VETERANS

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1788. Reproductive treatment and care for spouses and surrogates of veterans.

1789. Adoption assistance.

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SEC. 1701. DEFINITIONS

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(6) * * *

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(H) Fertility counseling and treatment, including treatment using assisted reproductive technology.

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SEC. 1709B. ASSISTANCE FOR CHILD CARE FOR CERTAIN VETERANS RECEIVING HEALTH CARE

(a) PROGRAM REQUIRED.—The Secretary shall carry out a program to provide, subject to subsection (b), assistance to qualified veterans described in subsection (c) to obtain child care so that such veterans can receive health care services described in subsection (c).

(b) LIMITATION ON PERIOD OF PAYMENTS.—Assistance may only be provided to a qualified veteran under this section for receipt of child care during the period that the qualified veteran—

(1) receives health care services described in subsection (c) at a facility of the Department; and

(2) requires travel to and from such facility for the receipt of such health care services.

(c) QUALIFIED VETERANS.—For purposes of this section, a qualified veteran is a veteran who is—

(1) the primary caretaker of a child or children; and

(2)(A) receiving from the Department—

(i) regular mental health care services;

(ii) intensive mental health care services; or

(iii) such other intensive health care services that the Secretary determines that provision of assistance to the veteran to obtain child care would improve access to such health care services by the veteran; or

(B) in need of regular or intensive mental health care services from the Department, and but for lack of child care services, would receive such health care services from the Department.

(d) LOCATIONS.—The Secretary shall carry out the program in no fewer than three Veterans Integrated Service Networks selected by the Secretary for purposes of the program.

(e) FORMS OF CHILD CARE ASSISTANCE.—(1) Child care assistance under this section may include the following:

(A) Stipends for the payment of child care offered by licensed child care centers (either directly or through a voucher program) which shall be, to the extent practicable, modeled after the Department of Veterans Affairs Child Care Subsidy Program established pursuant to section 630 of the Treasury and General Government Appropriations Act, 2002 (Public Law 107–67; 115 Stat. 552).

(B) Direct provision of child care at an on-site facility of the Department.

(C) Payments to private child care agencies.

(D) Collaboration with facilities or programs of other Federal departments or agencies.

(E) Such other forms of assistance as the Secretary considers appropriate.

(2) In the case that child care assistance under this section is provided as a stipend under paragraph (1)(A), such stipend shall cover the full cost of such child care.

SEC. 1709C. ASSISTANCE FOR CHILD CARE FOR INDIVIDUALS RECEIVING READJUSTMENT COUNSELING AND RELATED MENTAL HEALTH SERVICES

(a) PROGRAM REQUIRED.—The Secretary shall carry out a program to provide, subject to subsection (b), assistance to qualified individuals described in subsection (c) to obtain child care so that such individuals can receive readjustment counseling and related mental health services.

(b) LIMITATION ON PERIOD OF PAYMENTS.—Assistance may only be provided to a qualified individual under this section for receipt of child care during the period that the qualified individual receives readjustment counseling and related health care services at a Vet Center.

(c) QUALIFIED INDIVIDUALS.—For purposes of this section, a qualified individual is an individual who is—

(1) the primary caretaker of a child or children; and

(2)(A) receiving from the Department regular readjustment counseling and related mental health services; or

(B) in need of readjustment counseling and related mental health services from the Department, and but for lack of child care services, would receive such counseling and services from the Department.

(d) LOCATIONS.—The Secretary shall carry out the program under this section in no fewer than three Readjustment Counseling Service Regions selected by the Secretary for purposes of the program.

(e) FORMS OF CHILD CARE ASSISTANCE.—(1) Child care assistance under this section may include the following:

(A) Stipends for the payment of child care offered by licensed child care centers (either directly or through a voucher program) which shall be, to the extent practicable, modeled after the Department of Veterans Affairs Child Care Subsidy Program established pursuant to section 630 of the Treasury and General Government Appropriations Act, 2002 (Public Law 107–67; 115 Stat. 552).

(B) Payments to private child care agencies.

(C) Collaboration with facilities or programs of other Federal departments or agencies.

(D) Such other forms of assistance as the Secretary considers appropriate.

(2) In the case that child care assistance under this subsection is provided as a stipend under paragraph (1)(A), such stipend shall cover the full cost of such child care.

(f) VET CENTER DEFINED.—In this section, the term "Vet Center" means a center for readjustment counseling and related mental health services for individuals under section 1712A of this title.

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Subchapter II. Hospital, Nursing Home, or Domiciliary Care and Medical Treatment

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SEC. 1720H. COUNSELING IN RETREAT SETTINGS FOR WOMEN VETERANS NEWLY SEPARATED FROM SERVICE IN THE ARMED FORCES

(a) IN GENERAL.—The Secretary shall provide, through the Readjustment Counseling Service of the Veterans Health Administration, reintegration and readjustment services described in subsection (c) in group retreat settings to women veterans who are recently separated from service in the Armed Forces after a prolonged deployment.

(b) ELECTION OF VETERAN.—The receipt of services under this section by a woman veteran shall be at the election of the veteran.

(c) COVERED SERVICES.—The services provided to a woman veteran under this section shall include the following:

(1) Information on reintegration into the veteran's family, employment, and community.

(2) Financial counseling.

(3) Occupational counseling.

(4) Information and counseling on stress reduction.

(5) Information and counseling on conflict resolution.

(6) Such other information and counseling as the Secretary considers appropriate to assist the veteran in reintegration into the veteran's family, employment, and community.

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Subchapter VIII. Health Care of Persons Other Than Veterans

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SEC. 1787. HEALTH CARE OF FAMILY MEMBERS OF VETERANS STATIONED AT CAMP LEJEUNE, NORTH CAROLINA

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SEC. 1788. REPRODUCTIVE TREATMENT AND CARE FOR SPOUSES AND SURROGATES OF VETERANS

(a) IN GENERAL.—The Secretary shall furnish fertility counseling and treatment, including through the use of assisted reproductive technology, to a spouse or surrogate of a severely wounded, ill, or injured veteran who has an infertility condition incurred or aggravated in line of duty in the active military, naval, or air service and who is enrolled in the system of annual patient enrollment established under section 1705(a) of this title if the spouse or surrogate and the veteran apply jointly for such counseling and treatment through a process prescribed by the Secretary.

(b) COORDINATION OF CARE FOR OTHER SPOUSES AND SURROGATES.—In the case of a spouse or surrogate of a veteran not described in subsection (a) who is seeking fertility counseling and treatment, the Secretary may coordinate fertility counseling and treatment for such spouse or surrogate.

(c) CONSTRUCTION.—Nothing in this section shall be construed to require the Secretary—

(1) to find or certify a surrogate for a veteran or to connect a surrogate with a veteran; or

(2) to furnish maternity care to a spouse or surrogate of a veteran.

(d) ASSISTED REPRODUCTIVE TECHNOLOGY DEFINED.—In this section, the term "assisted reproductive technology" includes in vitro fertilization and other fertility treatments in which both eggs and sperm are handled when clinically appropriate.

SEC. 1789. ADOPTION ASSISTANCE

(a) IN GENERAL.—The Secretary may pay an amount, not to exceed the limitation amount, to assist a covered veteran in the adoption of one or more children.

(b) COVERED VETERAN.—For purposes of this section, a covered veteran is any severely wounded, ill, or injured veteran who—

(1) has an infertility condition incurred or aggravated in line of duty in the active military, naval, or air service; and

(2) is enrolled in the system of annual patient enrollment established under section 1705(a) of this title.

(c) LIMITATION AMOUNT.—For purposes of this section, the limitation amount is the amount equal to the lesser of—

(1) the cost the Department would incur if the Secretary were to provide a covered veteran with one cycle of fertility treatment through the use of assisted reproductive technology under section 1788 of this title, as determined by the Secretary; or

(2) the cost the Department would incur by paying the expenses of three adoptions by covered veterans, as determined by the Secretary.

(d) ASSISTED REPRODUCTIVE TECHNOLOGY DEFINED.—In this section, the term "assisted reproductive technology" has the meaning given that term in section 1788 of this title.

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Part V. Boards, Administrations, and Services

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Chapter 73. Veterans Health Administration-Organization and Functions

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Sec.

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SUBCHAPTER II. GENERAL AUTHORITY AND ADMINISTRATION

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7330B. Facilitation of reproduction and infertility research.

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Subchapter II. General Authority and Administration

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SEC. 7330B. FACILITATION OF REPRODUCTION AND INFERTILITY RESEARCH

(a) FACILITATION OF RESEARCH REQUIRED.—The Secretary shall facilitate research conducted collaboratively by the Secretary of Defense and the Secretary of Health and Human Services to improve the ability of the Department of Veterans Affairs to meet the long-

term reproductive health care needs of veterans who have a genitourinary service-connected disability or a condition that was incurred or aggravated in line of duty in the active military, naval, or air service, such as a spinal cord injury, that affects the veterans' ability to reproduce.

(b) DISSEMINATION OF INFORMATION.—The Secretary shall ensure that information produced by the research facilitated under this section that may be useful for other activities of the Veterans Health Administration is disseminated throughout the Veterans Health Administration.

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Caregivers and Veterans Omnibus Health Services Act of 2010

(Public Law 111–163; 38 U.S.C. 1712A note)

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[SEC. 203. PILOT PROGRAM ON COUNSELING IN RETREAT SETTINGS FOR WOMEN VETERANS NEWLY SEPARATED FROM SERVICE IN THE ARMED FORCES

[(a) PILOT PROGRAM REQUIRED.—

[(1) IN GENERAL.—Commencing not later than 180 days after the date of the enactment of this Act, the Secretary of Veterans Affairs shall carry out, through the Readjustment Counseling Service of the Veterans Health Administration, a pilot program to evaluate the feasibility and advisability of providing reintegration and readjustment services described in subsection (b) in group retreat settings to women veterans who are recently separated from service in the Armed Forces after a prolonged deployment.

[(2) PARTICIPATION AT ELECTION OF VETERAN.—The participation of a veteran in the pilot program under this section shall be at the election of the veteran.

[(b) COVERED SERVICES.—The services provided to a woman veteran under the pilot program shall include the following:

[(1) Information on reintegration into the veteran's family, employment, and community.

[(2) Financial counseling.

[(3) Occupational counseling.

[(4) Information and counseling on stress reduction.

[(5) Information and counseling on conflict resolution.

[(6) Such other information and counseling as the Secretary considers appropriate to assist a woman veteran under the pilot program in reintegration into the veteran's family, employment, and community.

[(c) LOCATIONS.—The Secretary shall carry out the pilot program at not fewer than three locations selected by the Secretary for purposes of the pilot program.

[(d) DURATION.—The pilot program shall be carried out during the 2-year period beginning on the date of the commencement of the pilot program.

[(e) REPORT.—Not later than 180 days after the completion of the pilot program, the Secretary shall submit to Congress a report

on the pilot program. The report shall contain the findings and conclusions of the Secretary as a result of the pilot program, and shall include such recommendations for the continuation or expansion of the pilot program as the Secretary considers appropriate.

[(f) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to the Secretary of Veterans Affairs for each of fiscal years 2010 and 2011, $2,000,000 to carry out the pilot program.]

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(Public Law 111–163; 38 U.S.C. 1710 note)

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SEC. 205. PILOT PROGRAM ON ASSISTANCE FOR CHILD CARE FOR CERTAIN VETERANS RECEIVING HEALTH CARE

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(e) DURATION.—The pilot program shall be carried out during the 2-year period beginning on the date of the commencement of the pilot program *but not after the date of the enactment of the Women Veterans and Other Health Care Improvements Act of 2013*.

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