U.S. GOVERNMENT ACCOUNTABILITY OFFICE

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September 25, 2026

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The Honorable Jeanne Shaheen
Ranking Member
Committee on Foreign Relations
United States Senate

The Honorable Mike Lee
Chair
The Honorable Martin Heinrich
Ranking Member
Committee on Energy and Natural Resources
United States Senate

The Honorable Brian Mast
Chairman
The Honorable Gregory Meeks
Ranking Member
Committee on Foreign Affairs
House of Representatives

The Honorable Bruce Westerman
Chair
The Honorable Jared Huffman
Ranking Member
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House of Representatives

Compacts of Free Association: VA Is Pursuing Partial Implementation of Health Care Authorities in the Freely Associated States

The Department of Veterans Affairs (VA) provides a variety of benefits to veterans, their families, caregivers, and survivors. Specifically, the Veterans Health Administration (VHA) provides health care benefits to eligible persons and veterans. The U.S. maintains compacts of free association with three foreign countries in the Pacific—the Federated States of Micronesia (FSM), the Republic of the Marshall Islands (RMI), and the Republic of Palau—collectively known as the Freely Associated States (FAS). Under these compacts, citizens of the FAS can enlist in the U.S. military. Those who meet VA eligibility criteria can access certain VA benefits. Citizens from the FAS generally enlist in the U.S. military at higher per capita rates than some U.S. states.

We, along with VA's Inspector General, have identified significant challenges affecting veterans' access to health care benefits. For example, we found veterans living in the Pacific face added

challenges accessing VHA health care due to the areas' remoteness.[1] The Compact of Free Association Amendments Act of 2024 (COFA Amendments Act of 2024) gave VA discretionary authority to expand health care services to eligible veterans in the FAS by providing hospital care, medical services, and beneficiary travel payments.[2] Before providing hospital care or medical services to veterans in the FAS, VA must enter into agreements with the FAS to facilitate the furnishing of health services, including telehealth. These agreements with the FAS can also address matters such as the delivery of pharmaceutical products and medical surgical products. The COFA Amendments Act of 2024 required VA to, subject to the availability of appropriations, review implementation options for this authorization and engage with the FAS governments.[3] In an April 2025 memo provided to Congress, VA stated that it would not exercise these new authorities and officials told us in June 2026 that they had concluded their engagement with the FAS. However, during the course of this audit, VA indicated that it intends to resume engagement with the FAS and pursue exercising some of these authorities.

You asked us to examine the 2025 decision made by VA and any analysis completed to support this decision as part of our mandate under the COFA Amendments Act of 2024. This report (1) identifies challenges veterans face in obtaining health benefits in the FAS and (2) describes analyses completed by VA to assess implementation of veteran health service benefits authorized under the COFA Amendments Act of 2024.

To identify health care challenges veterans face in the FAS, we collected and reviewed documentation from VA on health services for veterans in the FAS. We also met with officials from VA, RMI, FSM, and Palau to discuss how veterans in the FAS obtain health care and challenges veterans face in accessing their health care benefits in all three countries.

To understand the analysis completed by VA on implementation of authorized health benefits, we collected and reviewed documentation produced by VA. We also met with officials from VA to discuss their analysis and any plans to further evaluate the implementation of authorized health benefits for FAS veterans.

We conducted this performance audit from May 2026 to September 2026 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

The VHA provides health care services to eligible veterans and individuals at various VA medical facilities across the U.S. and five U.S. territories. The VA Pacific Islands Health Care System consists of a VA medical center in Honolulu, Hawaii, and three outpatient clinics in the Philippines, American Samoa, Guam, and the Commonwealth of the Northern Mariana Islands

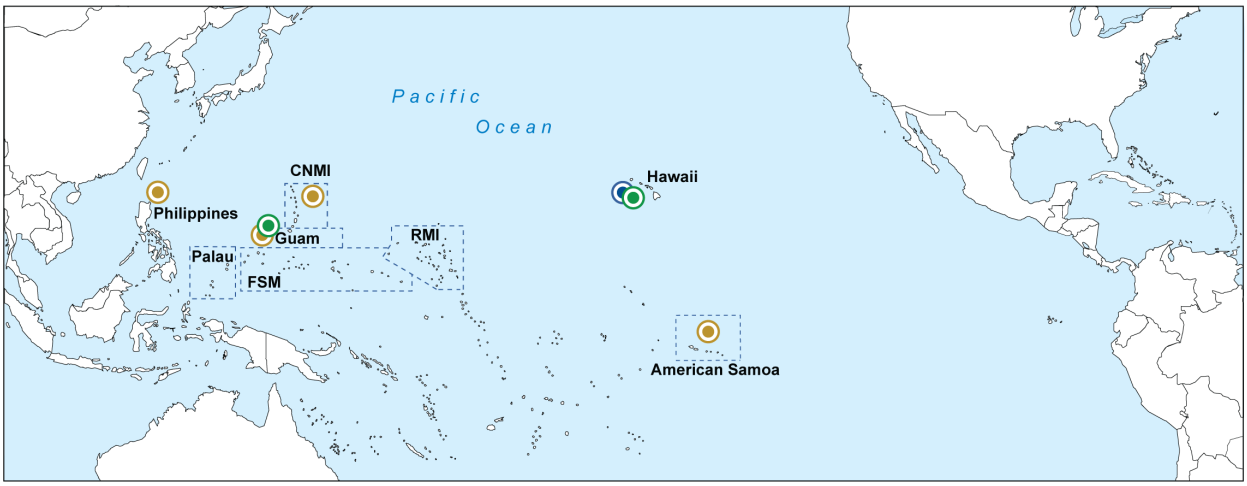
[1]GAO, *Veterans Affairs: Actions Needed to Improve Access to Care in the U.S. Territories and Freely Associated States*, GAO-24-106364 (Washington, D.C.: May 23, 2024). See also Department of Veterans Affairs Office of Inspector General, *Fiscal Year 2022 VA Inspector General's Report on VA's Management and Performance Challenges*. The VA Inspector General identified health care services and benefits among its top management and performance challenges.

[2]Pub. L. No. 118-42, div. G, tit. II, § 209, 138 Stat. 419, 438–39 (2024) (codified at 48 U.S.C. § 1988; 38 U.S.C. § 1724(f); 38 U.S.C. § 111(h)).

[3]*Id.* at 441.

(CNMI). These outpatient clinics can provide primary care, mental health care, and a limited number of specialty care services; VHA providers generally provide specialty care through telehealth, traveling providers, or by referring the veteran to the Honolulu VA medical center.[4] In addition, two regional military medical treatment facilities (Tripler Army Medical Center in Honolulu and U.S. Naval Hospital Guam) provide inpatient and some specialty care via resource sharing agreements between the VHA and the Department of Defense (DOD) for referred patients.[5] See figure 1 for a map with the locations of current health facilities that provide veteran care in the Pacific.

Figure 1: Map of Health Care Facilities Providing Veteran Care in Pacific Region



Legend: FSM = Federated States of Micronesia, RMI = Republic of the Marshall Islands, Palau = Republic of the Palau, CNMI= Commonwealth of the Northern Mariana Islands.

Source: Department of Veterans Affairs documentation (data), Map Resources (map). | GAO-26-109152

With no VHA facilities or providers in the FAS, and VHA telehealth services unavailable, the VHA Foreign Medical Program (FMP) is the only option for FAS veterans to access VHA health care in their home countries. Under this program, VHA can reimburse eligible veterans living or traveling abroad for certain health care services provided by local providers to treat certain conditions, generally service-connected disabilities or conditions aggravating a service-connected disability.[6] However, VA and FAS officials stated that the limited availability of health care services from local providers in the FAS limits the usefulness of this program.

Given this option is limited, FAS veterans must therefore travel to a U.S. state or territory to receive care at a VHA facility; however, according to VA regulation and policy, veterans living in the FAS are not eligible for reimbursement of travel costs between the U.S. and the FAS.[7] VA

[4]Specialty care services vary between clinics, but can include cardiology and neurology, among others.

[5]U.S. Army Garrison Kwajalein in the Marshall Islands has limited medical services available through the hospital on base. However, it is not a facility that currently provides veteran care.

[6]According to officials, VA may also reimburse the providers of such services directly.

[7]*See* 38 C.F.R. § 70.1(a); Department of Veterans Affairs, *VHA Directive 1601B.05 – Beneficiary Travel*. Exceptions are made when a portion of the trip is performed within the borders of the U.S.

currently reimburses eligible FAS veterans and other eligible beneficiaries for travel needed between U.S. areas. Because travel by veterans living in the FAS originates and ends in a foreign country, they must pay out of pocket for travel to the U.S. to access a VHA facility. Table 1 shows the approximate distances and flight durations FAS veterans would need to travel to the closest VA medical facilities. The costs associated with these flights may vary due to travel date, search date and time, etc. When we searched United Airlines' publicly available flight purchase platform in July 2026, the lowest cost for one round-trip seat on each flight depicted in the table was over $1,000.[8]

Table 1: Approximate Distances and Estimated Flight Duration between Capitals of Freely Associated States and Closest VA Medical Facilities

	Guam VA clinic	Honolulu VA Medical Center
Pohnpei (Federated States of Micronesia)	3-4 hour flight (1,016 miles)	8-10 hour flight (3,097 miles)
Majuro (Republic of the Marshall Islands)	8-10 hour flight (1,860 miles)	4-5 hour flight (2,276 miles)
Koror (Republic of Palau)	2 hour flight (981 miles)	10-12 hour flight[a] (4,748 miles)

Source: GAO analysis of geographic data and United Airlines flight data. | GAO-26-109152

[a]This flight reflects United Airlines' operated flight between Koror and Honolulu with a layover in Guam. However, United also operates a flight between Koror and Tokyo, from which other connection options to Honolulu exist, which are not reflected in this table.

The COFA Amendments Act of 2024 gives VA discretionary authority to furnish hospital care and medical services in the FAS.[9] This authority includes furnishing the care and services through contracts, reimbursement, or direct provision of services for any condition regardless of whether the condition is connected to the veteran's military service. The authorization includes beneficiary travel payments for any eligible person traveling in, to, or from the FAS. Before delivering hospital care or medical services in the FAS, VA must enter into agreements with the FAS to facilitate the furnishing of health services, including telehealth, under applicable laws. These agreements may address matters such as licensure, certification, and registration of health care personnel, and delivery of pharmaceutical and medical surgical products through the mail, among other things.

The COFA Amendments Act of 2024 also required VA, subject to the availability of appropriations, to conduct robust outreach to the FAS and assess options for the delivery of care using these new authorities.[10] In response, VA conducted an environmental scan of health care services in the FAS and produced a white paper outlining a needs assessment; implementation options with potential impact, cost, and regulatory implications; and a recommendation on an approach for implementation should the Secretary choose to implement the discretionary authority. Information from both documents was distilled into an action memo

[8]United Airlines is the only airline operating between these locations.

[9]Pub. L. No. 118-42, div. G, tit. II, § 209, 138 Stat. at 438.

[10]*Id.* at 441.

provided to the Secretary prior to the April 2025 decision not to implement the new discretionary authorities.

FAS officials noted actions their governments took in anticipation of implementation of new VA authorities. According to officials, Palau modified data collection tools to better capture veteran data, including basic demographics and veteran medical care needs. FSM established the Office of Veterans Affairs in 2024 to oversee veteran affairs. FAS and VA officials confirmed in June 2026 that all communication on this issue between VA and FAS stakeholders ceased following the April 2025 decision. However, as of July 2026, VA officials stated they were working towards further engagement with the FAS governments on implementation of certain authorities included in the COFA Amendments Act of 2024.

FAS and VA Identified Multiple Challenges in Accessing Healthcare in FAS

VA conducted its environmental scan of the current health care landscape in each of the three FAS from September 2024 to March 2025. VA and FAS officials stated that this process included monthly discussions between VA and FAS stakeholders. Officials identified various challenges in accessing health care in the FAS.

Limited services. All three countries offer publicly funded health care with the option of private supplemental coverage. The cost of public health services to the patient can vary depending on the service provided and whether the patient has additional insurance coverage. VA noted in its analysis that health infrastructure is inconsistent, especially in remote islands that constitute the FAS.

- Specialty and extended services remain largely unavailable and typically require off-island referrals. These include services such as oncology, cardiology, and advanced imaging. Preventive services are generally available, such as vaccines, nutrition, and screenings.

- According to VA documentation, FAS can import medications, including over the counter, controlled, and non-controlled substances from the U.S. According to VA documentation, local pharmacies in Palau are licensed and authorized to fill prescriptions from VA providers, provided they adhere to local licensing and dispensing regulations.[11] FSM and RMI may require additional steps to authorize its pharmacies or dispensaries to fill prescriptions issued by VA providers, according to VA.

- Psychiatric and mental health services and facilities are limited, and VA noted that there are insufficient mental health providers in the FAS to treat specific needs of veterans. FAS officials cited suicide as a risk for veterans facing post-traumatic stress disorders.

Varying telehealth access. VA documentation states that electricity, telecommunications, and mail services are generally accessible throughout the FAS and may be well-developed in urban regions. However, VA noted that infrastructure specific to telehealth varies significantly and that many facilities, such as smaller health centers and clinics on remote islands, operate with limited capacity. VA noted in its scan that RMI's partnership with organizations such as the Pacific Island Health Officers' Association has bolstered its telehealth capacity and such

[11]According to VA officials, VA providers cannot currently electronically send or issue prescriptions to veterans in the FAS. However, VA providers can prescribe medication to FAS veterans as part of health services rendered in the U.S. or its territories. According to VA officials, these prescriptions may be filled by pharmacies or dispensaries in the FAS if authorized by each FAS government.

services are already being utilized for consultations with Hawaii-based specialists under the RMI Medical Referral Program.[12] Additionally, VA medical facility pharmacies can only mail prescriptions or medical/surgical supplies within the U.S., which includes its territories and possessions. VA officials cited the Controlled Substances Act, which ordinarily requires providers to have at least one in-person appointment before prescribing medications that are controlled substances by means of the internet.[13]

Limited veteran enrollment. FAS and VA officials estimated that up to approximately 1,100 veterans reside in the FAS. Data collection efforts by FSM and Palau countries are ongoing.[14] FAS officials stated that veterans migrate often, as they may leave the FAS for extended periods to access VA services in the U.S. and Guam, which can complicate data collection. Data collected by VHA identified 462 known veterans residing in the FAS as of March 2025. According to VA, 144 were enrolled in VHA in fiscal year 2024.

FAS and VA officials noted the Veteran Benefits Administration (VBA) conducts regular outreach efforts to assist veterans with benefit registration and training on available services. However, both VA and FAS officials noted the limited success of these outreach efforts. VA officials estimated that in a recent outreach campaign to disabled FAS veterans, they called or sent emails to 147 known disabled veterans, with most going unanswered. According to officials, VBA conducted five visits to the FAS and U.S. territories in fiscal year 2025, including sessions in FSM and Palau. FAS officials stated veterans are frustrated with their inability to access health benefits once registered with VA. As a result, VA officials noted attendance at in-person outreach events is low and FAS officials stated there is little incentive due to lack of access to VHA benefits. Further, Palau officials stated that veterans often do not self-identify when obtaining services outside the VA health system. It can be difficult to estimate the full veteran population in each country and identify the health services to which these veterans need access.

VA Assessed Implementation Options and Agency Needs

VA conducted a variety of assessments, including the aforementioned environmental scan, from March 2024 to March 2025. According to VA officials, these assessments involved about 120 VA personnel and solicited input from multiple DOD entities on health care delivery in the FAS.[15] In a March 2025 action memo, VA outlined two options for implementation of the authorization, under the COFA Amendments Act of 2024.[16]

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[12]Medical referral programs are a subset of the national health care schemes in both RMI and Palau. These programs coordinate off-island referrals for more specialized services when necessary.

[13]21 U.S.C. § 829(e). This requirement does not apply to practitioners engaged in the practice of telemedicine as defined by 21 U.S.C. § 802(54).

[14]We recommended in GAO-24-106364 that VA assess underlying data sources of its VetPop model to identify the extent to which known data limitations impact accuracy of veteran population estimates in the U.S. territories and the FAS and VA consult with local government officials and stakeholders to identify and validate available veteran data sources.

[15]VA officials consulted the Defense Health Agency, U.S. Army Garrison Kwajalein Hospital, U.S. Coast Guard, U.S. Army Pacific Command, and the Defense Manpower Data Warehouse.

[16]VA assessed multiple options to provide authorized health care services in the FAS for eligible veterans and their feasibility. Options deemed less feasible and excluded from its final recommendation include sharing agreements with additional DOD facilities in the region and existing medical facilities in the FAS operated by their respective

1. **Maintain status quo**

   VA officials estimated the annual cost for health care expenditures for all currently enrolled veterans in the FAS is approximately $2 million. This annual cost includes beneficiary reimbursement for travel only within the U.S. and its territories (e.g., Guam or Hawaii in the Pacific) for authorized care and reimbursements through the FMP for service-connected care where available.[17] These benefits and associated restrictions are the same for all veterans regardless of location.

2. **Full approval of authorized care**

   VA officials estimated the annual cost of full implementation of discretionary authorities would be $26 million for currently enrolled veterans and a projected $200 million if all 1,100 potentially eligible veterans fully participate. This estimated annual cost includes expanded FMP reimbursements, telehealth (including infrastructure for telehealth access points), pharmaceutical delivery (including remote dispensing units), and beneficiary travel reimbursements for eligible veterans in, to, and from the FAS to the U.S. and its territories. Full implementation would provide veterans in the FAS comparable benefits available to veterans living in the U.S. and its territories. VA noted that this option would also expand FMP reimbursements beyond service-connected care to all medically necessary care and increase beneficiary travel benefits for travel outside U.S. areas only for FAS veterans. Thus, full implementation would mean that veterans living in the FAS would no longer have some of the restrictions that apply to other veterans living outside the U.S. and its territories.

In order to fully implement authorized care as detailed above, VA outlined necessary next steps:

- Establish an FAS-specific reimbursement model for all medically necessary eligible care, regardless of service connection, under the FMP.[18]

- Expand beneficiary travel reimbursement payments for travel in, to, and from the FAS for all care or services legally authorized to be provided by VA, regardless of service connection.[19]

- Incorporate costs into the next fiscal year budget. These costs include increased staffing to the FMP, telehealth equipment and staffing, pharmacy and medical supply delivery, and travel expenses covered by beneficiary travel benefits.

health agencies; establishment of direct VA services within the FAS; and contracting with community care networks in the FAS.

[17]Disability compensation, pension, and education benefits through the Veterans Benefits Administration are also available to veterans in the FAS but are not included in this estimated annual expenditure.

[18]Under the FMP, veterans living in the U.S., its territories, or abroad can receive medical care outside of the U.S. for certain conditions.

[19]Currently, eligible veterans living in the U.S., its territories, or abroad receive beneficiary travel reimbursement only for travel within the U.S. and its territories for eligible care and services.

- Enter into official negotiations with each of the FAS governments to establish agreements that will define care and services and facilitate delivery, among other matters.

Further, VA identified several regulatory implications tied to implementation of authorized care. These implications would include expansion of protections for health care professionals practicing telemedicine and exceptions to prohibitions of VA medical services outside the U.S. VA estimated in its 2024 assessment that the rulemaking process to address and amend applicable regulations would take approximately 2 years, with full implementation taking over 3 years, if prioritized.

In the March 2025 action memo, VHA recommended an approach for implementation should the Secretary choose to exercise VA authority to provide authorized care. As part of its recommendation, it noted the proposed delivery of health care for economically and geographically disadvantaged veterans in the FAS is substantiated by the critical lack of access to necessary health services and mental health treatments. Further, VA documentation and FAS officials highlighted broader strategic, political, and ethical objectives. For example, both VA and FAS officials underlined the key role the FAS play in U.S. national interests in the region and the strong military ties between the U.S. and the FAS communities. As FAS and U.S. officials have noted, the U.S. presence in the FAS is key to limiting China's influence in the region. Also, continued migration of veterans from the FAS to the U.S. and its territories to access health benefits further weakens the skilled labor force in each country and works against the overall U.S. goal to improve economic conditions through the compacts of free association. VA and FAS officials also noted the broken promise to veterans, made upon recruitment in their home countries and during their service, that they would have access to key benefits such as health care.

VA is Pursuing Partial Implementation of Authorization

When we met in June 2026, VA officials confirmed that all implementation efforts ceased following the April 2025 decision to maintain status quo. However, in July 2026, VA officials stated they were working towards further engagement with the FAS governments on implementation of certain authorities included in the COFA Amendments Act of 2024. In August 2026, officials confirmed that VA submitted a draft action memo to the Department of State (State) to begin the Circular 175 procedure that would allow them to enter into official negotiations with the FAS governments.[20] VA officials cannot negotiate or conclude international agreements with the FAS to facilitate expanded hospital care and medical services until this procedure is finalized. VA officials told us that they anticipated this process would entail several steps, including interagency discussions and multiple negotiations with the FAS to finalize an implementation package. VA officials noted that renewed discussions from January 2026 to June 2026 with interagency officials and congressional stakeholders led to the decision to pursue implementation of the following authorities:

[20]The Circular 175 procedure facilitates an orderly process for the negotiation, conclusion, reporting, publication, and registration of U.S. treaties and international agreements. U.S. government agencies must consult with State pursuant to the Circular 175 procedure before concluding an international agreement.

- Furnish VA reimbursements to providers or eligible service-connected veterans for care received in the FAS;
- Furnish VA medical services to service-connected veterans in the FAS from the U.S. via telehealth;
- Facilitate the delivery of pharmaceutical products and medical surgical products to service-connected veterans in the FAS from the U.S; and
- Furnish VA beneficiary travel benefits to eligible service-connected veterans traveling in, to, or from the FAS for authorized care.

VA did not provide an update on its budget plans or anticipated revisions to internal regulations. In September 2026, VA could not provide estimated timeframes for the implementation process, noting the process depended on State and negotiations with the FAS governments, among other factors. FAS officials confirmed that communication with VA resumed in August 2026, and VA indicated its intention to move forward with implementing certain authorities.

Agency Comments

We provided a draft of this report to the Department of Veterans Affairs and the governments of the Republic of Palau, Federated States of Micronesia, and Republic of Marshall Islands for review and comment. FSM provided comments, reproduced in enclosure I. VA, RMI and Palau provided technical comments, which we incorporated as appropriate.

GAO Contact and Staff Acknowledgements

We are sending copies of this report to the appropriate congressional committees, the Secretary of Veterans Affairs, and other interested parties. In addition, the report is available at no charge on the GAO website at http://www.gao.gov.

If you or your staff have any questions concerning this report, please contact Nagla'a El-Hodiri at elhodirin@gao.gov. Contact points for our Office of Congressional Relations and Media Relations may be found on the last page of this report. GAO staff who made key contributions to this report were Joe Carney (Assistant Director), Katie Bassion (Analyst-in-Charge), Nisha Rai, Alexa Stechschulte, Bahar Etemadian, and John Hussey.

//SIGNED//

Nagla'a El-Hodiri
Director, International Affairs and Trade

Enclosure

cc: cc list

Enclosure I: Comments from the Federated States of Micronesia

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September 10, 2026

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Re: FSM Comments - Compacts of Free Association: VA Plans to Partially Implement Authorities to Provide Health Care in the Freely Associated States (GAO-26-109152)

Dear Mr. Carney and Ms. Bassion,

On behalf of the Government of the Federated States of Micronesia (FSM), I am pleased to provide comments on the draft GAO report entitled "Compact of Free Association: VA Plans to Partially Implement Authorities to Provide Health Care in the Freely Associated States." As the report acknowledges, FSM veterans of U.S. military service do not receive the medical benefits they have earned after they return home to the FSM. This is a long-running issue and concern for our government, and we appreciate your report examining this critical issue.

The deep bonds between the U.S. and the FSM date back to World War II and continued through the U.S. administration of the United Nations Trust Territory for the Pacific Islands until 1986, when the FSM became a sovereign nation in free association with the United States.

The Compact of Free Association between the U.S. and the FSM, most recently amended in 2024, has since 1986 been the foundational document in the relationship between our two governments. Among other things, through the Compact, the FSM has granted the United States security and defense rights in our territory, which spans a vast region of the Pacific Ocean of utmost strategic importance to the United States. This includes the right of the U.S. military to operate in the FSM, and to deny foreign militaries access to the FSM's territory. This defense partnership is vital to securing and maintaining peace, stability, and prosperity in the Pacific.

The ties between our nations are also reflected in the fact that, under a special provision of our Compact, FSM citizens have proudly served in the U.S. military for many decades at very high rates, including some who have made the ultimate sacrifice in the course of their service. When our citizens enlisted, they did so with the understanding – reinforced by U.S. military recruiters – that they would receive the same benefits earned

by their fellow service members, regardless of where they later resided. However, when FSM citizens return home after service in the US military, they are unable to access the healthcare benefits they earned. Telehealth and pharmaceutical delivery, and beneficiary travel reimbursement are not available, and the Foreign Medical Program (FMP) remains an inadequate option for FSM veterans who are largely unable to utilize the program due to cost barriers. As the report notes, the limited availability of health care services from local providers limits the usefulness of FMP. Additionally, reimbursements for care under FMP happen after the fact and it only covers a limited scope of care. FMP is not a sufficient pathway for this population of veterans living in remote areas, many of whom have very limited financial resources, and this status quo has long been insufficient.

After many years of collaboration between FSM and Congress to remedy this situation, Congress authorized VA to provide benefits to Micronesian veterans in the Compact of Free Association Amendments Act of 2024.

From September 2024 through April of 2025, the U.S. and the FSM had productive consultations on several key issues, including telehealth, pharmaceutical delivery, and travel reimbursement. These benefits are essential to our citizens who have proudly served in the U.S. military in order to bring them closer to receiving benefits they were promised when they enlisted to serve.

Talks with the United States were productive, and we were working jointly in good faith toward a framework agreement as outlined in the 2024 Compact Act. The FSM government and VA officials met a dozen times, both virtually and in person, including a very productive session in Guam, in discussions that were extensive, substantive, and collaborative.

Despite this progress, the VA abruptly and unilaterally suspended talks in April 2025, without prior notice to the FSM and without explanation.

This was a significant setback not only for our veterans who were optimistic about the improvements to care that were anticipated under the new law. We have repeatedly asked VA to restart talks, including in a letter and meeting request to Secretary Collins that went unanswered. It is of paramount importance to our government that

our dialogue resumes immediately with the goal of reaching an agreement as quickly as possible.

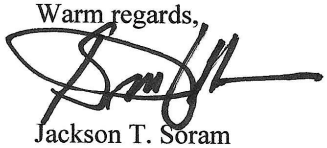
Following the VA's decision to maintain the status quo, several lawmakers pushed the VA to revisit their decision and implement the new authorities as intended in the COFA Amendments Act. Lawmakers pursued multiple legislative vehicles (including appropriations directives, amendments, and stand-alone legislation) to compel action, including raising the

issue during COFA oversight hearings. In December 2025, members of the House and Senate introduced bipartisan legislation requiring the VA to reach a framework agreement to provide certain healthcare services to veterans residing in the FAS. The Senate passed its standalone measure, the Caring for Veterans and Strengthening National Security Act (S. 3436), by unanimous consent in December 2025. A similar House bill, the U.S. Vets of the FAS Act (H.R. 6652), advanced in a committee. The two chambers subsequently included the legislation into a larger legislative package, the Take Care of America's Veterans Act (H.R. 9237/S. 4744), which is currently pending in Congress. These efforts reflect a shared recognition by Congressional leaders, that FSM veterans have waited long enough.

The package, pending before Congress, would require the VA, within one year, to implement telehealth, mail order pharmacy benefits, and travel reimbursement for veterans residing in the FAS (consistent with the amended Compact law). The FSM supports these congressional efforts to enable veterans to receive the care they earned without further delay and to ensure the VA implements the authorities provided in the 2024 law consistent with congressional intent.

Again, thank you for the opportunity to provide comments on the upcoming report on the lack of adequate health care for FSM veterans of U.S. military service.

Warm regards,



Jackson T. Soram