U.S. Department of Veterans Affairs

Veterans' Health Administration
Chief Strategy Office

2025 Survey of Veteran Enrollees' Health and Use of Health Care

Healthcare Analysis & Information Group (HAIG)

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Prologue

The Veterans who entrust their health care to VHA come from every corner of this country, every branch of service, and every generation of conflict. Their needs are as varied as their stories. Understanding those needs — with rigor, consistency, and humility — is among the most important work the Veteran Health Administration undertakes.

For twenty-three consecutive years, the Veterans Health Administration has administered the Survey of Veteran Enrollees' Health and Use of Health Care. That consistency is not incidental. It reflects a deliberate organizational commitment — a recognition that the needs of those we serve do not remain static, and that our strategies cannot afford to either. Each year, this survey gives enrolled Veterans a structured opportunity to tell us what their lives look like, what their health demands, and where our system is meeting them — and where it is not.

The twenty-third administration of this survey arrives at a moment of genuine consequence for VHA. The population of enrolled Veterans is evolving in ways that are both significant and accelerating. The expectations of those entering our system are different from those of previous generations. The health burdens carried by those who have been with us longest are deepening. And the environment in which we deliver care — technologically, economically, and socially — continues to shift beneath our feet.

In this context, the work represented by this report is not a routine exercise. It is a strategic necessity. Sound decisions about how we invest, how we organize our services, and how we prioritize the needs of millions of Veterans depend on the quality and honesty of the information we gather. This survey is one of the most important instruments we have for ensuring that our decisions are grounded in reality rather than assumption.

Leadership, at its best, is not the management of certainty. It is the disciplined navigation of complexity — informed by evidence, guided by values, and accountable to the people we exist to serve. The findings in this report will challenge us in places. They will affirm us in others. Both are necessary. Both are useful.

To the Veterans who participated in this survey and trusted us with their candid responses: your willingness to engage is itself an act of continued service. We do not take it lightly. Our responsibility — and our commitment — is to ensure that what you have shared shapes the care you receive.

To the Veterans who trusted us with their feedback: This report belongs to you.

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Delegated Authority of Chief Strategy Officer, Chief Strategy Office,

Veterans' Health Administration

2025 Survey of Veteran Enrollees — Executive Summary

Summary

The 23rd annual Survey of Enrollees gives us the clearest current picture of the roughly eight million Veterans who rely on us for their care. The headline is one of steadiness paired with quiet, accelerating change. The total enrolled population is essentially flat (7.99 million, a slight dip from last year), but the people inside that number are shifting underneath us. Nearly half are now 65 or older, and the burdens carried by our longest-tenured Veterans are deepening. At the same time, the Veterans newly entering the system are younger, more diverse in sex and ethnicity, and arriving with different expectations. For the first time, post-2001 service is the most commonly reported service era, edging past Vietnam.

A few findings deserve early attention. Most enrollees report at least "good" physical and mental health, but mental health slipped year over year across nearly every group, and our youngest Veterans report the lowest well-being of all — only 40 percent of those under 45 describe their mental health as at least good. Roughly one in three enrollees either receives help with daily living or believes they need it, yet most of their caregivers receive no formal support, and many don't know whether support exists. Smoking continues its long, encouraging decline to 10 percent, though it remains concentrated among Veterans who are uninsured, lower-income, or already in poor health. Most enrollees plan to keep using VA as their main source of care, but more than half also use community care, most often simply because it is easier to get to.

One operational note worth flagging up front: the response rate fell to 19.6 percent, the lowest in recent years, requiring an unplanned third sampling wave to hit our targets. We met our completion goals, but the trend itself is a signal.

Implications, Risks, and Takeaways

The dual mandate is no longer theoretical. Two distinct missions now run simultaneously: sustaining intensive, complex care for an aging population while building a system that earns the trust of younger, more diverse Veterans who have real choices about where to go. Investment, staffing, and service design decisions optimizing for one group can quietly underserve the other. Such competing demands are now planning reality, not future scenarios.

Mental health warrants the closest attention. The year-over-year decline is broad, and the concentration of distress among Veterans under 45 — the population least likely to have insurance outside VA and least engaged long-term — merits active monitoring. Veterans in that age cohort show high willingness to use digital tools for administrative tasks, suggesting accessible, low-friction digital channels are plausible. The limiting factor: willingness for remote mental health specifically drops sharply, meaning technology alone will not close the gap.

Coverage gaps cluster around the most vulnerable. Sixteen percent of enrollees have no insurance outside VA, with that figure rising among younger Veterans, women, and Priority Group 1 — the populations for whom VA is often the only safety net. These same Veterans are also more likely to smoke and report poorer health. The implication is concrete: for a meaningful slice of the population, anything making VA harder to reach effectively removes care options entirely.

Caregivers are doing essential work mostly without support. Nearly a third of enrollees need assistance with daily living, and most caregivers receive nothing from the system — many unaware support even exists. Both a service gap and an awareness gap exist here. The practical concern: caregiver burnout eventually surfaces as higher acuity and avoidable demand placed back on the system.

Community care use is a feedback signal, not just a cost line. Veterans are not leaving for quality reasons; the most common driver is convenience and ease of access. Location, appointment availability, and scheduling flexibility are where friction accumulates. Improving these elements is less about competing with community care and more about removing the pressures that force Veterans elsewhere.

Full demographic breakdowns, health status data, insurance coverage analysis, tobacco use trends, healthcare utilization patterns, and digital access findings — including detailed figures and year-over-year comparisons — are presented in the chapters that follow. Each section provides the supporting evidence behind the themes raised here and is intended to inform the deeper analytical and operational conversations ahead.

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Chapter 1. Overview of the Survey of Enrollees

The U.S. Department of Veterans Affairs (VA) operates the country's largest and most comprehensive integrated health care system through the Veterans Health Administration (VHA). Given that more than 13 million Veterans currently are eligible to receive care from the VA, it is important for VHA to understand their health care needs. The intent of the Survey of Veteran Enrollees' Health and Use of Health Care (Survey of Enrollees) is to collect information about enrollees' health care needs, along with demographic and socioeconomic factors that affect usage patterns, to help inform VHA's health care planning and future projections.

VHA provides primary and specialty care, a comprehensive pharmaceutical benefits package, and ancillary services to its enrollees through a geographically dispersed network of 170 medical centers and 1,193 outpatient sites.[1] For administrative purposes, VHA is divided into 18 geographical administrative areas called Veterans Integrated Services Networks (VISNs),[2] and VISNs are further divided into health care markets. Markets are health care areas within each VISN that have a sufficient population and geographic size to benefit from the coordination and planning of health care services and to support a full health care delivery system.

The VA Health Care system has approximately nine million enrolled Veterans, with slightly less than half of that population over the age of 65 (49%). Younger enrollees are more diverse in sex, race, and ethnicity; more affluent; and experience health care differently than their over-65 counterparts. VA Health Care must continue to be prepared to serve both aging Veterans and the rapidly growing, relatively young, and diverse group of Veterans who have served in more recent conflicts.

To better anticipate health care needs of all enrolled Veterans, the VHA Chief Strategy Office conducts an annual survey, the Survey of Enrollees, seeking responses from more than 40,000 Veterans who are enrolled in VA Health Care. The purpose of this report is to present the findings of the 2025 Survey of Enrollees.

1.1 Background of the Survey of Enrollees

The Survey of Enrollees is conducted annually to collect information on enrolled Veterans' health status, insurance coverage, use of VA and non-VA health care services, anticipated future health care use, and demographic characteristics. These data support VHA's annual projections of enrollment, utilization, and expenditures, as well as a range of budgetary and policy analyses. VHA has administered the Survey of Enrollees since 1999, coinciding with the establishment of the current enrollment system. Each year, a nationally representative sample of enrolled Veterans is surveyed, with sufficient sample sizes to support analyses across key geographic areas and stratification categories. In 2025, the final weighted estimate of enrolled Veterans represented in the survey sample was 8,469,440. After excluding ineligible respondents (including deceased individuals, non-locatable cases, and non-Veterans), the weighted analytic population described in this report was 8,387,023. Throughout this report, Veterans enrolled in the VA Health Care system are referred to as enrollees.

The 2025 Survey of Enrollees represented the 23rd administration of the survey. Since 2012, VA has employed a multimode data collection strategy that includes telephone, mail (paper), and web-based survey administration. For the 2025 survey, the sample design consisted of a primary sample (Wave 1) and a reserve sample (Wave 2), with the reserve sample deployed to supplement the primary sample as needed to ensure adequate response levels across key strata and maintain the representativeness of the final respondent pool. Data collection followed a sequential, ordered multimode approach using web-based and mail survey instruments. Although the original implementation plans included Computer-Assisted Telephone Interviewing (CATI) to achieve targeted response levels within specific strata, prior experience indicated limited effectiveness of this approach. Consequently, a third sample (Wave 3) was drawn in 2025 to support achievement of overall survey objectives; this wave utilized web-only data collection. Survey fielding occurred from April 18, 2025, through August 22, 2025. Additional details regarding the 2025 Survey of Enrollees methodology are provided in subsequent chapters of this report.

Trilogy Federal, LLC (Trilogy), a Service-Disabled Veteran-Owned project management and consulting firm, partnered with Westat, Inc. (Westat), a national research organization, to support the 2025 Survey of Enrollees. Responsibilities included survey methodology and design, Help Center management, and data collection. Navistar Direct Marketing (Navistar) provided personalization, printing, and mailing services. References to “the survey team” in this report denote the joint Trilogy–Westat team.

1.2 Methodology

The VHA’s 2025 Survey of Enrollees’ target population included all Veterans enrolled in VA Health Care as of September 30, 2024, who reside in the 50 U.S. states, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands. The survey team constructed the sample using the VHA enrollment file which contains the records of all Veterans enrolled in VA Health Care. The survey team used the variables available to stratify the sample, including the VISN market, Priority Group, and date of enrollment. Date of enrollment defines the enrollee type as pre-enrollee or post-enrollee.[3]

Following previous years’ protocols, the survey team excluded Veterans with incomplete information from the sampling frame, such as:

- Enrollees with missing or incomplete stratification information (i.e., VISN, market, priority group, and/or enrollee type);
- Enrollees with a missing street address, city, state, or zip code;
- Enrollees with street address values that are not actual street addresses. Examples of such street address values are 'GENERAL DELIVERY', 'NEED ADDRESS', 'NO KNOWN ADDRESS', 'STREET ADDRESS UNKNOWN', 'ADD ADDRESS', 'DELETE', 'NULL', and 'NONE’;
- Enrollees with missing gender data; and

- Enrollees with a listed age greater than 110 or less than 17 years old.

Lastly, the survey team excluded Veterans who were contacted for the 2024 Survey of Enrollees or who informed VA in the past that they did not want to participate in future surveys. However, the survey team did include these Veterans in the overall sampling frame for purposes of weighted response estimates (see Chapter 8).

The original VA file had 8,469,440 records. After these adjustments, the final sampling frame total came to 8,387,023.

To ensure an adequate number of completed surveys per domain, the survey team stratified the sampling frame into 108 strata by market, priority group, and enrollee type. The analytic domains were as follows:

- Individual VISNs (n=18);
- Priority groups (n=3) primarily based on Veteran level of disability, with priorities 1, 2, and 3 being one group; priorities 4, 5, and 6 being a second group; and priorities 7 and 8 being the third group; and
- Enrollee type (n=2) based on date of enrollment, with enrollment prior to March 31, 1999 (pre-enrollee) versus enrollment after this date (post-enrollee).

Priority Groups define an enrolled Veteran's priority for VA Health Care services. Priority Groups range from 1 to 8, with Priority Group 1 being the highest priority. Priority Groups are based on multiple factors, including the enrolled Veteran's service-connected disabilities, income, and other factors such as Prisoner-of-War status or receipt of a Purple Heart. Figure 1-1 defines Priority Groups and eligibility requirements.

Figure 1-1. VA eligibility categories and eligibility requirements

Priority Group	Eligibility Requirements
Priority Group 1	• Veterans with VA-rated service-connected disabilities that are 50% or more disabling • Veterans determined by VA to be unemployable due to service-connected conditions • Veterans awarded the Medal of Honor
Priority Group 2	• Veterans with VA-rated service-connected disabilities that are 30% or 40% disabling
Priority Group 3	• Veterans who are former Prisoners of War (POWs) • Veterans awarded a Purple Heart medal • Veterans whose discharge was for a disability that was incurred or aggravated in the line of duty • Veterans with VA-rated service-connected disabilities that are 10% or 20% disabling • Veterans awarded special eligibility classification under Title 38, U.S.C., § 1151, "benefits for individuals disabled by treatment or vocational rehabilitation"

Priority Group	Eligibility Requirements
Priority Group 4	• Veterans who are receiving aid and attendance or housebound benefits from VA • Veterans who have been determined by VA to be catastrophically disabled
Priority Group 5	• Nonservice-connected Veterans and non-compensable service-connected Veterans rated 0% disabled by VA with annual income below the VA's and geographically adjusted income limits (based on resident ZIP Code) • Veterans receiving VA pension benefits • Veterans eligible for Medicaid programs
Priority Group 6	• Compensable 0% service-connected Veterans • Veterans exposed to ionizing radiation during atmospheric testing or during the occupation of Hiroshima and Nagasaki • Project 112/SHAD (Shipboard Hazard and Defense) participants • Veterans who served in the Republic of Vietnam from January 9, 1962, to May 7, 1975 • Persian Gulf War Veterans who served from August 2, 1990, to November 11, 1998 • Veterans who served on active duty at Camp Lejeune for at least 30 days between August 1, 1953, and December 31, 1987 • Currently enrolled Veterans and new enrollees who served in a theater of combat operations after November 11, 1998, and were discharged less than 5 years ago
Priority Group 7	• Veterans with gross household income below the geographically adjusted income limits for their resident location and who agree to pay co-payments
Priority Group 8	• Veterans with gross household income above the VA and the geographically adjusted income limit for their resident location and who agree to pay co-payments

The survey team classified Veterans into three selection groups to support sample selection:

- **Group 1:** Veterans who were included in Wave 1 or Wave 2 of the 2024 Survey of Enrollees.
- **Group 2:** Veterans who were part of the 2024 sampling frame but were not selected for Wave 1 or Wave 2; and
- **Group 3:** Veterans who were not part of the 2024 sampling frame, representing Veterans newly enrolled in VA.

The survey team did not sample Veterans in Group 1 (enrollee was in Wave 1 or Wave 2 of the 2024 Survey of Enrollees) in order to reduce the survey burden on those Veterans who completed the survey the previous year. Those in Group 2 were over-sampled, permitting Group 2 to represent both Group 1 and Group 2.
The survey team approached sample allocation to meet the following VHA strata requirements:

1. Ensure at least 350 completed cases by VISN and priority group;
2. Ensure at least 2,000 completed cases by VISN;
3. Ensure that no cases from selection Group 1 are included;
4. Ensure that the sample size in selection Group 2 represents the population size in selection Groups 1 and 2; and
5. Ensure a total of 40,000 completed cases.

The survey team utilized a multi-wave sampling approach when selecting the survey sample. The same strata were used for both the main sample (Wave 1) and the planned reserve sample (Wave 2), with the cases sorted randomly within strata.
At week 12 of data collection, seeing a slower than expected response rate, the survey team made the decision to release a third wave to ensure minimum response targets would be met. Wave 3 was released during the 14th week of data collection and was web-only, with a single invitation letter and no additional follow-up.

Selecting the Wave 1 Sample

The survey team estimated a 23.9% response rate for 2025 based on the 2024 response rate. Using an initially estimated sample size of 161,271 needed to meet survey goals, the survey team selected a Wave 1 allocation of 129,482 with probabilities proportional to strata size.

Selecting the Wave 2 Sample

The survey team calculated a Wave 2 sample size of 31,789. The final size of the Wave 2 sample was 31,752.

Selecting Wave 3 Sample

Due to lower than anticipated response rates, the survey team, with coordination from VHA, made the decision to draw a Wave 3 sample. The survey team assessed the performance among VISNs and priority groups to estimate an additional sample necessary to meet the minimum targets. A Wave 3 sample of 54,975 was drawn.

In total, the survey team received 42,294 surveys that met the completion criteria during the 2025 data collection period exceeding VHA's goal of 40,000. The survey team met the goal of obtaining at least 350 completed surveys by VISN and priority group and at least 2000 complete cases per VISN.

Figure 1-2. Number of respondent enrollees, by Priority Group, age, and sex

Demographic Group	Number of Respondents
Priority Groups	
1	13,446
2-8	28,848
Age	
<45	1,587
45-64	8,832
65+	31,875
Sex	
Male	37,392
Female	4,902
All Enrollees	42,294

Figure 1-3. Number of completed surveys by mode

	Web	Paper	Telephone	Total
Number	22,154	20,140	0	42,294
Percentage	52%	48%	0%	100%

Figure 1-4. Comparison of Survey of Enrollees design, 2021, 2022, 2023, 2024, and 2025

	2021	2022	2023	2024	2025
Weighted population of enrolled Veterans	8,680,525	8,376,015	8,228,035	8,003,238	7,985,922
Weighted population as of	9/1/2020	9/1/2021	9/1/2022	9/1/2023	9/1/2024
Stratified sample size	139,167	188,177	162,926	187,205	216,209
Sample stratified by	VISN, market, Priority Group, pre- and post-enrollee	VISN, market, Priority Group, pre- and post-enrollee	VISN, market, Priority Group, pre- and post-enrollee	VISN, market, Priority Group, pre- and post-enrollee	VISN, market, Priority Group, pre- and post-enrollee
Number of completed surveys/interviews	42,351	44,248	41,196	44,689	42,294
Response rate	29.4%	23.6%	25.4%	23.9%	19.6%
Data collection timeframe	March 2021 to July 2021	April 2022 to July 2022	March 2023 to July 2023	February 2024 to June 2024	April 2025 to August 2025
Mode of data collection	Web, mail, and CATI*	Web, mail, and CATI*	Web, mail, and CATI*	Web, mail, and CATI*	Web, mail, and CATI*

*No CATI interviews were required for 2021, 2022, 2023, 2024, or 2025.

1.3 Weighting

The survey team calculated the stratum base weight based on the total target population and number sampled. The base weight for a sampled Veteran is the reciprocal of the probability that the Veteran was selected to participate in the 2025 survey. For the 2025 Survey of Enrollees, each Veteran in the sampling frame could be selected only once because they were identified and selected without replacement. Veterans had a probability of selection of 1, the base weight, if all within a stratum were selected. For stratum where not all Veterans were selected, the sampling probabilities are less than 1. When the probabilities are less than 1, the base weights will be greater than 1, which indicates that sampled Veterans will be representing themselves plus additional Veterans who were not sampled.

Table 1-5 demonstrates the computation of base weights. Let strata be indexed by letter h (h=1, …, 108). As noted above in Chapter 2, there were three selection groups (1,2,3). Veterans in Group 1 were not sampled to reduce the survey burden on those Veterans who completed the survey the previous year. In Group 2 and each sex/gender within a stratum, the base weight was calculated as (Nh1g+Nh2g)/nh2g where Nh1g and Nh2g were the population sizes of Groups 1 and 2 in stratum h, gender g; and nh2g was the sample size from Group 2, gender g in that stratum. In Group 3 within a stratum, the base weight was calculated as Nh3g/nh3g where Nh3g and nh3g are the population and sample size, respectively, of this group in stratum h, gender g. For illustration purposes, Table 1-5 shows the formulas for Strata 1, 2, 3, 4, and H, the final stratum, which is stratum 108 in the 2025 survey.

Figure 1-5. Base Weight Equations

Strata	Group	Sex/Gender	Number in Target Population	Number in Group 1	Number in Sample (Wave 1 + Wave 2)	Base weight
Stratum 1	2	F	N_{12F}	N_{11F}	n_{12F}	$(N_{12F} + N_{11F})/n_{12F}$
Stratum 1	3	F	N_{13F}		n_{13F}	N_{13F}/n_{13F}
Stratum 1	2	M	N_{12M}	N_{11M}	n_{12M}	$(N_{12M} + N_{11M})/n_{12M}$
Stratum 1	3	M	N_{13M}		n_{13M}	N_{13M}/n_{13M}
Stratum 2	2	F	N_{22F}	N_{21F}	n_{22F}	$(N_{22F} + N_{21F})/n_{22F}$
Stratum 2	3	F	N_{23F}		n_{23F}	N_{23F}/n_{23F}
Stratum 2	2	M	N_{22M}	N_{21M}	n_{22M}	$(N_{22M} + N_{21M})/n_{22M}$

Strata	Group	Sex/Gender	Number in Target Population	Number in Group 1	Number in Sample (Wave 1 + Wave 2)	Base weight
Stratum 2	3	M	N_{23M}		n_{23M}	N_{23M}/n_{23M}
Stratum 3	2	F	N_{32F}	N_{31F}	n_{32F}	$(N_{32F} + N_{31F})/n_{32F}$
Stratum 3	3	F	N_{33F}		n_{33F}	N_{33F}/n_{33F}
Stratum 3	2	M	N_{32M}	N_{31M}	n_{32M}	$(N_{32M} + N_{31M})/n_{32M}$
Stratum 3	3	M	N_{33M}		n_{33M}	N_{33M}/n_{33M}
Stratum H	2	F	N_{H2F}	N_{H1F}	n_{H2F}	$(N_{H2F} + N_{H1F})/n_{H2F}$
Stratum H	3	F	N_{H3F}		n_{H3F}	N_{H3F}/n_{H3F}
Stratum H	2	M	N_{H2M}	N_{H1M}	n_{H2M}	$(N_{H2M} + N_{H1M})/n_{H2M}$
Stratum H	3	M	N_{H3M}		n_{H3M}	N_{H3M}/n_{H3M}

Chapter 2. Demographic and Socioeconomic Characteristics

Demographic and socioeconomic information provides insights into the population of enrollees and their potential health care needs. The Survey of Enrollees asked Veterans enrolled in VA Health Care several demographic and socioeconomic questions to better understand their status related to health care. This chapter examines the key characteristics of enrolled Veterans and compares the 2025 results to prior years.

2.1 Demographics

Survey estimates from the 2025 Survey of Enrollees were weighted to produce population-level representations of Veterans enrolled in the Veterans Health Administration health care system. Accordingly, all enrollee counts and percentages presented in this report reflect weighted survey estimates and do not correspond to observed or administrative population totals.

Following the exclusion of ineligible respondents, the analytically weighted population total for the 2025 analyses is 7,985,922 enrolled Veterans. This represents a net decrease of 17,316 enrollees relative to the weighted total reported for the 2024 Survey of Enrollees. Unless otherwise specified, all analyses and estimates presented in this report are based on this weighted population total.[4]

Selected demographic characteristics of the 2025 enrolled Veteran population are presented below.

- Female enrollees represented 11 percent of the total enrollee population.
- Younger enrollees were more racially and ethnically diverse. While 77 percent of enrollees over 65 were White and non-Hispanic, only 61 percent of enrollees under 65 were White and non-Hispanic.
- Among all enrollees, more than one-third (35 percent) reported service after September 2001, making it the most frequently reported period of service. The Vietnam era was the second most frequently reported period of service (33 percent of enrollees). In prior survey years, the Vietnam era had been the most frequently reported period of service (35 percent), indicating a notable shift in the distribution of reported service periods.

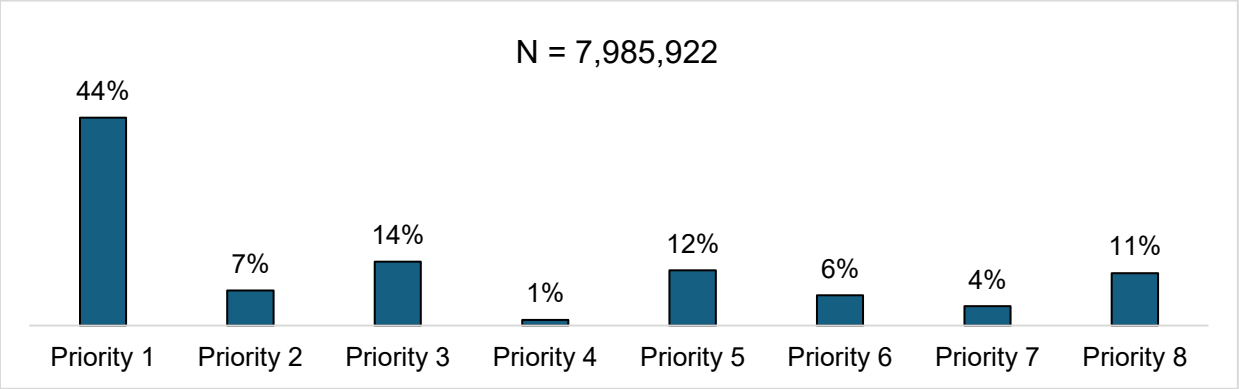
2.1.1 Priority Groups

The Veterans' Health Care Eligibility Reform Act of 1996 established a priority-based enrollment framework requiring the Department of Veterans Affairs to enroll Veterans according to defined eligibility criteria. Under this system, enrollees are assigned to one of eight Priority Groups based on service-connected disability status, income, and other qualifying factors.

Figure 2-1 presents the distribution of enrollees and corresponding weighted percentages by individual Priority Group. The largest share of enrolled Veterans (44 percent)[5] was assigned to Priority Group 1. Priority Group 3 accounted for 14 percent of enrollees and represented the second-largest Priority Group, followed by Priority Group 5 (12 percent) and Priority Group 8 (11

percent). Each remaining Priority Group comprised less than 10 percent of the enrolled Veteran population.

Figure 2-1. Percentage of enrollees by collapsed Priority Group



For analytic purposes, the eight VA Health Care Priority Groups were collapsed into two strata:

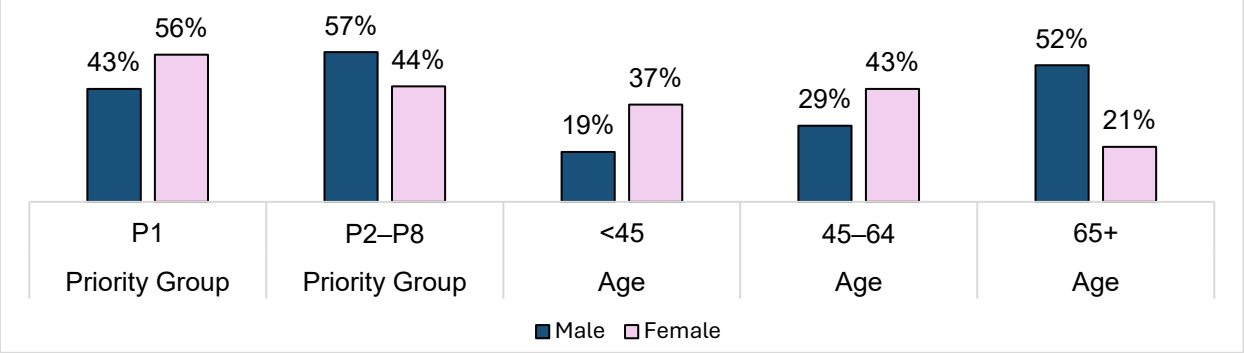
1. **Priority Group 1**: Veterans with service-connected disabilities rated at 50 percent or greater; Veterans determined to be unemployable due to service-connected conditions; and Veterans awarded the Medal of Honor.
2. **Priority Groups 2-8**: Veterans with lower-rated service-connected disabilities (Priority Group 2); Veterans with special eligibility classifications or lower-rated service-connected disabilities (Priority Group 3); Veterans with catastrophic disabilities (Priority Group 4); Veterans with nonservice-connected disabilities or with annual incomes below the VA Means Test threshold (Priority Group 5); Veterans with qualifying environmental exposure (Priority Group 6); and Veterans with no service-connected disabilities and annual incomes above the Means Test threshold (Priority Groups 7 and 8).

Compared with enrollees in Priority Groups 2–8, enrollees in Priority Group 1 are more likely to be younger, female, to have served in Operation Enduring Freedom, Operation Iraqi Freedom, and/or Operation New Dawn (collectively referred to as OEF/OIF/OND),[6] and to have served in a combat zone. Data from the National Center for Veterans Analysis and Statistics indicate that, although the overall Veteran population has declined since 1990, the number of Veterans with a service-connected disability has increased substantially, rising by 147 percent between 2008[7] and 2023.[8]

2.1.2 Sex and Age

In 2025, female enrollees accounted for 11 percent of the enrolled Veteran population, representing a one percentage point increase from 2024; the remaining 89 percent of enrollees were male. Figure 2-2 presents the distribution of enrollees by sex across collapsed Priority Groups and age categories. Female enrollees skew younger than male enrollees, with 80 percent under age 65, compared with 48 percent of male enrollees. In addition, the majority of male enrollees are assigned to Priority Groups 2–8, whereas the majority of females are assigned to priority group 1 (56 percent).

Figure 2-2. Percentage of enrollees by Sex, Priority Group, and Age

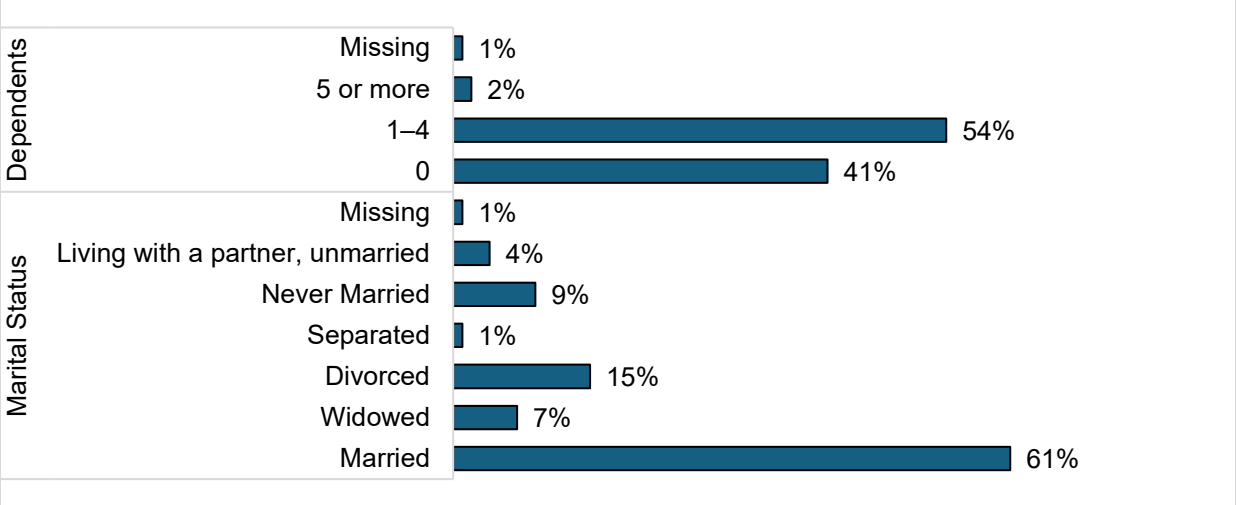


2.1.3 Marital Status and Dependents

In 2025, married enrollees comprised the majority of the enrolled Veteran population. Approximately 61 percent of enrollees reported being married, followed by 15 percent who reported being divorced, nine percent who reported never having been married, and seven percent who reported being widowed (Figure 2-3).

Enrollees also reported the number of dependents they currently support, defined as individuals who rely on the enrollee for at least half of their financial support (Figure 2-3). A majority of enrollees (58 percent) reported supporting one or more dependents.

Figure 2-3 Percentage of Enrollees by Marital Status and Dependents

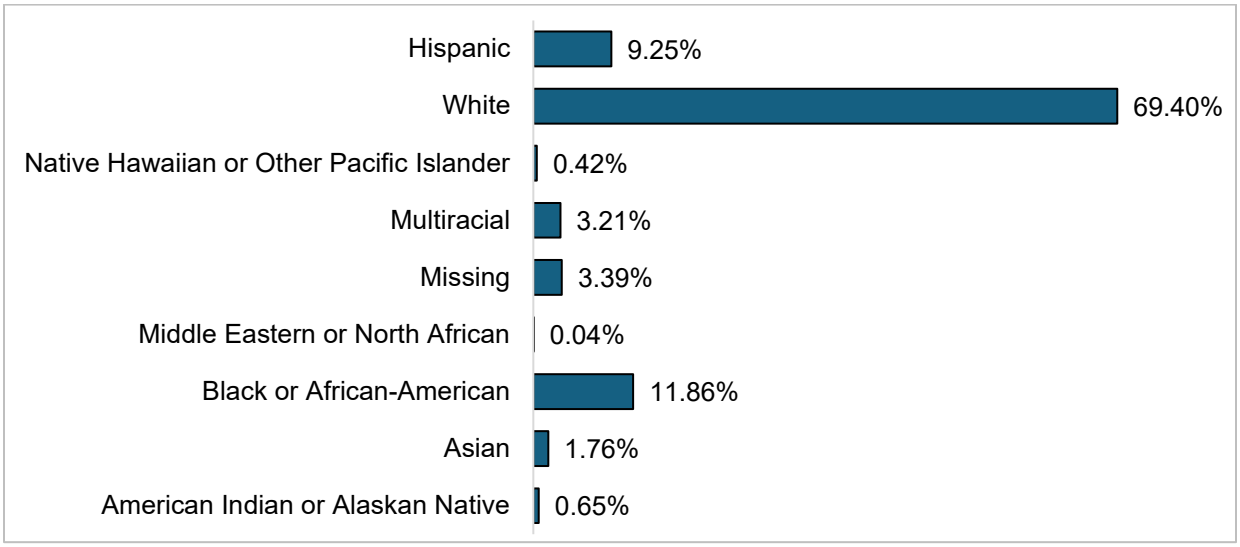


2.1.4 Ethnicity and Race

The predominant race and ethnicity among enrollees were non-Hispanic White. Enrollee race and ethnicity were assessed using two survey questions. The first item asked whether enrollees identified as being of Hispanic, Latino, or Spanish origin; nine percent of respondents indicated that they were of Hispanic origin. The second item asked enrollees to identify their race by selecting all applicable racial categories.

Figure 2-4 presents race and ethnicity as mutually exclusive categories, with enrollees selecting more than one race classified as multiracial. Overall, 69 percent of enrollees self-identified as non-Hispanic White, 12 percent as non-Hispanic Black or African American, and approximately three percent as multiracial.

Figure 2-4. Percentage of enrollees by race and ethnicity (mutually exclusive)



Note: No answer/missing represents those enrollees who did not answer the race and Hispanic origin questions, or indicated they preferred not to answer these questions. Respondents who selected more than one race were categorized as multiracial. Hispanic includes anyone who self-identified as Hispanic, regardless of race.

Race and Ethnicity by Age. Figure 2-5 presents the distribution of enrollee race and ethnicity by age group. Enrollees aged 65 or older were predominantly non-Hispanic White (77 percent), followed by non-Hispanic Black or African American (10 percent) and Hispanic (6 percent). In contrast, younger enrollees exhibited greater racial and ethnic diversity. Among enrollees under age 65, approximately 62 percent identified as non-Hispanic White. Additionally, 26 percent of enrollees under age 45 and 28 percent of enrollees aged 45 to 64 identified as either Black or Hispanic, compared with 16 percent of enrollees aged 65 or older. The proportion of enrollees identifying as Hispanic in the youngest age group (16 percent) was more than twice that observed among enrollees aged 65 or older (6 percent).

Figure 2-5. Ethnicity and race of enrollees, by age group (mutually exclusive)

Category	Age					
	<45		45-64		65+	
	N	%	N	%	N	%
Total	1,667,461	21%	2,432,512	30%	3,885,950	49%
White, non-Hispanic	1,029,157	62%	1,511,563	62%	3,001,896	77%
Black or African American, non-Hispanic	162,911	10%	404,527	17%	380,046	10%
Spanish, Hispanic, or Latino (a)	258,790	16%	262,225	11%	218,002	6%
Multiracial, non-Hispanic	77,037	5%	93,895	4%	85,491	2%

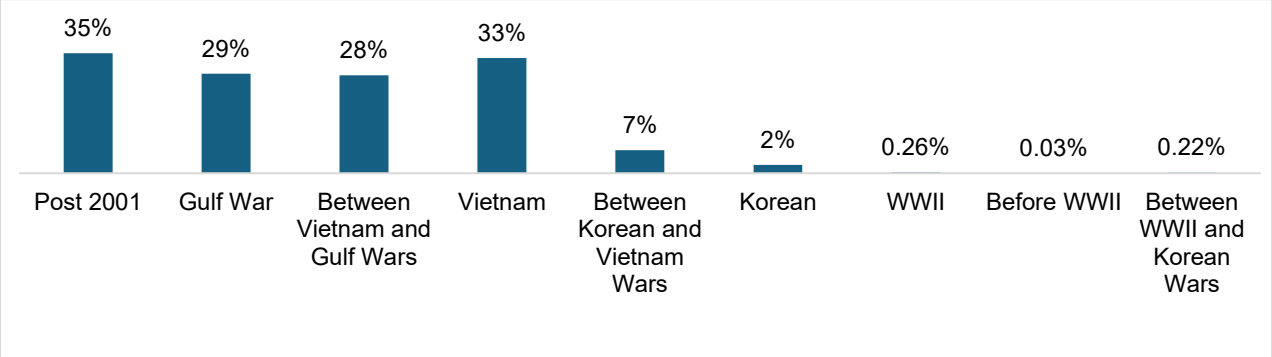
Category	Age					
	<45		45-64		65+	
	N	%	N	%	N	%
Asian, non-Hispanic	62,863	4%	41,353	2%	36,528	1%
American Indian or Alaskan Native, non-Hispanic	7,170	0%	18,487	1%	26,036	1%
Native Hawaiian or Other Pacific Islander, non-Hispanic	6,670	0%	15,811	1%	11,269	0%
Middle Eastern, non-Hispanic	834	0%	1,703	0%	777	0%
Missing/Prefer not to answer	61,863	4%	82,705	3%	125,905	3%

Note: Hispanic includes anyone who self-identified as Hispanic, regardless of race. Missing values represent those enrollees who did not answer whether they were of Hispanic origin or answered that they were not Hispanic but did not answer the race question. Percentages refer to the percentage of each age group column.

2.1.5 Active-Duty Period of Service /Combat Experience

Enrollees reported the period or periods of their active-duty military service and were permitted to select multiple periods, as applicable. Most enrollees (69 percent) reported a single period of service, followed by 19 percent who reported two periods and nine percent who reported three or more periods of service. The largest share of enrollees served in the post-2001 period (35 percent), followed by the Vietnam era (33 percent) and the Gulf War era (29 percent). An additional 28 percent reported service during the period between the Vietnam and Gulf War eras. Figure 2-6 presents the distribution of enrollees by period of service.

Figure 2-6. Percentage of enrollees by period of active-duty service (not mutually exclusive)

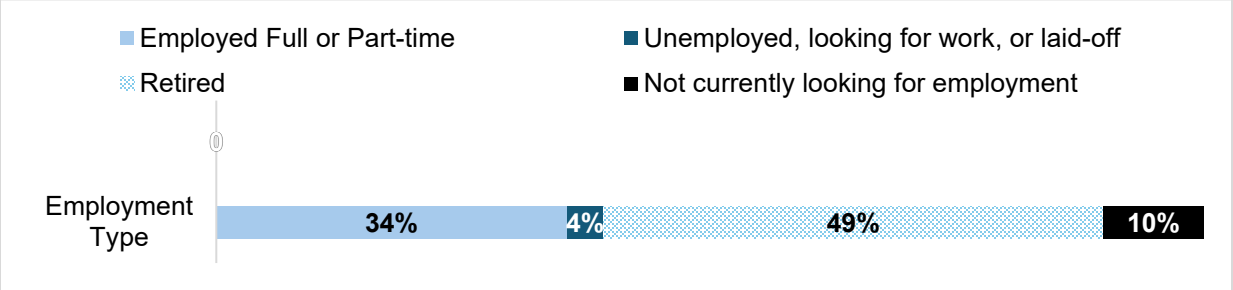


Note: Percentages sum to more than 100 percent because enrollees may select multiple periods of service. World War II (WWII) – December 1941 to December 1946. Between WWII and Korean War – January 1947 to June 1950. Korean War – July 1950 to January 1955. Between Korean War and Vietnam War – February 1955 to July 1964. Vietnam War – August 1964 to April 1975. Between Vietnam War and Gulf War – May 1975 to July 1990. Gulf War – August 1990 to August 2001. Post-2001 – September 2001 or later.

2.1.6 Employment Status

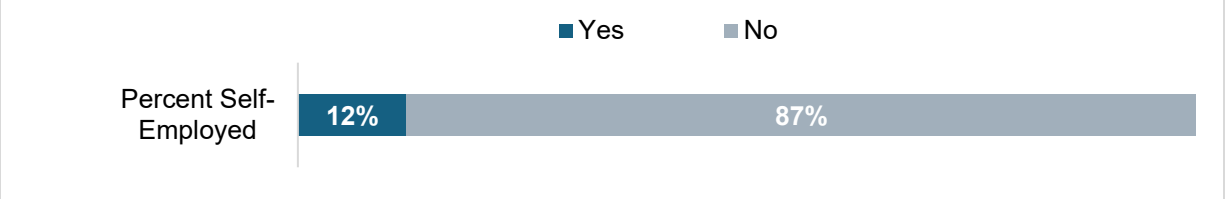
Economic and labor market conditions in the United States may influence the number of Veterans seeking health care benefits through VA, given that most individuals with health insurance obtain coverage through employer-sponsored plans.[9] Of enrollees in 2025, 40 percent were in the labor force (employed full time or part time, or unemployed and seeking work), eight percent were not seeking employment, and 50 percent were retired. Figure 2-7 (next page) presents the distribution of enrollees by employment status.

Figure 2-7. Percentage of enrollees by employment status



Self-Employment. Of enrolled Veteran who are employed, 12 percent reported being self-employed, with most indicating they are not self-employed (87 percent). See Figure 2-8.

Figure 2-8. Percentage of enrollees by self-employed (national level)

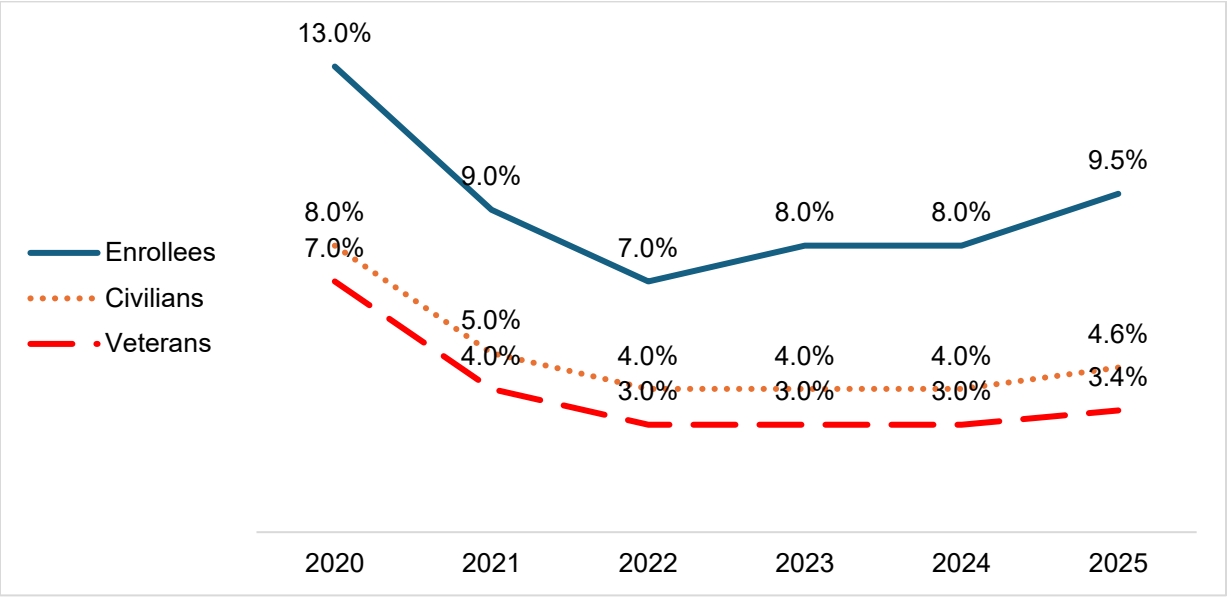


Note: The percentages in Figure 2-11 are based on the number of enrollees that are employed full- or part-time.

Unemployment Rate. The Bureau of Labor Statistics of the U.S. Department of Labor calculates the unemployment rate by dividing the number of individuals who do not have a job but are available for work and have actively sought work, by the total number of people in the labor force.[11] The labor force comprises those who are either employed or not employed but actively looking for a job.

In the 6 years between 2020 and 2025, the unemployment rate for enrollees was nearly double that of both civilians and Veterans. In 2025, the unemployment rate for enrollees was one percentage point higher compared to 2024. Figure 2-9 shows unemployment (next page).

Figure 2-9. Unemployment rates by population, 2020 to 2025



Note: Data for 2020 through 2023 represent annual unemployment rate estimates. Data for 2024 for both civilians and Veterans reflect unemployment rates as of September 2024 and are not seasonally adjusted. Veterans include enrollees. Sources: Civilians and Veterans data, 2020–2021: *Employment Situation of Veterans*, . Available at: https://www.bls.gov/news.release/archives/vet_04212022.pdf. Summary Table A; Civilians and Veterans data, 2022–2023: *Employment Situation of Veterans*, Summary Table A; Available at: https://www.bls.gov/news.release/vet.a.htm. Civilians and Veterans data, 2024: Bureau of Labor Statistics, *The Employment Situation—September 2024*, Available at: https://www.bls.gov/news.release/empsit.nr0.htm. Table A-5. Additional labor market context is informed by BLS TED reporting indicating that unemployment rates increased in 30 states over the year ending February 2025

Unemployment Rate by Enrollee Demographic Characteristics. Figure 2-10 presents unemployment rates by sex, age group, urban or rural residence, and collapsed Priority Group. Unemployment was highest among enrollees under age 45 (10.5 percent). Enrollees residing in rural areas experienced higher unemployment rates than those in urban areas (9.9 percent versus 9.4 percent). In addition, enrollees in Priority Group 1 had a higher unemployment rate than those in Priority Groups 2–8 (10.1 percent versus 8.9 percent).

Figure 2-10. Unemployment rates by sex, age, urban/rural, and priority group

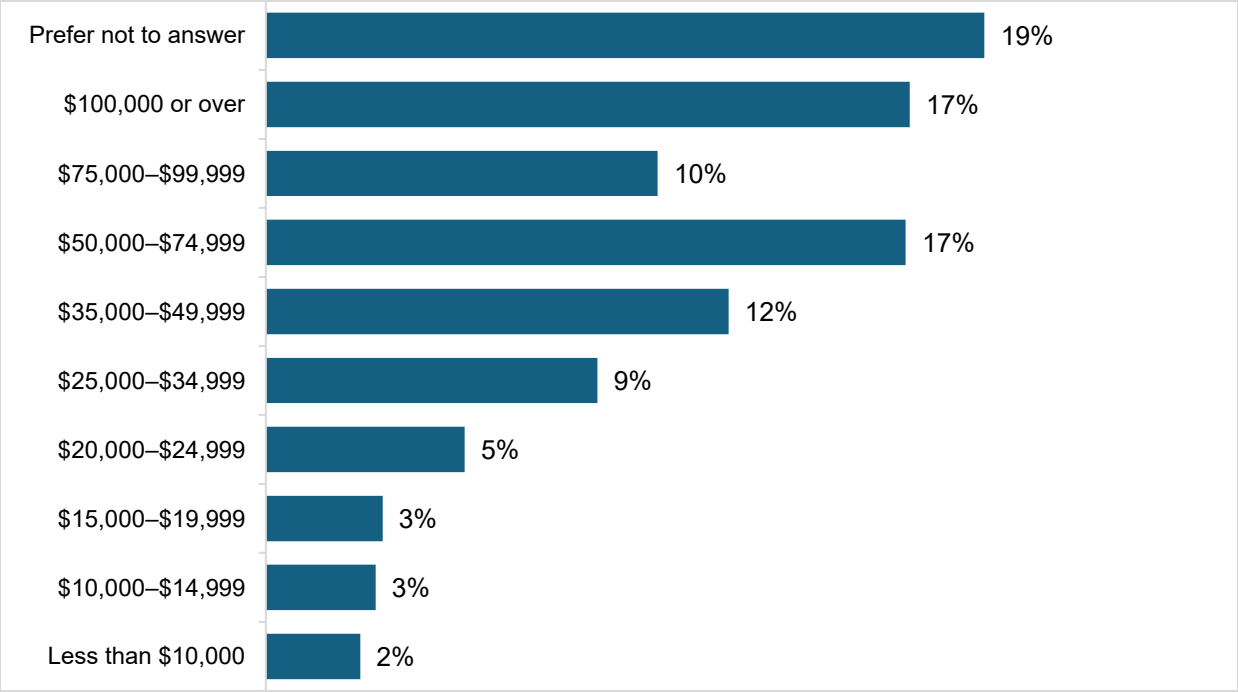
Demographic Group	In Labor Force (#)	Unemployed (#)	Unemployment Rate (%)
Total	3,037,778	287,080	9.5%
Sex			
Male	2,610,849	246,331	9.4%
Female	426,929	40,748	9.5%
Age Group			
<45	1,264,985	132,937	10.5%
45-64	1,441,415	119,868	8.3%

Demographic Group	In Labor Force (#)	Unemployed (#)	Unemployment Rate (%)
65+	331,378	34,274	10.3%
Urban/Rural			
Urban	2,130,222	200,988	9.4%
Rural	829,133	81,875	9.9%
Priority Group			
Priority Group 1	1,462,555	147,278	10.1%
Priority Group 2-8	1,575,224	139,802	8.9%

2.1.7 Income

Enrollees reported total annual household income by selecting from predefined income ranges. Results from the 2025 Survey of Enrollees indicate that 56 percent of enrollees reported household incomes of $35,000 or higher (Figure 2-11). Additionally, 27 percent of enrollees reported household incomes of $75,000 or more.

Figure 2-11. Percentage of enrollees by income group



Chapter 3. Public and Private Health Insurance

Enrolled Veterans have access to a range of health insurance options, including private insurance, TRICARE, Medicare, and Medicaid. Prior research has shown that having non-VA insurance coverage is associated with reduced reliance on VA Health Care.[10,11] Enrollees with multiple sources of coverage may also experience challenges related to continuity and coordination of care. This chapter describes the primary insurance options available to enrolled Veterans and their interaction with VA Health Care.

TRICARE. TRICARE is the Department of Defense health care program serving active-duty service members and members of the Reserve and National Guard. Veterans are eligible for TRICARE if they are military retirees with at least 20 years of service. Family members of active-duty service members are enrolled at no cost, while retirees and their dependents are required to pay annual premiums. In 2001, eligibility was extended to retirees aged 65 and older through TRICARE for Life, which provides wraparound coverage for Medicare beneficiaries by covering costs not paid by Medicare.

Medicare. Medicare is a federal health insurance program for individuals aged 65 or older and for certain individuals under age 65 with qualifying disabilities. Coverage is available through Original Medicare or Medicare Advantage. Original Medicare is a fee-for-service program consisting of Part A (hospital insurance) and Part B (medical insurance). Part A covers inpatient hospital services and generally does not require a premium, though deductibles apply. Part B is optional and requires a monthly premium and cost sharing. Individuals under age 65 who receive Social Security disability benefits for two years are automatically enrolled in Parts A and B. Medicare Advantage (Part C) consists of managed care plans offered by private insurers that provide Part A and Part B coverage.

Medicare beneficiaries may also purchase Medicare Supplement Insurance (Medigap) from private insurers to help cover costs not paid by Medicare, such as copayments and deductibles, including certain services received outside the United States. Alternatively, beneficiaries may enroll in Medicare Advantage plans, which are commonly offered as health maintenance organization (HMO) or preferred provider organization (PPO) plans approved by Medicare.

Prescription drug coverage is available through Medicare Part D, a voluntary benefit available to individuals enrolled in Medicare Parts A and B. Since 2006, Medicare beneficiaries have been able to obtain prescription drug coverage through private Part D plans, and some Medicare Advantage plans include Part D coverage. Medicare Part D is discussed in greater detail in Chapter 4.

Medicaid. Medicaid is a state-administered health insurance program for individuals and families with low incomes and limited resources. Veterans who qualify for Medicaid are not required to pay copayments for VA Health Care. Prior to the Affordable Care Act (ACA), Medicaid coverage for adults was limited; however, the ACA expanded eligibility in participating states to adults with incomes up to 138 percent of the federal poverty level. This expansion includes a substantial share of uninsured Veterans who may be eligible for Medicaid coverage

or subsidies. In most states, individuals with disabilities who receive Supplemental Security Income automatically qualify for Medicaid.[12]

Private Insurance. Private health insurance may be obtained through a Veteran's employer, a spouse or family member, or other nonfederal sources, including health insurance marketplaces established under the Affordable Care Act.

3.1 Insurance Status

The availability of public or private insurance coverage is a key factor associated with enrollee use of VA Health Care services. In 2025, most enrollees (82 percent) reported having some form of public or private health insurance coverage. Medicare coverage was reported by 45 percent of enrollees, while seven percent reported Medicaid coverage. Private insurance coverage through a current or former employer was reported by 44 percent of enrollees, and 26 percent reported TRICARE coverage. Among enrollees with Medicare, 32 percent reported enrollment in Medicare Part D, 30 percent reported enrollment in Medicare Advantage, and 49 percent reported having Original Medicare. Figure 3-1 presents the distribution of enrollees by insurance coverage type.

Figure 3-1. Percentage of enrollees reporting each type of insurance coverage

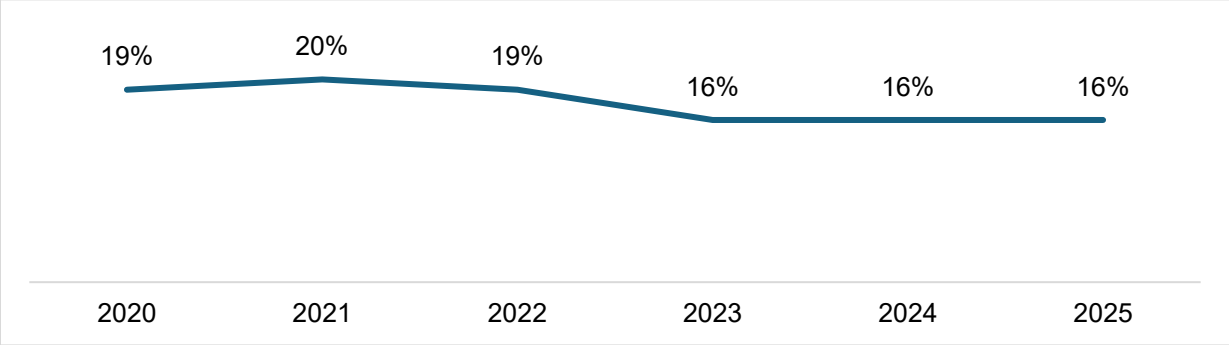
Type of Insurance	#	%
Medicare [a]	3,594,757	45%
Medicare Advantage [b]	1,091,525	30%
Medicare Part D [b]	1,153,186	32%
Medicaid [a]	538,660	7%
TRICARE [a]	2,049,627	26%
Private Insurance [a]	3,531,594	44%
No Coverage [a]	1,289,204	16%

a Denominator is all enrollees. Weighted N =7,985,922 enrollees.

b Denominator is enrollees with Medicare. Weighted N = 3,594,757 enrollees.

In this report, "no coverage" refers to the lack of any alternative insurance coverage, either public or private. Enrollees who did not report that they had Medicare, Medicaid, TRICARE, or private insurance coverage are considered to be uninsured.[13] In 2025, 16 percent of enrollees reported no public or private insurance coverage outside VA Health Care. This is the same as the percentage of enrollees who did not report insurance coverage in 2023 and 2024. (see Figure 3-2).

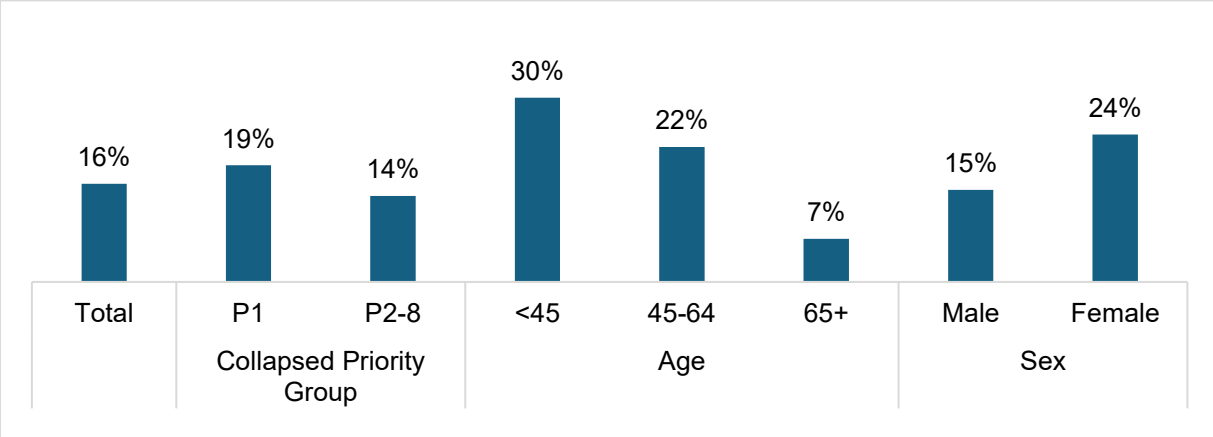
Figure 3-2. Percentage of enrollees with no insurance coverage 2020-2025, by year



Note: Denominator is all enrollees. Weighted N = 7,985,922 enrollees.

Insurance Coverage by Demographic and Socioeconomic Characteristics. As shown in Figure 3-3, enrollees in Priority Group 1 were more likely to be uninsured than those in Priority Groups 2–8 (19 percent versus 14 percent). Uninsured rates were also highest among younger enrollees. While seven percent of enrollees aged 65 or older and 22 percent of enrollees aged 45 to 64 lacked public or private insurance coverage, 30 percent of enrollees under age 45 were uninsured. In addition, a higher proportion of female enrollees were uninsured compared with male enrollees (24 percent versus 15 percent).

Figure 3-3. Percentage of enrollees with no insurance

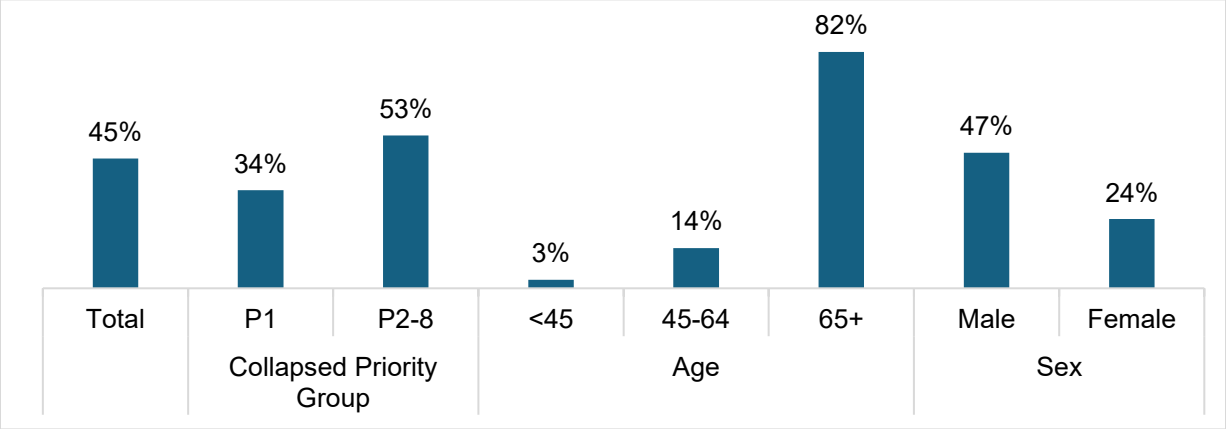


Note: Denominator is all enrollees. Weighted N = 7,985,922 enrollees. Differences between subgroups are statistically significant at the p<0.01 level (Chi squared test).

3.2 Medicare Coverage

The 2025 survey identified 45 percent of enrollees as having Medicare coverage (Figure 3-1). Figure 3-4 presents Medicare coverage rates by demographic characteristics and collapsed Priority Group. Enrollees with Medicare coverage were more likely to be assigned to Priority Groups 2–8. As expected, enrollees aged 65 or older were substantially more likely to have Medicare coverage than younger enrollees. In addition, Medicare coverage was more prevalent among male enrollees than female enrollees (47 percent versus 24 percent).

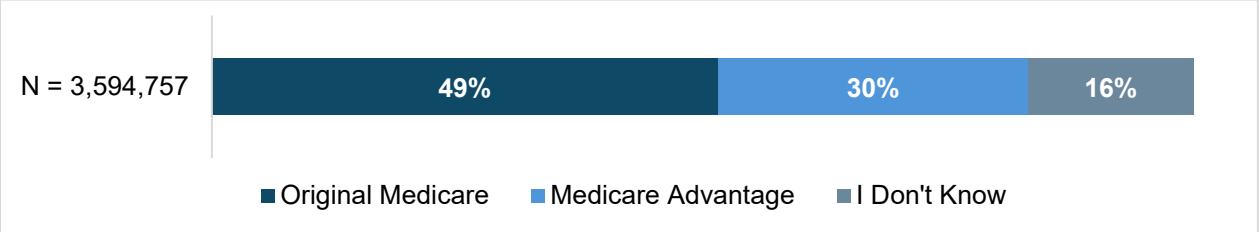
Figure 3-4. Percentage of enrollees with Medicare coverage



Note: Denominator is all enrollees. Weighted N = 7,985,922 enrollees. Differences between subgroups are statistically significant at the p<0.01 level (Chi squared test).

Forty-five percent of enrollees reported having Medicare coverage. Among these enrollees, 49 percent reported having Original Medicare, 30 percent reported having Medicare Advantage, and 16 percent reported that they did not know which Medicare plan they had. In addition, 32 percent of enrollees with Medicare reported having Medicare Part D coverage (see Figure 3-5).

Figure 3-5. Percentage of enrollees with Original Medicare or Medicare Advantage



3.2.1 Medicare Part D Coverage

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003, otherwise known as the Medicare Modernization Act (MMA), expanded the federal Medicare program by creating the prescription medication benefit called Part D. Prior to this law, Medicare did not offer a prescription drug benefit. Medicare Part D is a voluntary program available to anyone enrolled in Medicare Part A and/or Part B. Although most Medicare Advantage plans contain a prescription coverage plan, Part D is available to those whose plans do not cover prescriptions.

There are numerous Part D plans available, depending on the recipient's specific needs, income, and region. Since 2006, Medicare beneficiaries have been able to receive coverage for their prescription medications through Medicare Part D. As of October 2024, more than 53 million Medicare beneficiaries were enrolled in Medicare Part D.[14]

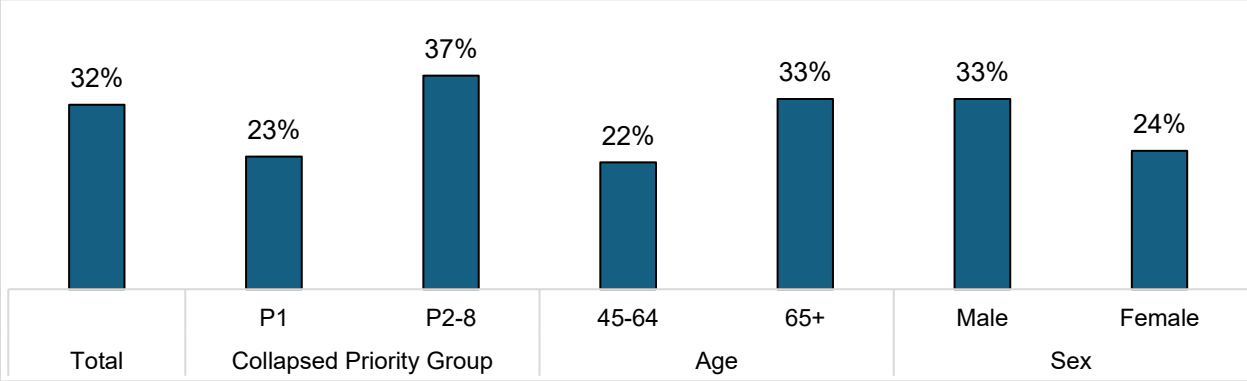
The VA prescription drug benefit is considered to be "creditable" coverage, which means that, on average, it provides benefits that meet or exceed those provided by Medicare Part D. Enrollees can have both VA prescription drug benefits and Medicare Part D coverage. However, VA prescription benefits and Medicare Part D do not work together. VA prescription drug benefits

cover medications obtained through VA providers, whereas Medicare Part D coverage generally does not cover medications obtained through VA providers. Although the VA pharmacy benefit is deemed equivalent to Medicare Part D, enrolled Veterans who meet low-income assistance thresholds under Medicare Part D may further reduce out-of-pocket expenses by using Medicare Part D than by using the VA pharmacy, thereby making Medicare Part D more attractive.[15]

Some Medicare Part D beneficiaries whose cost-sharing expenses exceed a certain threshold enter the coverage gap, colloquially called the "donut hole."[16] To get out of the coverage gap, beneficiaries had to pay a greater portion out of pocket until they reached the gap ceiling, after which they are covered under Part D again. The ACA endeavored to phase out the gap in coverage by requiring manufacturers to maintain a discount on the price of covered brand-name drugs in the coverage gap, reducing co-payments for brand-name and generic drugs in the gap, and gradually lowering co-payments to the level that applied before the gap. In 2020, Medicare considered the coverage gap in Part D benefits "closed," as the coinsurance rates had been lowered to 25 percent for both brand-name and generic drugs, meaning that based on the Centers for Medicare and Medicaid Services (CMS) Standard Model Medicare Part D plan, beneficiaries were paying the same cost-sharing in both the initial coverage phase and in the coverage gap.[17] Though the gap has closed, in 2024, Medicare Part D beneficiaries still pay out-of-pocket costs once they pass the initial benefit period threshold of $5,030 spent on prescription medications.[18] When total out-of-pocket costs reach $8,000, the beneficiary will reach the Catastrophic Benefit Period and pay minimal coinsurance or co-payment costs.[19] These changes to Medicare Part D passed in the Inflation Reduction Act to address the "donut hole" started in 2024.[20]

In 2025, enrollees who had Medicare coverage were asked if they had Medicare Part D. Thirty-two percent of enrollees with Medicare coverage reported that they had Medicare Part D coverage (Figure 3-6). Figure 3-6 also shows that enrollees in Priority Group 1 were less likely than enrollees in Priority Groups 2-8 to have Medicare Part D coverage. Additionally, more enrollees age 65 and older (33 percent) had Medicare Part D coverage than those age 45 to 64 (22 percent). A larger percentage of male enrollees (33 percent) had Medicare Part D coverage compared to female enrollees (24 percent).

Figure 3-6. Percentage of enrollees with Medicare coverage

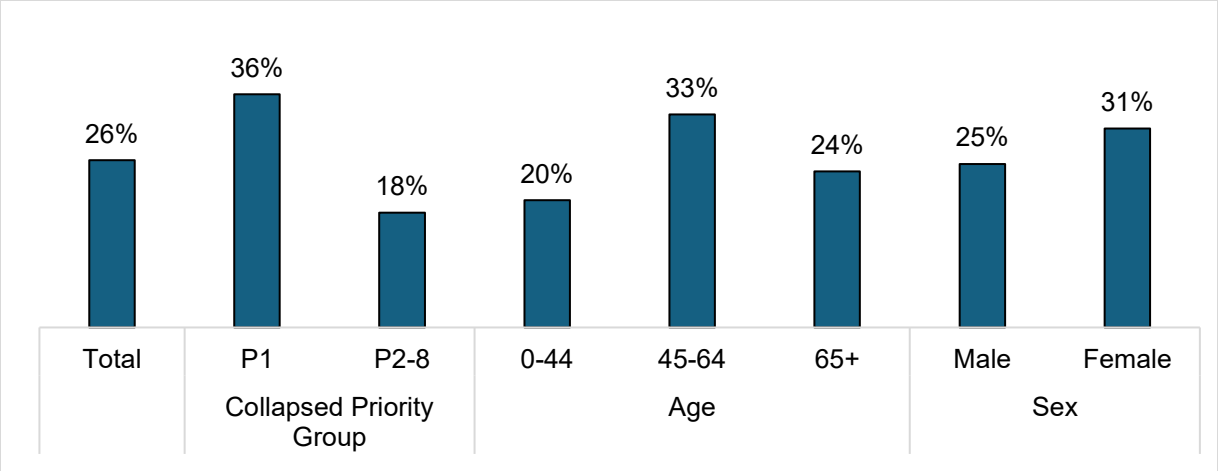


Note: Denominator is enrollees with Medicare. Weighted N = 4,015,443 enrollees. The percentage for <45 is not displayed as the frequency is too small (unweighted n<30) to provide a reliable estimate. Differences between subgroups are statistically significant at the p<0.01 level (Chi squared test).

3.3 Tricare Coverage

Twenty six percent of 2025 enrollees reported having TRICARE (including Tricare Prime, Tricare Select, and Tricare for Life) coverage. Figure 3-7 shows that TRICARE coverage was most common among enrollees in Priority Group 1. These enrollees generally have service-connected disabilities and were about 1.5 times as likely as other Priority Groups to have this coverage. Female enrollees were slightly more likely to have TRICARE than male enrollees (36 percent and. 28 percent, respectively). Those between the ages of 45 and 64 were more likely than younger and older enrollees to report having TRICARE coverage.

Figure 3-7. Percentage of Enrollees with TRICARE Coverage

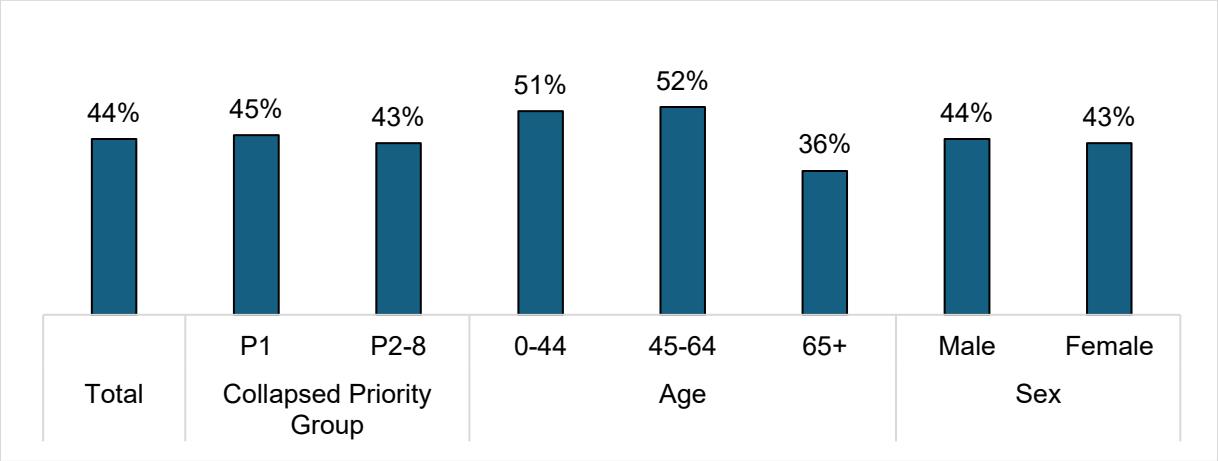


Note: Denominator is all enrollees. Weighted N = 7,985,922 enrollees. Differences between subgroups are statistically significant at the p<0.01 level (Chi squared test).

3.4 Private Individual or Group Health Plans

Forty-four percent of 2025 enrollees reported having private health insurance. Enrollees were asked whether they were covered by individual or group health plans through a current or former employer or union. Figure 3-8 show that enrollees between 45-64 years of age were more likely than their respective counterparts to have private insurance, followed closely by enrollees in the 0-44 age group (51 percent). Among Priority Groups, those in Priority Group 1 were more likely to be covered by private individual or group health plans (45 percent) compared with enrollees in Priority Groups 2-8 (43 percent). Forty-three percent of female enrollees had private, or group health insurance coverage as compared to 44 percent of male enrollees.

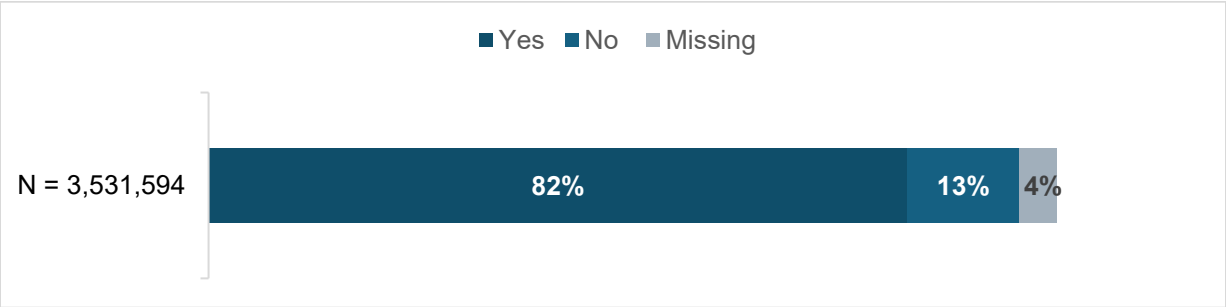
Figure 3-8. Percentage of enrollees with private or group health plans



Note: Denominator is all enrollees. Weighted N = 7,985,922 enrollees. Differences between subgroups are statistically significant at the p<0.01 level (Chi squared test).

For enrollees with coverage by an individual or group health plan, most (82 percent) had an individual plan that included prescription drug coverage as part of that plan, and 13 percent of enrollees had a private individual or group health plan that did not include prescription drug coverage (see Figure 3-9).

Figure 3-9. Prescription Drug Coverage



Chapter 4. Current Health Status and Assistance Needs

Self-reported health status is an important determinant of enrollees' use of VA Health Care services. The Centers for Disease Control and Prevention (CDC) has noted that emotional well-being is associated with health-, job-, and social benefits. Further, higher levels of emotional well-being have been associated with decreased risk of disease.[21] Previous research indicates that enrolled Veterans who use VA for all of their health care are more likely to be in poor health than enrolled Veterans who use VA for only some or none of their health care.[22,23] While Veterans recently separated from the military report health issues, they also often have relatively stronger social relationships.[24] The research also suggests that Veterans who use VA Health Care services for at least some of their care have a substantially elevated health burden compared to other Veterans.[25]

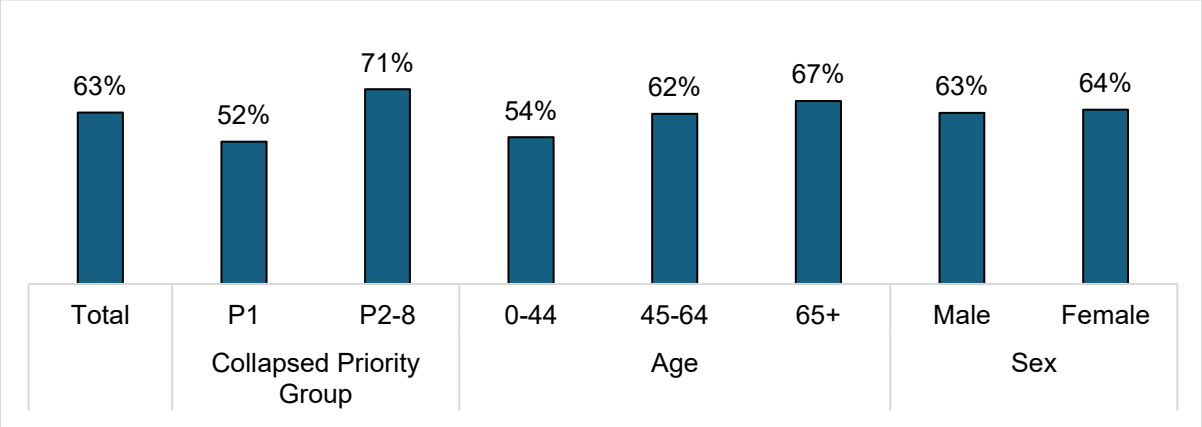
The 2025 Survey of Enrollees gathered information about enrollees' perceived health status and caregiver assistance needs. Enrollees provided information on their physical health, mental health, and emotional needs. Enrollees also provided an overview of the level of assistance they receive from caregivers and the support their caregivers receive.

4.1 Physical Health

Enrollees rated their physical health on a scale from "poor" to "excellent."

Overall, most enrollees (63 percent) reported they were in at least "good" physical health (good, very good, or excellent). The percentage of enrollees who reported at least "good" physical health differed by Priority Group. Fifty-two percent of enrollees in Priority Group 1 reported at least "good" physical health compared to 71 percent of enrollees in Priority Groups 2 to 8. Figure 4-1 displays the percentage of enrollees that reported "good," "very good," or "excellent" physical health overall by collapsed Priority Group, age, and sex.

Figure 4-1. Percentage of enrollees in at least good physical health, by collapsed Priority Group, age, and sex



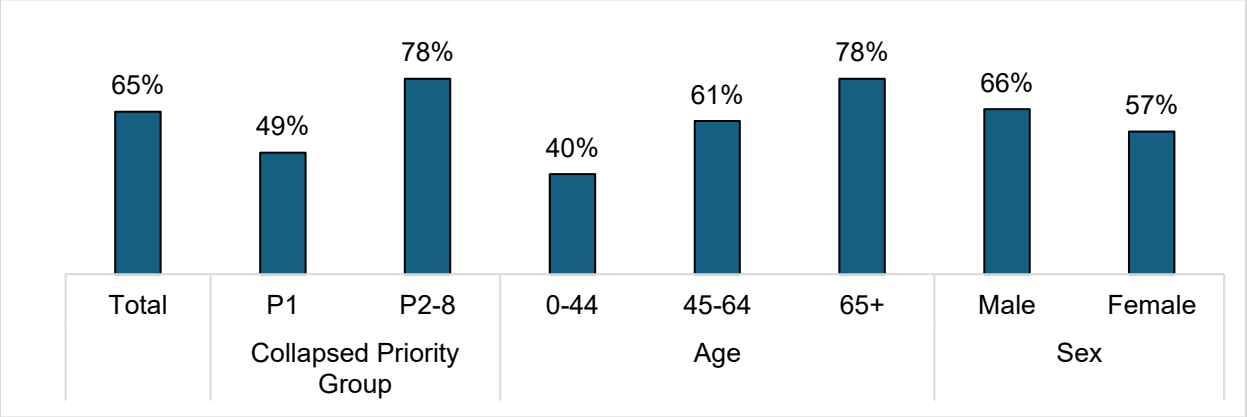
Note: Denominator is all enrollees. Weighted N= 7,985,922 enrollees. Differences between subgroups are statistically significant at the p<0.01 level (Chi squared test)

4.2 Mental Health

Enrollees rated multiple aspects of their mental health, including overall mental health, social and emotional support, satisfaction with life, involvement in important aspects in life, and functioning in life, on a scale from “poor” to “excellent. Figure 4-2 displays the percentage of enrollees that reported “good,” “very good,” or “excellent” mental health overall and by collapsed Priority Group, age, and sex.

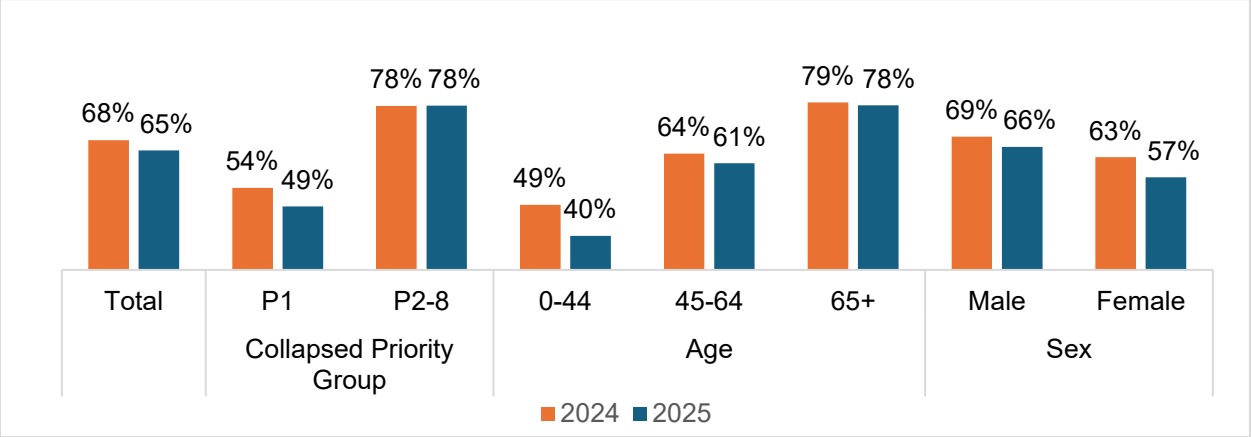
Most enrollees (65 percent) had at least “good” mental health. Younger enrollees and enrollees in Priority Group 1 reported the lowest levels of at least “good” mental health. Forty percent of enrollees under 45 reported at least “good” mental health, while 61 percent of enrollees aged 45 to 64 and 78 percent of those 65 and older reported the same. Additionally, 49 percent of enrollees in Priority Group 1 reported at least “good” mental health. Male enrollees (Figure 4-3) also reported having at least “good” mental health (66 percent) at a higher rate compared to female enrollees (57 percent).

Figure 4-2. Percentage of enrollees in at least good mental health, by collapsed Priority Group, Age, and Sex



Note: Denominator is all enrollees. Weighted N= 7,985,922 enrollees. Differences between subgroups are statistically significant at the p<0.01 level (Chi squared test)

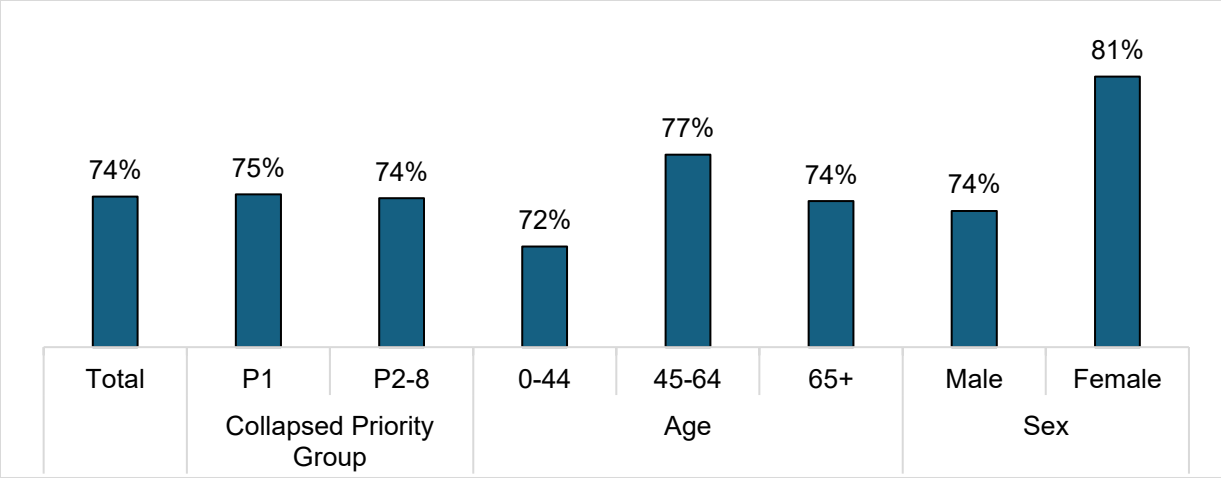
Figure 4-3. Percentage Comparison of 2024 and 2025 results for enrollees in at least good health, by collapsed Priority Group, age, sex



Note: Denominator is all enrollees. Weighted N= 7,985,922 enrollees. Differences between subgroups are statistically significant at the p<0.01 level (Chi squared test)

Enrollees provided the frequency that their social and emotional support needs are met on a scale from “never” to “always.” Figure 4-4 displays the percentage of enrollees that “sometimes,” “usually,” or “always” receive the social and emotional support they need overall and by collapsed Priority Group, age, and sex. Most enrollees reported they at least sometimes receive the social and emotional support they need (74 percent). Differences in social and emotional support were exceptionally large for women in comparison to men, as 81 percent of female at least sometimes received the social and emotional support they needed compared to 74 percent of male enrollees.

Figure 4-4. Percentage of enrollees that at least sometimes receive needed social and emotional support, by collapsed Priority Group, age, and sex



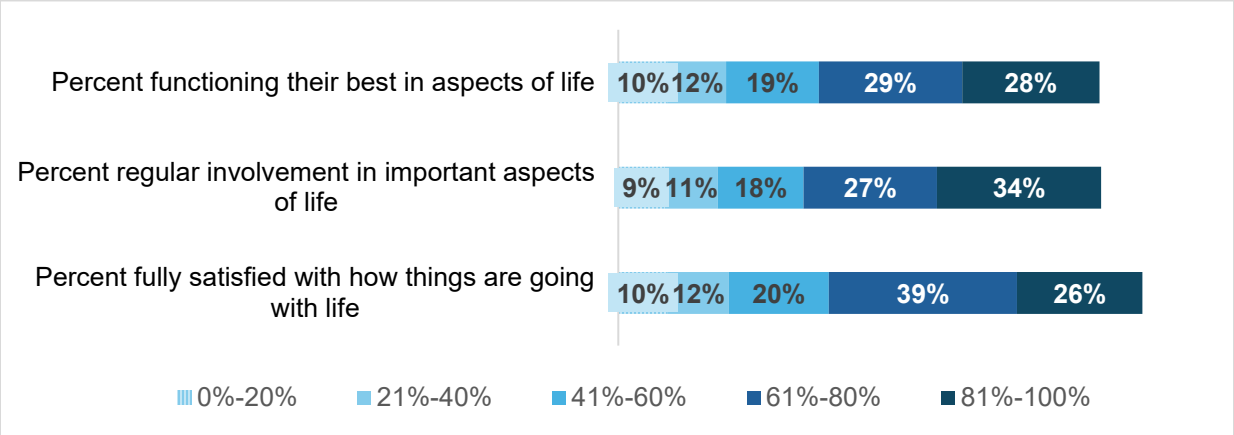
Note: Denominator is all enrollees. Weighted N= 7,985,922 enrollees. Differences between Priority Groups, under 45 and 66 and older, and sex are statistically significant at the p<0.01 level (Chi squared test).

Enrollees were asked to consider the most important things that they do or wish to do in their lives and then were asked a series of three questions, keeping the things that are important to them in mind. In these questions, they were asked to rate their satisfaction with how things are

going, regular involvement in these aspects of life, and how they are functioning in these aspects of life on a scale from zero to 100. This question had been developed and validated by VHA Office of Patient Centered Care and Cultural Transformation and was adopted for the Survey of Enrollees.

Figure 4-5 displays enrollee responses to these questions. Seventy-seven percent of enrollees were satisfied with how things were going in life at least 41 percent of the time. Similarly, most enrollees (80 percent) had regular involvement in aspects of their life that are important to them at least 41 percent of the time. Further, 77 percent of enrollees reported that, at least 41 percent of the time, they function best in aspects of their life in which they participate.

Figure 4-5. Percentage of enrollees by level of satisfaction, involvement, and best functioning in important aspects of life (on percentage scale) in the last three months

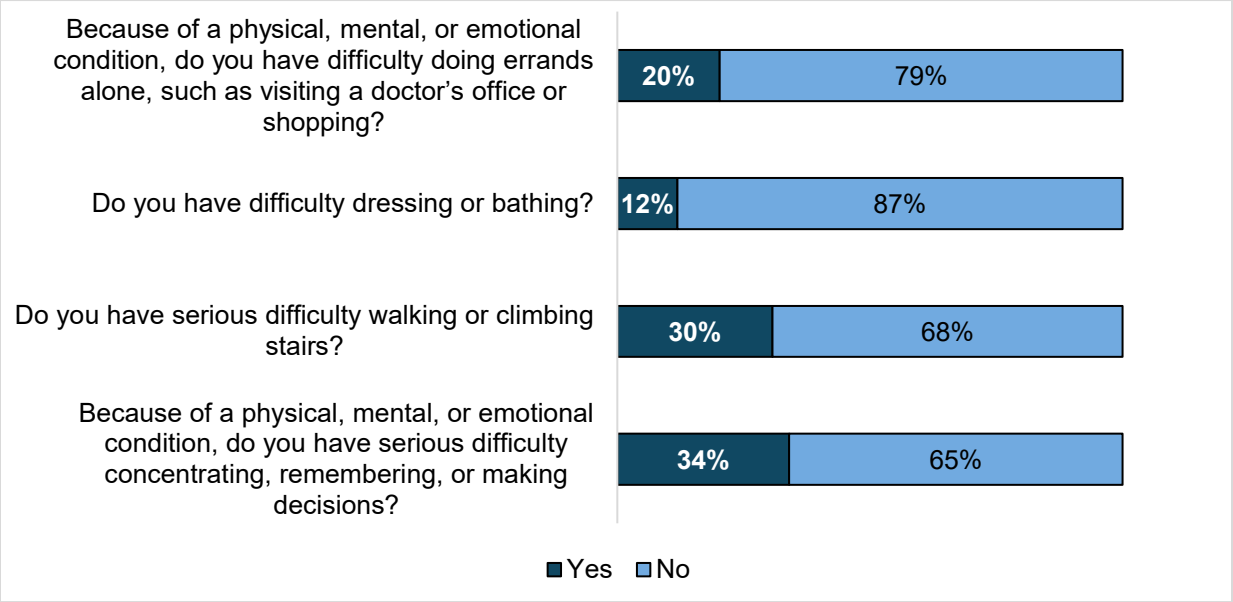


Note: Denominator is all enrollees. Weighted N= 7,985,922 enrollees

4.3 Assistance in Daily Activities

VHA has a Caregiver Support Program that offers support services, including financial services, to caregivers of eligible Veterans enrolled in VA Health Care. To assess the need for caregiver assistance in the overall enrollee populations, as well as determine the extent to which VHA's caregiver assistance programs are used, a series of questions about how enrollees receive help with daily activities were developed. Enrollees described if they encountered difficulty with basic daily activities and the level of assistance they receive for daily activities such as household chores, bathing, preparing meals, or transportation from family, friends, neighbors, or others. They also provided context regarding who supports them. The figure below displays the percentage of enrollees who encounter difficulties in 4 daily activities.

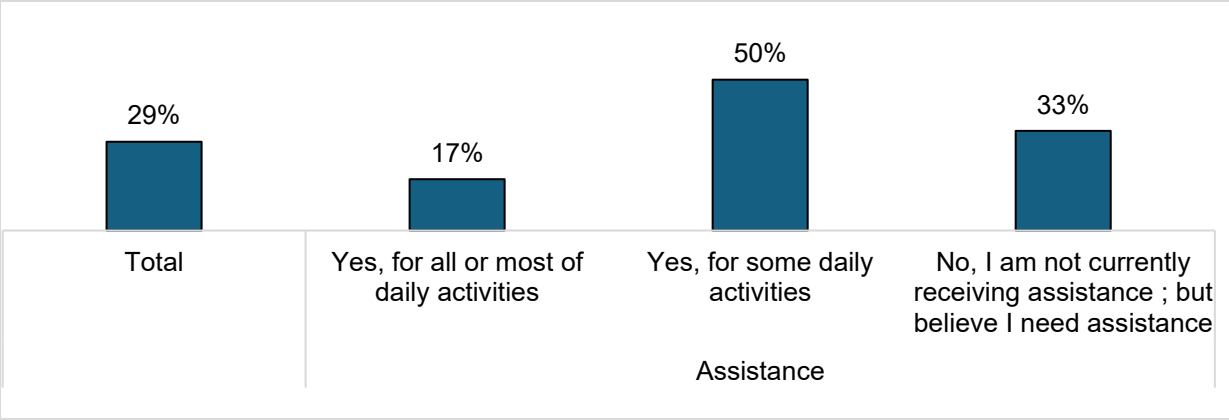
Figure 4-6. Percentage of enrollees by receipt of assistance for daily activities



Note: Denominator is all enrollees. Weighted N= 7,985,922 enrollees

Overall, twenty-nine percent of enrollees either receive assistance with daily activities, or do not receive any assistance but believe they need assistance. Of those that receive, or believe they need assistance, seventeen percent receive assistance for all or most daily activities, fifty percent receive assistance for some daily activities, and thirty-three percent (see Figure 4-7) receive no assistance and believe they need it.

Figure 4-7. Percentage of enrollees who receive assistance or believe they need assistance by assistance received level

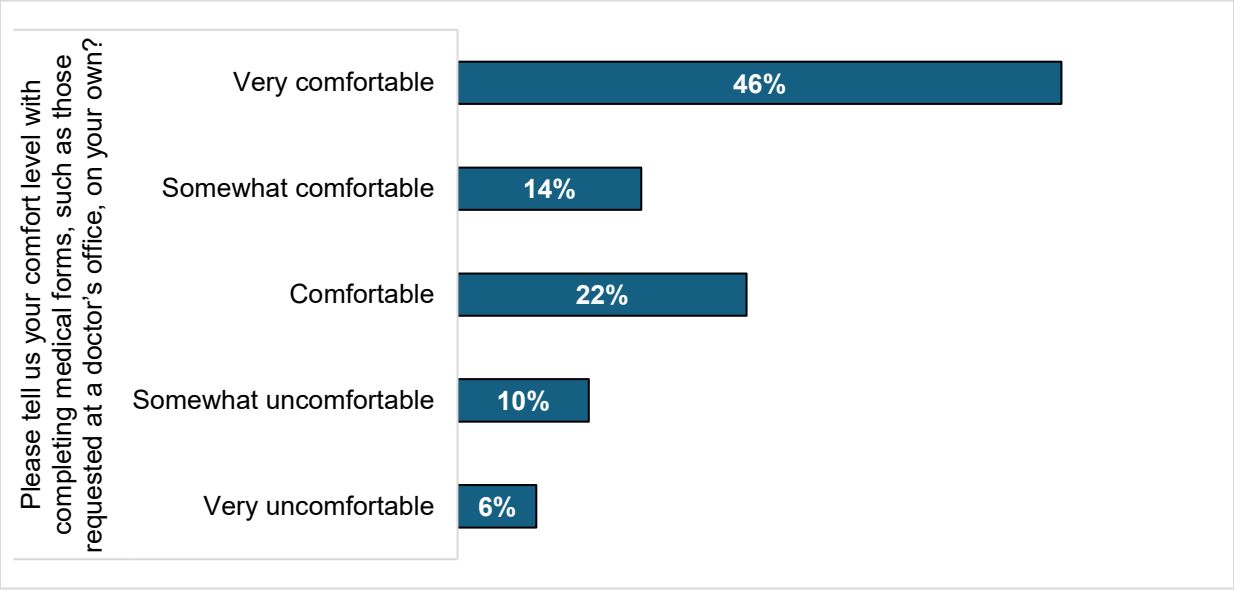


Note: Denominator is all enrollees who receive assistance. Weighted N= 7,985,922 enrollees

Enrollees were also asked about their comfort level completing medical forms, such as those requested at a doctor's office, on their own. Eighty-two percent of enrollees reported being at least somewhat comfortable completing these forms on their own, while sixteen percent

reported being at least somewhat uncomfortable completing these forms alone. Figure 4-8 displays the breakdown of comfort levels filling out medical forms alone among enrollees.

Figure 4-8. Percentage of enrollees comfort level filling out medical forms

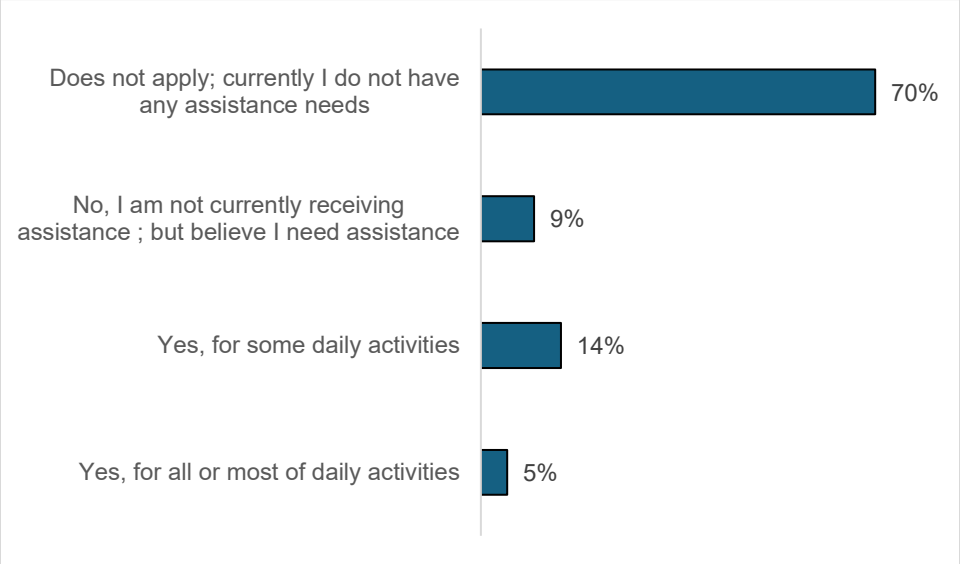


Note: Denominator is all enrollees. Weighted N= 7,985,922 enrollees

4.4 Support for Caregivers

Enrollees provided information on the levels of support their caregivers receive, including utilization of VA Caregiver Support Program's Program of Comprehensive Assistance for Family Caregivers (PCAFC) or Program of General Caregiver Support Services (PGCSS), awareness of VA education resources and VA sponsored programs, and enrollment in caregiver support programs. Enrollees reported that most of their caregivers (73 percent) do not receive support services from any program, and 17 percent of enrollees do not know if their caregivers receive any support services (Figure 4-9) of the level of assistance they receive from caregivers and the support their caregivers receive.

Figure 4-9. Among enrollees receiving assistance, percentage of enrollees that have primary caregivers who receive support services from any caregiver support program



Note: Denominator is enrollees that receive assistance for daily activities. Weighted N= 7,985,922 enrollees

Chapter 5. Smoking and Tobacco Use

The Survey of Enrollees serves as an important source of data on the prevalence of smoking among the enrolled population. Smoking is a significant health problem for Veterans and remains an important measure in assessing the health of enrolled Veterans. The CDC states that people who smoke are more likely than people who do not smoke to develop heart disease, stroke, and lung cancer, and estimates that cigarette smoking causes nearly one in five deaths each year in the United States. The CDC also states that smoking continues to be the leading cause of preventable death and disease in the U.S.[26] Although most young people who smoke start smoking prior to age 18, many in the military begin during their period of service.[27]

5.1 Cigarette Smoking Status Overview

As in past enrollee surveys, the survey team modeled the 2025 survey questions about cigarette smoking after the Behavioral Risk Factor Surveillance System (BRFSS), a national health survey conducted by the CDC. The survey asked enrollees whether they smoked at least 100 cigarettes in their lifetime. Enrollees who indicated that they had *not* smoked 100 cigarettes in their lifetime were not asked any further questions about smoking. Enrollees who indicated that they had smoked at least 100 cigarettes were asked six additional questions about their smoking history. Specifically, the survey asked whether they currently smoked every day, some days, or not at all. Those who indicated that they smoked at least some days were considered to be enrollees who currently smoke. The survey asked enrollees who currently smoke about any attempts to quit in the past 12 months.[28] Enrollees who currently smoke was asked about the length of time since they last smoked regularly. All enrollees, regardless of their cigarette smoking status, were also asked whether they currently used chewing tobacco, snuff, or snus, and whether they currently used e-cigarettes (also known as vapes or electronic nicotine delivery systems).

Based on their responses to the series of questions, enrollees were classified into six groups: (1) enrollees who have never smoked, (2) enrollees who have smoked, (3) enrollees who currently smoke, (4) recent unsuccessful quitters, (5) enrollees who formerly smoked, and (6) recent successful quitters. These are defined as:

Have you smoked at least 100 cigarettes in your entire life?

1. Enrollees who answered “No” were “enrollees who have never smoked.”
2. Enrollees who answered “Yes” were “enrollees who have smoked.”

Of “enrollees who have smoked”: Do you now smoke cigarettes every day, some days, or not at all?

3. Enrollees who answered, “every day” or “some days” were **“enrollees who currently smoke.”**
4. Enrollees who answered, “not at all” were **“enrollees who formerly smoked.”**

Of “enrollees who currently smoke”: During the past 12 months, have you stopped smoking for more than one day because you were trying to quit smoking?

5. Enrollees who answered “Yes” were **“recent unsuccessful quitters.”**

Of “enrollees who formerly smoked”: How long has it been since you last smoked cigarettes regularly?

6. Enrollees who answered, “Less than a year ago” were **“recent successful quitters.”**

In 2025, a total of 53 percent of enrollees were classified as enrollees who have smoked. Using all enrollees as the denominator, enrollees who currently smoke made up 10 percent of the total enrollee population, which is lower than the 2024 number (11 percent). Closely matching last year’s numbers, 41 percent of enrollees were considered enrollees who formerly smoked. In the past year, 2 percent of the enrollee population successfully quit smoking, which is similar to 2025 (1.7 percent). Figure 5-1 (next page) depicts the smoker status classification of enrollees in the six groups, along with percentages of each group.

Figure 5-1. Smoker Status Classification

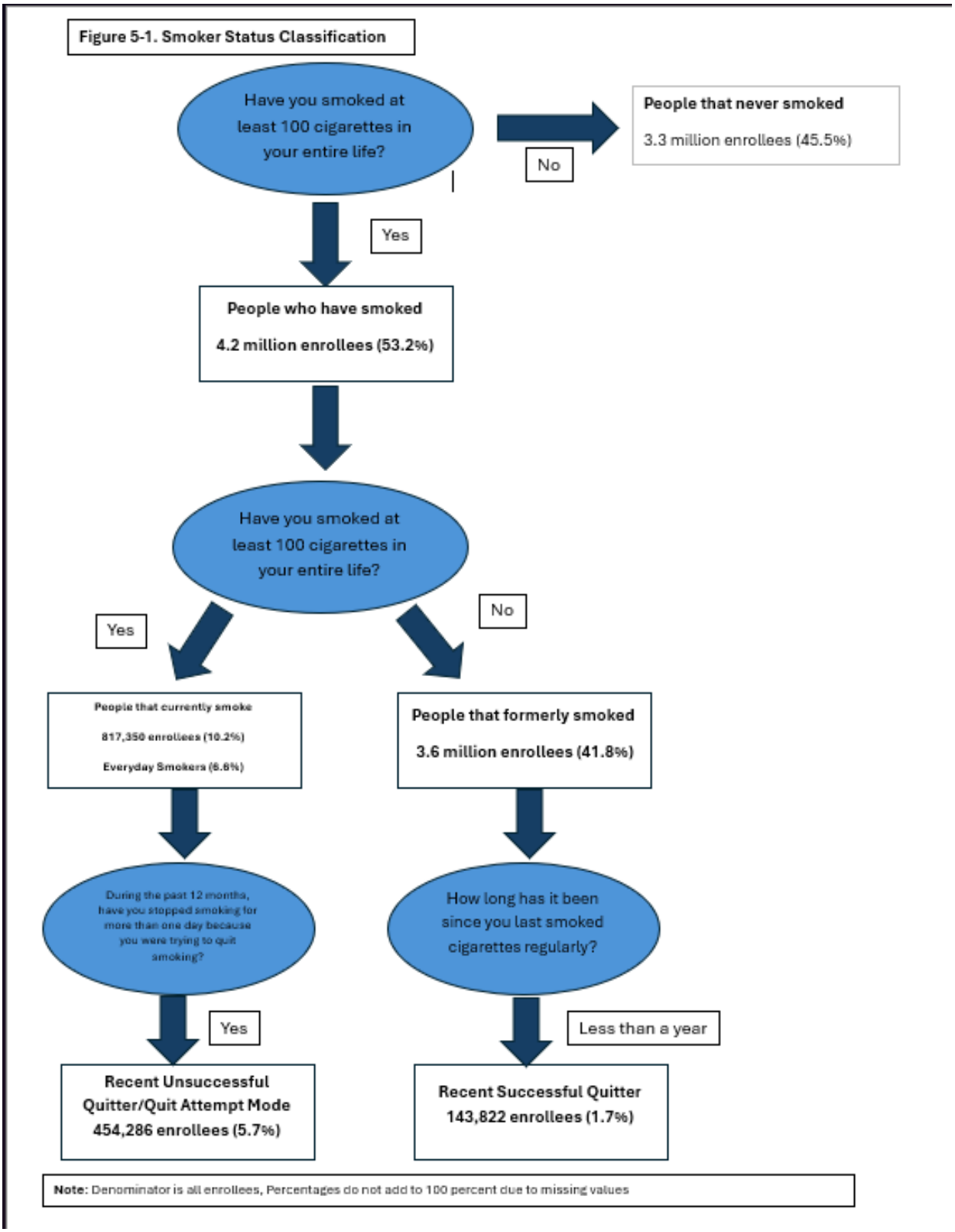


Figure 5-2 shows smoking status over the past five survey cycles. The proportion of enrollees that have never smoked has slowly increased from 43 percent (2020) to 45 percent (2024). In the past year, two percent of the enrollee population successfully quit smoking which is similar to the proportion of enrollees that successfully quit from 2020 to 2023.

Figure 5-2 also shows the decline in enrollees who currently smoke from 13 percent in 2020 to 11 percent in 2024. This follows a similar decreasing trend among enrollees who currently smoke in the general U.S. adult population, which dropped from 21 percent in 200531 to about 12 percent in 2022.

Figure 5-2. Enrollee smoking status, by year

Smoking Status	2020	2021	2022	2023	2024	2025
Enrollees who have never smoked	3,711,467	3,812,622	3,634,702	3,679,682	3,636,272	3,632,058
% Enrollee population	42.5%	43.9%	43.4%	44.7%	45.4%	45.5%
Enrollees who have smoked	4,941,589	4,816,256	4,662,363	4,524,861	4,337,270	4,248,426
% Enrollee population	56.6%	55.5%	55.7%	55.0%	54.2%	53.2%
Enrollees who currently smoke*	1,161,301	1,116,112	1,067,431	939,875	876,980	817,350
% Enrollee population	13.3%	12.9%	12.7%	11.4%	11.0%	10.2%
Recent unsuccessful quitters	629,755	550,451	557,788	449,668	430,194	454,286
% Enrollee population	7.2%	6.3%	6.7%	5.5%	5.4%	5.7%
Enrollees who formerly smoked	3,711,495	3,637,363	3,512,796	3,501,583	3,368,762	3,339,797
% Enrollee population	42.5%	41.9%	41.9%	42.6%	42.1%	41.8%
Recent successful quitters	164,221	154,980	145,516	126,398	127,993	143,822
Enrollee population	8,725,547	8,680,525	8,376,015	8,228,035	8,003,238	7,985,922

"Enrollees who currently smoke" include enrollees who also reported that they are currently smoking every day or some days.

Note: Those missing information on smoking status are included in the enrollee population for percentage calculations. Recent successful quitters datapoint not asked in 2025 survey.

5.2 Cigarette Smoking by Select Characteristics

There were notable differences in smoking rates across different Priority Groups, age groups, and sex (see Figure 5-3, page 41). Enrollees in Priority Group 1 were less likely to be current or former smokers (49 percent) compared to enrollees in Priority Group 2-8 (55 percent).

Younger enrollees reported being current or former smokers at a lower rate compared to older enrollees. Enrollees under 45 and in the 45-64 age group were equally likely to be current or former smokers (44 percent), compared to sixty percent in the 65+ age group. Enrollees aged less than 45 and enrollees aged 45 to 64 were most likely to be current smokers (12 percent) 65 and older (8 percent). While only eight percent of enrollees 65 and older were current smokers, 52 percent of these enrollees were former smokers, which was the largest proportion of any age group. A lower percentage of female enrollees (38 percent) indicated that they were current or

former smokers compared to male enrollees (53 percent). However, both groups had similar rates of enrollees who currently smoke as a percentage of their respective groups (10 percent).

When comparing current smoker status among VA enrollees by additional characteristics, notable differences emerged. Across all racial and ethnic groups, Middle Eastern non-Hispanic and Multiracial non-Hispanic enrollees had higher current smoking rates than White non-Hispanic and Hispanic enrollees. In terms of health status, enrollees who reported being in “fair” or “poor” physical health (14 percent) or mental health (13 percent) were more likely to be enrollees who currently smoke than those who reported being in “good”/ “very good”/ “excellent” physical health (8 percent) or mental health (9 percent). Enrollees that reported being in “good”/ “very good”/ “excellent” mental health were also more likely to be former smokers (43 percent) compared to those that reported being in “fair” or “poor” mental health (40 percent) The proportion of enrollees who currently smoke was much higher among uninsured (16 percent than those who had health insurance (9 percent). Additionally, a larger proportion of enrollees with health insurance (43 percent) were former smokers compared to enrollees that did not have health insurance (34 percent). Further enrollees that earned over $35,000 smoked at a lower rate (8 percent) compared to enrollees that earned under $35,000 (18 percent).

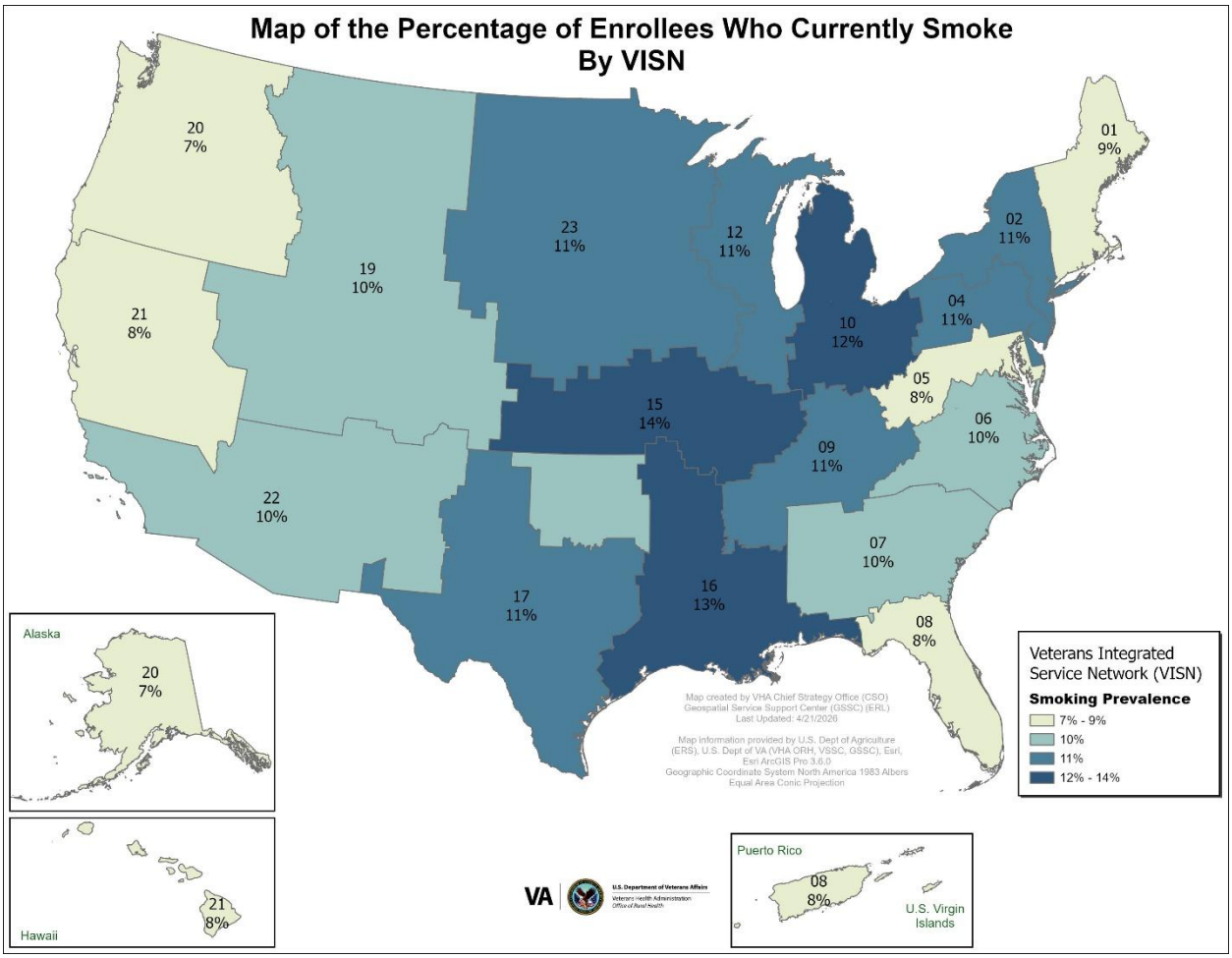
Figure 5-3. Current smoking status, by select characteristics

	Current		Former		Total Enrollees
	#	%	#	%	#
Collapsed Priority Group					
Priority Group 1	328,148	9%	1,396,471	40%	3,535,021
Priority Group 2-8	489,203	11%	1,943,326	44%	4,450,901
Age					
<45	196,820	12%	536,632	32%	1,667,798
45-64	300,829	12%	777,439	32%	2,432,488
65+	319,702	8%	2,025,726	52%	3,885,635
Sex					
Male	729,831	10%	3,098,139	43%	7,132,360
Female	87,519	10%	241,659	28%	853,562
Race and ethnicity (mutually exclusive)					
White, non-Hispanic	542,248	10%	2,548,121	46%	5,542,519
Black, not-Hispanic	117,992	12%	258,228	27%	947,430
American Indian / Alaskan Native, non-Hispanic	6,967	13%	20,904	40%	51,651
Native Hawaiian, non-Hispanic	3,930	12%	13,124	39%	33,631
Hispanic	77,274	10%	268,370	36%	739,297
Multiracial, non-Hispanic	35,780	14%	107,610	42%	256,517
Middle Eastern, non-Hispanic	719	21%	745	22%	3,422
Asian, Non-Hispanic	11,962	8%	39,532	28%	140,925
Missing	20,477	8%	83,164	31%	270,530
Insurance status					
Insured	591,593	9%	2,852,295	43%	6,561,724
Not insured	206,247	16%	441,294	34%	1,289,204
Physical Health Status					
Good/Very Good/Excellent	407,892	8%	2,088,288	42%	5,009,941
Fair/Poor	406,584	14%	1,232,789	42%	2,938,785
Mental Health Status					
Good/Very Good/Excellent	454,654	9%	2,231,870	43%	5,191,082
Fair/Poor	358,617	13%	1,089,509	40%	2,756,052
Income					
<$35,000	315,738	18%	765,012	43%	1,781,140
$35,000+	480,475	8%	2,503,921	42%	5,975,788

Note: Denominator is all enrollees in the group, including those missing information on smoking. "NA" denotes cells that do not have enough respondents (unweighted n<30) to provide a reliable estimate. Respondents who selected more than one race were categorized as multiracial. Missing values for race and ethnicity represent those enrollees who did not answer whether they were of Hispanic origin or did not answer the race question. Differences between collapsed Priority Groups, age, sex, insurance status, mental health, physical health, and income are statistically significant at the p<0.01 level (Chi squared test) for former and current smokers. Differences for Hispanic, White, Black, and Asian enrollees are also statistically significant at the p<0.01 level (Chi squared test) for former and current smokers. Health status was based on self-reported survey data.

Figure 5-4 shows the percentage of enrollees who currently smoke by Veterans Integrated Services Network (VISN). The percentages of enrollees who currently smoke range from seven percent (VISN 20) to 14 percent (VISN 15) of the enrollee population. In half of the 18 VISNs, the rate of enrollees who currently smoke is lower than the overall national average of adult enrollees who currently smoke (11 percent).

Figure 5-4. Percentage of Veterans who Currently Smole per VISN



5.3 Use of Smokeless Tobacco and E-Cigarettes

While smoking rates have been on the decline among the general adult population, the overall usage rates of smokeless tobacco products (e.g., chewing tobacco, snuff, snus) have been steady and e-cigarettes have increased.[29] E-cigarettes are a group of electronic tobacco products that may also be known as e-cigs, vapes, e-hookahs, vape pens, and electronic nicotine delivery systems (ENDS). Among younger demographic groups, such as middle- and high-school students, e-cigarettes are the most common tobacco product used.[30,31] Less is known about the use of e-cigarettes among Veterans, but recent studies have suggested that

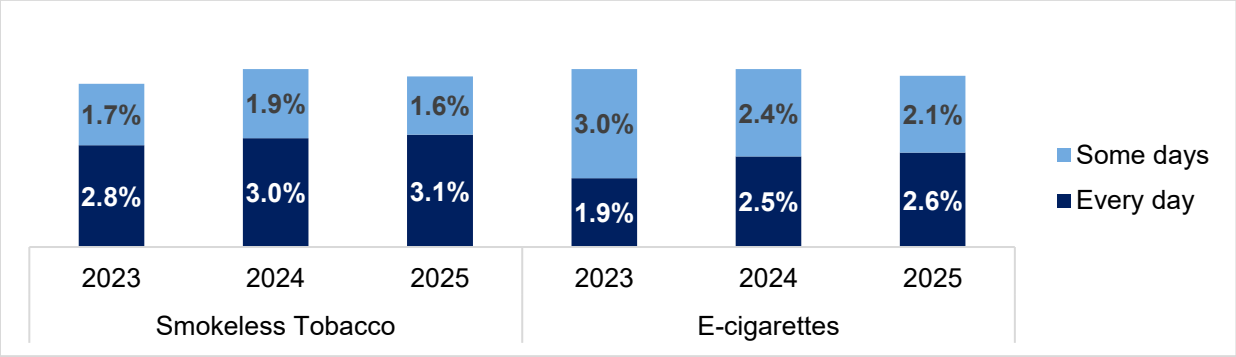
use of e-cigarettes or vaping products has already passed cigarette smoking in popularity among young adults in the Air Force.[32]

Even though smokeless tobacco and e-cigarettes are often perceived as less harmful alternatives to smoking, both still contain nicotine and cause nicotine dependence and pose several serious health risks to the user. According to the FDA, smokeless tobacco products contain a mix of 4,000 chemicals, including as many as 30 that are linked to cancer.[33] Smokeless tobacco products are also linked to increased risk of developing oral, esophageal, and pancreatic cancers, and can cause stained teeth and damaged gum tissue.[34] E-cigarettes may also contain aerosols that can introduce cancer-causing chemicals, volatile compounds, and heavy metals into the lungs. Chemicals used to flavor the vapor, such as diacetyl, have also been linked to serious lung diseases. Lastly, many young people use both e-cigarettes and traditional cigarettes, and there is some evidence that using e-cigarettes increases the likelihood of smoking cigarettes in the future.[35]

To measure the prevalence of smokeless tobacco use and e-cigarette and/or other vaping product use among enrollees, two questions were asked of enrollees: whether they currently use smokeless tobacco products such as chewing tobacco, snuff, or snus, and whether they use e-cigarettes or other vaping products (“Every day,” “Some days,” or “Not at all”).

Between 2023 and 2025, smokeless tobacco use increased slightly from 2.8 to 3.1 percent. Over the same period, the prevalence of e-cigarette or other vaping product use increased slightly among everyday users (from 1.9 to 2.6 percent). Overall prevalence of e-cigarette use (those that used every day or somedays) decreased from 4.9 to 4.7 percent (see Figure 5-5).

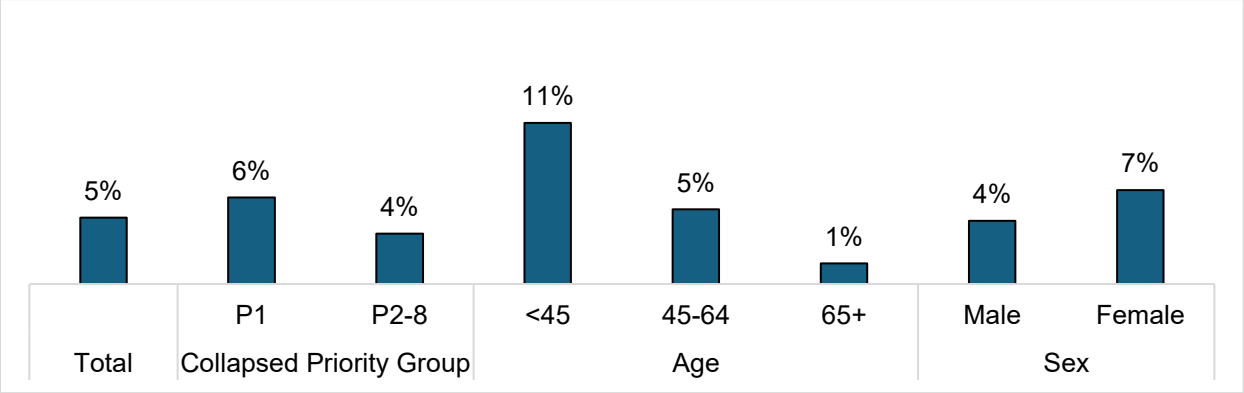
Figure 5-5 Among enrollees, prevalence of smokeless tobacco and e-cigarette use



Note: Denominator is all enrollees. Weighted N = 7,985,922 enrollees.

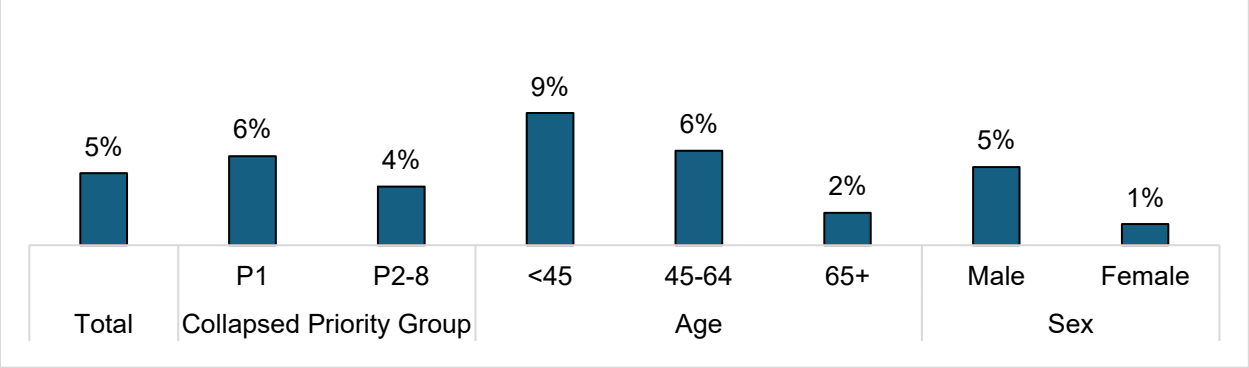
Figure 5-6 shows that the use of e-cigarettes varies across age and sex, while Figure 5-7 shows the use of smokeless tobacco products varies by collapsed Priority Group and age. Enrollees under the age of 45 were more likely to use smokeless tobacco (9 percent) or e-cigarettes (11 percent) compared to other enrollees. The use of smokeless tobacco products and e-cigarettes or other vaping products were lowest among enrollees aged 65 and older (one percent and two percent, respectively). Additionally, male enrollees were more likely than female enrollees to use smokeless tobacco products (five percent compared to one percent. Enrollees in Priority Group 1 had a higher rate of e-cigarettes or vaping products (six percent) compared to those in Priority Groups 2-8 (four percent).

Figure 5-6 Among enrollees, use of smokeless tobacco products by Priority Group, age, and sex



Note: Denominator is all enrollees, weighted N=7,985,922. Differences between subgroups are statistically significant at the p<0.01 (Chi squared test)

Figure 5-7 Among enrollees, use of e-cigarettes by Priority Group, age, and sex



Note: Denominator is all enrollees, weighted N= 7,985,922. Differences between subgroups are statistically significant at the p<0.01 (Chi squared test)

Chapter 6. Healthcare Use

Veterans face elevated risks for both mental and physical health conditions, underscoring their vulnerability as a patient population. In Fiscal Year 2024, the Veterans Health Administration (VHA) demonstrated notable gains in care quality and system performance: 58 percent of VA hospitals achieved 4- or 5-star ratings in the CMS Overall Hospital Quality Star Ratings, compared with 40 percent of non-VA hospitals, indicating a structural quality advantage within the VA system. Other operational indicators also reflected progress, including stronger Veteran preference for VA-delivered care and lower-than-expected growth in community care use. [36]

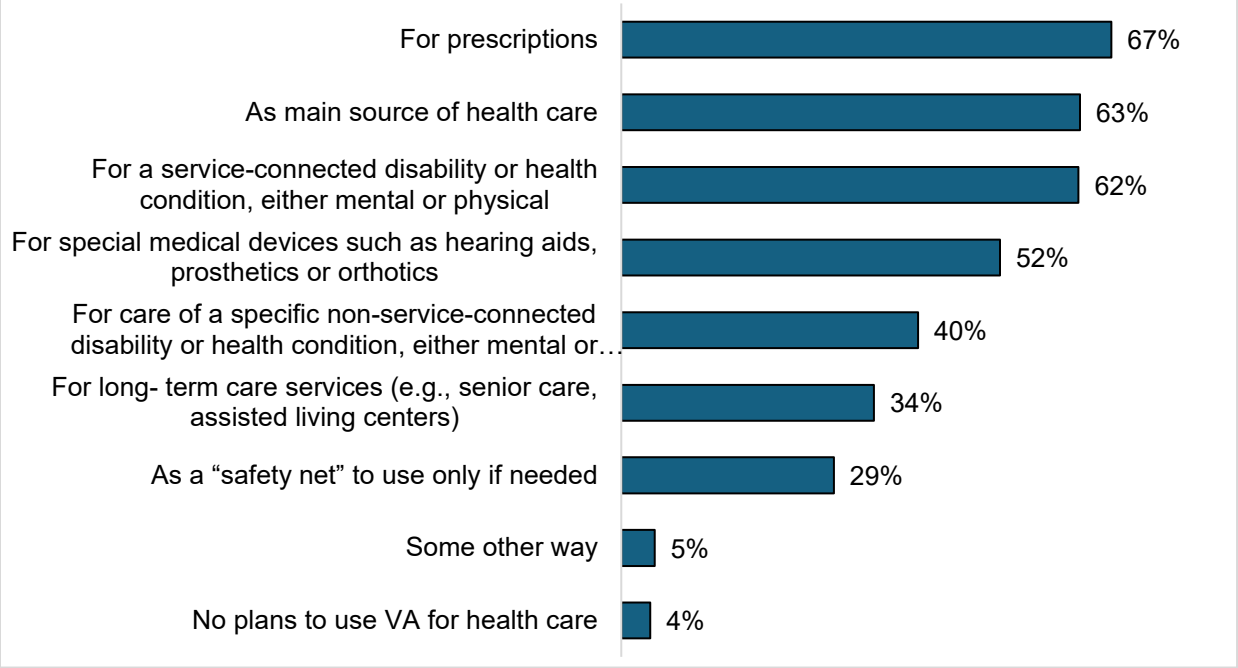
Independent research consistently shows that VA care performs as well[37,38] as or better than other U.S. health systems across safety, effectiveness, mortality, morbidity, and overall quality, supported by VHA's ongoing efforts to improve care coordination. A 2019[39] study further demonstrated that Veterans who use VA health care tend to have greater socioeconomic and clinical vulnerability—being more likely to be Black, younger, female, unmarried, less educated, and lower income—and to exhibit higher rates of combat exposure, trauma, psychopathology, suicidality, chronic medical conditions, disability, and functional impairment.

6.1 Current Use of VA

According to the Fiscal Year (FY) 2022-2028 Strategic Plan, VA projects that the Veteran population will change dramatically by sex, race/ethnicity, and age in the coming decades. To understand the needs of a changing enrollee population, it is crucial to examine enrollees' reasons for current and future use of VA Health Care. The 2025 Survey of Enrollees asked enrollees to identify ways they plan to use VA services to meet their health care needs.

Figure 6-1 (next page) shows that sixty-three percent of enrollees plan to use VA services as a main source of health care. Additionally, 67 percent of enrollees plan to use VA services for prescriptions and sixty-two percent plan to use VA for a physical or mental service-connected disability or health condition. Five percent of enrollees plan to use VA services in some other way and four percent have no plans to use VA health care in the future.

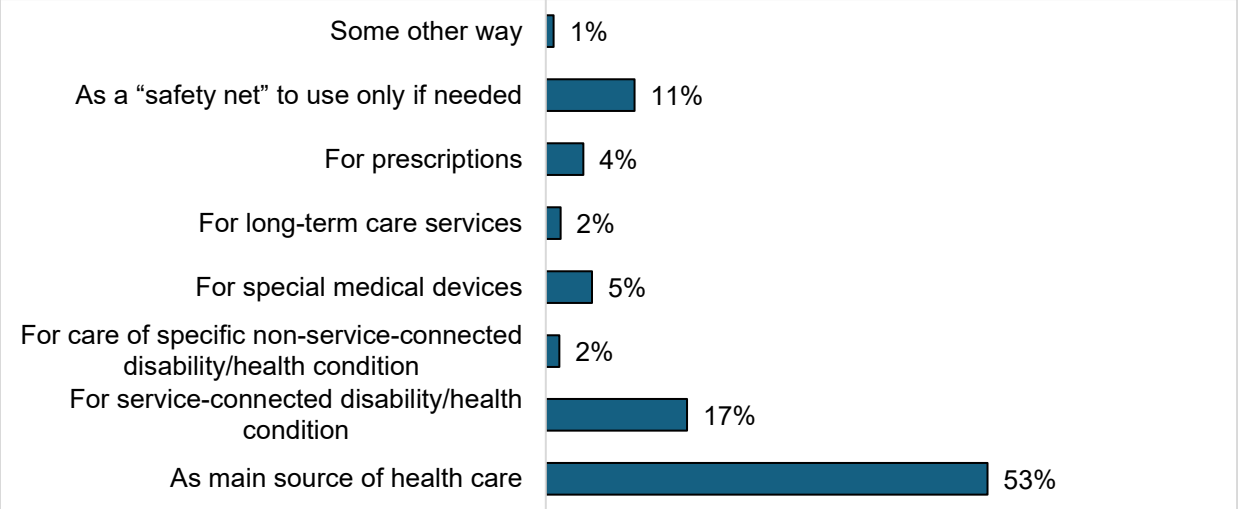
Figure 6-1 Enrollees Planned Future Engagement with VA Health Care Services



Note: Denominator is all enrollees, N = 7,985,922. Missing responses are not shown.

Enrollees who indicated having plans to use VA in the future were then asked to select the option that best describes the primary way the plan to use VA health care in the future. Over half of enrollees that plan to use VA in the future indicated primarily using it as a main source of healthcare (53 percent), followed by seventeen percent of enrollees using VA services primarily for a service-connected disability or health condition (See Figure 6-2).

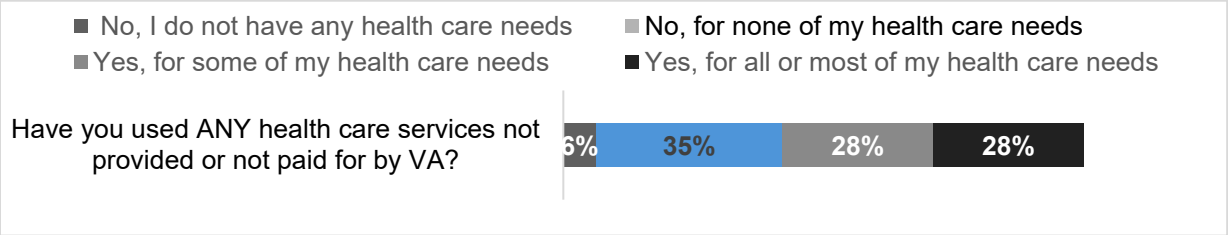
Figure 6-2. Enrollee’s Primary Intended Use of VA Health Care



Note: Denominator is all enrollees who did not select having no plans to use VA health care in the future, N = 7,649,681. Missing responses are not shown.

Enrollees were asked if they have used any services not provided by or paid for by VA. Fifty-six percent of enrollees indicated using services not provided or paid for by the VA for some or all of their health care needs (28%). Thirty-five percent indicated not using services not provided or not paid for by the VA for any of their healthcare needs (See Figure 6-3).

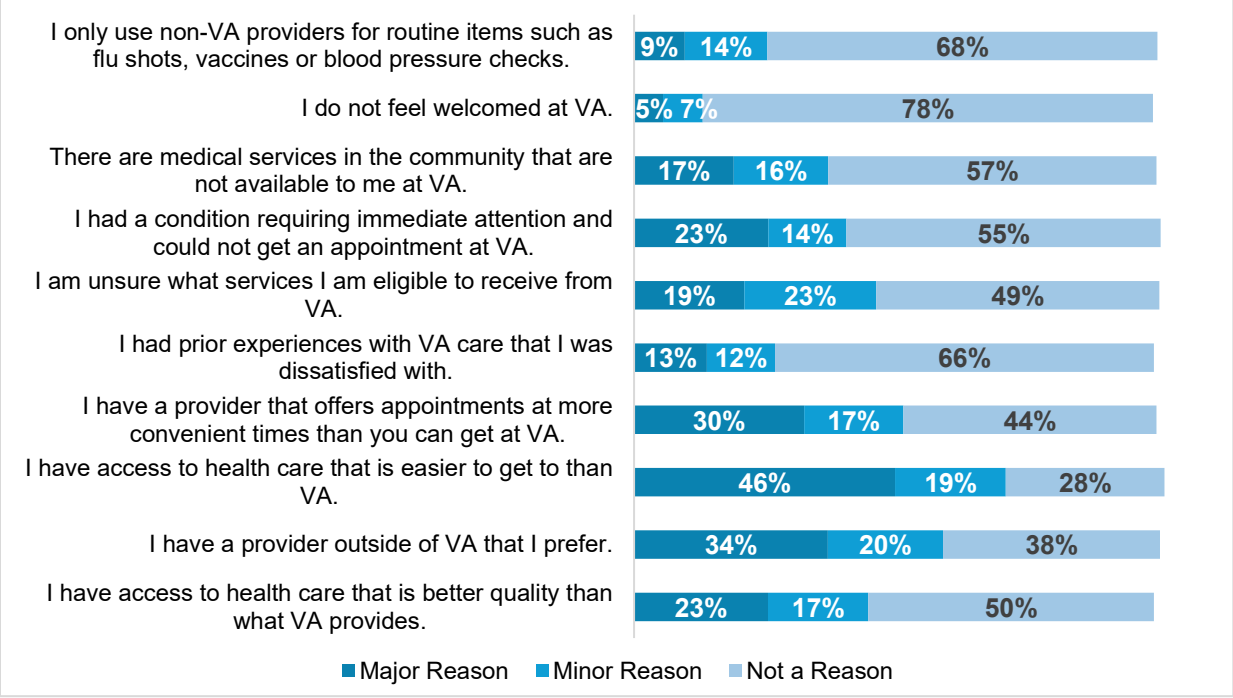
Figure 6-3. Use of Non-VA, Non-VA-Funded Health Care Services



Note: Denominator is all enrollees, N = 7,985,922

Enrollees that indicated they used any non-VA provided or paid-for services were also asked their reasons for deciding to use those services, instead of VA Health Care, for some or all their health care. They were given the option of selecting that each reason was a “major”, a “minor”, or “not a reason” for their decision (Figure 6-4). Enrollees most frequently indicated that non-VA health care was easier to get to (46 percent), as a major reason for using services other than VA. Additionally, 34 percent of enrollees indicated having a preferred provider outside of VA and 30 percent of enrollees indicated having a provider that offered appointments at more convenient times than those available at VA were major reasons for using services outside the VA.

Figure 6-4. Reasons enrollees use services other than VA



Note: Denominator is enrollees that indicated they used any non-VA provided or paid for health care services, weighted N = 4,677,508 enrollees. Percentages of respondents who did not answer the question are not shown.

Chapter 7. Digital Access to VA Healthcare, Information and Resources

Since the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH Act), the federal government has made significant investments in the adoption of health information technology, with the aim of transforming health care delivery and promoting person-centered and self-managed health. Health providers and hospitals have followed suit by improving their existing electronic systems and services. For example, VA has been modernizing its electronic health record (EHR) system to provide enrolled Veterans with seamless care as they transition from military service to Veteran status and when they choose to use community care.[40]

In support of the modernization effort, VA released an online feature that allows enrolled Veterans to access their medical images and associated study reports online. This feature, called the VA Medical Images and Reports, allows enrolled Veterans with a premium account to view, download, and share copies of their radiology studies, such as X-rays, mammograms, magnetic resonance imaging (MRI) scans, and computerized tomography (CT) scans from the VA EHR.[41] Another effort to make medical records more accessible is through the Blue Button Initiative, which enables enrolled Veterans to access their health records electronically and share with doctors, trusted family members, or caregivers.[42.]

As more providers adopt health information technologies and make health care available through remote means (e.g., email, phone consultations, mobile applications, video), understanding how enrollees access the internet, the frequency of internet use, and reasons for internet use across enrollee subgroups becomes increasingly important. Barriers to electronic health platforms affect both providers and patients. Barriers to providers include cost pressures, time limitations, cultural differences, poor usability, and lack of steady and consistent access for patient users.[43] To help understand patient barriers to online usage, VA conducted a study of VA patient portal usage at a large VA health care facility. Results showed that short-term and long-term portal usage was associated with having broadband at home, high self-rated ability to use the internet, and overall online behavior. Digital inclusion, or ready access to the internet and digital skills, appears to be a social determinant in patient exposure to portal services.[44]

This chapter examines Veterans' access to the Internet, their comfort with digital technologies, and their willingness to use online tools and virtual care services to support their health care needs. The measures included in this section assess both the types of Internet connections available within Veterans' households—such as cellular data plans, broadband, satellite, and dial-up services—as well as barriers among those who do not currently use or have access to the Internet. These barriers include limitations such as lack of service availability, cost concerns, discomfort using computers or mobile devices, and lack of interest in Internet use. Understanding these structural and personal barriers provides important context for evaluating digital readiness across the Veteran population.

Beyond infrastructure and access, this chapter also explores Veterans' attitudes toward using technology for health-related activities. Respondents were asked how willing they would be to

engage in a range of digital behaviors, including accessing their health records, reviewing test results, completing online health assessments, communicating securely with providers, and using mobile apps or text messaging to support self-management. These measures provide insight into both current levels of engagement and the potential for broader adoption of digital health tools.

Finally, the chapter assesses Veterans' interest in remote health care and virtual consultation models, including remote visits with both Mental Health and non-Mental Health providers. In addition, respondents were asked about their willingness to share health information online and receive medical guidance either from a VA provider or from computer-based decision systems without direct provider interaction. Together, these findings help describe the landscape of digital access, technological confidence, and openness to emerging models of technology-enabled health care delivery, highlighting opportunities to expand virtual care while identifying populations who may benefit from additional support or alternative approaches.

7.1 Access to the Internet

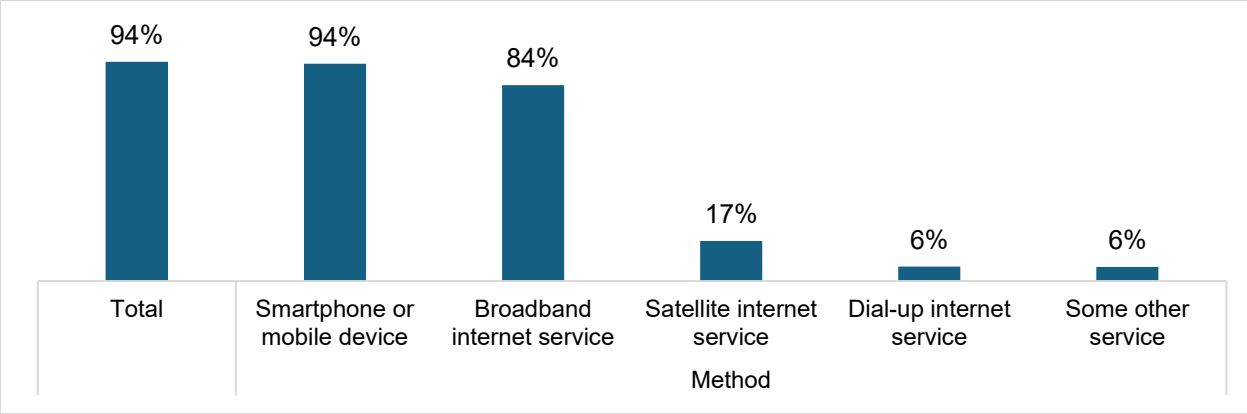
A 2018 study suggests that internet use for health resource access is critical for Veterans and their caregivers, with those who feel the most technologically comfortable benefiting most from online resources.[45] Another study on older Veterans digital disparities reported that among those without access, older Veterans frequently had close social ties with home Internet service and indicated they would feel comfortable seeking help from these ties, who were also willing to go online on the Veteran's behalf for health-related needs.[46]

More than four in five enrollees (88 percent) in the 2025 survey reported using the internet, at least occasionally, compared to 87 percent in 2024.

This section describes the types of Internet services available to Veterans and members of their households. Respondents were asked whether they have access to a range of connection types, including cellular data plans for smartphones or mobile devices, broadband services such as cable, fiber optic, or DSL installed in the home, as well as satellite and dial-up Internet services. An additional category captures access through other or less common Internet service options. Examining the distribution of these service types provides insight into the reliability, speed, and flexibility of Internet access across households, which has important implications for the feasibility of online communication, digital health tool use, and participation in virtual care services. Overall, ninety-four percent of enrollees indicated having some form of access to the internet, and roughly five percent indicated having no means of accessing the internet. Figure 7-1 provides a breakdown of the methods used to access the internet.

The most commonly reported access types were a cellular data plan for a smartphone or mobile device (94%) and broadband Internet service installed in the home (84%), suggesting that most respondents have access to relatively high-speed or mobile connectivity. Far fewer respondents reported access through satellite Internet service (17%), and only small proportions indicated use of dial-up Internet service (6%) or some other type of Internet service (6%). These results highlight that while Internet access is widespread, the quality and mode of connection vary, with broadband and mobile access being the dominant forms of connectivity.

Figure 7-1. Breakdown of Methods Used to Access the Internet

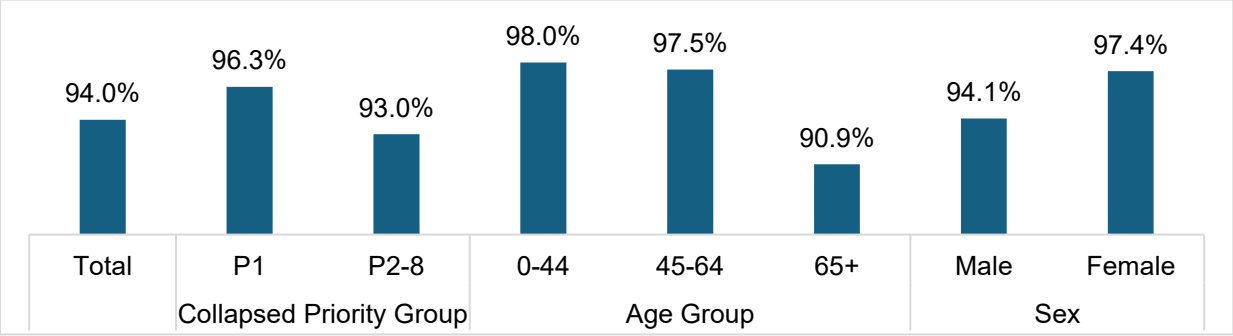


Note: Denominator is enrollees that reported having internet access, N = 7,540,442

7.2 Places Where Enrollees Access the Internet

Most households in which a Veteran resides have internet access, use/own a computer or smartphone regardless of gender, age, economic status or educational level. Figure 7-2 presents the percentage of respondents reporting household Internet access, stratified by priority group, age group, and sex. Overall, 94% of respondents indicated having Internet access. Rates were slightly higher among those in Priority Group P1 (96.3%) compared with those in Groups P2–8 (93.0%). Internet access was highest among younger and middle-aged respondents, with 98.0% of those ages 0–44 and 97.5% of those ages 45–64 reporting access. In contrast, access was lower among respondents ages 65 and older (90.9%), indicating a modest age-related digital access gap. Differences by sex were also observed, with a higher percentage (97.4%) of female respondents reporting Internet access compared with 94.1% of male respondents. Taken together, these findings suggest that while Internet access is widespread across respondent groups, older Veterans and those in lower priority categories are somewhat less likely to report access.

Figure 7-2. Household Internet Access

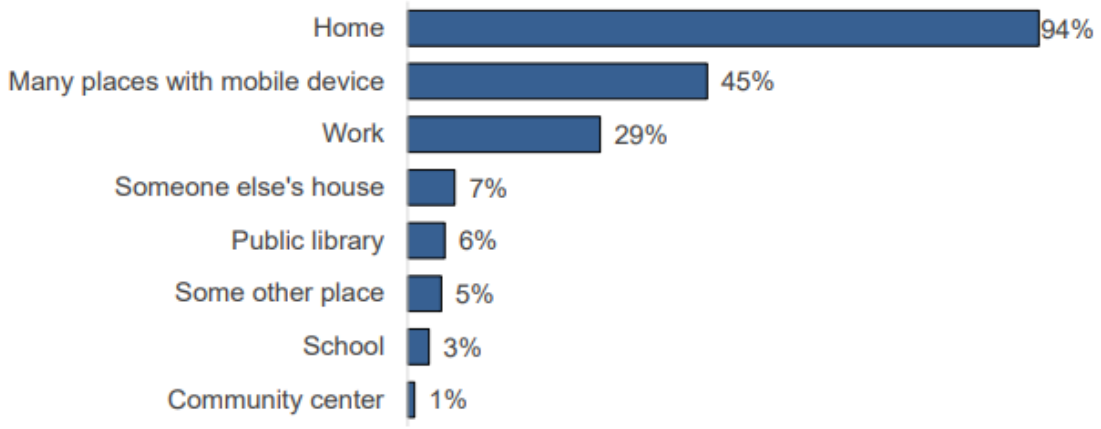


Note: Denominator is all enrollees in each demographic group.

As shown in Figure 7-3, the most common place where enrollees access the internet is at home (94 percent). Enrollees also reported accessing the internet through mobile devices such as a cellphone or tablet (45 percent) and at work (29 percent). A much smaller share of enrollees

reported accessing the internet at someone else's house (7 percent), a public library (6 percent), some other place (5 percent), a school (3 percent), or a community center (1 percent).

Figure 7-3. Places Where Enrollees Access the Internet



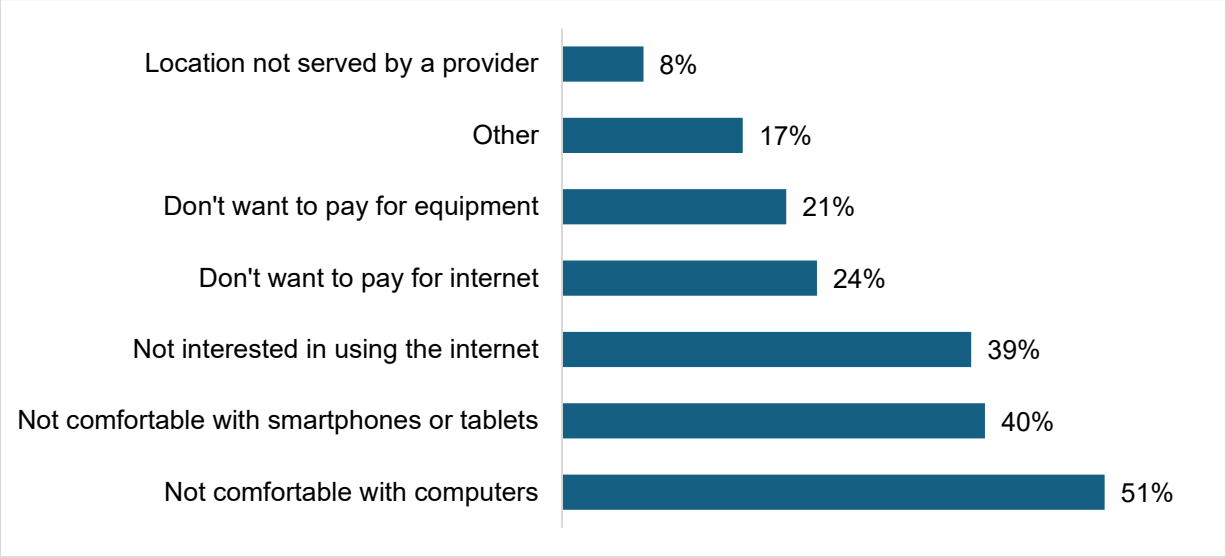
Note: Denominator is enrollees that reported having internet access, N = 7,540,442

7.3 Barriers to Internet Usage and Access

This section examines the reasons reported by respondents who do not use or do not have access to the Internet. The items in this measure capture both structural and personal barriers, including lack of service availability in their location, discomfort using computers, smartphones, or tablets, and costs associated with Internet service or necessary equipment. Additional reasons include lack of interest in using the Internet and other unspecified barriers. A response option is also included for individuals who indicate that they do, in fact, have Internet access. Together, these measures help identify the underlying factors contributing to non-use of Internet services and provide insight into populations that may face greater challenges in adopting digital technologies or participating in technology-enabled health care.

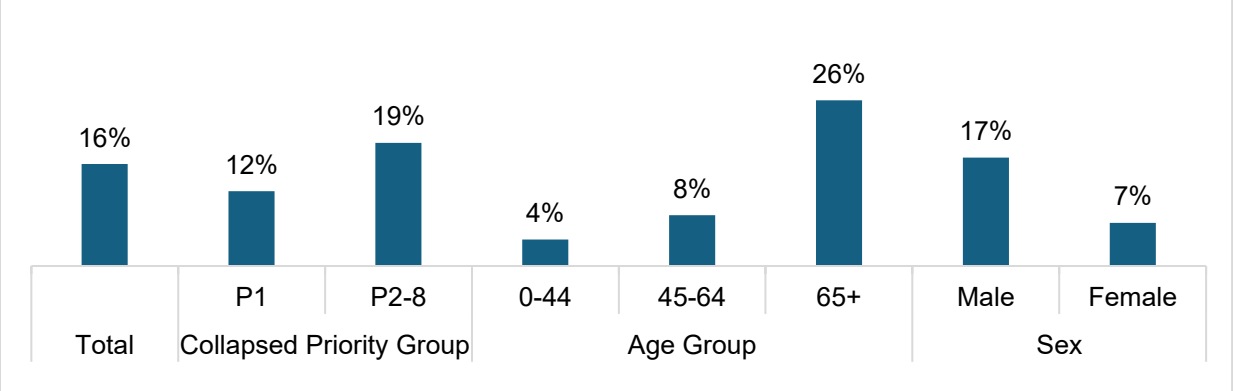
For enrollees who do not use or have the internet, over half (51 percent) reported it is because they are not comfortable with computers (see Figure 7-4). Forty percent of enrollees do not use the internet because they are not comfortable with smartphones or tablets. Thirty-nine percent indicated that they had no interest in using the internet (a decrease of 14% from 2024). Only 8 percent of enrollees reported they do not use the internet because their location is not serviced by an internet provider (see Figure 7-5).

Figure 7-4. Percentage of enrollees by reasons they do not use or have access to the internet



Note: Denominator is enrollees who are not internet users. Weighted N = 1,259,013 enrollees. Categories are not mutually exclusive, and enrollees can be counted in more than one category.

Figure 7-5. Demographic breakdown of those who do not use the internet or have a barrier to internet access:



Note: Denominator is enrollees in each demographic group.

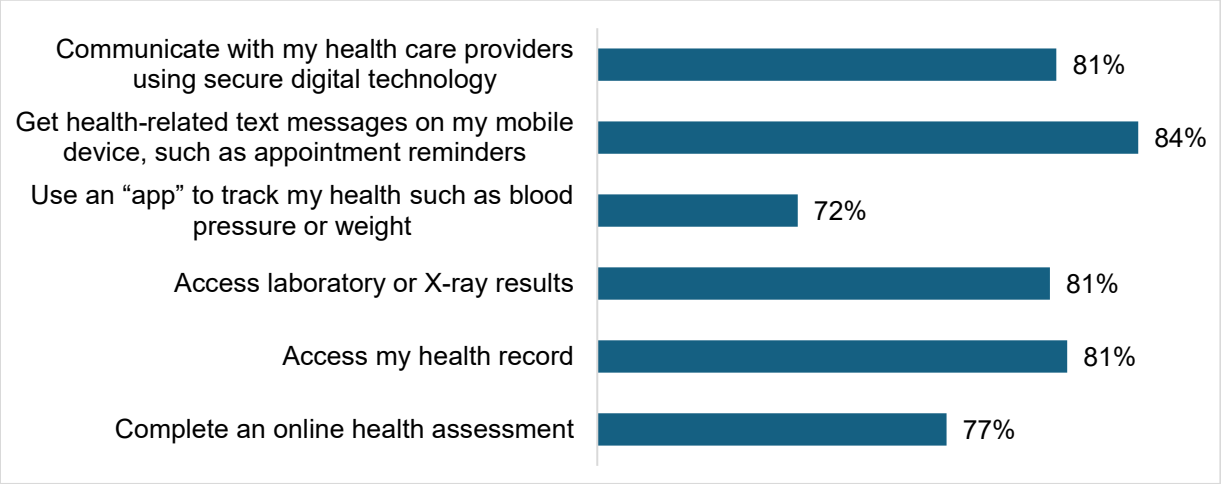
7.4 Readiness and Willingness to Use Internet for VA Information and Activities

Telehealth is one of VA's efforts to use technology and data to implement patient-centric care. Telehealth is a term used to describe various technologies such as Home Telehealth, Clinical Video Telehealth, and Store-and-Forward Telehealth (enabling sites in need of specialized consults to forward clinical data, images, and/or videos), all of which use "modern technology to provide clinical care and patient education when the patient and provider are in separate locations.[47] Telehealth enables patients to receive medical exams from primary care providers, consult with specialists, participate in counseling, monitor chronic conditions, and share/receive diagnostic information, while circumventing barriers such as stigma, geographic distance, and travel costs. Veterans' Health Administration (VHA) telehealth services have seen a steady

annual growth in the last several years[48] and have been a critical resource for delivering clinical programs and services to meet the psychosocial and health needs of enrolled Veterans and their caregivers.[49,50,51]

The 2025 Survey of Enrollees asked about existing use and/or willingness to perform virtual health-related tasks, willingness to schedule virtual consultations or appointments, and willingness to share information and receive medical opinions as part of a virtual consultation or appointment. Figure 7-6 displays the percentage of enrollees that already use a telehealth-related task or were "somewhat willing" or "very willing" to do the task on a computer or mobile device. Enrollees were most willing to use telehealth for accessing their personal records (82 percent), scheduling medical appointments, accessing lab or x-ray results, or refilling prescription medication (all 81 percent). Enrollees showed less support for using telehealth to complete an online stress/anxiety assessment (65 percent) and for online support groups (46 percent). Enrollees were not asked about their willingness to perform the listed tasks in-person as compared to their willingness to perform them via telehealth.

Figure 7-6. Percentage of enrollees who already use or would be at least somewhat willing to perform telehealth-related tasks

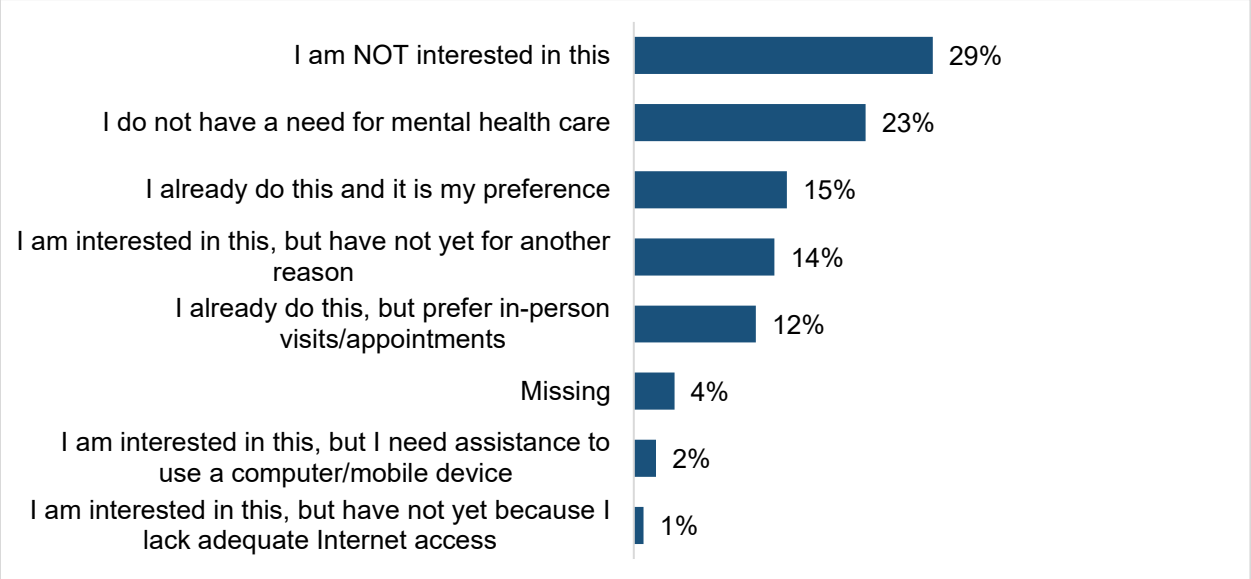


Note: Denominator is all enrollees. Weighted N = 7,985,922 enrollees. Categories are not mutually exclusive, and enrollees can be counted in more than one category.

Telehealth has the potential to improve access to services and help reduce the inequalities in health care use, and ultimately, outcomes attributable to socioeconomic, geographic, and demographic differences among enrolled Veterans. However, for these benefits to be realized, it is important for these technologies to reach subgroups of enrollees who are disproportionately less willing or able to adopt these new practices by providing the information and support they need to overcome any barriers to access and use.

Figure 7-7 shows enrollees' willingness to meet with mental health provider remotely. Overall, 23 percent of enrollees reported they do not have a need for mental health care, and 29 percent indicated they were not interested in meeting with a mental health provider remotely. More than one-quarter of enrollees (27 percent) had a slight preference for remote visits (15%) compared to in-person appointments (12%)

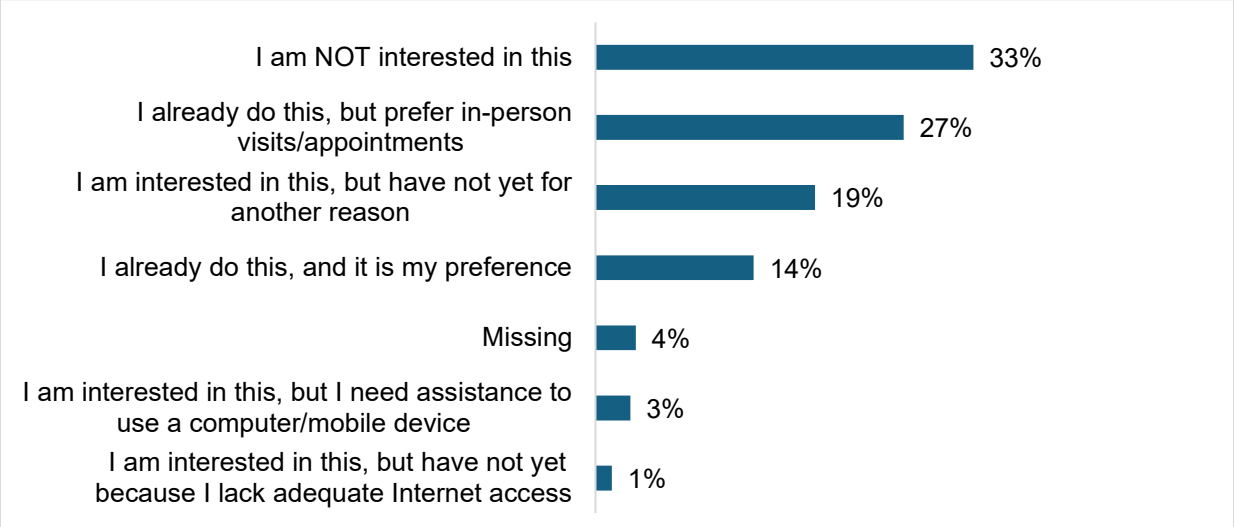
Figure 7-7. Percentage of enrollees that have met with or are willing to meet with a mental health provider remotely



Note: Denominator is all enrollees in each demographic group. Weighted N = 7,985,922 enrollees.

Enrollees were also asked about their experience with and willingness to meet with a non-mental health provider remotely. One-third (33 percent) of enrollees were not interested in meeting with a non-mental health provider through virtual means. Twenty-seven percent of enrollees said they currently meet virtually with non-mental health providers but prefer those appointments to be in-person. Only 14 percent of enrollees reported they meet remotely with a non-mental health provider and prefer the virtual method. See Figure 7-8.

Figure 7-8. Percentage of enrollees that have met with or are willing to meet with a non-mental health provider remotely



Note: Denominator is all enrollees in each demographic group. Weighted N = 7,985,922 enrollees.

Chapter 8. Conclusion

The 2025 Survey of Veteran Enrollees provides a comprehensive overview of the demographic characteristics, health status, insurance coverage, health care utilization patterns, and digital engagement of Veterans enrolled in the Veterans Health Administration (VHA). As in prior years, the findings offer critical insight into the evolving needs of the enrollee population and inform VHA's strategic planning, resource allocation, forecasting, and care-delivery transformation efforts.

The 2025 results highlight several continued trends in the enrollee population. The overall number of enrolled Veterans remains stable, though the population continues to age, with nearly half of all enrollees aged 65 or older. At the same time, younger cohorts entering the system are more diverse in sex, race, and ethnicity, with increasing representation of post-2001 service members and female Veterans. These demographic shifts underscore the dual challenge facing VHA: meeting the complex needs of older Veterans while continuing to adapt to the expectations and experiences of younger and more diverse enrollees.

Health insurance coverage patterns continue to demonstrate high levels of dual use between VA and non-VA care. Eighty-two percent of enrollees reported having some form of public or private insurance, with Medicare and private employer-based plans remaining the most common. TRICARE coverage remains particularly prevalent among service-connected Veterans in Priority Group 1. However, 16 percent of enrollees reported having no insurance coverage outside VA, with uninsured rates highest among younger Veterans and those in Priority Group 1. These patterns have direct implications for care coordination, financial assessment, and future demand on VA services.

Findings related to current physical and mental health highlight persistent disparities across demographic groups. While a majority of enrollees report at least "good" physical and mental health, enrollees in Priority Group 1 and those under age 45 continue to report lower overall health status and reduced emotional well-being. Assistance with daily activities remains an important area of need, with nearly one-third of enrollees either receiving or believing they need caregiver support. These results reinforce the importance of ongoing investment in whole-health approaches, caregiver support programs, and integrated mental health services.

Smoking and tobacco-use trends continue to show gradual improvement. The proportion of enrollees who currently smoke decreased to 10 percent in 2025, continuing a multi-year downward trajectory. However, smoking remains more common among enrollees experiencing poor physical or mental health, those with lower incomes, and those without health insurance. Use of smokeless tobacco and e-cigarettes showed

modest increases among younger enrollees, underscoring the need for targeted cessation interventions and continued monitoring of emerging nicotine-use behaviors.

Patterns of VA and non-VA health care use indicate that while most enrollees plan to rely on VA as their main source of care or for prescription services, more than half use some non-VA services for at least part of their care. Convenience, access, and existing relationships with community providers continue to influence these decisions. Such findings emphasize the need for continued improvements in access, appointment availability, and communication about eligibility and available services.

Digital access and telehealth readiness remain areas of both strong performance and opportunity. Internet access among enrollees is high overall, but meaningful gaps persist among older Veterans and those in lower priority groups. While most enrollees express willingness to use digital tools—particularly for accessing records, viewing lab results, and receiving reminders—interest in remote clinical encounters varies by type of service and Veteran need. These findings support ongoing efforts to expand digital literacy, improve user experience, and ensure that technology-enabled care models are accessible and acceptable to all enrolled Veterans.

Taken together, the 2025 Survey findings reaffirm the importance of a flexible, Veteran-centered health care system that anticipates and adapts to the needs of a changing enrollee population. The report highlights areas where VHA has made sustained progress—such as smoking reduction, digital engagement, and expanded care options—while identifying populations that continue to face barriers related to health status, insurance coverage, functional limitations, and technology access. These insights will support VHA's strategic planning, forecasting, and operational decision-making as the organization continues its mission to provide high-quality, equitable, and accessible care to all who have served.

References:

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[2] U.S. Department of Veterans Affairs. (2022). Veterans Integrated Services Networks (VISNs). Washington, DC: Author. Available at: https://www.va.gov/HEALTH/visns.asp. Retrieved on: October 28, 2024.

[3] In 1999, Congress enacted VA Health Care reform that affected Veteran enrollment status. Prior to 1999, Veterans could not be enrolled. However, if a Veteran used the VA Health Care system within two years of March 31st, 1999, users were grandfathered into the system. Therefore, if a Veteran has a date of enrollment listed as prior to March 31, 1999, the date the reform was enacted, the Veteran was identified as a pre-enrollee. Veterans with enrollment dates after March 31, 1999, were defined as post-enrollees.

[4] Urban/rural, age, sex, Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), and/or Operation New Dawn (OND) (collectively referred to as OEF/OIF/OND), and Priority Group data came from the VA administrative data file. Otherwise, results are from survey response data

[5] Throughout this report, all figures have values rounded to the nearest whole number for ease of reading. As a result, summing totals from figures may not match summing of values in the tables that use one decimal place.

[6] Operation Enduring Freedom spans October 7, 2001 through December 28, 2014; Operation Iraqi Freedom spans March 19, 2003, through August 31, 2010; Operation New Dawn spans September 1, 2010, through December 15, 2011. For more information, see Salazar Torreon, B. (2019). U.S. periods of war and dates of recent conflicts. Washington, DC: Congressional Research Service. Available at: https://fas.org/sgp/crs/natsec/RS21405.pdf.

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