



# OPERATION: KEEP THE PROMISE

2020

## DAV's Critical Policy Goals

1. Ensure Veterans Exposed to Toxic Substances Receive Full and Timely Benefits, Particularly for Burn Pits, Agent Orange and Other Known Exposures
2. Enhance Veterans' Survivor Benefits
3. Fully and Faithfully Implement the VA MISSION Act
4. Strengthen Veterans Mental Health Care and Suicide Prevention Programs
5. Enact Legislation to Address Gaps and Inequities in the VA's Women Veterans Health Care Program

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DAV empowers veterans to lead high-quality lives with respect and dignity. It is dedicated to a single purpose: fulfilling our promises to the men and women who served. DAV does this by ensuring that veterans and their families can access the full range of benefits available to them; assisting them with employment; fighting for the interests of America's injured heroes on Capitol Hill; and educating the public about the great sacrifices and needs of veterans transitioning back to civilian life. DAV, a nonprofit organization with more than 1 million members, was founded in 1920 and chartered by the U.S. Congress in 1932.



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## **Ensure Veterans Exposed to Toxic Substances Receive Full and Timely Benefits, Particularly for Burn Pits, Agent Orange and Other Known Exposures**

The men and women who serve are often placed in situations that have long-term health effects that will impact their individual functioning, often results in industrial impairments, which require physical rehabilitation and future health care. When service members are subjected to toxins and environmental hazards, our sense of duty to them must be heightened as many of the illnesses and diseases due to these toxic exposures may not be identifiable for years, even decades, after they have completed their service.

Although there has been some notable progress achieved over the past two decades for veterans who suffered illness due to toxic and environmental exposures, there are still too many who have yet to receive the full recognition, health care and benefits our nation owes to them.

### **Burn Pits and Concession of Exposure**

During Operations Desert Shield/Desert Storm (1990–1991) and since, burn pits were utilized not only in Iraq, but also in Kuwait, Oman, Qatar, United Arab Emirates, Saudi Arabia and Bahrain. Since September 11, 2001, burn pits have been used throughout the operations in Afghanistan and Djibouti, as well as in Iraq after March 20, 2003.

Several studies have indicated that veterans were exposed to airborne toxins from burned waste products including, but not limited to: plastics, metal/aluminum cans, rubber, chemicals (such as paints, solvents), petroleum and lubricant products, munitions and other unexploded ordnance, wood waste, medical and human waste and incomplete combustion by-products. Since there is no current presumptive service connection for burn pit exposure, veterans must file claims for direct service connection for diseases and illnesses related to burn pit exposure. From 2007 to 2018, the VA received over 11,000 claims specific to burn pit exposure and denied 80% of those claims. Many of these denials are due to veterans not knowing what toxins they were exposed to, thus impeding their ability to obtain a medical opinion relating the condition to the specific toxins.

One way to overcome this is to concede burn pit exposure for veterans currently eligible to join the VA Airborne Hazards and Open Burn Pit Registry as well as concede their exposure to the same chemicals and toxins noted in VA's M21–1 Manual, including but not limited to: (1) particulate matter; (2) polycyclic aromatic hydrocarbons (PAH); (3) volatile organic compounds; and (4) toxic organic halogenated dioxins and furans (dioxins).

A concession of burn pit exposure will not establish presumptive service connection; however, it will remove the requirement for veterans having to prove their individual exposure to burn pits and the types of toxins emitted from such pits for disability claims based on direct service connection.

- **Congress should enact S. 2950, as it will concede burn pit exposure and remove the obstacles for veterans having to prove their individual exposure to burn pits and the types of toxins emitted, for claims based on direct service connection.**

### **Pending Agent Orange Presumptive Diseases**

Notwithstanding numerous laws and regulations governing how the VA makes “presumptive” decisions, there are still gaps and breakdowns that have left some veterans, particularly Vietnam veterans, waiting years for their exposure to be recognized or their diseases to be associated with Agent Orange. Originally, the Agent Orange Act of 1991 included provisions requiring timely action by the VA Secretary when reports from the National Academies were received recommending adding new diseases associated with Agent Orange exposure; however, those provisions expired in October 2015.

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The Persian Gulf War Veterans Act of 1998, codified at 38 U.S.C. § 1118, originally had these same types of time-required actions by the Secretary; however, those requirements expired on October 1, 2011. None of the other presumptive toxic exposures have time requirements for the Secretary to act, which means there are no current time requirements on the Secretary to act on any recommendations made by the National Academies in reference to any additional diseases related to toxic exposures.

The National Academy of Medicine's "Veterans and Agent Orange" 2014 update, published in 2016, concluded that there was compelling evidence for adding bladder cancer and hypothyroid conditions as presumptive diseases. Further, the study clarified that Vietnam veterans with "Parkinson-like symptoms," but without a formal diagnosis of Parkinson's disease, should be considered under the presumption that Parkinson's disease is service connected.

The December 2018 National Academy of Medicine report notes there is sufficient evidence of a relationship between hypertension and Agent Orange and recommended it to be added to the presumptive list. VA internal documents reveal that the Administration challenged the previous Secretary's authority to add the presumptive diseases and even impeded action. Bladder cancer, hypothyroidism and "Parkinson-like symptoms" have been held up for more than three years while veterans are suffering and dying from these diseases. Even more troubling is the Administration is outweighing the cost of adding these diseases over those who are in dire need.

- **Congress should enact legislation, such as H.R. 2200 or H.R. 5610 to add the presumptive diseases of hypertension, bladder cancer, hypothyroidism and "Parkinson-like symptoms," which the National Academy of Medicine has scientifically associated to Agent Orange exposure.**

### **Presumptive Decision-Making Framework**

The presumptive processes and the presumptive decision-making process are not consistent among all of the different types of exposures. Which means that not all presumptive processes are the same when it comes to establishing concession of exposure, adding new diseases linked to the exposure, identifying requirements for additional studies, or the requirements for the Secretary to act on adding new diseases linked to exposure.

- **To provide consistency, an overall presumptive processes framework needs to be established by Congress. This framework would apply to all future exposures and presumptive diseases which should include requirements for future studies on all presumptive toxic exposure related diseases, a time requirement for action from the Secretary, and upgrade of the classifications of scientific association.**

### **Additional Toxic Exposures**

As we have established, our service men and women are consistently exposed to dangerous locations and harmful environments with contaminants and toxins. Veterans need Congressional action to ensure the VA continues to expand known exposures, like Agent Orange in Thailand, and to study the adverse long-term health effects of other toxic exposures such as Ft. McClellan and PFAS contaminated water found at 401 military installations.

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## Enhance Veterans' Survivor Benefits

Dependency and Indemnity Compensation (DIC) is a monthly benefit paid to eligible survivors of veterans who passed away due to a service-connected condition or from a nonservice-connected condition if the veteran had a totally disabling service-connected condition for a period of time, generally 10 years, before their death. This benefit was intended to protect against spousal impoverishment after the loss of their veteran spouse. To ensure that these survivor's benefits continue to provide for the veteran's loved ones, DAV urges Congress to increase the DIC rates, eliminate the arbitrary 10-year criteria for DIC eligibility, reduce the remarriage age to 55, and remove the 10-year delimiting date for spouses and surviving spouses to utilize Dependents Educational Assistance, which is an educational benefit for dependents and survivors.

### Increase DIC Rates

While DIC has assisted many survivors of disabled veterans, the value of the current benefit is insufficient to provide meaningful support to survivors of severely disabled veterans. A veteran who is receiving 100% disability compensation today would receive approximately \$3,279 a month, whereas the current DIC benefit is only \$1,340 a month.

When a veteran receiving compensation passes away, not only does the surviving spouse have to deal with the heartache of losing their loved one, but they also have to contend with the loss of approximately \$24,000 a year. This loss of income to a survivor's budget is devastating, especially if the spouse was also the veteran's caregiver and dependent on that compensation as their sole income source.

The rate of compensation paid to survivors of service members who die in the line of duty or veterans who die from service-related injuries or diseases was established in 1993 and has been minimally adjusted since then. In contrast, monthly benefits for survivors of federal civil service retirees are calculated as a percentage of the civil service retiree's Federal Employees Retirement (FERS) or Civil Service Retirement System (CSRS) benefits, up to 55 percent. This difference presents an inequity for survivors of our nation's heroes compared to survivors of federal employees.

- **Congress should enact S.1047 or H.R. 3221, as both would increase DIC rates to 55% of 100 percent disability compensation and provide parity with other federal programs. We urge Congress to index these rates for inflation.**

### Eliminate the 10-Year Rule

If the veteran passes away due to a nonservice-connected condition before the veteran has reached 10 consecutive years of being totally disabled, their dependents are not eligible for any DIC benefit, even though many of these survivors were caregivers who sacrificed their own careers to take care of the veteran and could potentially be left destitute. The DIC program would be more equitable for all survivors if they were eligible for a partial DIC benefit starting at five years of the veteran being totally disabled and reaching full entitlement at 10 years.

- **We urge Congress to enact legislation to change DIC to a graduated benefit to make survivors eligible at five years for 50% of the full benefit amount, increasing proportionally to 100% at 10 years.**

### Reduce the Remarriage Age

Surviving spouses also face another unfair burden. Under the existing DIC law, a surviving spouse loses their benefit if they remarry before age 57, whereas the Civil Service Retirement System as well as the Survivor Benefit Plan (SBP) allow surviving spouses to remarry at age 55 without a loss of benefits.

- **Congress should enact H.R. 1911, which would, in part, reduce the remarriage age for a surviving spouse to 55 to provide parity with other federal programs.**

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### **Remove the Dependents Educational Assistance Delimiting Date**

Spouses and surviving spouses eligible for educational benefits under Dependents Educational Assistance, also referred to as Chapter 35, only have a 10-year period to apply for and complete these programs of education beginning either from the date the veteran is rated permanently and totally disabled or the date of the veteran's death. However, in many instances, most notably in the case of caregivers, family obligations and the need to care for the veteran, requires spouses and surviving spouses to defer using these benefits for years, leaving many unable to apply in a timely manner, resulting in a loss of earned educational opportunities.

- **We urge Congress to remove the 10-year delimiting date for spouses and surviving spouses to use their Dependents Educational Assistance benefits.**

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## Fully and Faithfully Implement VA MISSION Act of 2018

The VA MISSION Act of 2018 (P.L. 115–182) contains a number of critical policy priorities for DAV. Most notably, the law calls on the VA to provide for access to timely, high-quality care; expand the VA's internal capacity to provide care; modernize and align the VA's health care system infrastructure; and extend VA's caregiver program to all severely injured service-connected veterans. The MISSION Act was developed through a long and deliberative process that led to a broadly-supported, bipartisan consensus, specifically rejecting more radical approaches, such as outsourcing of services that could lead to the diminution of care and eventual wholesale privatization of the VA. Because millions of service-disabled veterans and their family caregivers rely on the VA health care system and the specialized care it provides, the law must be fully and faithfully implemented as intended by all stakeholders.

Unfortunately, recent decisions by the VA signal its willingness to depart from the bipartisan agreement contained in the MISSION Act. For example, the VA replaced the previous 30-day, 40-mile access standards to receive care in the community with much looser requirements, significantly increasing the number of veterans eligible to receive private-sector care from 8 percent to 40 percent of the 9.5 million enrolled veterans. Yet, VA has failed to establish a system to monitor the quality of care provided in the new VA Community Care Network (VCCN) or consult with veterans service organizations on a survey to assess veteran satisfaction required by the law. The MISSION Act authorized the VA to develop a tiered community network where providers with higher quality and lower costs would be placed in the most-preferred tier rankings to ensure veterans are easily able to choose the highest quality providers; the VA has not implemented this provision. Finally, the MISSION Act required two sets of market capacity assessments—one to guide creation of the VCCN and the other to inform a future Asset and Infrastructure Review process—and both were to be conducted in an open and transparent manner in consultation with veterans and VSO stakeholders. Instead, the VA has combined the two assessments and conducted them in a closed manner without any meaningful VSO stakeholder input.

The MISSION Act contains numerous provisions to strengthen the VA's ability to recruit, hire and retain high-quality medical professionals. Yet since enactment, the average vacancy level increased to over 43,000 throughout fiscal year 2019 and the average number of veterans waiting over 30 days for appointments has grown to over 740,000.

The MISSION Act also mandates a multi-year Asset and Infrastructure Review (AIR) process to examine existing VA health care facilities and develop a long-term plan to realign and modernize them. This plan must be reviewed and approved by the VA, an independent commission, the President and Congress. The commission will consist of nine members chosen by the President, including three members specifically representing major veterans service organizations. The AIR process will only be successful if veterans and VSO stakeholders are fully informed, consulted and engaged throughout the process.

Finally, the law required expansion of the caregiver support program to all eras of veterans to begin on October 1, 2019, contingent on the certification of a robust IT system to support program expansion. Yet despite having 16 months from enactment of the MISSION Act in June of 2018 to October 2019, the VA failed to meet this statutory deadline, which will delay for at least eight months the expansion of the program to support severely injured and aging veterans of World War II, the Korean and Vietnam War eras.

- **Congress must closely oversee the VA to ensure the VA MISSION Act is fully and faithfully implemented as intended in an open and transparent manner that provides regular opportunities for meaningful participation from VSOs and veterans at all critical decision points.**
- **Congress must provide the VA with sufficient and timely funding to fully implement the VA MISSION Act, and to meet the full demand for care by enrolled veterans within VA facilities and through non-VA providers in the Veterans Community Care Program.**

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## Strengthen Veterans Mental Health Care and Suicide Prevention Programs

The Department of Veterans Affairs (VA) reports that about 17 veterans and 3 members of the National Guard and Reserves take their lives each day. For each of the past 10 years, this has meant more than 6,000 veterans take their lives each year.

The VA's most recent annual report on suicide (2019) shows that veterans are 1.5 times more likely to commit suicide than non-veteran peers. Women veterans are 2.2 times more likely to commit suicide than non-veteran women. Rates of suicide among veterans are also affected by age, with younger age groups at greatest risk, as well as those experiencing, unemployment, lower incomes, homelessness and diagnoses of sleep disorders, pain and traumatic injury, in addition to mental health conditions.

The VA operates a comprehensive array of mental health care services oriented toward recovery for veterans including evidence-based treatment for post-traumatic stress disorder, substance use disorder, depressive disorders, anxiety and other mental illnesses such as bipolar disorder and schizophrenia. The VA also has screening programs that allow clinical providers to identify and make immediate referrals to behavioral health staff that are integrated into primary care teams lowering veterans' stigma for seeking treatment and ensuring urgent interventions. Veterans are also afforded supportive wraparound services such as case management, care coordination, housing and other benefits that allow them to be stabilized in a therapeutic environment.

Recognizing significantly higher rates of suicide among veterans than other American adults, the VA has implemented a plethora of services, including a veterans' crisis line, placement of suicide prevention coordinators at each VA medical center, targeted initiatives to assist families in coaching veterans into care, and developed predictive analytics to identify veterans most at risk of self-directed violence. The Veterans Crisis Line has answered approximately 3.2 million calls per year since 2007. It has initiated the dispatch of emergency services to callers in crisis approximately 100,000 times. These contacts resulted in more than 564,000 referrals to the VA Suicide Prevention Coordinators who engage and track these veterans to assure they are receiving necessary mental health services. Despite these efforts, rates of suicides among veterans—even those using the VA—continue to outpace those of other Americans.

The Department has consistently pledged reduction of suicides as its number one clinical goal and granted special eligibility to mental health care for certain veterans who are at higher risk. Yet, the VA reports that most of the veterans committing suicide have not used the veterans health care system. Many veterans don't use the VA—not because they don't chose to—but often because they don't believe they are eligible, don't know how to apply or don't know about the services offered.

To address this population outside of the VA, the White House made a Proclamation for a Presidential Roadmap to Empower Veterans and End the National Tragedy of Suicide (PREVENTS), which describes a federal government approach to addressing this crisis in partnership with the state and local governments and the private sector. DAV stands ready to assist with this “all hands on deck” plan, but continues to support a primary and integral role for the VA in any new suicide prevention initiatives for veterans.

- **Congress should enact legislation to ensure VA receives appropriate funding levels to hire and train a sufficient number of mental health providers, improve and promote access to VA services, and better coordinate mental health and community care services.**
- **A comprehensive suicide prevention and outreach plan must promote VA eligibility and mental health services, particularly targeted to veterans not engaged in VA care.**
- **The VA must ensure that veterans receiving care from community partners receive high quality, evidence-based care.**

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## **Enact Legislation to Address Gaps and Inequities in the VA's Women Veterans Health Care Program**

DAV is committed to ensuring our nation's women veterans have access to high quality, gender-sensitive and specialized health care services to the same extent as their male peers. We support legislation to improve the Department of Veterans Affairs (VA) women's health program, and innovative methods to address barriers to care women veterans often experience.

According to VA, women veterans' use of VA health care increased by 175% over a 15 year period. This upward trend that continues today reflects women's growing presence in the military and veteran populations. Today's women service members are eligible for all military assignments which greatly increases the likelihood of exposure to combat hostilities, war-related injuries and environmental hazards. According to the VA, in 2015, 63 percent of women veteran patients had a service-connected disability, and were eligible for a lifetime of treatment, compensation, education and other VA benefits.

The rapid growth of the women veterans' population in addition to the influx of younger veterans returning from wartime service has, at times, overwhelmed the VA, resulting in unmet needs and gaps in programs designed to help this population. DAV's 2018 report—Women Veterans: The Journey Ahead confirmed persistent gaps and problems in the range of VA programs available to women veterans and their access to them. The report also noted that many women veterans require not only veteran-focused care but unique, gender-sensitive services and programs to achieve a successful transition and recovery from post-deployment health and mental health challenges.

Providing women veterans the care and services they need remains challenging as the VA must focus on: a more diverse, clinically complex and younger population seeking care; increasing demand for gender-specific and specialized services; expanding access through its community care network; improving care standards; and training clinical providers to offer expert care to women veterans at all sites of care.

To address these challenges the House of Representatives formed a Congressional task force in 2019, and held a series of roundtables and hearings to seek stakeholder feedback on issues and proposed legislation to improve women veterans' health services. The VA also established an internal task force and initiated a Stand Up to Stop Harassment Now! campaign that proposes to create a safe, respectful and welcoming environment for all veterans as they seek VA care or their earned benefits.

DAV supports the following comprehensive measures aimed at changing culture, stopping harassment and improving health services for women veterans:

- ▶ **Congress should enact S. 514 /H.R. 3224, the Deborah Sampson Act—and a final version of the bill that includes the following provisions:**
  - **A plan to change VA culture and create an environment that is harassment free, welcoming to women veterans and recognizes their contributions in military service.**
  - **Elevation of VA's Women's Health program to an Office of Women's Health, along with the necessary resources to fix existing privacy and safety deficiencies, recruit and train a sufficient number of providers that have expertise in women's health, and ensure comprehensive, quality gender-specific care at all VA sites of care.**
  - **A plan to ensure community partners are well-prepared to address women veterans' health care needs by making training about their unique needs widely available and developing standards that assure appropriate access to care and quality of services.**
  - **Initiate VA policies and practices to coordinate and monitor care for women veterans with complex care needs who are at risk of experiencing adverse health outcomes due to military exposures.**





## BY THE NUMBERS



More than 1 million veteran members are organized into nearly 1,300 local chapters and 52 departments, including Puerto Rico.



DAV assisted veterans, service members and their families with more than 223,000 claims for earned benefits in 2019.



More than 11.7 million claims have been submitted by DAV since the organization was chartered by Congress in 1932.



More than 1.1 million veterans trust DAV with their power of attorney to represent them for benefits claims and have received \$21 billion in earned benefits in 2019.



In 2019, over 1 million hours were donated by volunteers in VA hospitals and clinics.



Volunteer drivers in DAV's Transportation Network provided more than 615,000 no-cost rides for ill and injured veterans to VA medical facilities in 2019.



With a value of more than \$84 million, 3,678 vehicles have been donated to the VA since 1987 for transporting veterans to appointments.



Since 2014, DAV has co-hosted 607 traditional and virtual job fairs, connecting nearly 210,000 active-duty, Guard and Reserve members, veterans and their spouses with employment, resulting in more than 146,000 job offers.



In 2019, DAV provided 470 emergency relief drafts, totaling more than \$290,000, and roughly 370 supply kits for disaster victims.