



OPERATION: **KEEP THE PROMISE**

DAV | 2019

DAV's Critical Policy Goals for 2019

1. Strengthen Veterans Health Care
2. Improve Care for Women Veterans
3. Establish Benefits Based on Burn Pit Exposure
4. Enhance Survivors' Benefits
5. Justice for Blue Water Navy Vietnam Veterans
6. Ensure a Sufficient VA Budget for FY 2020

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 non-profit organization with more than 1 million members, was founded in 1920 and chartered by the U.S. Congress in 1932.

Strengthen Veterans Health Care

The VA MISSION Act (Public Law 115-182), signed on June 6, 2018, was designed to expand veterans access to health care through a new integrated community care program and make major investments to increase VA's internal capacity to provide care. The law also establishes a comprehensive process to modernize and realign VA's hospitals and outpatient clinics and will expand VA's caregiver support program to include seriously injured veterans from all eras. With provisions of the law beginning to take effect this year, it is now up to the 116th Congress to ensure that the MISSION Act is fully, faithfully, and effectively implemented.

It is especially critical for VA to develop and operate the new Veterans Community Care Program (VCCP) in accordance with the widespread compromise reached by all key stakeholders. The most important principle is that VA must remain the coordinator and primary provider of care, with the new VCCP networks filling gaps to ensure seamless access for enrolled veterans. If the law is not implemented as intended, VA's ability to provide timely and high quality care could be adversely impacted, and millions of veterans who choose and rely on VA health care would suffer.

The VA MISSION Act consolidates several existing community care programs, including the Choice Program, into the new VCCP, using local integrated networks of community providers. To ensure the best health outcomes for veterans, the Department of Defense (DOD) and VA's academic affiliates should be preferred providers in the network due to their experience and expertise in military and veteran medicine, as well as their close connections to the VA health care system.

The law requires VA to promulgate numerous regulations by June 6, 2019 to begin operating the VCCP by July 7, 2019. VA is also required to develop and publish new access standards to replace the current 30-day, 40-mile "choice" standards. The new access standards must be both clinically appropriate and realistically achievable, otherwise the costs could become unsustainable, and VA could be forced to choose between fully funding its medical facilities or diverting funds to pay for private care through the VCCP.

The VA MISSION Act contains numerous provisions to strengthen VA's ability to recruit, hire and retain high quality medical professionals, to help address the 40,000 vacancies at the start of 2019. The law also expands VA's authority to operate telehealth programs across state lines and requires VA to develop new health care programs specifically targeted to rural and underserved areas, both of which must remain priorities and be fully funded.

The MISSION Act establishes a multi-year Asset and Infrastructure Review (AIR) process to examine VA's existing health care facilities and develop a long-term plan to realign and modernize them. This plan must be reviewed and approved by 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 (VSO). The AIR process will only be successful to the degree that veterans and VSO stakeholders are fully informed, consulted and engaged throughout the process.

Congress must:

- **Closely oversee 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.**
- **Provide 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.**

Improve Care for Women Veterans

In 2018, DAV released a special report *Women Veterans: The Journey Ahead* that identifies gaps in federal programs and includes 45 recommendations to improve VA health care and specialized services for women veterans of all service eras.

Today, women are serving in greater numbers in the U.S. military and likewise, the number of women veterans seeking VA health care services continues to increase—more than doubling over the past decade. This unprecedented growth in the number of women veterans coming to the VA for care required the Department to make significant changes to improve access and the quality of care for women patients.

VA dedicates significant resources to recruit and train hundreds of health providers who have an interest in treating women patients. To ensure they have the necessary skills and are proficient in women's health, VA began conducting mini-residencies that provide hands-on training and mentoring. VA researchers have been key to identifying specific challenges in caring for this population by looking at the specific demographic characteristics, health care utilization patterns and medical conditions of women veteran patients so that policymakers can determine how they can improve health outcomes and better serve this growing population.

VA research indicates women veterans are more intensive users of VA outpatient services and mental health services compared to their male veteran counterparts, and are at higher risk for homelessness and suicide relative to non-veteran women. Notably, 63 percent of women veteran patients in the Veterans Health Administration (VHA) have a service-connected disability, and are eligible for a lifetime of treatment, compensation, education and other VA benefits. The recent integration of women into all military occupations has increased exposure to combat and hazardous occupations and thereby women are at increased risk for serious war-related injuries such as limb loss, traumatic brain injury, as well as the consequent risks of developing post-traumatic stress disorder (PTSD) or other post-deployment behavioral health issues. Wartime deployments have also resulted in a number of new transition and reintegration challenges for women veterans and additional challenges for the VA.

Not all women veterans' gender-specific health care needs can be met at all treatment sites within VHA, such as maternity care; therefore, women are more likely to use contract care than their male peers. Changes in community care plans proposed under the VA MISSION Act, are more likely to affect the care of women veterans. Based on the complex health needs of many women veterans, it will be essential that care coordinators, policies and best practices are in place to carefully coordinate and monitor women veterans' care, especially for women veterans with service-connected conditions that place them at higher risk for complications during pregnancy.

While VA continues to make progress in meeting the needs of a rapidly growing women veterans' population, there is far more to be done to ensure that programs and services are designed to meet their unique needs and that women veterans have access to timely, comprehensive health care services at all VA points of care, including its network of community providers.

VA must:

- **Provide women veterans equitable access to the same health care services and programs as male veterans, including VA's specialized services for substance use disorders, homelessness and treatment for PTSD related to combat or military sexual trauma. Most importantly, these programs must be tailored to meet the unique needs of women veterans.**
- **Ensure proper coordination of care for women patients with complex care needs who must frequently access gender-specific health care services in the community and especially for women veterans with war-related injuries and/or service-related conditions who are at higher risk for poor health outcomes.**

Establish Benefits Based on Burn Pit Exposure

During Operations Desert Shield/Desert Storm (1990-1991) and since, burn pits were utilized in Iraq, Kuwait, Oman, Qatar, United Arab Emirates, Saudi Arabia, and Bahrain. During Operation Joint Endeavor in Bosnia (1995-1996) burn pits were considered operational necessity and since September 11, 2001, burn pits have been used in Afghanistan, Djibouti and Iraq.

Several studies have indicated that these veterans were exposed to 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. The pits did not effectively burn the volume of waste generated, and smoke from the burn pit blew over bases and penetrated all living areas.

Currently, the Department of Veterans Affairs (VA) does not provide presumption of service connection for diseases related to burn pit exposure, but continuing research may soon establish such links. In October 2018, the VA announced they are contracting with the National Academy of Medicine to provide a comprehensive study of burn pit effects, due in 2020 or later. This means we may be years away from potentially establishing presumptive diseases related to burn pit exposures.

Since there is no current presumptive service connection, veterans must file claims for direct service connection for diseases and illnesses related to burn pit exposure, which requires them to provide sufficient evidence of burn pit exposure and of a nexus between the burn pit exposure and their current disability. While we know, in general, where burn pits were used, it can be difficult to document each individual veteran's exposure to a burn pit, especially during combat operations and in war zones.

While awaiting scientific studies on linkage between burn pit exposure and specific diseases, Congress should enact legislation to concede burn pit exposure for all veterans currently eligible to join the VA Airborne Hazards and Open Burn Pit Registry, and it should include the same chemicals and toxins noted in VA's M21-1 Manual. To be clear, a concession of burn pit exposure will not establish presumptive service connection; however, it will remove the requirement of veterans having to prove their individual exposure to burn pits and the types of toxins emitted for claims based on direct service connection.

Combat veterans who were discharged or released from active service on or after January 28, 2003, are eligible to enroll in the VA health care system for five years from the date of discharge or release. However, this does not address many of the illnesses or diseases that can develop after the five-year period, such as cancers and multisystem diseases. Veterans exposed to burn pits, in many cases, have no alternatives for health care beyond the established period.

Congress should enact legislation to:

- **Concede burn pit exposure for all veterans eligible to join the VA Airborne Hazards and Open Burn Pit Registry, and should include the same chemicals and toxins noted in VA's M21-1 Manual.**
- **Extend or eliminate the five-year period for VA health care for combat veterans or to amend 38 U.S.C. Section 1710 to include VA health care for veterans exposed to burn pits.**

Enhance Survivors' Benefits

Dependency and Indemnity Compensation (DIC) is a monthly benefit paid to eligible survivors of veterans who pass 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 ten years before their death. The value of the current benefit, however, is insufficient to provide meaningful support to survivors of severely disabled veterans. A veteran who is receiving 100 percent disability compensation today would receive approximately \$3,227 a month whereas the current DIC benefit is only \$1,283 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 the 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. To restore the value of this benefit, Congress should adjust the DIC benefit to a more equitable 55 percent of the amount provided for disability compensation to a veteran rated totally disabled, and then index it for inflation.

If the veteran passes away due to a nonservice-connected issue before that 10-year period, 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 if survivors were eligible for a partial DIC benefit based on the number of years they were married to a totally disabled veteran.

Under the existing DIC law a surviving spouse would lose their benefit if they remarry before the age of 57, whereas federal employee survivors in receipt of Civil Service Retirement System benefits and veterans who are signed up for the Survivor Benefit Plan (SBP)—which is an out-of-pocket insurance purchased by military retirees—both allow surviving spouses to remarry at age 55. Congress should enact legislation to allow surviving spouses to remarry at age 55 and maintain their eligibility for DIC benefits.

Congress should also correct the longstanding inequity that offsets DOD Survivor Benefit Program (SBP) payments against VA DIC benefits. For military retirees who enroll in SBP, upon their death the SBP payments to their survivors would be reduced by the amount of DIC that the survivor was already entitled to receive. It is important to point out that SBP is not a government gratuity benefit, rather, it is an out-of-pocket insurance that is purchased by the service member for their survivors' protection in case of their death.

Dependents and survivors eligible for educational benefits under Chapter 35 have only 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 cases of caregivers, family obligations or the need to provide care for the veteran, cause dependents, 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.

Congress should enact legislation to:

- **Increase DIC rates to 55 percent of disability compensation and index them for inflation; change DIC to a graduated benefit to make survivors eligible at 5 years for 50 percent of the full benefit amount, increasing proportionally to 100 percent at 10 years; and reduce the remarriage age for a surviving spouse to 55.**
- **Repeal the inequitable offset between military retiree purchased SBP annuities and DIC, because there is no duplication of benefits involved, and remove the 10-year delimiting date for spouses and surviving spouses to use their Chapter 35 educational benefits.**

Justice for Blue Water Navy Vietnam Veterans

Congress passed the Agent Orange Act of 1991 to provide benefits and presumptive diseases to veterans exposed to Agent Orange. When VA implemented the Agent Orange Act, it determined that veterans who received the Vietnam Service Medal, to include those who served in the waters offshore, were exposed to Agent Orange. In 1993, a VA General Counsel opinion held that veterans with service in the waters offshore were exposed to Agent Orange.

The Veterans Benefits Improvements Act of 1996 extended the wartime period for service in Vietnam. Subsequently, a VA General Counsel opinion in 1997 misinterpreted that statute and determined only veterans who physically served in Vietnam were exposed to Agent Orange. In 2002, the VA updated its manual reiterating that exposure to Agent Orange was conceded only to those physically in Vietnam. The decision to exclude Blue Water Navy veterans from exposure to Agent Orange was not based on medical or scientific evidence, law, or actual Congressional intent; it was based on a misinterpretation.

In 2006 the Court of Appeals for Veterans Claims held that VA's interpretation was incorrect; however, the VA subsequently appealed that decision to the U.S. Court of Appeals for the Federal Circuit. In 2008 the Federal Circuit upheld VA's decision to exclude Blue Water Navy Vietnam Veterans.

Lawmakers began introducing legislation in 2008 to clarify their intent of including Blue Water Navy Vietnam veterans as exposed to Agent Orange. During the 115th Congress, H.R. 299, Blue Water Navy legislation, passed the House of Representatives with a vote of 382 to 0 in June 2018. However, the bill was not successful in the Senate. Senate leadership tried to pass the bill by unanimous consent, but due to the objections of two Senators, the bill failed as the 115th Congress closed in December 2018.

At the beginning of the 116th Congress, House Veterans' Affairs Committee Chairman Mark Takano and Ranking Member Dr. Phil Roe introduced two bills, H.R. 299 and H.R. 203, respectively. Both bills, the Blue Water Navy Vietnam Veterans Act of 2019, contain the same essential language as was introduced in the 115th Congress. Subsequently, the U.S. Court of Appeals for the Federal Circuit (Federal Circuit), made a landmark decision on January 29, 2019.

In *Procopio v. Wilkie*, the Federal Circuit overruled the VA's previous misinterpretations and held that it was Congress's intent to include the territorial seas as serving in Vietnam. The Court defined the territorial seas as 12 nautical miles from the coast of Vietnam.

VA can attempt to overturn *Procopio v. Wilkie* by appealing the decision within 90 days to the U.S. Supreme Court. This could result in a stay or hold being placed on all Blue Water Navy veterans claims until the outcome of the appeal is decided. VA will issue guidance to process and interpret *Procopio v. Wilkie* either via regulation or by their manual. That guidance could be contrary to the intent of the Federal Circuit decision. Pending legislation would protect and codify the decision to ensure its correct interpretation and application for all affected veterans.

- **Congress should enact H.R. 203/299 or similar legislation to protect and codify the Federal Circuit Court decision, to ensure all Blue Water Navy Vietnam veterans receive the benefits earned through their service.**

Ensure a Sufficient VA Budget for FY 2020

To ensure service-disabled veterans get timely access to the health care and benefits they need and deserve, Congress must provide the Department of Veterans Affairs (VA) sufficient resources to meet the rising demand for care and to carry out reform efforts required by the VA MISSION Act of 2018.

DAV and *The Independent Budget* (IB) recommends \$103.3 billion for all VA discretionary programs for fiscal year (FY) 2020 and \$90.8 billion in advance appropriations for VA medical care accounts for FY 2021. These resources are essential given the monumental VA reform efforts underway to modernize the veterans' health care system.

Because of insufficient data from VA, our funding recommendation does not reflect the total budgetary effect of the VA MISSION Act of 2018. Moving forward, Congress must ensure VA has sufficient resources to deliver comprehensive care to all enrolled veterans, provide timely benefits, carry out new requirements imposed on the Department, and make needed system upgrades.

For FY 2020, DAV and the IB recommend total medical care funding of \$88.1 billion. This is an increase of \$7.5 billion over VA's current mandatory and discretionary medical care funding level and includes specific increases for: increasing costs of more advanced prosthetics being prescribed for seriously disabled veterans, expansion and improvement of health care and benefits services for women veterans and to begin the first phase of expanding access to VA's comprehensive caregiver supports to veterans severely injured before September 11, 2001.

For Medical and Prosthetic Research, DAV and the IB propose \$840 million, an additional \$61 million over current funding levels to maintain its success in delivering direct and significant contributions to improved care for veterans and an elevated standard of care for all Americans.

To improve VA's health care system infrastructure, we recommend \$3.8 billion for major and minor construction accounts for FY 2020. This will allow VA to complete or begin construction on key projects including correcting seismic deficiencies and other safety risks, and address projects that have been placed on hold for years. Continuing the effort to modernize VA's electronic health records in FY 2020 will recommend \$1.8 billion.

For the Veterans Benefits Administration (VBA), we recommend \$3 billion to keep pace with current and future claims and appeals workload in light of the Appeals Modernization Act, which is estimated to take full effect early this year, and the hiring throughout this year to meet the Vocational Rehabilitation and Employment program counselor-to-client ratio of 1:125.

Congress must provide:

- **VA more than \$103 billion in FY 2020 to ensure the Agency makes needed improvements, fully and faithfully implements the VA MISSION Act of 2018, and is able to timely deliver benefits and services to all enrolled veterans, particularly ill and injured veterans, their families and survivors.**
- **\$90.8 billion in FY 2021 advance appropriation.**



BY THE NUMBERS



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



In 2018, DAV provided 3,569 emergency relief drafts totaling more than \$1.2 million and roughly 305 supply kits for disaster victims.



With DAV's assistance, service members, veterans and their families received more than \$20 billion in benefits in 2018.



More than 11.5 million claims submitted by DAV since being chartered by Congress in 1932.



More than 1 million veterans trust DAV with their Power of Attorney (POA) to represent them for benefits claims.



In 2018, over 2 million hours were donated by departments, chapters and volunteers helping ill and injured veterans in VA hospitals and clinics.



Volunteer drivers in DAV's Transportation Network provided more than 625,000 no cost rides for ill and injured veterans to VA medical facilities in 2018.



3,517 vehicles with a value of over \$80 million donated to VA since 1987 for transporting veterans to appointments.



145 traditional and virtual job fairs sponsored in 2018 in partnership with RecruitMilitary and Veteran Recruiting, connecting 52,685 active duty, Guard and Reserve members, veterans and their spouses with employment.