OPERATION: KEEP THE PROMISE

DAV | 2025

DAV's Critical Policy Goals

- Strengthen presumptive policies to ensure toxic-exposed veterans receive earned benefits in a timely manner
- Eliminate gaps in mental health care and suicide prevention with a focus on gender-tailored care
- Prevent congress or VA from reducing, offsetting or taxing veterans benefits
- Modernize and strengthen benefits for survivors
- Expand comprehensive dental care services to all service-disabled veterans
- Enhance long-term care by providing assisted living and increasing caregiver support
- Sustain the VA health care system by reforming infrastructure planning and funding mechanisms
- Protect veterans benefits and services by ending PAYGO offsetsand budget caps that cut funding

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

Strengthen presumptive policies to ensure toxic-exposed veterans receive earned benefits in a timely manner

The Challenge

Military service members have been harmed by toxic exposures for more than a century, including by mustard gas in World War I, atomic testing in World War II, Agent Orange in Vietnam, sarin gas in the Persian Gulf War, contaminated water at Camp Lejeune and burn pits in Afghanistan, Iraq and other locations where troops were deployed after 9/11. Unfortunately, toxic-exposed veterans often have to overcome significant obstacles to receive benefits and health care they deserve. Toxic wounds and illnesses can take years or decades to manifest, and by the time they do, it's almost impossible to prove exactly what they were exposed to or why that made them ill.

The enactment of the Honoring our PACT Act of 2022 provided the largest expansion of health care and benefits for toxic-exposed veterans in a generation. In addition to expanding health care access for millions of veterans, the law created presumptives for burn pits and other toxic exposures to cover veterans who develop cancers and respiratory conditions specified in the law. The PACT Act also codified a new internal VA decision-making process for creating future presumptives for other toxic exposures; however, it does not include adequate accountability measures to ensure timely decisions in the future.

Although the PACT Act has already delivered new benefits and health care eligibility to millions of veterans, the law does not cover every toxic-exposed veteran. There are still too many waiting for formal VA recognition of service-connected toxic wounds that would allow them access to life-changing benefits and health care to ease their pain and suffering–including those who served at the Karshi-Khanabad Air Base (commonly known as K2) in Uzbekistan and Fort McClellan in Alabama.

According to ***Ending the Wait for Toxic-Exposed Veterans*** – a report released by DAV and the Military Officers Association of America – it takes more than three decades, on average, from the first incidence of a military toxic exposure to a formal governmental acknowledgment of that exposure. For those military toxic exposures that VA has made a formal concession of exposure and established presumptions of service connection, veterans have been forced to wait 34.1 years, on average, before they were eligible to receive benefits and health care based on presumptive service connection.

Recommendations

- To provide quicker and more equitable outcomes for veterans, Congress should approve legislation to establish a new legal framework for creating toxic exposure presumptives using three distinct steps: (1) acknowledgment of a possible toxic exposure risk; (2) concession of exposure to toxic substances; and (3) presumption of service connection between exposures and diseases.
- The VA must establish a series of timelines and triggers to ensure it makes timely decisions. The legislation should also expand federal research on toxic exposures, create an independent scientific review process for toxic exposures injuries and illnesses, and establish a veterans stakeholder advisory commission to strengthen oversight and transparency of the VA presumptive-making process.

Eliminate gaps in mental health care and suicide prevention with a focus on gender-tailored care

The Challenge

The Department of Veterans Affairs (VA) has invested heavily in suicide prevention, providing extensive mental health services for veterans with post-traumatic stress disorder (PTSD), substance use disorders, traumatic brain injuries, depression, anxiety and military sexual trauma (MST). However, too many veterans decide to end their lives and gaps remain in care, resources and understanding—particularly among historically underserved populations like women and must be addressed to ensure all veterans are effectively served in a timely, equitable manner.

For example, 1 in 3 female veterans and 1 in 50 male veterans report experiencing MST, which is a known risk factor for suicide and other negative mental health consequences among all veterans. VA's innovative and life-saving suicide predictor model identifies at-risk veterans who may benefit from enhanced care and intervention. However, that model does not incorporate MST or other known risk factors for suicide, like intimate partner violence.

According to the VA's 2024, National Veteran Suicide Prevention Annual Report there were 6,407 veteran suicide deaths in 2022. Notably, between 2021 to 2022, the percentage of veteran suicides that involved firearms increased 7.1%—with firearms involved in 73.5% of all veteran suicides. The report noted significantly higher rates of firearm suicide among veterans compared to their civilian peers (69.6% higher than male non-veterans and 144.4% higher than female non-veterans). The report underlines a critical need for targeted suicide prevention strategies, particularly concerning secure firearm storage and mental health support.

While the VA prioritizes lethal-means safety among veterans by requiring safe storage practices training to their providers, it does not require community care providers to be trained in such prevention efforts. The VA also trains its providers in trauma-informed care practices to address the specific needs of veterans with known trauma histories—this should also be a training requirement for community providers.

Last year, DAV released a special report, ***Women Veterans: The Journey to Mental Wellness***, that revealed gaps in how the VA accounts for the unique risk factors contributing to suicide among women veterans and offers over 50 recommendations that would help bolster gender-tailored care and improve VA's suicide prevention efforts for all veterans, including the three major recommendations below.

Recommendations

- The VA should revise its suicide predictor model to incorporate additional risk factors, specifically including MST and intimate partner violence.
- The VA should amend its contracts with community care providers to require those who treat veterans to be trained in suicide prevention and lethal-means safety counseling. Alternatively, Congress could mandate such training.
- The VA should require all community network providers to be trained in trauma-informed care practices used by VHA providers to address the specific needs of veterans with known trauma histories.

Prevent congress or VA from reducing, offsetting or taxing veterans benefits

The Challenge

Over 5.6 million disabled veterans receive compensation for injuries, illnesses and disabilities caused or aggravated by their military service. However, veterans who also earned military retirement benefits due to a medical retirement are prohibited from concurrently receiving their medical retirement pay and Department of Veterans Affairs (VA) disability compensation. Similarly, the concurrent receipt of military pensions based on longevity of service and disability compensation for veterans who are rated at 40% or less is also prohibited by law.

Because VA disability compensation is tax-free, veterans in these situations typically choose to collect their full disability compensation and their military retirement is reduced each month by the amount of their disability compensation. This offset is an unjust reduction because military retirees receive a pension in compensation for military service, whereas veterans receive disability compensation to compensate for injuries and illnesses that impair their earnings capacity–two separate and unrelated purposes. In 2003, Congress recognized this inequity when it enacted legislation to phase in concurrent receipt for disabled veterans rated 50% or greater. However, it did not correct this unfair practice for veterans rated 40% or lower or for those who were medically retired.

Federal law also currently requires veterans who receive disability compensation to pay back any special separation pay they may have received for ending their military career early, either voluntarily or–in some cases–involuntarily. There is no relation between the purposes of special separation pay and disability compensation, and there should be no pay back or offsets required.

In recent years, proposals have been floated to begin taxing VA disability compensation payments and count it as income when determining eligibility for other federal benefits. Some have proposed phasing out Total Disability for Individual Unemployability (TDIU)–a disability compensation rating based on a veteran's inability to achieve and maintain gainful employment–once a veteran reaches Social Security retirement age. Finally, there have been proposals to reduce benefit levels for disability compensation across-the-board for current or future veterans and to phase out lower disability compensation payments altogether. Each of these attempts to reduce the amount of disability compensation for service-disabled veterans is wrong and must be fully and permanently rejected.

Recommendations

- Congress should enact legislation to eliminate all offsets of any military retirement or separation pay against VA disability compensation.
- Congress must ensure, through word and deed, that it will reject any and all attempts to reduce, offset or tax veterans' disability benefits.

Modernize and strengthen benefits for survivors

The Challenge

Our nation's obligation to the men and women who serve also extends to the survivors of service members and veterans, particularly service-disabled veterans. The Department of Veterans Affairs (VA) Dependency and Indemnity Compensation (DIC) program was created in 1993 to provide a tax-free monthly benefit to surviving spouses, children and parents of:

- Military service members who died in the line of duty;
- Veterans whose death resulted from a service-related injury or disease; and
- Veterans who were totally disabled from service-connected conditions for at least ten years before their death; or were totally disabled at least five years immediately following their release from active duty until their death; or were totally disabled for at least one year and were a former prisoner of war.

The basic DIC benefit for a single surviving spouse of a veteran in 2025 is $1,653.07 per month, which can be increased if there are dependent children or other special circumstances. Since the 2025 VA disability compensation rate for a 100% service-connected veteran with a spouse is $4,044.91 per month, the DIC benefit for a surviving spouse would be approximately 41% of that amount. By comparison, monthly benefits for survivors of federal civil service retirees are calculated as a percentage of their federal retirement benefits, which can be up to 55% of the total benefit. Veteran surviving spouses eligible for DIC should at least have parity with their federal civil service survivors and receive 55 % of their veteran's disability compensation rate. This increase to DIC payments would equate to approximately $6,860 more per year.

Furthermore, survivors of veterans who die before they reach 10 years as a 100% totally disabled veteran do not qualify for any DIC benefit, even if the veteran died after being totally disabled for 9 years and 11 months. In addition, surviving spouses who are currently in receipt of DIC benefits will lose them entirely if they remarry before age 55. These rules have undercut the purpose of DIC, which is to provide adequate care for surviving spouses.

Recommendations

- Congress should enact comprehensive legislation to modernize and strengthen DIC support for survivors of disabled veterans. The legislation should:
  - Increase DIC rates to 55% of the 100% VA disability compensation rate.
  - Provide a graduated benefit to survivors of veterans who were totally disabled for five years equivalent to 50% of the full DIC benefit amount, increasing proportionally each 10% until reaching 100% after 10 years.
- Congress should eliminate the remarriage age penalty for a surviving spouse so that they remain eligible for DIC benefits regardless of when they choose to remarry.

Expand comprehensive dental care services to all service-disabled veterans

The Challenge

The Department of Veterans Affairs (VA) only provides full dental care to a limited number of veterans enrolled in its health care system, which includes those who have a service-connected dental disability, are 100% service disabled and those receiving Total Disability for Individual Unemployability (TDIU). The VA also provides partial dental care to veterans who have a health condition linked to, or that would be made worse by, a dental condition as well as homeless veterans and certain veterans receiving Vocational Readiness and Employment (VR&E) services. In total, only about 500,000 of the 9 million veteran enrollees in the VA health care system have any dental eligibility.

Yet, the VA health care model is specifically designed to be holistic, integrated and preventative—a system that treats the whole health of the veteran. The failure to provide dental care is a significant and harmful gap in VA's health care coverage.

Studies show that poor dental hygiene can lead to a number of chronic health conditions, including infections from decaying and dying teeth, which can be life-threatening if not treated. Poor dental health has also been linked to heart attacks, strokes, heart failure, diabetes, endocarditis, chronic kidney disease, chronic obstructive pulmonary disease, gastritis, rheumatoid arthritis and cognitive impairment. Gum disease, called periodontitis, has been linked to premature birth and low birth weight. Germs in the mouth can spread to the lungs causing pneumonia and other respiratory problems. A number of cancers have also been linked to gum disease, including gastrointestinal tract, lung, breast, prostate gland and uterine cancer. Other conditions that might be linked to oral health include eating disorders, rheumatoid arthritis and an immune system condition that causes dry mouth called Sjogren's syndrome.

Poor dental health can also lead to emotional, mental and financial challenges. Many people who are ashamed to show their teeth to others tend to have lower self-esteem, suffer from depression and find it difficult to interview for and secure employment. While once thought of as a "cosmetic" service, dental care today is critical to a person's overall health and well-being.

Recommendations

- Congress should enact legislation to expand eligibility for full dental care coverage to all service-disabled veterans, making it a standard part of VA's health benefits package.
- Congress must provide funding to increase the number of VA dentists and other oral clinicians, open new dental clinics and expand treatment space in VA health care facilities.
- VA must work with its community care networks to increase the availability of dentists and other oral health care specialists to improve access across the country, particularly in rural areas.

Enhance long-term care by providing assisted living care and increasing caregiver support

The Challenge

There are an estimated 8.3 million veterans 65 years or older out of approximately 18 million total veterans living today. Approximately 4.9 million are 75 or older, and 1.3 million are 85 or older. The Department of Veterans Affairs (VA) projects that in 10 years the number of veterans aged 85 and older will increase by 33% and the subset of women veterans aged 85 and older could more than double. This aging trend is mirrored in the general population, putting an increasing strain on our nation's health care infrastructure to provide sufficient long-term care support to aging Americans.

To meet the needs of aging veterans, the VA offers various long-term care programs, ranging from intensive bed-based care to home and community-based options. Programs include Homemaker and Home Health Aide Care, Home Based Primary Care, Skilled Home Health Care, Respite Care, Adult Day Health Care and the Caregiver Support Program. For more comprehensive care, veterans have access to VA-operated Community Living Centers (CLCs), State Veteran Homes (SVHs) or contracted community nursing homes.

However, there is a gap in care for veterans who are unable to stay at home but do not require full nursing home support. Assisted living care offering semi-independent living with meals, housekeeping, medication management and help with daily activities would be an appropriate and ideal option. This would help fill the gap by providing a less intensive, yet supportive, environment for aging veterans.

Caregivers also provide essential support to veterans, helping them remain at home as long as possible. Integrating assisted living care with robust caregiver support could fill a significant gap in the VA's long-term care. Studies have shown that over 60% of caregivers experience symptoms of burnout, and most do not know where to turn for help. DAV operates its own Caregivers Support program to help facilitate assistance to our unsung heroes and has connected over 1,250 caregivers to an array of public and private resources in just the first year of its launch. However, the VA has a special obligation to aid caregivers of service disabled veterans and must continue to expand and strengthen its caregiver program, particularly for those severely disabled veterans who would otherwise require institutional care.

Recommendations

- Congress should require the VA to offer assisted living care options for service-disabled veterans, including VA-operated SVHs and contracted community options, as an alternative to skilled nursing care for veterans who can no longer live independently.
- The VA should establish graduated care facilities, allowing veterans to transition smoothly from independent living to assisted living to nursing home care as they age and their care needs change.
- The VA must provide comprehensive resources for caregivers to include respite care, training and financial assistance. Integrating caregiver support into assisted living options ensures a holistic approach to veteran care, addressing both veterans' needs and those of their caregivers.

Sustain the VA health care system by reforming infrastructure planning and funding mechanisms

The Challenge

The Department of Veterans Affairs (VA) operates the largest integrated health care system in the country, providing direct care to more than 7 million veterans each year through a system of over 1,750 access points including medical centers, community outpatient clinics, Vet Centers and community living centers. The VA has more than 5,600 buildings with over 150 million square feet of space, much of which was built more than 50 years ago. Unfortunately, federal funding to maintain, repair and replace VA hospitals and clinics has been woefully inadequate for decades, regardless of which political party has been in control of Congress or the White House, presidency or executive branch.

The VA's Strategic Capital Investment Plan, which estimates the cost to maintain its health care infrastructure, shows that VA should be investing $85 billion over the next decade, or roughly $8.5 billion per year. Instead, the VA's last budget request for FY 2025 was only $2.8 billion for major and minor construction projects. Periodically, the VA and Congress have attempted a grand effort to address the longstanding backlog of construction projects, such as the recent Asset and Infrastructure Review (AIR) process; however, like previous efforts, the AIR process failed.

The decades-long failure to properly fund, maintain and expand the VA's infrastructure to meet rising demand for care by veterans has led to an unsustainable growth in community care and related funding, threatening the long-term viability of the entire VA health care system.

Recommendations

- Congress should enact legislation to create a new VA infrastructure funding process that aligns demand for care with capacity to deliver that care based on proven capital planning methodologies used by other governmental and private institutions. For example, most states require homeowner associations (HOAs) to conduct studies of the cost to maintain their infrastructure, which includes an actuarial schedule for annual investments into a reserve fund to pay for repairs and replacements when they are necessary. VA can and should do the same.
- To ensure proper funding for the repair, renovation and replacement of existing VA facilities, Congress should require the VA to conduct a quadrennial review of the lifecycle costs for maintaining its health care infrastructure. Congress should then be required to provide full funding for the actuarial cost to meet those obligations each year, deposited into a capital reserve fund.
- Congress should require the VA to conduct a quadrennial review to create a prioritized list of VA construction projects so Congress can provide sufficient funding for repurposing, realigning and expanding existing facilities or for constructing new VA facilities in response to changes in veterans' demand for care. Congress would then be required to deposit at least the first two years of funding required for each project it approves into a capital improvement fund.

Protect veterans benefits and services by ending PAYGO offsets and budget caps that cut veterans' funding

The Challenge

In an attempt to control federal debt and deficits, Congress has adopted laws and rules to limit its ability to increase federal spending, regardless of the need for or merit of that spending. So-called "fiscal responsibility" reforms have included budget caps, sequestration and a particularly insidious mechanism called "PAYGO," which stands for "pay-as-you-go." It requires Congress to cut existing benefits before adding new benefits. However, unlike any other government program, veterans' benefits and care have already been paid for through the sacrifices of those who served.

Both the House and Senate adopted PAYGO rules at the start of the 118th Congress. The Senate PAYGO rule requires that any legislation increasing mandatory spending, such as a bill to expand eligibility for veterans' benefits, must include equal revenue increases or spending cuts in other mandatory programs within the same department, i.e. the Department of Veterans Affairs (VA). The House adopted a variation of PAYGO called "CUTGO" ("cut-as-you-go"), which requires any legislation increasing mandatory spending to be offset only by cuts to other mandatory benefits, not by revenue increases.

Because Congress is reluctant to cut current benefits provided to veterans, particularly those for disabled veterans, it has become increasingly difficult to enact legislation that would create new VA benefit programs or expand eligibility for existing VA benefit programs, even when a large majority of House and Senate members support such legislation.

In addition, the Statutory Pay-As-You-Go Act of 2010 looks at the cumulative effect of all legislation at the end of each year, and if there were increases in net mandatory spending, the Office of Management and Budget (OMB) orders across-the-board cuts, called sequestration, to all federal programs. This also inhibits Congress from enacting legislation to strengthen and expand veterans benefits and services.

Finally, in recent years Congress and the Administration have relied on multi-year budget cap deals in lieu of annually-approved budgets, which set out broad limits on overall discretionary spending, including VA health care. Such caps can artificially force VA spending to be constrained below its actual need for funding in order to prevent cuts to other federal programs.

Recommendations

- Congress should exempt all veterans' programs, benefits and services from Statutory Pay-As-You-Go Act requirements, including sequestration, as well as any House and Senate PAYGO rules adopted for the 119th Congress.
- Congress and the Administration should exempt all federal budget Function 700: Veterans Benefits and Services from any budget cap deals in order to encourage VA budget requests that honestly reflect the true demand for veterans benefits and services.