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REVIEW OF VETERANS' DISABILITY COMPENSATION: BENEFITS IN THE 21ST CENTURY

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SEPTEMBER 17, 2009

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WITNESSES

REVIEW OF VETERANS' DISABILITY COMPENSATION: BENEFITS IN THE 21ST CENTURY

THURSDAY, SEPTEMBER 17, 2009

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 9:34 a.m., in room 418, Russell Senate Office Building, Hon. Daniel K. Akaka, Chairman of the Committee, presiding.

Present: Senators Akaka, Brown, Tester, Begich, Burris, Burr, and Johanns.

OPENING STATEMENT OF HON. DANIEL K. AKAKA, CHAIRMAN, U.S. SENATOR FROM HAWAII

Chairman AKAKA. This hearing will come to order.

This morning the Committee continues our work on veterans' disability compensation. Specifically, we will be focusing on issues relating to compensation payments for service-connected disabilities.

Discussions about the veterans' disability compensation system often involve two separate but related elements of how the government pays compensation to those injured in military service. The first part is the timeliness and accuracy of compensation decisions, which we held a hearing on in July. This is an important issue which requires reforming the current process by which VA adjudicates claims for benefits. The Committee agrees that veterans deserve timely, accurate adjudication of their claims for benefits. We are now working to determine how best to meet that goal.

The second issue relates to the factors that determine how much a veteran should be compensated for his or her disability. This is a very complex question that the Committee continues to consider and is a topic for today's hearing.

There are a number of considerations that must be taken into account when we look at what influences how much a veteran is compensated for injuries related to military service. How is a veteran's quality-of-life affected by a disability? How do we calculate loss of earnings related to the disability? How accurate is VA's current ratings schedule? What is the role of rehabilitation in making a disability determination? These are but a few of the questions that we are addressing today.

Calculating the appropriate level of compensation for those disabled in service is a complex matter. For example, there is data, based on comprehensive studies, suggesting that some veterans do not receive an appropriate level of compensation, while some others

may be overcompensated. As a result, efforts designed to help some veterans could inadvertently hurt others. We need to be deliberate as we work to develop solutions that will result in appropriate reform of the disability compensation system.

Again, I want to welcome everyone to today's hearing. I look forward to the testimony from our two panels and to continuing to work with the many interested parties in the months ahead as we seek to craft a workable reform of the VA disability compensation system.

Senator Burr?

STATEMENT OF HON. RICHARD BURR, RANKING MEMBER, U.S. SENATOR FROM NORTH CAROLINA

Senator BURR. Thank you, Mr. Chairman. Aloha.

Chairman AKAKA. Aloha.

Senator BURR. Thank you for calling this hearing. I want to welcome our panel of experts and committed individuals to solve this.

Mr. Chairman, the brave men and women who have served and sacrificed on our behalf deserve a disability system that meets their needs and, more importantly, a system that helps them to achieve full and productive lives. But in reality, the outdated disability system our Nation's veterans currently have may not be able to meet the needs of the 21st century veteran.

As far back as 1956, the commission chaired by General Bradley stressed that, and I quote, "Our philosophy of veterans' benefits must . . . be modernized, and the whole structure of traditional veterans' programs brought up to date." But no fundamental changes were made then or since, despite a number of reports laying out for all of us the system's shortcomings.

Just last Congress, the Veterans Disability Benefits Commission and the Dole-Shalala Commission again stressed the need to update the system. Those commissions outlined many fundamental problems, including the fact that the purpose of disability compensation, and I quote, "Is unduly restrictive . . . and inconsistent with current models of disability." They also found that the aim of the veterans' disability program should be rehabilitation, but the goal has not been met.

Both commissions recommended updating the VA Schedule for Rating Disabilities to reflect modern medical criteria and current injuries. They recommended compensating veterans for loss of quality-of-life in addition to the loss of earnings capacity. And perhaps more importantly, they stressed the need to emphasize treatment and rehabilitation of injured veterans.

In light of these commissions' reports, VA requested a detailed study of how the recommended changes could be made, and today we will hear about the results of that study. We will also discuss a recent report from VA suggesting maybe even more studies are needed before changes should be made to the disability system.

Although I realize the VA may be reluctant to take on additional challenges at this time, it is understandable that many veterans, including a group in North Carolina that write me frequently, have quite frankly lost patience with five decades of studies that have not been acted on by this Committee or by the VA. Our Nation's veterans, particularly those now coming back from war with dev-

astating injuries, deserve better than a system that was outdated before they were born.

As we now know, their disabilities may affect all aspects of their lives, including community activities, household chores, and time spent with family. They deserve a system that will compensate them for the full impact of their injuries and will give them every opportunity to overcome their disabilities and succeed in civilian life.

Mr. Chairman, I hope—I desperately hope—this is the last hearing we have to have on the recommendations for changes to our disability system. I know that Admiral Dunne, General Scott, Senator Dole, Secretary Shalala didn't do this just because it was a job or it was an offer. They did it because there is a problem. And many have spent countless hours preparing reports that, if this Committee doesn't act, will continue to collect dust like the studies that have come before them.

At a time that we take every opportunity to talk about the increased investment we make in veterans services, now is not the time to fall short of what is tough, and that is getting the disability schedule right, making sure that the next generation of warriors understand that we understand them now, but more importantly that we understand their expectations. We are willing to make sure that they have got the tools to meet those expectations—not just in treatment—but in the way we treat the reimbursements.

So, it is my hope that we will see today a commitment to move forward and I look forward to working with my colleagues on whatever that path is. I thank the Chair.

Chairman AKAKA. Thank you very much, Senator Burr.

Now we will hear from Members of the Committee with their opening statements. Senator Tester?

STATEMENT OF HON. JON TESTER, U.S. SENATOR FROM MONTANA

Senator TESTER. Thank you, Mr. Chairman. I want to thank you for holding this hearing. Thank you for your statements; and I want to thank the Ranking Member for his statement, too. I want to thank the witnesses for being here. Admiral Dunne and General Scott, thank you both particularly for your service and thank you for your continued service to the country by being here today.

I meet regularly with veterans across the State of Montana. I have been at homeless shelters and visited amputees. I have talked with men and women who have suffered from PTSD and TBI. I have been to Walter Reed and Bethesda Naval to see young men from Montana whose lives have been profoundly changed by serious injury in their service to this country.

Today, I am thinking about them, and quite honestly, I am worried about them. I am worried about those physically and mentally disabled folks who suffer from injuries both invisible and all too visible. How do we put a price tag on traumatic disability and diminished quality-of-life caused by war? We have established commissions and committees, reorganized, restructured, and revamped.

Today, we once again talk about the complexity of overhauling an outdated schedule for rating disabilities, and it seems we have been here before. In fact, General Scott, I believe I first met you

in 2007 when you were before this Committee presenting your work from the Veterans Disability Benefits Commission. Now you are back with a new commission and new recommendations; and don't get me wrong, I love to see you here, it is good to see you again, but on this complicated issue, there is no doubt that we need to measure twice and cut once, not the other way around.

Ultimately, we are here to get things done for the veterans. We all know that. They are an important part of this process and I want to thank the VSOs for answering the call to duty once again by preparing some important recommendations for disability claims and disability benefit reform. Those are voices that we need to listen to, as well, during this discussion.

So thank you, Mr. Chairman. I look forward to the solutions that we will be offered toward getting the rating system right. Thank you.

Chairman AKAKA. Thank you very much, Senator Tester.

Senator Johanns?

STATEMENT OF HON. MIKE JOHANNS,
U.S. SENATOR FROM NEBRASKA

Senator JOHANNS. Mr. Chairman, thank you very much. To the Chairman and Ranking Member, thank you for your determination here. These are enormously important issues.

I don't want to speak long, because I don't want to be repetitious. I could just add my words of support to so much of what has been said this morning, and that actually would be sufficient for an opening statement.

I did want to underscore something. I was especially interested in the Economic Systems, Inc. report that found that mental disabilities are oftentimes more disabling in terms of the loss of earning capacity than physical ones, yet our disability system really doesn't mirror that. This is an area of significant interest for me—it was when I was the Governor of Nebraska, and continues to be as I am a Member of the U.S. Senate.

So, my hope is that as we concentrate on what we need to do here, we concentrate on that mental disability aspect in a very, very aggressive way, because I think it has just been left way behind. We have so much better understanding of mental disability today than we did even 5 or 10 years ago. It is time to bring that to our age, if you will.

So, I do appreciate your dedication. One thing I have especially appreciated about being on this Committee is working with the people who work in this area. I think they care deeply about the veterans, want to do the right thing, and are frustrated when things aren't going the way they should. And now we just simply have to figure out how we grab these issues and move them forward. My hope is that in a very bipartisan way we can do that. Thank you.

Chairman AKAKA. Thank you very much, Senator Johanns.

Senator Brown?

STATEMENT OF HON. SHERROD BROWN,
U.S. SENATOR FROM OHIO

Senator BROWN. Thank you, Mr. Chairman and Ranking Member Burr for holding his hearing.

Like many of my colleagues, as Senator Tester said, in August we went home to listen on a whole host of issues. One of the most productive couple of hours I spent was listening to—really doing a roundtable with—veterans and veterans advocates and people who had served their country—like Admiral Dunne and General Scott—in Chillicothe, Ohio, in the heart of Appalachia.

Chillicothe is home to a VA medical center which serves veterans in Southeast Ohio in its main medical center and its five community-based outreach clinics, which are increasingly important, especially in rural areas around my State and other States. There were 3,500 inpatient admissions last year. The hospital is known for its excellence in psychiatric services, in primary and secondary medical services, and in post-acute care.

About 90,000 Ohio veterans receive monthly disability compensation. Many of them were in the audience that day, some were in the roundtable and some were watching. Each is affected, as we know, by the VA schedule of rating disabilities. Each faces a difficult task of understanding its complexities.

We need to continue to dig deeper—as this Committee is doing, as you three are doing—into why there is not uniform disability compensation. A service-connected disability should be rated the same whether the veteran is in Dayton, Ohio, or Daytona Beach, Florida. These problems—the backlog in the rating disparities—in many ways relate back to the VA's schedule of rating disabilities. There must be commonalities with veterans at every rating level, wherever they may live, yet we aren't seeing that.

I am concerned, too, about the quality-of-life component of disability compensation. It is a qualitative evaluation that produces a quantitative result. We need to be sure that this evaluation isn't creating arbitrary benefit differentials. Trust in the VA is eroded when a complicated, subjective formula spits out a rating and a dollar amount, leaving the veteran in the dark as to the process and the rationale behind the compensation. You could just feel that frustration in the hearts and minds of so many veterans that were at that roundtable that morning.

VA could improve the situation by simplifying and rationalizing the benefits formula. More broadly, we should simplify the process by which veterans receive these earned benefits. By providing a fully-integrated system from the Veterans Health Administration to the Veterans Benefits Administration, we could make VA run more efficiently and be more veteran-friendly.

There is also an information overflow problem. Veterans are inundated with paper. This only adds confusion to an already confusing system. As it stands, there is a brisk market for VA "how-to" books. [Laughter.]

The system is that complicated. One book, *The Complete Idiot's Guide to Your Military and Veteran Benefits*, is 400 pages. Another book, *The Veterans Survival Guide: How to File and Collect on VA Claims*, is almost 300 pages. The VA's own guide for Federal benefits for veterans is more than 150 pages.

If we work to modernize the payment structure, four principles should be followed. One, any change to the system must make it more fair.

Two, transparency must be an overarching goal. Veterans must be able to much more easily understand the system, the reasons, and the amounts of their compensation.

Third, it must reduce red tape and focus on increasing efficiency in order to increase timeliness of claims processing and payments.

And last, the system must be designed to maximize earned benefits for veterans, not to minimize compensation awards or the size of those awards.

I am glad we are having this hearing today. I am encouraged that VA and Congress are working together with veterans and with VSOs to find ways to modernize and bring into the 21st century the way that VA handles veterans disability compensation. And I thank all three of you for your service to our country.

Chairman AKAKA. Thank you, Senator Brown.

And now we will hear from Senator Begich.

Senator BEGICH. Mr. Chairman, I will pass and am anxious to hear from the witnesses.

Chairman AKAKA. Thank you.

I want to welcome our principal witness from VA, the Honorable Patrick W. Dunne, Under Secretary for Benefits. I also want to welcome Dr. George Kettner, who is President of Economic Systems, and General James Terry Scott, who is the Chairman of the VA Advisory Committee on Disability Compensation.

Thank you all for being here this morning. Your full testimony will, of course, appear in the record.

Admiral Dunne, will you please proceed?

STATEMENT OF PATRICK W. DUNNE, UNDER SECRETARY FOR BENEFITS, VETERANS BENEFITS ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

Admiral DUNNE. Mr. Chairman, Ranking Member Burr, and Members of the Committee, thank you for inviting me here today to speak on the timely and important issues related to disability compensation for our Nation's disabled veterans.

Compensation for service-connected disabilities is based on replacing the average loss in veterans' wage earning capacity. The Congressional directive mandates that ratings shall be based, as far as practicable, upon the average impairments of earning capacity. As a result, the VA ratings schedule was developed as a means to compensate veterans for the income from employment that they would have received if not for the service-connected disability.

Recently, this approach to disability compensation has been challenged as inadequate because it focuses only on employment loss and not on the larger issue of quality-of-life loss. Definitions of quality-of-life loss vary and may focus on the domains of physical and mental health or may address the individual's general overall satisfaction with life.

The Dole-Shalala Commission recommended compensating a veteran for: the inability to participate in favorite activities; social problems related to disfigurement or cognitive difficulties; and the

need to spend a great deal of time performing activities of daily living.

General Scott and Dr. Kettner have also overseen studies on quality-of-life, and I look forward to their testimony today. Each of these studies has provided valuable information about quality-of-life and has also shown there are many issues to be addressed. My written testimony provides written comments, and I would like to highlight several areas.

First, VA does not have statutory authority to incorporate quality-of-life payments into its disability compensation scheme.

Second, there is no universally recognized method to determine how to adequately and fairly compensate for the impact of a disability or combination of disabilities on a veteran's quality-of-life.

Third, VA already has a number of special benefits that implicitly compensate for quality-of-life loss; among these are ancillary benefits, special monthly compensation, and total disability based on individual unemployability. Special monthly compensation and ancillary benefits are provided to veterans in addition to compensation for service-connected disabilities under the current rating schedule.

Fourth, any proposal must, in our view, be administratively feasible and ensure consistency across decisionmakers.

And finally, VA stands ready to work closely with this Committee and Congress to ensure that all veterans' benefits meet the criteria to care for him who has borne the battle.

Mr. Chairman, this completes my statement, and I would be happy to respond to questions.

[The prepared statement of Admiral Dunne follows:]

PREPARED STATEMENT OF PATRICK W. DUNNE, UNDER SECRETARY FOR BENEFITS, VETERANS BENEFITS ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

Mr. Chairman and Members of the Committee, Thank you for inviting me to speak today on the timely and important issues related to providing disability compensation to our Nation's disabled Veterans, with particular attention to issues related to loss of quality of life (QOL).

I. QUALITY OF LIFE LOSS

Background

Compensation for service-connected disabilities provided by the Department of Veterans Affairs (VA) is based on replacing the average loss in Veterans' wage-earning capacity. The Congressional directive at 38 U.S.C. § 1155 mandates that "ratings shall be based, as far as practicable, upon the average impairments of earning capacity." As a result, the VA rating schedule was developed as a means to compensate Veterans for the income from employment that they would have received if not for the service-connected disability. In recent years, this approach to disability compensation has been challenged as inadequate because it focuses only on employment loss and not on the larger issue of QOL loss. VA has received input on QOL loss from numerous sources. As a result, an effort has been made to clarify the implications for adopting a policy of QOL loss compensation in conjunction with the current average earnings loss compensation system. Those sources providing information and recommendations to VA include: the President's Commission on Care for America's Returning Wounded Warriors (Dole-Shalala Commission); the Veterans' Disability Benefits Commission (Benefits Commission); the Center for Naval Analyses (CNA); the National Academy of Sciences' Institute of Medicine (IOM); and Economic Systems, Incorporated (EconSys).

Definitions of QOL loss vary and may focus on the domains of physical and mental health or may address the individual's overall satisfaction associated with life in general. The IOM traces the concept back to the Greek philosopher Aristotle's description of "happiness." The IOM uses a definition encompassing the cultural, psy-

chological, physical, interpersonal, spiritual, financial, political, temporal, and philosophical dimensions of life. A more succinct definition utilized by EconSys refers to an overall sense of well-being based on physical and psychological health, social relationships, and economic factors.

Dole-Shalala Commission

QOL loss was addressed in the 2007 *Report of the President's Commission on Care for America's Returning Wounded Warriors*, also referred to as the Dole-Shalala Commission. Although the report was primarily focused on ways to assist severely wounded servicemembers returning from Iraq and Afghanistan, it recommended that Congress should restructure VA disability payments to include compensation for non-work-related effects of permanent physical and mental combat-related injuries. According to the report, this would compensate a disabled Veteran for the inability to participate in favorite activities, social problems related to disfigurement or cognitive difficulties, and the need to spend a great deal of time performing activities of daily living. As a result of the report, VA contracted for a study on QOL loss with EconSys, which was completed in 2008.

In terms of existing compensation, the EconSys study agrees with prior studies that earnings loss is on average at least fully compensated under the current system and in some cases overcompensated. However, studies agree that certain conditions such as mental health are undercompensated. Prior studies found that QOL loss does exist for service-disabled Veterans and recommended that VA examine possibilities for QOL compensation, acknowledging that implementation would be lengthy and have significant cost implications.

Veterans' Disability Benefits Commission

The Benefits Commission was created by the National Defense Authorization Act of 2004 and produced a final report in 2007 that provided recommendations to VA on a wide range of issues related to the claims process and the benefits award system. Among the issues addressed was QOL loss. The report included recommendations that VA disability compensation should account for QOL loss. In addition, it recognized special monthly compensation benefits and ancillary benefits as existing vehicles to assist with QOL loss among disabled Veterans. The Benefits Commission incorporated information from the CNA and IOM studies into its final report, agreeing with these organizations that QOL loss existed among disabled Veterans and that VA disability compensation should address it. The Benefits Commission also supported the idea that VA should undertake studies designed to research and develop QOL measurement tools or scales and ways to determine the degree of loss of QOL on average resulting from disabling conditions in the rating schedule. However, it acknowledged that QOL loss assessment is a relatively new field and still at a formative stage. Therefore, implementation would be a long-term, experimental, and costly activity.

Center for Naval Analyses

A major study on QOL loss among Veterans was conducted by CNA at the request of the Benefits Commission. It focused on whether the current VA benefits program takes into account QOL loss. A survey was conducted to determine whether QOL loss existed among disabled Veterans and whether parity existed between the amounts of VA compensation received by disabled Veterans and the average earned income of non-disabled Veterans. CNA determined that QOL loss does exist among disabled Veterans. It was also determined that VA generally compensated adequately for lost earnings and in some cases overcompensated, as with Veterans who enter the system at retirement age, which CNA stated implies a built-in QOL loss payment for these Veterans. However, CNA found that undercompensation occurred for younger Veterans with more severe disabilities and for all categories of mental disabilities compared to physical disabilities. It was also pointed out that, while QOL loss was greater among disabled Veterans than non-disabled Veterans and the general population, those Veterans with mental disabilities showed the greatest QOL loss.

Institute of Medicine

A second QOL loss analysis incorporated by the Benefits Commission into its final report came from the 2007 report, *A 21st Century System for Evaluating Veterans for Disability Benefits*, produced by IOM at the commission's request. This lengthy review of the VA disability benefits process addressed QOL loss. A distinction was made by IOM between current VA compensation for a Veteran's work impairment and a compensation system based on "functional limitations" on usual life activities, which would include non-work disability. IOM concluded that the Veterans' disability compensation program should compensate for: work disability, loss of ability

to engage in usual life activities other than work, and QOL loss. IOM also recommended that VA develop a tool for measuring QOL loss validly and reliably and develop a procedure for evaluating and rating the QOL loss among disabled Veterans.

II. ECONOMIC SYSTEMS REPORT

The most recent study of QOL loss was conducted by EconSys and reported in its *Study of Compensation Payments for Service-Connected Disabilities, Volume III, Earnings and Quality of Life Loss Analysis*, released in September 2008. VA tasked EconSys with analyzing potential methods for incorporating a QOL loss component into the current rating schedule and with estimating the costs for implementing these methods. The EconSys study proposed three methods that might be utilized by VA.

The first and simplest method would be to establish statutory QOL loss payment rates based only on the combined percentage rate of disability. This method would "piggy-back" the QOL loss payment on top of the assigned disability evaluation under the current rating schedule. The amount of the payment would be determined by assigning a QOL score, ranging from –2 to 4, with 4 representing death and negative values representing an increase in the QOL of the Veteran. Although this method would be the easiest to administer because significant changes to the VA medical examination and rating process would be unnecessary, it raises issues of fairness. EconSys found that the severity of QOL loss does not mirror the severity of earnings loss captured in the ratings schedule. Moreover, EconSys found that QOL loss varies greatly both by condition and by individual, meaning that different Veterans with the same disability rating or the same condition could vary widely in their QOL. Under this method, a Veteran with minimal actual QOL loss could receive the same extra QOL loss payment as a Veteran with severe actual QOL loss. EconSys has estimated that additional program costs for implementing this method range from $10 billion to $30.7 billion annually.

A second optional method proposed by EconSys would key QOL loss payment amounts to the medical diagnostic code of the primary disability, as well as the combined percentage rate of disability. This option anticipates that Congress would create a separate pay scale based on the Veteran's combined degree of disability and primary disability. This method would arguably produce more accurate QOL loss payments because two variables rather than one would be involved and previous studies have shown that some disabilities, such as mental disorders, are associated with greater actual QOL loss than others. However, implementing this would involve conducting large sample-size surveys to assess the average QOL loss for each of over 800 diagnostic codes and then factoring in the additional loss for each of the ten percent increments of the rating schedule up to 100 percent. No surveys like this have been conducted in the past as a means to assign a dollar value to QOL loss. Inherent in such surveys is the potential for inconsistency and inaccuracy because the data would involve Veterans' self-reported answers to subjective questions. Given the number of "diagnostic code-evaluation percentage" combinations involved, a QOL loss scale developed under this method would be extremely complex and require extensive computer system modifications. In the event that this optional method was implemented, it would likely be subject to the same issues of fairness as the first method. A Veteran with a low combined degree of disability may receive more total compensation than a Veteran with a high combined degree of disability because of a difference in the QOL loss value assigned to different diagnostic codes. Moreover, the disability identified as primary for existing compensation may not be the primary cause of a Veteran's QOL loss. EconSys has estimated that this method would result in program costs of $9 to $22 billion annually.

A third optional method proposed by EconSys would involve an individual assessment of each Veteran for QOL loss by both a VA medical examiner and a VA claims adjudicator. EconSys describes the process as involving a QOL loss assessment component to the medical examination. The claims adjudicator would review the medical examiner's report on QOL and assign a QOL rating based on the diagnosis and rating for the primary diagnosis. This method would involve establishing separate rating tables for earnings loss and QOL loss and using these in combination with subjective information received from the Veteran on perceived QOL loss. This method would arguably allow for the most accurate assessment of QOL loss because of its individualized nature. However, it would require extensive training of VA personnel to administer and interpret QOL loss assessment tools and then apply them to the rating process. Once again, issues of subjectivity and fairness would likely be involved. Timeliness of decisions would be negatively affected based on the complexity of the adjudicator's required QOL loss assessment. EconSys has estimated

that this method would result in annual administrative costs of approximately $71.5 million, plus program costs of $10 to $25.7 billion dollars annually.

III. IMPLEMENTING QUALITY OF LIFE LOSS COMPENSATION

VA Challenges

Implementing a disability rating system that included compensation for QOL loss would involve at least two major challenges. The first would be to accurately and reliably determine whether, and to what extent, a disabled Veteran suffers from QOL loss. The second would be to establish equitable compensation payments for varying degrees of QOL loss. The first challenge has been addressed by other organizations and has led to the development of QOL loss assessment tools. The most well known of these is the RAND Corporation's Short Form 36 Health Survey (SF–36) and Short Form 12 Health Survey (SF–12). These are survey questionnaires that measure physical functioning, role limitations due to physical health, bodily pain, general health perceptions, vitality, social functioning, role limitations due to emotional problems, and mental health. The questionnaires yield numerical scores that are interpreted to measure QOL loss in relation to the non-disabled population.

The CNA study conducted for the Benefits Commission utilized a survey instrument derived from the SF–36 and SF–12. The results showed that service-connected disabled Veterans were more likely to report QOL loss than non-disabled Veterans. However, CNA made it clear that the results were based on subjective self-reporting by Veterans and that, although survey instrument scoring showed a difference between disabled and non-disabled Veterans, the instruments were not able to show how much difference in QOL loss existed between the two groups. This is problematic because the second challenge of assigning a dollar value for compensation purposes depends on distinguishing different degrees of QOL loss among disabled Veterans. VA is unaware of whether this problem has been addressed by other organizations.

As EconSys stated in its study, users of existing QOL loss assessment instruments seek to make comparisons of QOL loss between different groups or to measure improvements in QOL loss as a result of treatment interventions. However, they are not trying to attach a dollar value to these differences. For example, the CNA study indicated a greater QOL loss among disabled Veterans compared to non-disabled Veterans, but it does not provide a model to measure the extent of differences and provide fair compensation accordingly.

The EconSys study, described above, provides options for implementing a compensation procedure for QOL loss among Veterans, but is not specific about how new assessment instruments would be developed. For example, in the second option offered by EconSys, part of the QOL loss payment would be tied to the medical diagnostic code for which the Veteran is service-connected. This is based on the assumption that certain medical disabilities generally produce greater QOL loss than others. To implement this option, VA would be required to develop new survey instruments that target specific diagnostic codes and minimize variations in reporting due to subjectivity. Surveys now in use, such as the SF–36 and SF–12, are generic and would be of little help. The burden of establishing appropriate QOL loss compensation would remain with VA and Congress.

VA would face many additional problems in the attempt to implement QOL loss compensation. Among them would be the potential for a change in the Veteran's QOL loss. Since a major goal of VA is successful treatment and rehabilitation for disabilities, it is likely that the mental and physical health of some Veterans would improve over time and QOL loss would be reduced. On the other hand, a Veteran's circumstances may lead to an increase in QOL loss. Therefore, the issue of how to adjust compensation payments for changes in a Veteran's QOL loss over time would need to be addressed.

An additional concern presented by two of the EconSys options is the potential for appeals of Veterans' ratings. In options two and three, it is highly likely that Veterans with similar conditions of similar severity would receive different ratings and awards. This inconsistency introduces an equity issue that could lead to additional appeals and therefore a more frustrating process for Veterans.

Current VA Compensation

Most of the organizations that have provided input to VA on QOL have stated that VA already has a number of special benefits that implicitly, if not expressly, compensate for QOL loss. Among these are ancillary benefits, special monthly compensation, and total disability based on individual unemployability. Special monthly compensation and ancillary benefits are provided to Veterans in addition to compensation for service-connected disabilities under the current rating schedule.

Ancillary benefits include the extensive programs of Home Loan Guaranty and Vocational Rehabilitation and Employment Services. Certain ancillary benefits are intended to provide assistance to Veterans with special needs due to exceptional handicaps that result from service-connected disabilities. One major ancillary benefit, authorized by 38 U.S.C. §3902, is assistance with the purchase of an automobile or other conveyance with adaptive equipment necessary to ensure that the Veteran can safely operate the vehicle. Another ancillary benefit provides assistance with housing needs for certain severely disabled Veterans. Authorization for providing assistance to Veterans in acquiring housing with special features and residential adaptations is provided by 38 U.S.C. §2101(a) and (b). Additionally, a yearly clothing allowance is authorized by 38 U.S.C. §1162 when a service-connected disability requires a Veteran to use a prosthetic or orthopedic appliance, including a wheelchair, which tends to wear out or tear the Veteran's clothing. A clothing allowance is also authorized when a physician prescribes medication for a service-connected skin condition that causes irreparable damage to a Veteran's outer garments.

In addition to these benefits, special monthly compensation, authorized by 38 U.S.C. §1114, provides a range of special monthly payments over and above the current rating schedule disability compensation for Veterans with service-connected disability who are housebound, in need of aid and attendance from others to accomplish daily living activities, have severe hearing loss or visual impairment, or have loss, or loss of use, of extremities or reproductive organs. In addition, VA is authorized to pay special monthly compensation to female Veterans for breast tissue loss.

VA regulations authorize a rating of total disability based on individual unemployment if a Veteran is unable to obtain, or maintain, substantially gainful employment because of service-connected disabilities. This is an extra-schedular benefit resulting in compensation paid at the 100-percent schedular rate for Veterans who have been awarded a single 60-percent or a combined 70-percent disability rating and are unable to work as a result of their service-connected disability. The benefit is also available based on a VA administrative review, if the schedular requirements are not met.

IV. CONCLUSION

This testimony attempts to outline some of the issues and challenges that VA would face if authorized to provide QOL loss compensation. If VA is to provide QOL loss compensation consistent with the proposed options in the EconSys study, statutory changes would be required. Additional administrative costs for training VA personnel and reconfiguring VA computer systems, as well as the costs for providing additional benefits to Veterans, would be considerable. The implications for adopting such a policy are significant for VA. This testimony also illustrates how, in addition to compensation provided under the rating schedule, VA provides special monthly compensation, ancillary benefits, and extra-schedular ratings to Veterans with certain service-connected disabilities, which multiple studies have recognized as existing tools to promote the QOL of Veterans.

As always, VA maintains its dedication to fairly and adequately serving the disabled Veterans who have sacrificed for our country.

Chairman AKAKA. Thank you very much, Admiral Dunne.

Dr. Kettner, your testimony, please.

STATEMENT OF GEORGE KETTNER, Ph.D., PRESIDENT, ECONOMIC SYSTEMS, INC.

Mr. KETTNER. Chairman Akaka, Ranking Member Burr, and Members of the Committee, thank you for the opportunity to appear before you today.

I served as Project Director of a recent study of lost earnings and loss of quality-of-life for veterans with service-connected disabilities, and a transition benefit for veterans undergoing vocational rehabilitation. We compared veterans with service-connected disabilities to a matched group of veterans without service-connected disabilities.

We found that, overall, actual earnings plus disability compensation for veterans with service-connected disabilities was 7 percent above the earnings of the respective comparison group without

service-connected disabilities. On average, veterans rated 30 percent or less did not experience serious wage loss. Approximately 55 percent of 2.6 million veterans receiving disability compensation are rated at 30 percent or less. Veterans rated 40 to 90 percent experienced wage loss, but their VA disability compensation more than made up for the loss. For veterans rated at 100 percent, their earnings and disability compensation was 9 percent less than expected and, hence, did not fully compensate for lost earnings.

We also found considerable differences in earnings loss across different diagnoses for a given rating level, resulting in serious inequity in the disability payment system. Several of the most prevalent diagnostic codes are candidates for changes to the rating schedule because there is no earnings loss associated with those diagnoses at the 10 percent or 20 percent rating levels. Examples include arthritis, hemorrhoids, tinnitus, and diabetes.

We found that mental health disorders, in general, have a much more profound impact on employment and earnings than do physical disabilities. Adjustments to the ratings criteria could overcome much of this disparity, but not for those already rated 100 percent, unless the benefit amount for the 100 percent rating were increased, as well.

Veterans receiving disability compensation have, on average, 3.3 rated disabilities. VA uses a look-up table for combining individual disability ratings into a combined degree of disability rating. The earliest known table dates from 1921 and has changed very little since then. These formulas result in ratings that overcompensate veterans for lost earnings, particularly when combining multiple disabilities with loss ratings.

Special monthly compensation is a series of awards for loss of limbs, organs, or functional independence. SMCs are not awarded to compensate for average loss of earnings capacity and can be viewed as payments for loss of quality-of-life. The amount of SMC monthly payments above the regular scheduled payment for the 100 percent rating ranges from about $600 to $1,900 for the most severely disabled veterans. SMC payments are not made for PTSD and other mental health conditions.

Certain SMCs are paid to veterans for assistance with activities of daily living. For example, SMC-L provides $618 per month above the normal 100 percent amount, and SMC-S for housebound veterans provides $302. Survey results indicate that the monthly cost of hiring an assistant ranges from about $500 to $11,000, depending on how many hours of care are provided. A recent study estimated the lost wages and benefits of family caregivers of severely injured and active duty servicemembers at $2,800 per month. The current amount of the SMCs for assistance is well below these estimated costs.

The literature generally defines quality-of-life as an overall sense of well-being based on physical and psychological health, social relationships, and economic factors. We found that quality-of-life loss occurred for veterans at all levels of disability. We also found that loss of quality-of-life increases as disability increases, but there are wide variations in the loss of quality-of-life with each disability rating.

QOL is an individualized perception and people adjust to disability differently. About half of those individuals with severe disabilities report relatively high degrees of life satisfaction. We also found that veterans receiving individual unemployability and SMC payments report significantly greater QOL loss, as well as greater earnings loss. Veterans with mental disabilities rated 100 percent show much greater quality-of-life loss than veterans with physical disabilities rated at 100 percent.

Putting an economic value on quality-of-life is subjective and value-laden. Hence, we developed different options for quality-of-life loss payments, ranging from an average amount of $100 a month to almost $1,000 a month, depending on the benchmark for measuring loss of quality-of-life. Examples of benchmarks include veteran self-assessment, societal views, awards made by foreign governments, SMC payments, and Individual Unemployability benefits for veterans over the age of 65.

We identified options for payment of living expenses for disabled veterans participating in vocational rehabilitation and employment. Options include monthly payment for core living expenses of about $1,900 to $3,000 for veterans living alone, or with two dependents to cover housing, food, and transportation. Additional daily living costs, such as apparel and services, could be provided for about $500 to $935 per month.

A major issue to be decided in providing a transition benefit is which VR&E participants would be eligible depending on severity of disability, medical discharge, and time since discharge. Options presented range from as few as 3,400 applicants per year to as many as 29,000 applicants.

Mr. Chairman, I thank you for the opportunity to appear before you today. I welcome any questions you or the Committee Members may have.

[The prepared statement of Mr. Kettner follows:]

PREPARED STATEMENT OF GEORGE KETTNER, PH.D., PRESIDENT, ECONOMIC SYSTEMS, INC.

Chairman Akaka, Ranking Member Burr, and Members of the Committee, thank you for the opportunity to appear before you today to present the major results of Economic Systems' *Study of Compensation Payments for Service-Connected Disabilities* completed last year for VA. This study was requested largely as a follow on to the President's Commission on Care for America's Returning Wounded Warriors, known as the Dole-Shalala Commission.

VA DISABILITY COMPENSATION RATING SYSTEM

The VA Disability Compensation Program provides monthly benefit payments to veterans who become disabled as a result of or coincident with their military service. Payments generally are authorized based on an evaluation of the disabling effects of veterans' service-connected physical and/or mental health impairments. Monthly payments are authorized in percentage increments from 10% ($117 in 2008) to 100% ($2,527 in 2008). The process for determining ratings for disability compensation benefits uses the VA Schedule for Rating Disabilities (VASRD) to assign the level of severity of the disabilities.

The VASRD contains over 700 diagnoses or disability conditions, each of which may have up to 11 levels of medical impairment. The lowest level of impairment starts at 0% then increases in 10% increments up to a maximum of 100%. Disability compensation, as determined by the VASRD, is intended to replace average impairment in earnings capacity.

Eligibility requires that a determination be made that the condition is a service-connected disability. Service-connected means that the condition occurred during or was aggravated by military service, is one of several "presumed" conditions, or, for

chronic conditions, became evident within one year of discharge from the military. It does not require that the disability be work related or be caused by conditions in the work environment. In this regard the VA Disability Compensation Program combines elements of both disability insurance voluntarily provided by employers and workers' compensation programs mandated by government.

Claimants with a combined rating between 60 to 90% who are determined to be unemployable solely as a result of service-connected conditions qualify for Individual Unemployability (IU). Claimants determined to be entitled to IU receive the same benefit payment amount as those rated at the 100% disability level. Conditions or circumstances that result in the claimant not being employable override the medical impairment rating. IU is similar to the Social Security Disability Insurance (SSDI) program in that both provide payments because the beneficiary is deemed to be unemployable.

Special monthly compensation (SMC) is a benefit paid in addition to or instead of the VASRD-based benefits. Examples include: loss of or loss of use of organs, sensory functions, or limbs; disabilities that confine the veteran to his/her residence or result in the need for regular aid and attendance; a combination of severe disabilities that significantly affect mobility; and the existence of multiple, independent disabilities each rated at 50% or higher.

We were asked by VA to address three major areas in our analysis: earnings loss resulting from service-connected disabilities, the impact of those disabilities on quality of life, and a possible transition benefit for veterans engaging in VA's vocational rehabilitation and employment program. Some of our most significant findings relate to the following topics:

- Adequacy of Disability Compensation
- Disabilities Without Earnings Loss
- Additional Diagnostic Codes
- Earnings Loss for Veterans with Post Traumatic Stress Disorder (PTSD), Other Mental Health Disorders, and Traumatic Brain Injury (TBI)
- Methodology Used to Calculate Combined Degree of Disability
- Individual Unemployability Benefits
- Special Monthly Compensation
- Quality of Life Payment Options
- Transition Benefit Options.

ADEQUACY OF DISABILITY COMPENSATION

A crucial part of the loss of earnings analysis is determining the wages that the veteran would have received if he or she had not experienced a service-connected disability (SCD). The estimates of these potential earnings depend on tracking the actual earnings of individuals in a comparison group who did not have SCDs but who were otherwise matched to the disabled veterans on personal characteristics. The personal characteristics used to match the disabled veterans and the veterans without SCDs were age, gender, education at the time of entry into the service, and status as an officer or enlisted person when discharged from active duty. The analysis of loss of earnings was primarily based on comparisons of the earnings in 2006 of veterans with SCDs and without SCDs as provided to the study by the Social Security Administration.

Assessment of the adequacy of disability compensation in relation to earnings loss requires determining if the payments are equitable vertically and horizontally. Vertical equity means that actual earnings loss should increase in proportion to increases in disability ratings and that compensation should offset that earnings loss. We found that overall, veterans with service-connected disabilities have earnings plus disability compensation 7 percent above their average expected earnings. The average was higher at each rating level except at the 100% rating level where the combined earnings and compensation was 9 percent less than expected. On average, veterans with a 30% or less combined disability rating did not experience serious wage loss. Approximately, 55% of 2.6 million veterans receiving disability compensation in 2007 were rated at 30% or less. Earnings losses for veterans with 40% to 90% combined rating did have wage losses, but their VA disability compensation more than made up the loss. In contrast, actual earnings losses plus disability compensation for veterans with 100% combined rating fall short of average expected earnings by about 9%. In 2007, 9.1 percent of veterans receiving disability compensation had a combined rating of 100%, up from 7.5 percent in 2001. Thus, vertical equity is not fully achieved.

Horizontal equity means that actual earnings loss should be the same or similar for the same disability ratings but with different types of disabilities. We found considerable differences in earnings loss across different diagnoses for a given rating

level, resulting in serious inequity in the payment system. For example, for veterans with a 50% combined rating, the range was from no earnings losses for genitourinary or endocrine medical conditions to over 40 percent earnings losses for non-PTSD mental conditions. Veterans with PTSD, Other Mental Disorders, and infectious diseases experience greater earnings losses than veterans diagnosed with other medical conditions rated at the same level. Thus, horizontal equity is not achieved.

One factor that is important to understanding the results of our earnings analysis is that it concentrates on veterans discharged since 1980. Our results, therefore, differ from the previous study conducted by CNA Corporation for the Veterans' Disability Benefits Commission as that study included veterans discharged before 1980. Our study does not include veterans of World War II, Korea, and Vietnam (relatively few) because they are largely past or approaching retirement age and because data on their essential demographic and human capital characteristics are not available from the Department of Defense (DOD) for analysis. We believe that this focus on more recent veterans is more appropriate for policy considerations for the future. More detailed discussion of the differences between our study and the study for the Veterans' Disability Benefits Commission (VDBC) is provided later.

DISABILITIES WITHOUT EARNINGS LOSS

In addition to examining the broad comparisons cited above, our analysis identified several diagnostic codes that are candidates for changes to the rating schedule because the impact of these conditions on earnings is not commensurate with the level of the rating. In particular, for several of the most prevalent diagnostic conditions, there is no earnings loss at the 10% or 20% combined rating levels. Examples of these diagnoses include: arthritis; lumbosacral strain; arteriosclerotic heart disease; hemorrhoids; and diabetes mellitus. The rating schedule criteria for the rating of these conditions could be adjusted so that a rating of zero percent instead of 10% or 20% would be assigned in the future to reflect that no earnings loss occurs at this level for these conditions.

ADDITIONAL DIAGNOSTIC CODES

We were asked to identify diagnostic codes that could be added to the over 700 existing codes in the rating schedule. Analogous codes are currently used in 9 percent of all cases. By sampling 1,094 cases in which analogous codes were used, we identified 33 ICD–9 codes that were used often enough to warrant addition to the rating schedule. These include disturbance of skin sensation, mononeuritis of lower limb, and unspecified hearing loss.

PTSD, OTHER MENTAL DISORDERS, AND TBI

Our analysis and previous studies conducted by the Bradley Commission in 1956, the Economic Validation of the Rating Schedule in 1972, and the Veterans' Disability Benefits Commission in 2007, are consistent in finding that mental health disorders in general have a much more profound impact on employment and earnings than do physical disabilities. We found that earnings loss for PTSD is 12 percent for veterans rated 10% and up to 92 percent for those rated 100%. For other mental disorders (other than PTSD), the earnings loss is 14 percent for those rated 10% and 96 percent for those rated 100%. Earnings loss for TBI rated 100% is similar at 91 percent.

A policy option for consideration is to adjust the VA Schedule of Rating Disabilities to eliminate rating PTSD at 10% and use the rating criteria for 10% to rate 30%, 30% to 50%, 50% to 70%, and combine the criteria for 70% and 100% at 100%. We note that this will not eliminate the deficiency at 100%; veterans rated 100% will still be receiving less in disability compensation and earnings combined than their expected level of earnings. We also note that these changes, especially if also made for mental health disorders in general, would have a significant impact on the issue of Individual Unemployability (IU). Veterans whose primary diagnosis is PTSD made up 32 percent of IU cases on the rolls in 2007 and 47 percent of new IU cases during the period 2001–2007. Including PTSD with all mental disorders, 44 percent of IU cases on the rolls in 2007 were mental disorders and 58 percent of new IU cases from 2001–2007 had mental disorders. Since the criteria for rating mental disorders at 100% require veterans to be unemployable, it is not clear why veterans with mental disorders who are unemployable are not rated 100% instead of IU.

METHODOLOGY USED TO CALCULATE COMBINED DEGREE OF DISABILITY

VA has used certain formulas over the years to assign a Combined Degree of Disability (CDD) when veterans have more than one service-connected disability. Veterans receiving disability compensation have on average 3.3 disabilities that they are rated for. The earliest known formula dates from 1921 and has changed very little since then. The CDD determines the amount of the disability compensation payment. The table below provides examples of how various individual ratings are combined using the four formulas. The formulas do not take into account the types of disabilities being combined.

Rating Schedule	1921	1930	1933	1945 to Present
Two 10% Ratings	19	19	20	20
Three 10% Ratings	28	19	30	30
Four 10% Ratings	37	19	30	30
Five 10% Ratings	46	19	40	40
One 30% and four 10%	58	58	50	50
One 70% and four 10%	82	82	80	80

A claimant who has three disabilities with each disability rated at 10%, receives a combined rating of 30%. A veteran with two service-connected disabilities, one rated 60% and one rated 10%, receives compensation only at the 60% rate. The current formula for combining additional ratings gives greater weight to multiple 10% ratings. The effect of additional 10% ratings is diminished if the primary diagnosis has a high rating. Having multiple low ratings increases the payment dramatically for a veteran whose primary diagnosis has a low rating; it has a negligible or much smaller effect for veterans who have a single condition with a high rating such as 80%.

In our analysis we found that actual earnings, on average, were higher for veterans with more disabilities at a given rating level such as 30%. This paradoxical result suggests that the rating for the first medical condition captures most of the impact of the veteran's overall medical conditions on his or her potential earnings. The ratings for the second, third, or additional medical conditions increase the CDD but the additional conditions do not further affect the veteran's earning capacity. The formula for combining disabilities results in ratings that over compensate veterans for lost earnings.

An option to the current single lookup table is to replace the current table with tables that reflect specific combinations of different disabilities. This will require conducting additional analysis of the impact of combinations of disabilities on earnings. The tables could be programmed for ease of use rather than manually applied as is the current practice. Such programmed tables could actually reduce the burden on raters.

Medical science has established for many years that certain diseases are prevalent together, examples of which include PTSD and major depressive disorder, and diabetes and cardiovascular diseases. It is quite likely that there are many diseases that are present together in individuals and that they cause a greater impact on the individual's earning capacity than would be the case with multiple unrelated minor ailments. Additional analysis of the impact of multiple diseases or disabilities could result in an enhanced approach to ratings for combinations of diagnoses. For example, nearly 30,000 service-connected veterans have a diagnosis of traumatic brain disorder and some 4,600 of these (15 percent) also have a service-connected diagnosis of PTSD and almost 800 (3 percent) also have a diagnosis of major depressive disorder. Likewise, of some 307,000 veterans with a service-connected diagnosis of PTSD, some 5,200 (1.7 percent) also have a service-connected diagnosis of major depressive disorder. Further analysis could determine if these diagnoses in combination have a greater or lesser impact on earnings.

INDIVIDUAL UNEMPLOYABILITY BENEFITS

The number of IU cases has grown from about 101 thousand in September 2001 to 190 thousand cases in September 2007, an increase of almost 90 percent. PTSD cases constituted about one-third of the IU cases in 2007 and one-half of new IU cases between 2001 and 2007. Forty-four percent of the IU cases in 2007 were for veterans age 65 and older; 64 percent for veterans age 55 and older.

Although age is clearly related to employment, it is not considered in IU determinations. While IU is not intended for veterans who voluntarily withdraw from the labor market because of retirement, new awards are often made to veterans who

are near or past normal retirement age for Social Security. In light of these circumstances it appears that IU determinations are made for veterans approaching or past retirement age based on providing retirement income or in recognition of loss of quality of life rather than for employment loss.

IU determinations depend on decisions about substantially gainful employment. In order to further facilitate the decisionmaking process for IU determinations, a work-related set of disability measures would be worth assessing. Consideration of this could supplement the medical impairment criteria in the VASRD.

An option for consideration would be for VA to adopt a patient-centered, work disability measure for IU evaluations. As with the current IU evaluation, assessments would address the individual's work history but also consider other factors including motivation and interests. Work disability evaluations would include relevant measures of impairment, functional limitation, and disability. Particular care should be taken to include measures of physical, psychological, and cognitive function. Assessments would evaluate the individual in the context of his or her total environment.

SPECIAL MONTHLY COMPENSATION FOR QUALITY OF LIFE

Special Monthly Compensation (SMC) is a series of awards for anatomical loss or loss of functional independence. These awards are evaluated outside of the Rating Schedule. SMCs are known by the letter designations K, L, M, N, O, P, R, and S. SMC K is the only award that can be made to veterans who are rated less than 100% and can be awarded one, two, or three times with each award $91 per month (2008 rates). SMC K is paid in addition to the amount paid for the Combined Degree of Disability rating. As of December 1, 2007, there were 188,747 veterans receiving SMC K awards. SMCs other than K are paid instead of the amount payable for 100% ratings, not in addition to the amount paid for 100% ratings. Since SMCs are not awarded with the intent of compensating for average loss of earnings capacity, they can be thought of as payments for the impact of disability on quality of life.

SMC FOR ASSISTANCE

Four different SMCs can be paid to veterans for assistance: L, S, R1, and R2. SMC L can be awarded either for loss of or loss of use of limbs or organs or to veterans rated 100% without such loss if they are in need of regular Aid and Attendance; in other words, if they need assistance with activities of daily living. In 2007, 48 percent of 13,928 veterans receiving SMC L were receiving that award because they needed assistance, rather than for loss of or loss of use of organs or limbs. SMC S can also be awarded to veterans rated 100% if they are housebound but do not meet the required level of assistance for SMC L. SMC R1 and R2 are awarded to catastrophically injured veterans, primarily to those with spinal cord injuries, who need the highest levels of assistance. The table below depicts the number of veterans receiving SMCs other than K and the amount of the award that is above the normal amount paid to veterans rated 100% without SMC. In the case of R1 and R2, the veteran must be awarded SMC O or P due to the severity of disability in order to qualify for the additional assistance provided by R1 or R2. Thus, if a veteran receives SMC L for assistance, the veteran is receiving only $618 per month above the normal 100% amount; and a veteran receiving SMC S for housebound is receiving only $302 above the 100% amount.

In 2007, 45,773 veterans received SMC L, S, R1, or R2 for assistance and $30,223,540 above the amount paid for the 100% rating. This was an average of $660 per month.

Special Monthly Compensation Rates Compared with Schedular 100% Rating

SMC Code	Veteran Alone	Amount for 100% or SMC O/P	Increased Amount for SMC	Number of Veterans	Monthly Benefit
Quality of Life					
L	$3,145	$2,527	$618	5,355	$3,309,390
L½	$3,307	$2,527	$780	1,887	$1,471,860
M	$3,470	$2,527	$943	1,839	$1,734,177
M½	$3,709	$2,527	$1,182	1,650	$1,950,300
N	$3,948	$2,527	$1,421	477	$677,817
N½	$4,180	$2,527	$1,653	250	$413,250
O/P	$4,412	$2,527	$1,885	2,661	$5,015,985
Total				14,119	$14,572,779

Special Monthly Compensation Rates Compared with Schedular 100% Rating—Continued

SMC Code	Veteran Alone	Amount for 100% or SMC O/P	Increased Amount for SMC	Number of Veterans	Monthly Benefit
Assistance					
L	$3,145	$2,527	$618	4,944	$3,055,392
L½	$3,307	$2,527	$780	1,742	$1,358,760
S	$2,829	$2,527	$302	31,361	$9,471,022
R1	$6,305	$4,412	$1,893	5,576	$10,555,368
R2	$7,232	$4,412	$2,820	2,151	$6,065,820
Total				45,773	$30,506,362

Source: Department of Veterans Affairs, Special Monthly Compensation, 12/1/07

Using the results of surveys conducted by the National Alliance for Caregiving and the American Association of Retired Persons and by the Veterans' Disability Benefits Commission, we estimated monthly costs of hiring assistance ranging from $520 for 8 hours of caregiving per week to $10,800 for full time, around the clock 24/7 care. The CNA Corporation issued a report for the Department of Defense in September 2008 on the average earnings and benefits loss of caregivers of seriously wounded, ill, and injured active duty servicemembers and estimated those losses as $33,500 annually or $2,800 per month. Regardless of which estimates are used, the current amount of the SMCs for assistance is well below either the cost of hiring such care or of the lost earnings and benefits of family caregivers.

QUALITY OF LIFE PAYMENT OPTIONS

Our review of the literature led us to define quality of life (QOL) for veterans as an overall sense of well-being based on physical and psychological health, social relationships, and economic factors. Our in-depth analysis of the data from the Veterans' Disability Benefits Commission's survey of more than 21,000 disabled veterans found that QOL loss occurred for veterans at all levels of disability and for all 40 diagnostic codes for which sufficient responses were available. We also found that loss of QOL increases as disability increases, but it does not increase as sharply as disability does, and that there is wide variation in the loss of quality of life at each disability rating. QOL is an individualized perception, and people adjust to disability. About one-half of individuals with severe disabilities report high degrees of life satisfaction.

The quality of life loss analysis paralleled the earnings loss analysis in many regards. In particular, we found that veterans receiving Individual Unemployability benefits and those receiving SMC payments report mental and physical QOL loss significantly greater than for other service-connected veterans. Fewer severe disabilities are associated with a greater loss of quality of life than a greater number of less severe conditions at a given level of combined disability.

Three broad options were presented to VA for implementing a QOL payment:

1. Statutory rates for QOL payments by combined degree of disability
2. Separate, empirically-based normative rates for QOL loss
3. Individual clinical and rater assessments plus separate empirically-based rates for QOL loss.

All three options would require periodic surveys to assess QOL impact. Option 3 would be the most complex and costly to implement and would require clinical and rater assessments each time a claim is filed. Options 1 and 2 would not be subject to veteran appeal if Congress approves the rate scale. However, in conjunction with implementing any QOL options, the criteria and benefits contained in the VA Schedule for Rating Disabilities should be adjusted to reflect average actual lost earnings, to ensure an overall equitable system.

Payment rates for QOL would have to be set by policy or statute and placing an economic value on QOL would be subjective and value laden. Options that use empirical data are provided in our report as examples of how such rates could be established. The monthly amounts depicted in the options range from $99 to $974. Volume III of our report contains an extensive description of the findings of the QOL analysis and of the possible rationales or bases for setting the amounts.

Foreign countries that award QOL payments link them closely to impairment and consider the circumstances of the individual veteran. QOL payments are considered the primary disability benefit and earnings loss payments are made only for actual earnings loss or a specified loss of earnings capacity. A veteran in Canada, for instance, must demonstrate inability to work in order to receive an earnings loss pay-

ment in addition to a QOL payment and must complete three years of vocational rehabilitation that results in unemployment before receiving ongoing earnings loss payments.

VA could structure its disability benefits like the foreign programs so that they are based primarily on QOL. QOL could be inferred from impairment, or it could be measured directly, with earnings loss paid only when an actual earnings loss occurred.

The systems used in both the United Kingdom (UK) and Canada pay QOL in lump sum payments and have several low rating levels for QOL payments. While making QOL payments in all 15 of its ratings, the UK system does not pay for earnings loss in the 4 lowest ratings of its 15-point rating scale. The Canadian schedule increases proportionally so that in 2008, after the 10% rating, each 5% rating increase in Canada has a payment increase of $12,909. The UK payments do not increase with a multiplicative constant. For instance, the highest payment is $565,000, the second highest payment is $399,000, the third highest is $228,000. The lowest pain and suffering payment in UK is $2,080. These payment schedules reflect their societies' view that severe disability merits very high QOL payments and low levels of disability merit recognition payments. These benchmarks suggest great flexibility in establishing payment levels for U.S. veterans.

Although our study focused on monetary compensation for QOL, the literature review and the analysis of the survey data indicates that greater QOL is supported by a strong family or social network and that employment is associated with a better quality of life. QOL of service-connected veterans may be improved by programs aimed at family members to help them to understand and support the disabled veteran, through case management directed to the holistic needs of the veteran, and employment assistance programs.

Our earnings analysis found that on average veterans' earnings plus disability compensation exceeds the expected earnings level by 7 percent. There are exceptions such as for mental health and TBI and those rated 100% where earnings plus compensation is significantly less than expected earnings. Some SMC payments can be thought of as payment for QOL. Taken together, a judgment could be made that veterans are currently compensated for QOL.

TRANSITION BENEFIT OPTIONS

Disabled veterans face a number of living expenses during their transition to civilian life before and during their participation in the VA Vocational Rehabilitation and Employment (VR&E) Program.

Providing transition assistance payments offset the foregone cost of earnings (time spent in rehabilitation and not working), which in turn increases the likelihood of entry and completion of rehabilitation. Providing transition assistance benefits to caregivers and family members could reduce the levels of stress and depression for veterans and caregivers, which in turn could raise the overall quality of life for both the patient and family members and caregivers. Providing and aligning financial incentives with successful completion of specific rehabilitation tasks could increase the likelihood that patients enter and successfully complete rehabilitation.

In order to estimate what an appropriate level of transition benefit should be, we selected housing, food, and transportation expenses to comprise a core group of living expenses that one would expect a living expense benefit to cover. We also considered additional "menu items" such as apparel and services, health care (for dependents of disabled veterans not rated 100%), personal care products and services, household operations, and child care. Based on statistical analysis of average living expenses, the core living expense option would be $1,898 for the veteran alone or $2,981 for a veteran with two dependents. This includes the average monthly housing allowance paid by DOD in the 11 most populous veteran population centers, the same rates that would be paid under the Chapter 33 Education program. The payment for additional expenses would be $511 for the veteran alone or $935 for a veteran with two dependents. A new transition benefit would be in lieu of the current subsistence allowance and precede the start of permanent disability compensation benefit. The 2007 monthly subsistence allowance was $521 (no dependents) and $761 (two dependents).

We identified several groups of veterans who could be eligible for such payments based on medical discharges, severity of disability, and time since discharge. Defining the purpose of a transition benefit is essential: would it be intended to ease the transition from military service to civilian life? If so, it is important to realize that veterans participating in the VR&E program fall into three groups: those who applied from just before discharge to two years after discharge (39 percent), those who

applied from three years to ten years after discharge (29 percent), and those who applied more than 10 years after discharge (32 percent).

The possible eligibility groups would range from a small group consisting of severely injured/ill who are medically discharged with ratings of 70% or higher who enter rehabilitation within two years of discharge, to a much larger group that would include all veterans currently eligible for VR&E. The most limited option would include 3,400 applicants per year and the most inclusive option would include approximately 29,000 each year.

Important policy decisions would need to be made in order to determine which veterans participating in VR&E would be eligible for a transition benefit.

METHODOLOGY DIFFERENCES WITH THE PREVIOUS STUDY

As discussed previously, our methodology differed in significant ways from the approach taken by the CNA Corporation in 2007 for the Veterans' Disability Benefits Commission (VDBC). Our study focused on service-connected and non service-connected veteran populations discharged since 1980. Data from the Defense Manpower Data Center (DMDC) is reliable for veterans discharged since that time and provides important demographic or human capital characteristics for individuals such as education level at time of entry into the military, gender, and officer or enlisted status. These characteristics can be used to ensure that the observed differences in earnings are due to the service-connected disabilities and not some demographic differences.

The study for the VDBC also used earnings data for non service-connected veterans from the Current Population Survey (CPS) which were self reported, in comparison with the actual earnings of service-connected veterans discharged prior to 1980. We conducted a thorough analysis of the CPS data and concluded that it was not reliable for this purpose for several reasons. Self-reported earnings are not as accurate as actual Social Security Administration earnings data and the CPS sample has 50 percent fewer veterans than the general population. Post 1980 veterans have better health, fewer limitations from disabilities, and higher rates of employment. Thus we focused on comparing earnings of veterans discharged since 1980. Although we obtained actual earnings data from the Social Security Administration on the entire population of 2.6 million veterans receiving disability compensation, we limited our analysis to the 1,062,809 service-connected disabled veterans discharged since 1980 and a demographically selected sample of 432,947 non service-connected veterans also discharged since 1980. These two populations were compared to determine the impact of service-connected disabilities on earnings. Actual earnings were compared, thus avoiding the use of survey data. A detailed explanation of why CPS data is not reliable for this comparison is provided in pages 132–136 of Volume III of our report. We believe that this comparison of veterans discharged since 1980 enables policymakers to focus more on veterans that VA rates today and will be rating in the future.

Another difference between our analysis and the CNA analysis was that we conducted a more detailed analysis of rating levels using the entire range of rating levels (10% through 100%, in 10% increments) while CNA used four groupings of ratings (10%, 20–40%, 50–90%, and 100%). We did this so as to be able to analyze all ten rating levels individually. We also used individual diagnostic codes to the maximum extent possible within the restrictions on release of individual-level data. The over 700 codes in the Rating Schedule were grouped into 240 similar diagnoses so as to avoid the possibility of individual veterans being identified. In contrast, the CNA study aggregated veterans into the 15 body systems with PTSD the only individually analyzed diagnosis. We also placed emphasis on analysis of veterans receiving Special Monthly Compensation and Individual Unemployability. Finally, we used 2006 earnings without estimating lifetime earnings while CNA used 2004 earnings to estimate lifetime earnings. We obtained annual earnings for veterans since 1951 but time constraints prevented including this information in our analysis as we would have preferred.

We realize that limiting the earnings analysis to veterans discharged since 1980 excludes 1.6 million of the 2.6 million veterans receiving disability compensation, especially most Vietnam veterans. However, demographic and human capital data available from DMDC is not considered accurate on veterans discharged prior to 1980. Therefore, it is not possible to identify a sample of non service-connected veterans from DMDC data closely matched on human capital characteristics to serve as a comparison group in an analysis of the impact of disability on earnings. It could be possible to randomly select a sample of non service-connected veterans from either the DMDC data or from the VA Beneficiary Identification and Records Locator Subsystem (BIRLS) matched on a more limited set of known characteristics such as

age, military rank, and date of discharge. This sample would lack key characteristics such as education level, military occupational series, and Armed Forces Qualification Test scores as is available on the post 1980 group and may not be as well matched to the service-connected veteran population. This limitation would need to be recognized.

In addition, if more time were available for the analysis, more detailed analysis of the earnings data for veterans discharged prior to 1980 and since 1980 could be completed, especially an analysis of lifetime earnings. Social Security Administration retains annual earnings for individuals from 1951. These annual earnings were captured last year but there was not sufficient time to analyze that data.

We note that of the estimated seven million living Vietnam Era veterans, 28.4 percent are age 65 or older and 44.6 percent are age 60 to 64 and thus are nearing the normal retirement age. Thus, the earnings of Vietnam Era veterans are likely to be already diminishing or very limited already.

For those already service-connected, it is unlikely that benefits would be reduced in any way. We suggest that the focus of policy or statutory adjustments should be on future earnings and that the emphasis of future analysis should be on veterans discharged since 1980 so that more precise comparisons can be made, even if veterans discharged prior to 1980 are also analyzed.

CONCLUDING REMARKS

In closing, our study completed last year provides a great deal of information on the adequacy of disability compensation and ways in which the program can be improved to better serve veterans. There are clear indications that overall the amount of compensation exceeds the average expected earnings loss yet it is inadequate for mental health and for those rated 100%. The methodology used to assign the overall combined degree of disability, and hence the amount of compensation paid, results in over compensating many veterans, especially at the lower rating levels. There are several diagnoses that either do not result in loss of earnings or the rating is higher than necessary. It could be concluded that quality of life is somewhat compensated by the amount compensation exceeds expected earnings loss and by some SMC payments. SMC payments for assistance are not equal to either the cost of hiring assistance or the lost earnings and benefits of family caregivers.

While the findings cited in this testimony provide accurate and reliable information upon which to base policy decisions, the timeframe for that study (seven months) did not permit a thorough analysis of certain aspects of the disability compensation program and of the inter-related nature of the findings. We would recommend that additional analyses be conducted. Restrictions intended to safeguard the privacy of individuals prevented the Social Security Administration from providing earnings at the individual veteran level. This meant that we could not analyze the impact on earnings of combinations or comorbidities of disabilities. We have discussed this issue with the Social Security Administration and believe a methodology could be used that safeguards the privacy of individuals yet enables such analysis. For the long term, we agree with the recommendation of the VDBC that VA and DOD should be granted statutory authority to collect and study appropriate data from the Social Security Administration and the Office of Personnel Management, namely earnings data, only for the purpose of assessing the appropriateness of benefits.[1]

Additional demographic or human capital characteristics could be analyzed in future studies to ensure that the impact on earnings is not due to factors such as education level at discharge, military occupational series, or Armed Forces Qualification Test scores. Also, consideration of such factors as time in service, period of service, and timing of diagnosis could shed additional light on the impact of disability on earnings.

In addition to analysis of earnings at the individual veteran level, earnings and quality of life results should be integrated so as to see the overall impact of disability on veterans. This could include assessing how comorbidities and the timing of the diagnoses as indicated by the date of original service-connected disability impact earnings and QOL. A technique called shadow pricing could also be used to measure the economic impact on quality of life.

Mr. Chairman, I thank you for the opportunity to appear before you today and would welcome any questions you or the Committee members may have.

Chairman AKAKA. Thank you very much, Dr. Kettner.
And now we will receive testimony from General Scott.

[1] Veterans' Disability Benefits Commission, 2007, pp. 318 and 320.

STATEMENT OF LIEUTENANT GENERAL JAMES TERRY SCOTT, USA (RET.), CHAIRMAN, ADVISORY COMMITTEE ON DISABILITY COMPENSATION

General SCOTT. Chairman Akaka, Ranking Member Burr, Members of the Committee, it is a real pleasure to be with you today representing the Advisory Committee on Disability Compensation.

The Committee is charged by the Secretary of Veterans Affairs under the provision of 38 U.S.C. Section 546 in compliance with Public Law 110–389 to advise the Secretary with respect to the maintenance and periodic readjustment of the VA Schedule for Rating Disabilities. Our charter is to assemble and review relevant information relating to the needs of veterans with disabilities, provide information relating to the character of disabilities arising from services in the Armed Forces, provide ongoing assessment of the effectiveness of the VA's schedule for rating disabilities, and provide ongoing advice on the most appropriate means of responding to the needs of veterans relating to disability compensation in the future.

The Committee has met ten times and has forwarded an interim report to the Secretary that addresses our efforts as of July 7, 2009. Copies of this interim report were furnished to majority and minority staff in both Houses of Congress, and I can provide additional copies for the record if so desired.

Our focus is in three areas of disability compensation: requirements and methodology for reviewing and updating the VASRD; adequacy and sequencing of transition compensation and procedures for servicemembers transitioning to veteran status, with special emphasis on seriously ill or wounded servicemembers; and disability compensation for non-economic loss, often referred to as quality-of-life.

You asked me to present the views of my committee on the structure of payments for disability compensation and what reform, if any, the Advisory Committee recommends. Our efforts to date have addressed the structure of payments for disability compensation in the following ways.

We believe that an updated and clarified ratings schedule will enable rating, examining, and reviewing officials to make a more accurate and timely assessment of a veteran's disability and its effect on average earnings loss. An updated and clarified ratings schedule should improve first-time accuracy and reduce the number of appeals and backlog that the appeals create. The Updated Rating Schedule should address the recognized inconsistencies in the mental versus physical disabilities and in the differences in age at entry into the disability system. Any remaining discrepancies between mental and physical disabilities could be addressed via the SMC system.

Recent studies by the Veterans Disability Benefits Commission, the Institute of Medicine, the Government Accountability Office, and the others have consistently recommended a systematic review and update process for the VASRD. The Congress has repeatedly demanded the same. I believe that the case for such a system is made and that sufficient data currently exists to proceed with a review and update.

My committee has informally recommended to the Secretary that the Deputy Secretary be tasked with oversight of the VASRD systematic review and update process to ensure that the VBA, VHA, and General Counsel are fully integrated into the process. We are also offering a proposed level of permanent staffing in both VBA and VHA to ensure that all 15 body systems are reviewed and updated as necessary in a timely way. We are proposing a priority among the body systems that takes into account the following: body systems that are at greater risk of inappropriate evaluation; body systems that are considered problem-prone; and relative numbers of veterans and veterans' payments associated with each body system.

At a previous hearing, I was asked if I thought the review and update of the VASRD could be done by contract. If the VA is unable to devote the entire resources to accomplish a timely review and update, contract assistance is a possibility. However, I believe that the expertise and background knowledge of the VA professionals are critical in this process and I encourage the VA to accomplish this very high priority task internally.

Regarding disability compensation for non-economic loss, also referred to as quality-of-life, we are reviewing the special monthly compensation program as a potential model for a quality-of-life system and we are analyzing options for the forms of compensation beyond a monetary stipend. One of our concerns is to avoid a compensation system for economic loss that encourages seeking increasingly higher levels of compensation. Our current view is that the quality-of-life compensation should be limited to clearly defined and very serious disabilities.

Regarding disability compensation related to the transition from servicemember to veteran status, we are reviewing the many recent changes and improvements to the transition program to determine if and where gaps in coverage and assistance may remain for veterans and families. We are also reviewing the vocational rehabilitation and education program as it relates to transition for disabled veterans.

In summary, our committee's work is progressing on a broad front. The parameters of our charter offer us the opportunity to look at all aspects of disability compensation and we are doing so. The committee has excellent access to the Secretary and his staff. The VA staff is responsive and helpful to the committee's request for information. It is our intent to offer interim reports to the Secretary semi-annually and to provide copies to the Veterans' Committees of both Houses.

Mr. Chairman, this concludes my statement and I welcome comments or questions.

[The prepared statement of General Scott follows:]

PREPARED STATEMENT OF JAMES TERRY SCOTT, LTG USA (RET), CHAIRMAN, ADVISORY COMMITTEE ON DISABILITY COMPENSATION

Chairman Akaka, Ranking Member Burr, and Members of the Committee: It is my pleasure to appear before you today representing the Advisory Committee on Disability Compensation. The Committee is chartered by the Secretary of Veterans Affairs under the provisions of 38 U.S.C. § 546 in compliance with Public Law 110–389 to advise the Secretary with respect to the maintenance and periodic readjustment of the VA Schedule for Rating Disabilities. Our charter is to "(A)ssemble and review relevant information relating to the needs of veterans with disabilities; pro-

vide information relating to the character of disabilities arising from service in the Armed Forces; provide and on-going assessment of the effectiveness of the VA's Schedule for Rating Disabilities; and provide on-going advice on the most appropriate means of responding to the needs of veterans relating to disability compensation in the future."

The Committee has met ten times and has forwarded an interim report to the Secretary that addresses our efforts as of July 7, 2009, to date. (Copies of this interim report were furnished to majority and minority staff in both Houses of Congress.)

Our focus is in three areas of disability compensation: Requirements and methodology for reviewing and updating the VASRD; adequacy and sequencing of transition compensation and procedures for servicemembers transitioning to veteran status with special emphasis on seriously ill or wounded servicemembers; and disability compensation for non-economic loss (often referred to as quality of life).

You asked me to present the views of my Committee on the structure of payments for disability compensation, and what reform, if any, the Advisory Committee recommends.

The Committee's efforts to date have addressed the structure of payments for disability compensation in the following ways:

1. An updated and clarified Rating Schedule will enable examining, rating and reviewing officials to make a more accurate and timely assessment of a veteran's disability and its effect on his or her average earnings loss. An updated and clarified Rating Schedule should improve first time accuracy and reduce the number of appeals and the backlog that appeals create. The updated Rating Schedule should address the recognized inconsistencies in mental versus physical disabilities and in differences in age at entry into the disability system.

Recent studies by the Veterans Disability Benefits Commission, the Institute of Medicine, the General Accounting Office and others have consistently recommended a systematic review and update process for the VASRD. The Congress has repeatedly demanded the same. I believe that the case for such a system is made and that sufficient data currently exists to proceed with a review and update. My Committee has informally recommended to the Secretary that the Deputy Secretary be tasked with oversight of the VASRD systematic review and update process to insure that the VBA, VHA and General Counsel are fully integrated into the process. We are also offering a proposed level of permanent staffing in both VBA and VHA to insure that all fifteen body systems are reviewed and updated, as necessary, in a timely way. We are proposing a priority among the body systems that takes into account the following: body systems that are at greatest risk of inappropriate evaluations; body systems are considered problem prone, and relative number of veterans and veterans' payments associated with each body system.

At a previous hearing, I was asked if I thought the review and update of the VASRD could be done by contract. If the VA is unable to devote the internal resources to accomplish a timely review and update, contract assistance is a possibility. However, I believe that the expertise and the background knowledge of the VA professionals are critical in the process and I encourage the VA to accomplish this very high priority task internally.

2. Regarding disability compensation for non-economic loss, also referred to as quality of life, we are reviewing the Special Monthly Compensation program as a potential model for quality of life system and we are analyzing options for forms of compensation beyond a monetary stipend. One of our concerns is to avoid a compensation system for non-economic loss that encourages seeking increasingly higher levels of compensation. Our current view is that quality of life compensation should be limited to clearly defined and very serious disability.

3. Regarding disability compensation related to transition from servicemember to veteran status, we are reviewing the many recent changes and improvements to the transition programs to determine if and where gaps in coverage and assistance may remain for veterans and families. We are also reviewing the Vocational Rehabilitation and Education program as it relates to transition for disabled veterans.

In summary, our Committee's work is progressing on a broad front. The parameters of our charter offer us the opportunity to look at all aspects of disability compensation and we are doing so. The Committee has excellent access to the Secretary and his staff. The VA staff is responsive and helpful to the Committee's requests for information. It is our intent to offer interim reports to the Secretary semi-annually and to provide copies to the Veterans Committees of both Houses of Congress.

Mr. Chairman, this concludes my statement. I welcome any comments or questions.

Chairman AKAKA. Thank you very much, General Scott.

I would like to open with a question to all witnesses.

If we are going to act as a Committee, as some of our colleagues suggest, what would you suggest as the highest priority, or what would you suggest we tackle immediately here? Let me start with Admiral Dunne.

Admiral DUNNE. Sir, I wouldn't be so bold as to tell the Committee what responsibilities they should take on. We are working as quickly as we can to work on the recommendations that have been given to us.

Specifically, just to give you an example, General Scott talked about personnel, et cetera. We have already hired two clinicians to work on modifying the schedule. We are coordinating with VHA to set up a committee that will be working very closely with the folks in VBA who are working on changing the schedule, and we have already done some preliminary work over the past couple of months to start in the mental health part of the rating schedule. By coincidence, tomorrow is the first all-day meeting with the VHA and VBA experts to start looking at mental health, to include review of PTSD, sir.

Chairman AKAKA. Thank you.

Dr. Kettner?

Mr. KETTNER. Well, I would agree with what Admiral Dunne just said. I think the burden is really on VA to work at adjusting, revising the rating schedule. I would say that over the past several decades, the rating schedule has never really been based on an economic analysis of lost earnings. It has been based on medical criteria and decisions made by medical practitioners, but the underlying benefit amounts linked to different criteria have never really been based on economic analysis of lost earnings. So this would be an opportunity, for the first time, to really integrate the economic loss analysis into revising the schedule along with reviewing and revising medical criteria.

Chairman AKAKA. General Scott?

General SCOTT. Well, I certainly agree that the VASRD should be the initial priority because it, if done properly, accurately, and on a timely basis, will address many of the anomalies that we face and many of the concerns that the Members of this Committee have expressed in their opening statements, to include timeliness, accuracy, the backlog, et cetera. So, I really believe that a concerted effort by the VA to update and revise, as necessary, the 15 body systems that make up the VASRD will go a long way toward solving a number of these issues.

I think that both the Economic Systems studies and the study done by CNA, chartered by the Veterans Disability Benefits Commission, indicate that there is a solid economic basis for the VASRD in terms of average loss of earnings. Arguably, there are pluses and minuses and puts and takes in there that need to be looked at, and I believe that most of them can be addressed in the revision of the VASRD.

As I commented, I think that we might have to look at something extra-schedular, so to speak, for the 100 percent mentally disabled—something along the lines of an SMC—if we can't get the VASRD to address that.

But I believe the data is there to validate the VASRD as a measure of average economic loss, and that we should proceed with the revisions to try to fix the different problems that have come up and have been cited in terms of percentage—particularly for mental disability and the like—and age of entry. I think we are ready to go with that and we should move out with it.

I think the quality-of-life assessment, as a system, is a second but close-behind priority. Again, we are looking now at something that might be modeled on the SMC system so that it addresses the loss of quality-of-life at the extreme levels of disability and does not burden VA with a grafted system or some sort of a need for a totally different analysis to come up with a quality-of-life assessment for each veteran.

As you know, sir, as well as anybody else, the VA struggles with the administrative load as presently constituted in terms of processing claims on a fair, equitable, and timely basis.

Then I believe the third thing is—as has been pointed out in the Dole-Shalala Commission and others—that the transition from servicemember to veteran needs a continuing look. Particularly, the emphasis that was made in one of the opening statements that the goal should be to return the veteran to, as nearly as possible, full membership in society, and the VR&E program is a great opportunity for improvement to accomplish that end. Thank you, sir.

Chairman AKAKA. Thank you very much.

We will have other rounds here, so let me call on Senator Burr for his questions.

Senator BURR. Thank you, Mr. Chairman.

Admiral Dunne, in July you were here and I discussed with you my desire that the reports from the Disability Benefits Commission and from Dole-Shalala not become part of that repository that everything else has. I asked you specifically to discuss it with General Shinseki and specifically what the next steps were in moving forward on their recommendations. Have you had an opportunity to do that?

Admiral DUNNE. Yes, sir. I discussed with the Secretary my evaluation of the Economic Systems report in terms of the action that we would take within VA to respond. We first discussed evaluations and if we compensate too much, too little, et cetera. While I recognize that Dr. Kettner and his group had a very short period of time to work with and only 1 year's worth of data, I was not prepared to recommend any changes based solely on 1 year's worth of data.

I was not about to recommend that all of our veterans who are currently receiving compensation for tinnitus should go to zero percent disability ratings immediately, because as you know, you can only get a 10-percent disability ratings for tinnitus. So, if you are receiving disability compensation for that right now, if we were to follow this recommendation, no one would be receiving compensation for that anymore, so——

Senator BURR. The Secretary was in agreement with your conclusions?

Admiral DUNNE. With my discussion, yes, sir.

Senator BURR. And would it be safe for me to make the statement that VA feels that further studies are required before they

could make any changes, act on any of the recommendations out of this——

Admiral DUNNE. No, sir. I can give you a few examples. First off, in the transition benefits area, there is already an additional study going on, which actually Economic Systems is performing for us, to take a look at the rehabilitation program that we currently have. As you know, there are some recommendations in there about levels of potential compensation during a transition period. We want to get the results from that study, which should be available by late spring next year and provide additional information on veterans' reaction to the VR&E program——

Senator BURR. What was the VA's expectations of Dr. Kettner's 6-month study?

Admiral DUNNE. That there would be some options presented, sir.

Senator BURR. And those options all require further study to refine, is sort of the way I interpret everything. Is that accurate?

Admiral DUNNE. No, sir, I——

Senator BURR. Most of them?

Admiral DUNNE. In——

Senator BURR. Most of them require further study?

Admiral DUNNE. Most of them, yes, sir, require more evaluation.

Senator BURR. Let me just ask Dr. Kettner, was it your understanding that you were going to do a study that had recommendations that required additional study or recommendations that were—is this indicative of the study, the 6-month study?

Mr. KETTNER. Yes. That is our report right there.

Senator BURR. And in your estimation, does that lack the specificity needed to make a determination?

Mr. KETTNER. Well, I think where the issue lies on this is the level of analysis we were able to perform in the 7-month study that we did. We were hindered to a certain degree in not being able to analyze data at the individual level.

Senator BURR. Was that discussed at——

Mr. KETTNER. Oh, yes. Right.

Senator BURR [continuing]. At the preliminary review, did you share with the VA——

Mr. KETTNER. Absolutely. Yes, sir.

Senator BURR. We are not provided this information. We are not going to be able to give you specific recommendations that you can act on?

Mr. KETTNER. Well, I may differ in assessing which options might be more practical to act on versus other options we presented. I think that where we had the most difficulty in our analysis was in looking at different combinations of disabilities. We were not able to sort out exactly what were the combinations in terms of identifying exactly what was second or third disability, and——

Senator BURR. I am trying to better understand for the Committee. Listen, I am not trying to play "gotcha" on any of this. I am trying to figure out, what did they share with you that they wanted to accomplish from a standpoint of the information that came out of your study? Because other than compiling in these books information that was available and making recommendations

off of it, the recommendations don't seem to have the basis proven in them to move forward. They require additional studies. I am trying to figure out, why did we do this?

Mr. KETTNER. We asked for and were not able to get earnings data at the individual level.

Senator BURR. And was that discussed during the review——

Mr. KETTNER. Yes.

Senator BURR. Before the review?

Mr. KETTNER. Before, during, and after.

Senator BURR. So what was the answer before the review? If you said, we can't get to it——

Mr. KETTNER. The answer is that the Social Security Administration, which is the source of our data, does not release data at the individual level. We have recommended that we obtain the data at the individual level so that we can do a more detailed analysis.

Senator BURR. And before this process started to take place, that one thing triggered you that you would not get the degree of clarity that would trigger VA to say, we need to move forward?

Admiral DUNNE. Senator, I had the privilege of being involved in setting up the statement of work for this study in a prior job. We realized after we got into it that we would be unable to get the data from Social Security in the timeframe to enable Dr. Kettner to finish the study within the amount of time that was available to do it. We are continuing to pursue that.

One of the things that we need to do to be able to maintain a viable rating schedule, is to get this data routinely—almost on an annual basis from Social Security—so that we can process it in-house every year and be able to recommend or evaluate where the disparities exist over a period of time.

Senator BURR. I am going to get into the annual update of the rating schedule in the next pass, and the Chairman and the Members have been very accommodating to me to let me run over.

Let me just ask one last question. How much did this study cost?

Admiral DUNNE. I would have to get you that answer for the record, sir. I don't recall.

Senator BURR. Dr. Kettner, do you know how much you charged for it?

Mr. KETTNER. Approximately $3 million.

Senator BURR. Three million dollars. I find it incredible that we knew before it started that we couldn't access the information we needed to conclusively come to a determination and we invested $3 million in a product that would do little more than trigger additional studies. I would only say that I guess my expectations shouldn't have been different because we do have five decades of this.

I will only say to my colleagues and to those from the VA, I am not going to let this out of my teeth. I don't care who I insult as I go through it, but we are going to get to the bottom of this and we are either going to move forward or we will find another avenue to use within or outside of the VA to accomplish it. It is not a promise to veterans out there that they are going to get a windfall check or that they are going to lose something. But we can come to a determination as to how broken this is, and more importantly,

how we fix it. Then we can get on a pathway to fixing it and quit studying the thing.

I thank the Chair.

Chairman AKAKA. Thank you, Senator Burr.

Now, Senator Tester, your questions.

Senator TESTER. Yes. Thank you, Mr. Chairman. I am going to follow up a little bit on Senator Burr's questions.

The answer you gave indicated to me that if you would have had the information from Social Security, the wage information, then you could have come forth with recommendations. Is that accurate?

Mr. KETTNER. Well, we were not asked to provide recommendations. We were asked to provide options, and that is what we did. We pointed out where there was economic loss and where there was not economic loss. So, for example——

Senator TESTER. OK. I appreciate that, and I don't mean to cut you off. But what you are saying is when it comes to quality-of-life issues, based around what kind of compensation they are going to get, your study based it off of wages?

Mr. KETTNER. We conducted two separate studies within our study: one on earnings loss; and another on quality-of-life loss. The two were very separate and distinct from each other.

Senator TESTER. OK. So what went into the quality-of-life loss?

Mr. KETTNER. We analyzed loss of quality-of-life based on a sample of 21,000 veterans. The survey of that information was conducted by a previous contractor. We took that study. We analyzed the——

Senator TESTER. Do you remember the criteria that was used? In other words, what were you using for criteria to determine quality-of-life lost? What were they using?

Mr. KETTNER. The survey was based on a series of questions that get a loss of quality-of-life. The instruments—the questions—were largely based on a set of questions developed by RAND Corporation many years ago and have been repeatedly used by many organizations in assessing loss of quality-of-life.

Senator TESTER. But what are those issues? I mean, I know they asked——

Mr. KETTNER. They cover a variety of different dimensions, loss of functional independence; the ability to walk or climb stairs; quality-of-life in terms of self-perception——

Senator TESTER. OK.

Mr. KETTNER [continuing]. One's satisfaction——

Senator TESTER. OK. That is good. So, when you make your recommendations for further study, how do you dovetail wage loss in with some of those quality-of-life things? Did you make any recommendation on that, because from my perspective, you have got two issues that are very distinct. You have got one, the ability to make a few bucks, and then the other one, the ability to actually do things like go fishing or go swimming. I am an outdoors kind of guy, so those are the kinds of things I relate to; whereas for somebody else it might be the ability to read books or something like that.

Mr. KETTNER. Right.

Senator TESTER. So, were you able to make a recommendation on how you value those?

Mr. KETTNER. We presented a range of different options for payments for loss of quality-of-life. There is—it is a very subjective kind of thing to make judgment on, and the judgments could rest on the veteran's self-perception of loss of quality-of-life, SMCs, or other criteria.

Senator TESTER. All right. I think you stated in your testimony, I think both you and Dr. Kettner stated that the studies agree that certain mental health conditions in particular are undercompensated. Are they undercompensated because of the rating system, because of a bias in the rating system, or because of a bias somewhere else?

Mr. KETTNER. I believe that where the VASRD is off the mark is simply for the reason that the criteria and the benefit amounts are linked to specific criteria which have never been based on economic analysis. If you don't do the economic analysis, you are never going to hit your target.

Now, is the VASRD in the general ballpark? Perhaps, yes. But within the ballpark, it is totally misaligned in terms of certain codes——

Senator TESTER. OK. It wasn't based on economic analysis. Was it based on quality-of-life analysis?

Mr. KETTNER. No. The economic loss analysis is totally separate from the quality-of-life analysis.

Senator TESTER. I would like you to give your opinion on that same question, Admiral Dunne. Is the rating system deficient in the things that Dr. Kettner talked about or is it something else?

Admiral DUNNE. Sir, in the mental health area, the rating schedule has been called into question as to whether it adequately compensates the veteran, and we are determined to investigate that. As I mentioned to the Chair earlier, we are into that already. There is a meeting tomorrow with experts to take a look at it and to evaluate the current rating schedule and see if it needs——

Senator TESTER. Do you have a timeline for that?

Admiral DUNNE. As soon as possible, sir; and I don't mean to say that flippantly, sir. I have learned from the TBI reg—which we did modify last year—that when we get these experts in the room and get them talking and consulting about the impact of these disabilities and how it should be evaluated and subsequently compensated, I can't really put a clock on it. They have to talk it out until they are able to reach consensus because that is really what we need in order to go forward.

Senator TESTER. First of all, I, like the Ranking Member, don't want to be critical on anything that is being done because you have got a difficult job—make no mistake about it. I would hope that part of that group of experts that you get in the room are some of the fighting men and women that have come back, because quite honestly, as I went around Montana—and I don't think Montana is any different than anywhere else—they are not afraid to give you their opinion. They also understand when people deserve the benefits and they understand when people don't deserve the benefits, and they are willing to tell it straight up both ways. So, I hope that you do use the VSOs or whatever method you want to use, but get the information from the folks that are receiving the benefits because I think it is critically important.

Admiral DUNNE. Sir, one thing I might add to that. When we do get to a proposed rating schedule on mental health or any other area, we publish it in the Federal regulations for comments from anyone, and we will address those comments, sir.

Senator TESTER. This is my opinion, you guys have to do your business, but I will push for this. I would bring them into the process much more than after the fact. I would bring them in early. I could make a lot of comparisons to what happens in offices; but if you bring them in early, you get their perspective early and it is more likely to be included in the final analysis that is put out for publication and still have them comment.

Chairman AKAKA. Senator Begich?

STATEMENT OF HON. MARK BEGICH,
U.S. SENATOR FROM ALASKA

Senator BEGICH. Thank you, Mr. Chairman. I am going to follow up a little bit on Senator Tester and Senator Burr and your comments, Mr. Chairman.

First, again, not to be critical, but you spend $3+ million, you expect some steps that will be pretty aggressive. But let me put that aside.

I am going to take what Senator Tester has said and go one more step, and that is my father-in-law is a retired veteran receiving disability. He doesn't read the Federal Register. I would venture to say most veterans aren't sitting around pulling out the Federal Register. You must engage them in the beginning of the process, not after. I have seen this Federal process where they do the 30-day notification, and then once it is done, they check the box and they say they are done. Honestly, that is unacceptable.

So, I would ask you to take what Senator Tester has said and make it a real step. Do it early. Engage them and not the Federal process way of posting it in the Federal Register. I mean, if I called my father-in-law right now and asked, have you looked at the Federal Register today, I know what he would say to me. I bet you if I called my brother-in-law and asked him the same thing—he was active—he would say the same thing. I would just encourage you to step it up to a little different level; not just consider it, but do it, to be very frank with you. You run the show, and I am just giving you my two bits here.

Admiral DUNNE. Senator, I have no problem with including veterans in the process, and we will find a way to do it.

Senator BEGICH. Thank you very much.

I am trying to figure out your response in regards to the questions with the rating system. Mr. Dunne, I know you are doing an analysis, because we have heard more about it today, but do you think, personally, there is a problem with the system? Do you?

Admiral DUNNE. I believe that we need to go through and evaluate the rating schedule and determine how we can improve it. We need to bring the appropriate experts together to take each of the disabilities, pull it apart, look at it, update it, and make that presentation. I do believe that.

Senator BEGICH. So, if you—I don't want to put words in your mouth—do you think there is room for improvement?

Admiral DUNNE. Yes, sir. There is always room for improvement.

Senator BEGICH. Here is the difficulty, Dr. Kettner and Mr. Dunne, you have the economic analysis and then you have the quality-of-life. I am not an attorney and wish no disrespect to any attorneys, but if I was a trial lawyer, they would argue economic damage and punitive damages. The punitive is always very difficult based on the circumstances. I mean, you see juries all the time kind of trying to figure that out.

I would imagine as you get to whatever proposal or recommendation that you recognize to put a finite number on that quality-of-life will be very difficult, and creating a range may be more reasonable, because the conditions can vary based on the person. I mean, you see juries going through this all the time. So, as you described, when you get a bunch of consultants in a room, I can only visualize what that is like. As a former mayor, I have experienced that many times. Yet, sometimes you have got to just pull the trigger and say, this is what we are doing, here is the range, move forward and see how it works.

I would hope that at some point, maybe both or either one could respond to this, that that would be kind of the objective, that we—to find a perfect system will be very difficult, but finding a system that we can move forward to start getting realistic results out of knowing the system needs to be improved is what should be the goal. Any comment? Mr. Dunne?

Admiral DUNNE. Well, yes, sir. I agree that we need to evaluate things and we need to move forward, but exactly how that is structured, I don't think is defined yet. There is no definitive decision on if quality-of-life should be an element of the compensation process. We are still struggling with that and trying to figure out the right answer. You can see I have one recommendation for quality-of-life. I have another recommendation to take it out of the SMC tables.

Senator BEGICH. Right.

Admiral DUNNE. I want to do the right thing for veterans. I don't want to jump into this fast, and I want to get the benefit of the Advisory Committee which the Secretary has set up, as well as the consideration of the work that Dr. Kettner has done, before I make any recommendations on something that impacts the lives of our veterans.

Senator BEGICH. I appreciate that.

My time is up, and I heard your response to Senator Tester on the timing. I know it is difficult to give some sort of timeline, and as you said, as soon as possible. I would ask, can you be a little bit more definitive? The reason I ask is, I have never known anyone in the military to not be able to have a time schedule with a goal and target. So, is it within 6 months? Three months? A year? I mean, when will we see a reform to the system——

Admiral DUNNE. Sir——

Senator BEGICH [continuing]. Whatever that reform might be?

Admiral DUNNE. Our estimate is that if you take an individual body system of the rating schedule, take that apart, and build that back up again, that is a year process.

Senator BEGICH. OK. Thank you very much. Thank you all three for your testimony.

Chairman AKAKA. Senator Burris?

STATEMENT OF HON. ROLAND W. BURRIS,
U.S. SENATOR FROM ILLINOIS

Senator BURRIS. Thank you, Mr. Chairman.

Interesting. Interesting testimony. I want to follow up on Senator Burr's question. Dr. Kettner, were you a sole source or did you do this competitively?

Mr. KETTNER. It was competitively awarded—full and open competition.

Senator BURRIS. Full and open competition?

Mr. KETTNER. Yes.

Senator BURRIS. Can you tell us how many—maybe Admiral Dunne can tell us—how many contractors were there, or you weren't there at the time——

Admiral DUNNE. Sir, I don't recall that I ever knew the answer to that, but I can find that out.

Senator BURRIS. OK. I assume, now, we are saying that there are further studies, so this will follow the Federal guidelines for dealing with contracting; and I would assume that there are some budget dollars for these. Do you have any idea what your allocation is for these studies?

Admiral DUNNE. I do not, sir. My office is not supervising that contract.

Senator BURRIS. Is not supervising the contract.

Admiral DUNNE. I will also find that answer out, sir.

Senator BURRIS. I would appreciate that.

I am concerned with some of my other colleagues' questions, too, because I am looking at TBI. I wanted you to talk about the challenges in rating TBI and how is the VA attempting to improve diagnosis, diagnostics of some of the signature diseases of this war. I mean, there is going to be something else coming up. So, can you give me some insight on how we are attempting to improve diagnosis of Traumatic Brain Injuries?

Admiral DUNNE. Senator, I have no medical background and do not supervise the medical portion of VA, but I can certainly make arrangements for a briefing for you from our medical experts.

Senator BURRIS. OK, because that seemed to be the latest thing, PTSD, which is really the biggest thing on our veterans, then TBI, which is very hard to diagnose. So, I would assume that there are just different levels for different individuals because individuals are going to react differently to various circumstances. I would assume, Dr. Kettner, that those are some of the problems that would come out in your study, would they not? How do you really get a norm in reference to what would be applicable to a compensated situation for a person. I would assume all of these criteria come into effect, you know, age and education, family life. Are some of those criteria what you put into your analysis?

Mr. KETTNER. Yes. We controlled for human capital differences, such as education, age, whether or not the veteran was an officer versus an enlisted, and to the best of our ability, we controlled for those differences.

I might also mention that we did analyze TBI as a separate diagnosis and found that they were being—in those instances, there was undercompensation for TBI cases.

Senator BURRIS. I assume, or I understand I heard General Scott say that most of those were underestimated, is that correct? A lot of those compensated amounts are just off-kilter. I get all these veterans coming to me saying that they are not really receiving enough money for what they really suffered. Is that what you said in your testimony, General Scott?

General SCOTT. The analysis that was done for the VDBC regarding average earnings loss would indicate that the average earning loss for mental disabilities does not—that the average loss is in excess of the compensation. And the second part—the study that Dr. Kettner referred to that was done also for the VDBC regarding quality-of-life—clearly indicated that the quality-of-life for those veterans suffering from mental disabilities was markedly lower than the quality-of-life suffered for those with physical disabilities. So yes, sir. I think the answer to your question is yes in both cases.

Senator BURRIS. Now, help me out here, because I am new to the Senate and I wasn't here when Senator Burr and our distinguished Chairman were here, but you mentioned something about Social Security and having to get the data from Social Security. So, is there an offset? If you are getting Social Security or some disability under Social Security, is there an offset for the veterans compensation? What does Social Security data have to do with the veterans?

Mr. KETTNER. We simply use the Social Security Administration earnings data for purposes of our earnings loss analysis. We went to that source because it provides a relatively accurate source of data on earnings as opposed, for example, to using survey data or self-reported data. You don't get data as accurate. But when you——

Senator BURRIS. Pardon me, Doctor. You mean you are not going to Social Security to see whether or not these veterans are collecting Social Security, but you are just trying to get basic information and the Social Security Administration wouldn't give you that basic information for you to continue your study? Is that what you are saying?

Mr. KETTNER. They gave us data aggregated to a certain level. We couldn't get the data at the individual level for privacy reasons. Now, since our study was——

Senator BURRIS. Pardon me. Why would you need——

Mr. KETTNER. We have uncovered another possibility of getting at this data, which would be that we could instruct the—we could give instructions to the Social Security Administration on exactly how to run the analysis at the individual level and thereby that would be an avenue that could be taken to circumvent the problem we have talked about—the Social Security Administration not releasing——

Senator BURRIS. Well, I am still not clear on why you need Social Security data, and my time has expired, Mr. Chairman. I don't know whether I am going to have time to pursue that or not, but I am not clear on the need for the Social Security data for comparison. It is not—may I have a couple extra minutes, Mr. Chairman?

Chairman AKAKA. If you pursue that, yes.

Mr. KETTNER. OK. Let me try this again.

Senator BURRIS. Please.

Mr. KETTNER. We measure the actual earnings of veterans with disabilities and compare them to the earnings of veterans without disabilities, OK. So, the veteran over here, he has a disability, he makes $20,000 a year. Another veteran over here that we have matched in terms of the same education level and age and other characteristics, his income is $30,000 a year. His earnings are $30,000 a year. So that is a difference of $10,000. That is what we are trying to find out.

We go to the Social Security Administration because we know they have accurate data. It has to be accurate. It is reported. The earnings data is reported by employers to the Social Security Administration.

Senator BURRIS. Wouldn't the IRS have the same data?

Mr. KETTNER. Well, yes, IRS is another possibility, but there are certain issues involved as to how best to get the data. There are bureaucratic obstacles always involved in getting the data. We only had 7 months for our study and we had to move very quickly on this, so we took certain courses to——

Senator BURRIS. Well, I am with Senator Burr. I don't see how you could have 7 months and not know that you are going to need this, then get caught up and now there has got to be another study which you may have to spend another $3 million.

Mr. KETTNER. Well, part of the study was discovery. We didn't know all of this at the beginning. We did ask for individual data at the beginning, so we knew from the beginning that we would be facing a certain obstacle. But in the course of our study, we discovered more things than we knew when we first started.

We feel very confident in a lot of our studies. For example, on tinnitus, tinnitus is a 10-percent rating. I can say unequivocally that there is no earnings loss for tinnitus veterans. Whether or not you want to—we are just reporting our result, our statistical result. Whether or not you want to change their rating from 10 percent to 0 percent, that is a value judgment that others in government have to make. We are not making that judgment. We are just reporting on the statistical results.

At the same time, we can say that those veterans rated at 100 percent are not getting enough compensation. They are, on average, 9 percent below what they should be getting. We are very confident about that. We would not say we need to do more studying for that.

Where our confidence starts to decline is when we have to look at different combinations of disabilities. We have tinnitus there, hemorrhoids, and diabetes. When you put them all together, you get a certain combined rating. We are very confident that the VA is overcompensating at the lower levels, but you would have to look at—to get even more accurate, you would have to look at what are the exact combinations of different disabilities to really fine-tune this as accurately as possible, and that is where our hands are tied behind our back in terms——

Senator BURRIS. Thank you, Doctor. My time has expired. Thank you, Doctor. Thank you, Mr. Chairman.

Chairman AKAKA. Thank you very much, Senator Burris.

Dr. Kettner, the question of whether to compensate for loss of quality-of-life has the potential to change veterans disability com-

pensation considerably. Let me ask you this question, and I am going to ask General Scott to also comment on this. Do you believe that VA should work on changes to the rating schedule before addressing whether loss in quality-of-life should also be compensated?

Mr. KETTNER. Absolutely. They should get the VASRD in better alignment before adding on quality-of-life, because you could be compounding current inequities in the system right now.

When we look at quality-of-life, you know, there is a tremendous amount of variation across ratings. It jumps around quite a bit. We believe part of the reason is that the rating schedule itself—the regular schedule ratings schedule—is so misaligned that when you try to line up quality-of-life loss analysis, it is more of a random kind of thing, and there is more variation than you would expect to see. So, we strongly recommend fixing the VASRD first before taking on quality-of-life.

Chairman AKAKA. Thank you for that. When I asked about what are your priority of any change, you mentioned the rating schedule.

General Scott?

General SCOTT. Sir, you did indeed ask for a priority and that is what each of us gave you. I think it is a good thing in terms that we all have the same priority when we talk about it.

I guess my perspective on working quality-of-life would be that an assessment of the different models for determining how to compensate for quality-of-life can go on in parallel with the updating and revision of the VASRD. But the application of dollars, if you will, to a quality-of-life model might want to wait until we had been through the VASRD and the updated revision done.

So, that may be an equivocal statement, sir, but I think that you can work the model, which I believe is what the VA is doing. They are working—they are taking the input from us, they are taking the input from the studies that have been done and from the other advisory efforts that are ongoing to try to develop a model or models for quality-of-life compensation, and I think that can go on in conjunction with updating the VASRD. But again, you might want to wait to put the dollars against it until the VASRD is updated. Thank you, sir.

Chairman AKAKA. Admiral Dunne and General Scott, last year, Congress passed the Veterans' Benefits Improvement Act of 2008, which became law. It was Public Law 110–389. This law required VA to establish an Advisory Committee on Disability Compensation. Congress intended that the committee would be composed of individuals with experience with VA's disability compensation system or who are leading experts in fields relevant to disability compensation.

My question to both of you is how are the requirements of the Congressionally-chartered committee met by the Advisory Committee that General Scott now chairs? Stated differently, which members are experts in which fields of expertise? General Scott, will you begin, and I will ask Admiral Dunne to comment.

General SCOTT. Well, let me start by saying that I will send you the bio sketches of the members of the committee for the record. The previous Secretary selected the current Members of the Committee. The legislation offered the opportunity, as I recall, for 18 members; and the Secretary at the time chose not to fill it entirely,

leaving the opportunity for the new Secretary or the Veterans Committees in the House and Senate to offer candidates.

The legislation, as I recall, requires the Committee to report out to the Congress on a biennial basis, and in my statement, I told you that we are submitting interim reports to the Secretary twice a year, semi-annually, and that we are obviously providing copies to the Committees. So, we are probably over-reporting in terms of what the law required, but not in terms of what we think we should be doing in terms of keeping both the Secretary and you informed.

As a matter of fact, I remarked to Admiral Dunne this morning that this committee is reaching its 1-year anniversary next month; that he and the Secretary might want to consult with you and the House to offer some additional recommendations for putting more people on it so that we don't all expire at the same time next year, at the end of the 2-year mark. The appointments of the people that are on it now were for 2 years and so far no one has indicated they weren't going to serve out the 2 years. What I would propose to do is, again, at the end of the 2 years, is have the Secretary ask the Committees if they would have recommendations regarding what should occur.

In response to one of the staffers who asked essentially the same question, was there proper expertise there and all that. At the time, my answer was I really don't know, because I haven't gotten to know the members that well. I also told them that if the Committees wanted to make changes, it was available in terms of adding people now. So that would be my basic response to your question.

I will say this. There are some distinguished members on that committee. I don't necessarily include myself in that, but there is a former Surgeon General who is a true expert in the transition from military to veteran and who thoroughly understands the medical side. There is a medical doctor whose background is psychiatry who is very, very helpful. There is also a Ph.D. from Johns Hopkins on it.

So, this is a committee made up of people with a wide variety of experiences and talents, and as I said, sir, at the beginning, I will furnish copies of the bio sketches of all the members, and perhaps your staff can take a look at them. Then, I believe, sir, that the Committee can make up its own mind of whether the people that you more or less intended or anticipated would be involved are on it or not; and then the opportunity is there to change the make-up of the committee as we go along, sir.

RESPONSE TO REQUEST ARISING DURING THE HEARING BY HON. DANIEL K. AKAKA TO LTG JAMES TERRY SCOTT, CHAIRMAN, ADVISORY COMMITTEE ON DISABILITY COMPENSATION

Advisory Committee on Disability Compensation
Membership Biographical Information
October 2008

Chair

LTG James Terry Scott (Ret.)
LTG Scott is a partner at Watson & Associates, a financial services firm located in Coleman, Texas. He joined the firm in 2001. He also teaches political science at Howard Payne University in Brownwood, Texas. He is a member of the Board of Directors of Calibre Corporation, a technical services company based in Alexandria, Virginia. He previously served as the Director of the National Security Program at the John F. Kennedy School of Government at Harvard University. He retired from the U.S. Army after more than 32 years of service. LTG Scott has a Master's Degree in Business Administration from Fairleigh-Dickinson University and a Bachelor's Degree from Texas A&M University.

Members

Charles Battaglia
Mr. Battaglia is a member of the Board of Directors for the Wounded Warrior Project. He previously served as Executive Director of the 2005 Defense Base Closure and Realignment Commission and also as a senior staff member of the U.S. Senate, serving in several positions. He headed the Bush Transition Team for the Department of Veterans Affairs and was appointed to serve as a Commissioner on VA's Capital Asset Realignment for Enhanced Service (CARES) Commission. He retired from the U.S. Navy after more than 25 years of service as a commissioned officer. Mr. Battaglia has a Master's Degree in Business Administration from Bryant University and a Bachelor of Science Degree from Boston College.

Robert J. Epley
Mr. Epley is an independent consultant working in the areas of strategic planning, training, performance management, and the operations of federal entitlement programs. Mr. Epley served with the Department of Veterans Affairs for 31 years. He was Director of the Compensation and Pension Program for three years before his promotion to the position of Associate Deputy Under Secretary for Policy and Program Management. In that capacity, he coordinated the activities of five major programs that collectively administered about $29 billion in annual benefits at the time. He received a Bachelor of Science Degree in Political Science from Western Michigan University.

LTG Thomas Carney (Ret.)
General Carney was elected to the CALIBRE Board of Directors in March 1999. He has been an independent consultant to numerous companies, include CALIBRE, since his retirement in June 1994. Prior to being a consultant, General Carney held the position of

Chief Executive Officer for the Library of Congress. He has also served on the Board of Directors of USAA, AFBA, and Army Emergency Relief. During his 31 years of distinguished service in the United States Army, General Carney served in a number of key command and staff positions including Deputy Chief of Staff for Personnel, Headquarters, Department of the Army.

Major Daniel Gade
Major Gade is the Associate Director for Domestic Policy for the White House's Domestic Policy Council. In that capacity, he is responsible for disability and healthcare issues, as well as matters relating to active military personnel and veterans. He is the first person in this position to be on active military duty since the post was created in 2001. Major Gade is the first Associate Director for Domestic Policy to have acquired a disability as the result of wartime injuries. He is pursuing his Master's Degree in Public Administration from the University of Georgia.

Dr. Robert Burke, Ph.D.
Dr. Robert Burke is Associate Professor and Chair of the Department of Health Services Management and Leadership, and Director of the Wertlieb Educational Institute for Long-Term Care Management at George Washington University. He holds a joint appointment in the Department of Health Policy and in the Health Sciences Program in the School of Medicine. Prior to joining the faculty at the School of Public Health and Health Services in 2002, Dr. Burke held senior research positions at the Institute of Medicine, the General Accounting Office (now the Government Accountability Office), the Health and Retirement Funds of the United Mine Workers and the Pepper Commission. For the past decade, he has worked with the Health Care Financing Administration (now the Centers for Medicare and Medicaid Services), directing the design of new prospective payment systems for post-acute care. He holds a Doctor of Philosophy (Medical Sociology) from the University of Florida.

Bonnie Carroll
Ms. Carroll is the National Director for Tragedy Assistance Programs for Survivors (TAPS), the national veterans service organization that provides peer support, grief and trauma resources and information, casualty casework assistance and crisis intervention for veterans and their families. Previously she served as the Deputy Senior Advisor for Programs in the Ministry of Communications, Coalition Provisional Authority, in Baghdad, Iraq, and as the Deputy White House Liaison for the Department of Veterans Affairs. She served in the U.S. Air Force Reserve from 2001-2004. Ms. Carroll holds a degree in Public Administration and Political Science from American University.

Dr. Ronald Blanck, D.O.
Dr. Blanck is the Vice Chairman of Martin, Blanck and Associates, having joined the firm in June 2006. Prior to joining the firm, Dr. Blanck served as President of the University of North Texas Health Science Center at Fort Worth from August 2000 until June 2006. He is a veteran of the U.S. Army, finishing his career as the Surgeon General of the U.S. Army and commander of the U.S. Army Medical Command (Lieutenant General,

U.S. Army, Retired). Dr. Blanck is a graduate of the Philadelphia College of Osteopathic Medicine.

Deneise Turner Lott, J.D.
Ms. Turner Lott has served as an Administrative Judge with the Mississippi Workers' Compensation Commission since November 1988. She is currently senior judge and is the first woman to hold that position. She was engaged in private law practice with an emphasis on disability claims before joining the Commission as a staff attorney. She later served the Commission as senior staff attorney. She also received her law degree from the University of Mississippi School of Law. She has served on several bar committees and has twice served as chair of the Administrative Law and Workers' Compensation Section of the Mississippi Bar. She regularly provides programs for continuing legal education credit on workers' compensation topics.

Edward R. Reese, Jr.
Mr. Reese, a disabled combat veteran of the Persian Gulf War, was appointed National Service Director for the 1.3 million-member Disabled American Veterans (DAV) in June 2002. Mr. Reese works at DAV National Service & Legislative Headquarters in Washington, D.C. Mr. Reese enlisted in the U.S. Army in 1984, and was an Airborne Infantry Rifle Squad Leader in the 82nd Airborne Division during the Persian Gulf War. Following the war, he served as an elite "Black-Hat" instructor in the Air Movement Operations Course and Jump Master Course at Fort Bragg, N.C. Mr. Reese joined the DAV professional staff in 1995, and has served in many different positions with the organization. He attended Fayetteville Technical Community College and Kaplan College for Professional Studies earning his Paralegal Degree.

Dr. Richard T Katz
Dr. Katz is currently a professor of clinical neurology at Washington University School of Medicine and is appointed to the Barnes Jewish Hospital. He is a primary reviewer of several different medical journals and has interests in evaluation of disability and assessment of pain. Dr. Katz graduated from Case Western Reserve University with a Doctor of Medicine and received training in a combined program in physical medicine and rehabilitation from Northwestern University.

Chairman AKAKA. Thank you, General. I would like the Committee to have your request and would also like to know what else you may need for the record.

General SCOTT. Yes, sir.

Chairman AKAKA. Admiral Dunne?

Admiral DUNNE. Mr. Chairman, first, I would offer that General Scott is one of the distinguished members of the Advisory Committee. Beyond that, I would say that the circumstances as he presented them are as I understand them, and I have nothing to add, sir.

Chairman AKAKA. Thank you.

Let me pass it on to Senator Burr for his questions.

Senator BURR. Thank you, Mr. Chairman. And Admiral, I don't think you took my last comments personally. I hope you didn't. They were not intended to be personally directed to you. I don't suggest to you or to the VA that we move on important decisions before we have all the information we need to get it right.

But I do want to try to present for you why there is a level of frustration on my part. You very clearly said in your testimony—being critical of the study for several reasons, you said, and I

quote, "It did not provide the detail and longitudinal analysis to warrant significant policy changes," yet my interpretation of Dr. Kettner's testimony reflects that the information that he provided is reliable and accurate enough to be the basis for policy decisions.

So, I hope that VA, company, contractor, will have some conversations that better lay out what the clarity is we need to make the important policy decisions before we begin the next study.

Now, the VA report on the Economic Systems study, and I quote, said "consideration could be given" to addressing the loss of quality-of-life for additional disabilities through special monthly compensation, and you mentioned it, as well. There are currently 260,000 veterans that receive special monthly compensation. Is the VA planning to send the Congress proposed legislation to expand special monthly compensation?

Admiral DUNNE. As we look through the ratings schedule and come up with changes, if legislation is required to implement that, sir, we certainly would do that. I have been talking with the folks at Compensation and Pension Service right now on the mental health side. There is some discussion about mental health versus coverage under SMC. What I am not certain of right now is modifications to that. If we determine they are necessary, can we make them simply through regulation, or is legislation required? So, we may have the capability to do it right now.

Senator BURR. But we are in agreement, mental health is not currently covered under special monthly compensation and it is just a question of whether we need to make some changes legislatively——

Admiral DUNNE. Yes, sir——

Senator BURR [continuing]. Correct?

Admiral DUNNE. I am not an expert in SMC, but to the best as I understand it——

Senator BURR. That is my understanding. I may be wrong, but——

Admiral DUNNE. Yes, sir. To the best of my understanding, it is not covered right now.

Senator BURR. I think we all agree that the VA rating schedule is probably the cornerstone of the entire disability compensation system. In its first report to the Secretary, the Advisory Committee on Disability Compensation indicated that the VA has not dedicated sufficient full-time employees to keeping the VA Schedule for Rating Disabilities up to date. Would I take it that the comment you made about the addition of two new clinicians is part of that review process?

Admiral DUNNE. Yes, sir, that is correct. As we go through this, there may be the need to have different experts, depending upon which part of the ratings schedule we are looking at. So, in some cases, we are contracting for an expert for a period of time to support that.

Senator BURR. Admiral, how many full-time employees are hired to continually look at this rating schedule and update it?

Admiral DUNNE. I would have to get you the exact number, sir. I am aware of the addition of two, and I know several of the senior members of Compensation and Pension Service work on it periodically, but are not dedicated to it 100 percent of their time. How-

ever, those individuals, in my mind, are key and essential to making this happen. For instance, the Director and the Deputy Director, who will be involved all day tomorrow, are not working on it 100 percent of the time, but they are essential to the success of tomorrow's event.

Senator BURR. How important do you believe keeping this schedule up to date is?

Admiral DUNNE. Very important, sir. I am not sure how to——

Senator BURR. You know, clearly, I think it is. I think that is part of the problem, that we haven't regularly updated it. Until I know the number of folks, I couldn't make an assessment as to where it shows the level of commitment to continuing. To me, two new clinicians is not a major additional commitment. It may be if there are 500 people that look at it all the time—if there are two people that look at it all the time and we are doubling, two to four, then we might both look at it and say that is not indicative of the type of commitment that we should have.

What role do you believe the Advisory Committee on Disability Compensation should play in making sure that the rating schedule is updated?

Admiral DUNNE. Sir, they have the opportunity to, first off, look at and evaluate what we are doing. General Scott and the Director of Compensation and Pension Service are in routine communication. The committee looks at what we are doing and makes recommendations based on that, and we try to act on those recommendations.

Senator BURR. Now, the VA report on the Economic Systems study, and again I quote, said, "We believe that recurring studies of earning loss relationships should be conducted on a regular schedule to ensure that the changes to the ratings schedule accurately compensate to the extent practical, for earnings loss."

Admiral, do you know of any significant study that has been done since the 1970s on that earnings loss relationship?

Admiral DUNNE. I am aware of a study which is referred to as the ECVARS study, which I believe was done in the early 1970s. I have not read that, sir, but I believe it took a look at the economic parameters of the ratings schedule.

Senator BURR. But there hadn't been a—General, do you have anything to add that you might be able to shed some light on that from the standpoint of how long it has been?

General SCOTT. The Center for Naval Analysis did a study for the Veterans Disability Benefits Commission that essentially validated the relationship between the average earnings loss and the compensation schedule, broadly speaking. Now, with the exceptions that we discussed off and on here today—age of entry, seriously disabled, mental versus physical, et cetera.

So, in the sense that has any economic validation been done, I would say that the ECVARS study, which was mentioned by Admiral Dunne, is one. The CNA study done on behalf of the VDBC is a second one. And significant parts of the study done by Economic Systems recently all address sort of the economic foundation of the VASRD.

Now, one can conclude that it is generally on the mark, but has variations that should be fixed and can be fixed mostly in the

VASRD; or one can conclude that it is off by some small percentage and more studying should be done to determine exactly what and exactly how. I am of the view that sufficient information has been provided by those three studies to enable, as I mentioned before, the continuing revision and updating of the VASRD, which should fix a lot of these problems. So yes, sir, I think that those three studies are relevant.

Senator BURR. But to dig just a little bit deeper, are you at odds with the VA relative to the conclusion you have come to that there exists enough data to proceed with review and update, or is there less light in between the two of you than I interpret?

General SCOTT. I think you will have to ask the VA representative whether the VA believes that adequate economic analysis had been done, but clearly from my comments, I think we can proceed with what we have here.

Senator BURR. Admiral?

Admiral DUNNE. Sir, I don't think there is disagreement on the fact that we need to take a look at the mental health part of the ratings schedule. But I would disagree with saying, just based on 2006 data, that we should do something specifically like take a 10 percent disability rating to a 0 percent disability rating. I would want to go back and take a look at more years' worth of data to see what it is.

I believe we need to take a look at it. We need to evaluate it. I am just not ready to say that every conclusion in here is one that should be acted on precisely.

Senator BURR. General, one last question. The Chairman has been incredibly accommodating to me this morning. You stated that you felt that updating the ratings schedule was a very high priority task. Do you believe that the VA agrees with that being a very high priority task?

General SCOTT. Well, I believe that they agree that it is a high priority task. I am not sure that the level of concern that I have regarding how quickly we need to move on it is reflected in what I have seen come out of the VA so far. But again, you have obviously read this report that we submitted to the Secretary where we—in no uncertain terms—not only told them what they should do, but probably in too much detail told them how to do it. We may have been a bit out of bounds by saying they should hire nine people to do this, et cetera.

But the point was, we felt—the committee felt that it was important that the VA focus full-time effort on updating the ratings schedule and we fully understand that it will take about a year to do a body system. The committee's position is that we ought to be doing about three or four of these at a time so that it doesn't take 15 years to get from 1 through 15.

I can't speak to whether the VA agrees with that approach or not, but that is the committee's recommendation, unanimous as a committee, to forward that to the Secretary and suggest that that is the way we should go on it. So, we believe it is a very high priority and it will fix so many of the small things that we talk about—not small in terms of impact on veterans, but all the second- and third-order issues that we are all confounded by, in my judgment, can be fixed inside that.

Senator BURR. I thank you for your observations, and more importantly, your involvement on the Advisory Committee. I hope all of you understand that what I am trying to do is establish points that we can begin to move forward from. If we can't do it on all of them, we can't. Let us know that up front. If we can, then let us find the agreement to move forward. I tend to look at agency issues in 4-year segments. There are some natural things that cause me to do that, and I know that when you get on the downhill side of the 4 years, you are less likely to get agencies to make major changes because all of a sudden you have individuals that have been there a long time that say all I have to do is wait out until this happens and I don't have to go through the tough decisions and the tough work.

So, we have a very short window to accomplish high priority tasks. And I hope if you, as chair of the Advisory Committee, see it as a high priority task, then I want to understand up front, is that where the VA sees it or is it seen as a lesser task, and if there is a difference, can we work this out to all come up with a common timeline. I think my expectations and hopes are that we are not talking about 15 years to accomplish many of these things. Hopefully we are looking at studies in the future that don't require follow-up studies, because I think it does play into the hands of some that would prefer to see this carried from 4 years to 4 years to 4 years.

Admiral, Doctor, General, thanks.

Chairman AKAKA. Thank you very much, Senator Burr.

I want to thank Admiral Dunne, Dr. Kettner, and General Scott for your responses. We continue to look to working together with you in trying to resolve this as quickly as we can. So, thank you very much for your time.

[Pause.]

Chairman AKAKA. I want to welcome our second panel this morning. Our first witness is Katy Neas, who is Vice President of Government Relations for Easter Seals; Susan Prokop, who is Associate Advocacy Director for the Paralyzed Veterans of America; and retired Air Force Colonel John L. Wilson, who is Associate National Legislative Director for the Disabled American Veterans.

Thank you all for being here this morning. Your full testimony will be, of course, in the record.

Ms. Neas, will you please present your testimony first.

STATEMENT OF KATY NEAS, VICE PRESIDENT, GOVERNMENT RELATIONS, EASTER SEALS

Ms. NEAS. Sure. Certainly. Thank you, Mr. Chairman. It is an honor to be here today to give Easter Seals' perspective on the Department of Veterans Affairs' disability compensation system.

Easter Seals is a 90-year-old organization that works with all people of all ages with all types of disabilities and our goal is to help them live, learn, work, and play in their communities. We work with each individual in the context of their families and in the context of their communities and we can't address each individual's needs in isolation.

My goal today is to provide some insights on Federal policy affecting people with disabilities that hopefully can inform you as you consider your work ahead.

Americans with disabilities have made great strides over the past three decades and it is essential that the VA build on these gains. I would like to list just three of the main victories we have witnessed.

In 1973, thanks to Section 504 of the Rehabilitation Act, all programs funded by the Federal Government need to be accessible and usable by people with disabilities. In 1975, with the passage of the Education for All Handicapped Children's Act, children with disabilities secured the right to an appropriate public education. And in 1990, all children and adults with disabilities won the right to be free from discrimination in employment services provided by State and local governments, public accommodations, transportation, and telecommunications, thanks to the passage of the Americans with Disabilities Act.

As a result of these important laws, people with disabilities expected to be fully included in their families and in their communities and have the supports they need to live the lives that they choose. There is a rallying cry within the disability rights movement about "Nothing about us without us," and I think, if anything we learned from the first panel, that that is something that we hope the VA takes to heart. Again, nothing about us without us.

I would like to provide some specific recommendations about how veterans with disabilities should be helped by the VA. Most importantly, veterans with disabilities and their lives need to be considered holistically. A veteran with a disability is likely to have increased expenses through their years beyond medical and therapeutic care. For instance, they may have additional out-of-pocket expenses such as assistive technology, transportation, home modification, and other supports to maintain their independence.

One of the things that was racing through my mind during the first panel was an individual's quality-of-life is something that only that individual can determine for themselves. Some people like to play rugby. I am not a rugby player. If you see people who play wheelchair rugby, they are a different breed of person who like risks and things. There are a lot of other people that we have served that are farmers that simply want a lift on their tractor so they can go back to work, or a home modification.

A lot of our folks come from rural areas, and as Senator Tester commented, they just want to go fishing. That is all they really want to do. That is what they enjoyed in life before their service and when they go home after their service, they want to go fishing. Can they get into their boat? Is there a dock that will accommodate their wheelchair? Can they do the things that they wanted to do before they acquired their injury? I think those are the kinds of things that only an individual can say for themselves, and no rating system can be complete if it doesn't accommodate that individual's perspective on what is important to them as an individual.

I would like to ask you to keep in mind some basic disability policy precepts that affect certainly our work and the work that we try to have Congress consider, that whenever you make a decision, that those decisions are based on fact, objective evidence, state-of-

the-art science, and a person's needs and preference, not based on administrative convenience and generalizations, stereotypes, fear, and ignorance. Again, a quality-of-life is something that is very personal.

I have met thousands of families over the 20 years I have been working in this field. When they have a child with a disability, at the beginning, they think their world has ended. And if you ask them at a later point in their life, they will tell you having that child was the best thing that ever happened to them because that child gave them perspective they wouldn't have otherwise had.

I think a person who acquires a disability through their service to our country needs to be afforded that opportunity to determine for themselves what is important for them and not have the rest of us dictate what their life should be all about.

I think providing the supports for a person to have independent living skills—what is it going to take for them to go back to their homes and their families, to go back to being a dad or a brother or a son? Those things need to be accommodated.

We need to allow people to be in the most inclusive setting based on what they want. We need to recognize economic self-sufficiency as a legitimate outcome of public policy. And we need to provide support systems for employment-related supports.

In conclusion, Easter Seals recommends that revisions of the disability compensation system should take into account the totality of a person's potential ability as well as future supports that they may need to maintain independence. Thank you very much for the opportunity to be here today.

[The prepared statement of Ms. Neas follows:]

PREPARED STATEMENT OF KATY NEAS, VICE PRESIDENT, GOVERNMENT RELATIONS, EASTER SEALS

Good morning Chairman Akaka, Ranking Member Burr, and Members of the Committee. I am indeed honored to be here today to provide Easter Seals' perspective on the Department of Veteran's Affairs (VA) disability compensation system. Thank you for the opportunity to speak.

My goal today is to provide some insights on Federal policy affecting people with disabilities that can inform how you consider compensation for veterans with disabilities. Americans with disabilities have made great strides over the past three decades, and it is essential that the VA build on these gains. I'd like to list just three of the main victories we have witnessed:

1. In 1973, thanks to section 504 of the Rehabilitation Act, all programs funded by the Federal Government needed to be accessible to people with disabilities.

2. In 1975, with the passage of the All Handicapped Children's Protection Act, children with disabilities secured the right to an appropriate public education.

3. In 1990, all children and adults with disabilities won the right to be free from discrimination in employment, services provided by state and local governments, public accommodations, transportation and telecommunications, thanks to the passage of the Americans with Disabilities Act.

As a result of these important laws, America has a new outlook on where people with disabilities belong. People with disabilities expect to be fully included in their families and in their communities and have the supports they need to live, learn, work and play.

Military servicemembers and veterans are a major focus for Easter Seals. In communities nationwide, Easter Seals is being asked to help meet the needs of America's military servicemembers and veterans with disabilities and their families. Our goal is to promote their successes by helping them attain their personal and family goals while becoming full participants within their own communities. We have utilized our nationwide network of accessible camps to provide therapeutic recreation and camping experiences to veterans with disabilities and their families. Easter Seals has also partnered with the National Military Family Association to host

week-long Operation Purple experiences for children of deployed parents at five Easter Seals affiliate camp sites. Later this year, the partnership will stage Operation Purple Healing Adventure for servicemembers and veterans with disabilities and their families at Easter Seals Camp ASCCA in Alabama. And finally we provide a significant amount of adult day services and other supports to the Nation's older veterans through the Nation's largest network of adult day service centers.

In addition to these nationwide efforts, in our headquarters city of Chicago, with generous funding from the McCormick Foundation, Easter Seals has launched two programs that benefit servicemembers, veterans and their families:

- Operation Employ Veterans provides training to employers on effective methods to recruit, employ, and retain veterans with disabilities.
- Community OneSource provides information, system and resource navigation and personalized follow-up supports for servicemembers, mobilized Guard and Reserves and veterans with disabilities and their families as they reintegrate back into their home communities. This is an initiative we hope to take national very soon.

For 90 years, Easter Seals has been the leading non-profit provider of services for individuals with autism, developmental disabilities, physical and mental disabilities, and other special needs. Through therapy, training, education and support services, Easter Seals creates life-changing solutions so that people with disabilities can live, learn, work and play in their communities. Based on this wealth of experience, we are able to make some recommendations today about how veterans with disabilities should be viewed by the Department of Veterans Affairs when calculating compensation.

First, veterans with disabilities and their lives need to be considered holistically when considering compensation.

Calculations of potential lost earnings do not account for the reality of many veterans with disabilities lives. A veteran with a disability is likely to have increased expenses through the years beyond medical and therapeutic care. For instance, they may need assistive technology, transportation, housing modification and other supports to maintain health and independence. In most cases many of these expenses, even when subsidized, are out-of-pocket expenses that a veteran without a disability would not have.

In addition, a veteran with a disability may be able to work with supports like those listed above and may not have as much in lost earning, but the increased costs of the supports needed could still financially devastate the veteran. For instance, advances in prosthetic technology help veterans with lost limbs do work related tasks that were not conceivable when compensations policies were set so earnings potential can be very different for this generation of veterans with disabilities. However, even a veteran with a disability who is a relatively high earner could still be devastated financially by the supports needed to remain independent.

As decisions are made about potential changes to disability compensation systems and other decisions affecting veterans with disabilities, I urge you to keep in mind some of the basic disability policy precepts that we in the broad disability community always try to infuse into legislation:

A. Equality of Opportunity

- Individualization—Make decision affecting an individual based on facts, objective, evidence, state-of-the art science and a person's needs and preferences; not based on administrative convenience and generalizations, stereotypes, fear and ignorance.
- Effective and Meaningful Opportunity—Focus on meeting the needs of all persons who qualify for services and supports, not just the "average" person by providing reasonable accommodations and reasonable modifications to policies, practices, and procedures.
- Inclusion and Integration—Administer programs in the most integrated setting appropriate for the individual (i.e., the presumption is that a person who qualifies for a public program must receive services in an inclusive setting with necessary support services and the burden of proof is on the government agency to demonstrate why inclusion is not appropriate to meet the unique needs of the individual) and administer programs to avoid unnecessary and unjustified isolation and segregation (i.e., do not make a person give up his/her right to interact with nondisabled persons in order to receive the services and supports).

B. Full Participation

- Provide for active and meaningful involvement of persons with disabilities and their families in decisions affecting them specifically as well as in the development of policies of general applicability i.e., at the systems/institutional level. ("Nothing about us without us")

• This means policies, practices, and procedures must provide for real, informed choice; self-determination, empowerment; self-advocacy; person-centered planning and budgeting.

C. Independent Living
• Recognize independent living as a legitimate outcome of public policy.
• Provide for independent living skills development.
• Provide necessary long-term services and supports such as assistive technology devices and services and personal assistance services.
• Provide cash assistance.

D. Economic Self-Sufficiency
• Recognize economic self-sufficiency as a legitimate outcome of public policy.
• Support systems providing employment-related services and supports.
• Provide cash assistance with work incentives.

In conclusion, Easter Seals recommends that revisions of the disability compensation system should take into account the totality of a person's potential ability as well as future supports that may be needed to maintain independence. Thank you very much for this opportunity to testify today.

Chairman AKAKA. Thank you very much, Ms. Neas.
Ms. Prokop?

STATEMENT OF SUSAN PROKOP, ASSOCIATE ADVOCACY DIRECTOR, PARALYZED VETERANS OF AMERICA

Ms. PROKOP. Thank you, Mr. Chairman. On behalf of the Paralyzed Veterans of America, we appreciate this opportunity to share with you some observations about Federal disability policy as it affects veterans with disabilities.

As you requested, our testimony today focuses on several areas of Federal disability policy affecting our members as people with disabilities: Social Security; employment; and housing. You have the details in our written statement. Though not intended as exhaustive, this information should, we hope, prompt you and other policymakers to ask in future disability policy deliberations, how might this affect veterans with disabilities.

What I will do in my remarks this morning is highlight several principles recently expressed by the National Council on Disability for evaluating disability programs and how the VA disability system stacks up against those principles.

NCD urges the Federal Government to ensure that its programs and services for people with disabilities are consistent with the overarching goals of the ADA, promoting equality of opportunity, full participation, independent living, and economic self-sufficiency. NCD criticizes policies that force individuals with disabilities to impoverish themselves, give up jobs, and otherwise limit their freedom in order to obtain the basic necessities of life.

As you know, veterans with service-connected disabilities receive a wide array of services and supports from the VA. The same can be said for veterans with catastrophic non-service-connected disabilities. All of these benefits are provided regardless of income. Compare these VA benefits to those available to non-veteran people with disabilities on SSDI or SSI in which benefits are limited by earnings and many services and supports are provided only under certain restricted circumstances. What separates veterans with disabilities who receive Social Security benefits from their non-veteran counterparts is their access to the VA health care system and its ancillary supports and services, regardless of their income.

As PVA has stated in past testimony, VA compensation is meant to offset more than economic loss. It reflects the fact that even if a veteran works, the disability doesn't stay at the office when he or she goes home at the end of the day. In many respects, VA compensation and its ancillary benefits, and even the benefits for veterans with non-service-connected catastrophic disabilities, reflect many of the standards embodied in the first principle outlined by NCD.

NCD's second principle says that ensuring sound fiscal policy in disability programs should be based on long-term human costs and benefits. Here, NCD cautions against policies that fail to take into account the overall cost to society or to other programs when cost shifting occurs. A case in point is the VA pension program cash cliff, which limits the ability of low-income veterans to reenter the workforce, unlike their counterparts on SSI.

A related perverse aspect of public policy involves VA benefits interaction with civilian disability systems. As noted in our statement, some married veterans eligible for compensation and pension elect to receive only pension because their service-connected benefits would knock their spouses off SSI and cost them their Medicaid.

Third, NCD notes that there are gaps between many Federal programs where there should be bridges. According to this standard, veterans who clearly meet SSA's criteria for disability should not have to undergo a second disability determination after receiving their 100 percent rating from the VA, nor should low-income veterans deemed permanently and totally disabled by the VA have to obtain a separate doctor's note attesting to their disability to receive assistance from HUD.

The foregoing positive description of VA benefits is not meant to dismiss the many challenges still facing the VA system. It is merely to suggest that policymakers may want to look to the VA system as a model that at least breaks the chain between health care and poverty for people with disabilities. Indeed, compared to other Federal disability programs and systems, the VA system recognizes that there are factors beyond someone's earnings capacity that call for ongoing supports and services in order to maintain a decent quality-of-life.

I appreciate this opportunity to testify and would be happy to answer any questions you may have. Thank you.

[The prepared statement of Ms. Prokop follows:]

PREPARED STATEMENT OF SUSAN PROKOP, ASSOCIATE ADVOCACY DIRECTOR, PARALYZED VETERANS OF AMERICA

Mr. Chairman and Members of the Committee—on behalf of Paralyzed Veterans of America, I thank you for asking PVA to share with you some observations about Federal disability policy as it affects veterans with disabilities. As the only Congressionally-chartered veterans' service organization solely devoted to representing veterans with spinal cord injury and/or dysfunction (SCI/D), PVA is uniquely qualified to speak to these issues because our members include those with service-connected disabilities as well as those who sustained spinal cord injuries or illnesses after their discharge from the military. Maximizing "the quality of life for its members and all people with spinal cord injury/dysfunction" has been part of PVA's mission since its founding. As part of that mission, PVA has been a longstanding participant in coalitions to advance the larger cause of disability rights and to improve government programs and policies that support and assist Americans with disabilities.

Our testimony today focuses on three areas of Federal disability policy that affect our members as people with disabilities—Social Security, employment and housing. Each of these areas has been the subject of considerable debate within disability policy circles over the past several years. Yet, when policy debates arise or when changes are proposed concerning programs affecting Americans with disabilities, veterans with disabilities are often overlooked. Moreover, seldom is attention given to the interaction between veterans' benefits and those they receive from other Federal disability programs. These comments are not meant to be exhaustive of the many ways VA and other Federal disability programs relate to one another. Perhaps some of the information presented here may stir enough interest so that policymakers in future deliberations on disability policy might ask—how will this affect veterans with disabilities?

VETERANS WITH DISABILITIES AND SOCIAL SECURITY

Veterans with significant disabilities are very often Social Security disability beneficiaries as well.

According to the Social Security Administration's (SSA) latest Annual Statistical Supplement—in 2007, there were 434,000 Social Security beneficiaries who were service-connected disabled veterans rated 70–100% under age 65. Another 153,000 beneficiaries of Social Security were non-service-connected disabled veterans under age 65. There were also 1,540,000 service-connected disabled veterans under age 65 whose disabilities were rated below 70%. These latter individuals likely have other non-service related conditions or disabilities that qualify them for Social Security disability benefits.

Veterans with disabilities on Social Security can fall into one of several categories. They can be service-connected disabled veterans getting compensation and Social Security Disability Insurance (SSDI). They might be getting compensation and be eligible for SSDI but their earnings are too high to receive Social Security disability benefits. They might be veterans with catastrophic non-service-connected disabilities—like spinal cord injury—which will qualify them for SSDI as long as their earnings are limited. They can be low income veterans with non-service-connected disabilities who are eligible for supplemental security income—or SSI—under Social Security; or they might be veterans who had a modest earnings record and who may receive a small SSDI check supplemented by VA Pension. It's even possible that a veteran, if injured before age 22, could get Social Security Childhood Disability benefits based on his/her parents' earnings records—if the veteran's parents are retired, disabled or deceased.

VA Compensation and Social Security Disability Insurance—There is no offset between SSDI and Compensation benefits—nor should there be. Compensation is earned through military service and SSDI is an earned benefit based on a person's work record and payment of FICA taxes. Once a veteran receives SSDI and compensation, few if any complications arise between those two benefit programs. However, the process by which veterans with significant disabilities obtain SSDI could be improved through better coordination between SSA and the Department of Veterans Affairs (VA).

While the Department of Defense and VA have taken steps to smooth the processes between their disability systems, veterans with severe disabilities must still undergo a second disability determination to apply for SSDI. The Veterans Disability Benefits Commission has reported that only 54% of veterans rated 100% are receiving SSDI and has stated "either these veterans do not know to apply for SSDI or are being denied the insurance."

Granted, some of those veterans may not be receiving SSDI because they are working above the earnings limit for that program. Nevertheless, PVA finds it mystifying that veterans with 100% disability ratings from the VA and the requisite quarters of coverage should have to go through another application process to receive SSDI. Some policymakers contend that the reason for the two disability determinations is related to the differing definitions of disability used by SSA versus the VA. The Social Security Administration's Wounded Warrior Program has been making efforts to reach out to newly-injured servicemembers to inform them of and expedite applications for their SSDI benefits. However, this SSA initiative applies only to servicemembers injured after October 1, 2001 and resources often limit the extent to which SSA can make its presence known in the VA system. Legislation has been introduced in Congress to allow automatic qualification for SSDI to 100% service-connected disabled veterans. While there may be details that still require attention, PVA supports this move and hopes Congress can find a way to advance this policy.

VA Pension, Supplemental Security Income and other low income support programs—Typically, a low income veteran with a significant non-service-connected dis-

ability—and without an adequate work record to qualify for SSDI—may qualify for Supplemental Security Income or SSI. As an income-tested program, SSI carries with it limits on other income and assets or resources—but these are generally less generous than the VA pension program. As a result, it benefits a veteran in these circumstances to be on pension. Veterans' spouses, who meet appropriate criteria, can also receive pension payments from the VA.

Some veterans may have had low paying jobs or not had an extensive earnings history but receive a small SSDI benefit based on that work record. These DI benefits will offset any VA pension payments up to the allowed pension level. This dual eligibility can have ramifications for the veteran if he or she attempts work, as described in the next section.

Among the most complicated public policy interactions are those involving VA pension and other Federal income assistance programs. As a means-tested program, VA pensions count all income to reduce—or even eliminate—the pension payment. However, the VA does not count as income for pension purposes SSI, welfare, food stamps, Medicaid and housing aid. On the other hand, SSI, welfare, and other Federal disability programs do count VA pension as income. As a result, a veteran can get in trouble with those programs if the VA pension is not reported accurately. The VA Aid and Attendance payments that accompany some pension benefits as well as homebound benefits are not counted as income by Social Security. Unfortunately, sometimes these benefits are questioned as income by Social Security offices causing major headaches for the veteran on pension.

Although Federal policies sometimes make it difficult for veterans with disabilities to navigate the programs to which they are entitled, there have been occasions where Congress did account for veterans' circumstances in larger programmatic changes. The Medicare Modernization Act was one of those few times that policymakers remembered veterans in crafting a piece of non-VA related legislation. Medicare—as you know—is a benefit available to those on Social Security. Individuals on SSDI get Medicare after a two year waiting period. When Medicare Modernization passed, the law declared that VA prescription drug coverage would be considered creditable coverage for those not signing up for the Part D benefit right away. Thus coverage under the VA immunizes a veteran from the late sign up penalty for Part D.

VETERANS WITH DISABILITIES AND EMPLOYMENT PROGRAMS

Typically, discussions about veterans' employment center on veteran-specific programs operated by the VA, Small Business Administration or Department of Labor. Understandably, this is due to the fact that most veterans, even those with modest service-connected disabilities, are eligible for the VA's Vocational Rehabilitation and Employment (VR&E) Program. For veterans with non-service-connected disabilities, the DOL offers programs and services through its Veterans Employment and Training Administration and SBA hosts a number of programs tailored to veteran small business owners and service-disabled veteran small business owners. PVA, through *The Independent Budget*, has offered numerous recommendations for improvements to the VR&E and other VA employment programs that need not be repeated in this testimony.

State vocational rehabilitation programs—Veterans with significant disabilities are also eligible for and often seek services from state vocational rehabilitation (VR) agencies. Many state VR agencies have memoranda of understanding with their state department of veterans' affairs to coordinate services to veterans with disabilities. Some state agencies have identified counselors with military backgrounds to serve as liaisons with the VA and veterans' groups.

There are significantly more state VR counselors than there are VR&E counselors around the Nation. These numbers of vocational experts can amplify the assistance available to veterans with disabilities if appropriate outreach and partnerships are established and training provided to improve cross-agency coordination.

For some veterans with service-connected disabilities, establishing eligibility for state VR services may prove challenging. While most veterans with ratings at 40 percent and below are unlikely to qualify for state VR services, those with ratings between 50 percent and 70 percent might qualify depending on a state's admission criteria and the ability of VR professionals to assess appropriately a veteran's functional capacity.[1] Participants at a May 2008 Department of Education symposium on VR and returning veterans suggested that, because of differing eligibility criteria among state VR systems, the potential exists for veterans in some states to be

[1] Proceedings of the 34th Institute on Rehabilitation Issues, U. S. Department of Education Rehabilitation Services Administration, May 5–6, 2008.

bounced between state VR & VR&E. One way to address this concern would be for the VA to work with the Rehabilitation Services Administration (RSA) to establish consistent criteria for state agencies' acceptance of veterans with service-connected disability ratings.

Social Security Work Incentives and VA Pension "Cash Cliff"—The Social Security Administration offers a variety of work incentives to enable SSDI and SSI disability beneficiaries to go to work. The Ticket to Work program provides beneficiaries with vouchers to buy vocational services of their own choosing and rewards vocational service providers for helping SSDI and SSI recipients reduce their reliance on benefits. PVA realized that many of the veterans being served by its vocational rehabilitation program were on SSDI. So, a little over a year ago, our program became an employment network under Ticket to Work in order to take advantage of the payments offered by SSA for successful beneficiary employment outcomes.

Other Social Security policies enable those on SSI to gradually work themselves off of benefits by reducing the amount of their disability benefits as earned income rises. Although the VA pension is often likened to SSI, unlike that latter program, VA pensioners face a "cash cliff" similar to that experienced by beneficiaries on SSDI in which benefits are terminated once an individual crosses an established earnings limit. Because of a modest work record, many of these veterans or their surviving spouses may receive a small SSDI benefit that supplements their VA pension. If these individuals attempt to use SSA's work incentives to increase their income, not only is their SSDI benefit terminated but their VA pension benefits are reduced dollar for dollar by their earnings.

Over twenty years ago, under P. L. 98–543, Congress authorized the VA to undertake a four year pilot program of vocational training for veterans awarded VA pension. Modeled on SSA's trial work period, veterans in the pilot were allowed to retain eligibility for pension up to 12 months after obtaining employment. In addition, they remained eligible for VA health care up to three years after their pension terminated because of employment. Running from 1985 to 1989, this pilot program achieved some modest success. However, it was discontinued because, prior to VA eligibility reform, most catastrophically-disabled veterans were reluctant to risk their access to VA health care by working.

The VA Office of Policy, Planning and Preparedness examined the VA pension program in 2002 and, though small in number, seven percent of unemployed veterans on pension and nine percent of veteran spouses on pension cited the dollar-for-dollar reduction in VA pension benefits as a disincentive to work.[2] Now that veterans with catastrophic non-service-connected disabilities retain access to VA health care, work incentives for the VA pension program should be re-examined and policies toward earnings should be changed to parallel those in the SSI program.

Other Efforts to Improve Disability Work Incentives—Proposals to modify SSI income, asset and resource limits to encourage work and savings illustrate another way in which veterans with disabilities are left out of public disability policy discourse. Many policy strategies have been discussed over the years to raise resource limits under SSI so that beneficiaries would be encouraged to work and save enough to purchase a home, for retirement, or to open a business. Because low income veterans with disabilities are likely to be on VA pension—with its own asset/resource limitations—rather than SSI, they would not benefit from such proposals. If efforts are made in the future to remove work disincentives for low income people with disabilities, low income veterans with disabilities should be part of the conversation.

HOUSING AND VETERANS WITH DISABILITIES

Obviously, accessible housing is vitally important to PVA members. Unlike other people with disabilities, our members are fortunate to have access to the VA's home modification grants that help overcome architectural barriers in housing. At the same time, they also benefit from the same fair housing laws that protect other Americans with disabilities and from the same provisions in the Rehabilitation Act that call for federally-assisted multi-family housing to serve people with disabilities. Like other people with disabilities, they are also adversely affected when the Federal Government fails to properly enforce existing housing accessibility laws and regulations.

Low Income Housing Policy and Veterans with Disabilities—For low income veterans with disabilities, however, Federal housing policy is sometimes at odds with their status as veterans. A 2007 Government Accountability Office (GAO) report

[2] Evaluation of VA Pension and Parents' DIC Programs—VA Pension Program Final Report, ORC Macro, Economic Systems, Inc., Hay Group, Dec. 22, 2004, www1.va.gov/op3/docs/pension.pdf

noted that, in 2005, some 2.3 million veteran renter households were considered low income. Of those households, 39 percent had at least one veteran member with a disability. GAO reported that neither the VA nor other housing agencies were reporting on specific housing conditions and costs of veterans who rent.[3]

Veterans who meet income and other eligibility criteria for HUD can receive housing assistance, if they meet HUD's criteria for elderly households or households with a member with a disability. In most respects, HUD's treatment of various veterans' benefits in determining household income and subsidy amounts is quite generous. Yet, even though a veteran must be determined permanently and totally disabled by the VA to qualify for VA pension, HUD will not accept documentation from the VA attesting to a veteran's permanent and total disability. Instead, veterans must obtain additional evidence of disability from a medical doctor before they can be qualified for housing assistance. HUD issued a notice on Dec. 13, 2004 indicating plans to reevaluate this issue but has never followed up on that notice.

THE VA'S PLACE IN NATIONAL DISABILITY POLICY

"Quality of life" has become the latest catch-phrase in disability policy circles throughout government, academia and private industry. In its annual communication to Congress this year, the National Council on Disability (NCD) said that its report "focuses on the current quality of life of people with disabilities in America and the emerging trends that should be factored into both the design and evaluation of the Federal Government's disability policies and programs in the coming years."[4]

Describing future policy directions, NCD outlines several principles that should "guide the review of existing government programs, as well as to serve as a road map for the design of new government programs." These principles offer one framework within which to evaluate VA disability policy and how it fits into the overall disability paradigm.

Ensure that Federal Government programs and services for people with disabilities are consistent with the overarching goals of the ADA—promoting equality of opportunity, full participation, independent living, and economic self sufficiency. NCD criticizes policies that force individuals with disabilities to impoverish themselves, give up jobs and otherwise limit their freedom in order to obtain the basic necessities of life.

As this Committee knows, veterans with service-connected disabilities receive a wide array of services and supports from the Department of Veterans Affairs. Veterans with the most significant disabilities receive disability compensation, highest priority admission to the VA health care system, the VA prescription drug program, durable medical equipment and prosthetics; home modification grants, VA vocational rehabilitation and employment services; vehicle modifications; and aid and attendance benefits.

Veterans with non-service-connected disabilities deemed "catastrophic" get high priority access to the VA health system; smaller home modification grants; certain automobile modifications; and aid and attendance benefits.

All of these benefits are provided regardless of income.

Compare these benefits to those available to non-veteran people with disabilities on SSDI or SSI. For those on SSDI, Medicare is available—after a lengthy waiting period during which their health may have deteriorated. Durable medical benefits under Medicare that would otherwise allow a person with a disability to live independently are covered only if limited to a person's home. Personal attendant services are available only to those on Medicaid and only if a state offers those benefits under its state plan. Otherwise, a person with a significant disability is consigned to a nursing home in order to receive attendant care. And to receive services under Medicaid, a person must be poor and have few if any assets or resources. Some states have enabled working people with disabilities to buy into their Medicaid program but they have to live in the right state to access this opportunity. And as for home and vehicle modifications and other long term services and supports that would enable people with disabilities to live independently, fully participate in society and seek economic self-sufficiency—these are sometimes—but not always—available through inadequately funded public programs.

What separates veterans with disabilities who receive Social Security benefits from their non-veteran counterparts is their access to the VA health care system and its ancillary supports and services—regardless of their income. Veterans with

[3] Rental Housing—Information on Low-Income Veterans' Housing Conditions and Participation in HUD's Programs, GAO–07–1012, August 2007

[4] National Disability Policy: A Progress Report, National Council on Disability, March 31, 2009

even modest service-connected disabilities gain access to VA medical centers, outpatient clinics, home health care services, durable medical equipment and pharmaceutical benefits. Veterans with non-service-connected "catastrophic" disabilities are also eligible for VA health care. However stressed and under-funded the Veterans Healthcare Administration may be, it is available to most veterans with disabilities no matter how low or high their income.

A December 2007 article in the American Journal of Public Health examined numbers of uninsured veterans from 1987 to 2004. In recommending expansion of VA eligibility to address this problem, the authors note that the VA health system "appears to offer more equitable care of equivalent or higher quality compared with that of private sector alternatives."[5] The article goes on to state that the VA "accounts for much of the advantage in insurance coverage that veterans enjoy compared with non-veterans."[6]

As PVA has stated in past testimony, disability compensation is intended to do more than offset the economic loss created by a veteran's inability to obtain gainful employment. It also takes into consideration a lifetime of living with a disability and the every day challenges associated with that disability. It reflects the fact that even if a veteran holds a job, when he or she goes home at the end of the day, that veteran does not leave the disability at the office.

In many respects, VA compensation and its ancillary benefits—and even the benefits for veterans with non-service-connected catastrophic disabilities—reflect many of the standards embodied in the first principle outlined by NCD.

Protect the cost benefits of government programs or policies for people with disabilities based on long term human costs and benefits. Here, NCD cautions against policy decisions based mainly on costs and which fail to take into account the overall costs to society or to other programs when cost shifting occurs.

As outlined in this testimony, elements of the VA pension program are obviously grounded in cost control rather than the long term well being of low income veterans with disabilities. A case in point is the cash cliff imposed on recipients of VA pension unlike their counterparts in SSI and which limits their ability to reenter the workforce.

Another perverse aspect of public policy related to this principle involves VA benefits and their interaction with civilian disability systems. Some veterans are married to spouses whose only access to health care coverage comes through Medicaid. At last year's training conference for PVA's service officers, a senior benefits advisor related how some married veterans eligible for compensation and pension elect to receive only pension. Even though their benefits are consequently lower, they decline the service-connected benefits to which they are entitled because compensation would knock their spouses off SSI and cost them their Medicaid. As NCD states in its report, policies such as this force "otherwise self-sufficient people to resort to public safety nets."

Build program bridges. NCD notes that there are gaps between many Federal programs "where there should be bridges" and challenges government agencies to "work together to create seamless transitions into and out of their programs, for example, by establishing presumptive eligibility, transferring application records and eliminating arbitrary waiting periods."

According to this standard, veterans who clearly meet SSA's criteria for disability should not have to undergo a second disability determination after receiving their 100% rating from the VA. In addition, veterans who are deemed permanently and totally disabled by the VA should not be required by HUD to obtain a separate doctor's note attesting to their disability.

The foregoing positive description of VA benefits is not meant to dismiss the variety of changes PVA believes are needed to improve the VA system. It is merely to suggest that policymakers may want to look to the VA system as a model that, at least, breaks the chain between health care and poverty for people with disabilities.

The VA disability system recognizes that there are factors beyond someone's earnings capacity that call for ongoing supports and services in order to maintain a decent quality of life. Rather than trying to diminish the VA compensation program, it should be held up as a gold standard for improving the inadequacies of other Federal disability systems.

Thank you again for this opportunity to testify. I would be happy to answer any questions you may have.

Chairman AKAKA. Thank you very much, Ms. Prokop.

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[5] Lack of Health Coverage Among US Veterans from 1987 to 2004, December 2007, Vol. 97, No. 12, American Journal of Public Health, Himmelstein et al, p. 4

[6] Ibid

Colonel Wilson?

STATEMENT OF LIEUTENANT COLONEL JOHN L. WILSON, USAF (RET.), ASSOCIATE NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS

Colonel WILSON. Thank you, sir. Mr. Chairman, Ranking Member Burr, and Members of the Committee, I am pleased to have this opportunity to appear before this Committee this morning on behalf of Disabled American Veterans to address the report by the Advisory Committee on Disability Compensation.

The Advisory Committee focused on three general parts. Part one, the necessity and methodology of updating the Veterans Administration Schedule of Rating Disabilities, or VASRD. Part two, physician compensation adequacy and sequencing for servicemembers moving to veteran status. And finally, part three, quality-of-life compensation.

In reference to part one, we agree with the importance of a systematic review and update of the VASRD as it is the source of all disability compensation ratings. It has a ratings scheme that addresses illnesses and conditions that run into the hundreds and should reflect the most recent medical findings in each and every case.

DAV agrees with the Advisory Committee's assessment that a systematic process is lacking and one is a necessity. We also agree with the Committee's recommendations that, one, the Deputy Secretary of the VA provide oversight of the VASRD process with the VHA and Office of General Counsel fully integrated into this VBA process.

Two, immediately increase staff at the VBA to nine full-time employees, per the committee's specifications.

And three, VHA must be allowed to establish a permanent administrative staff for this VASRD review. At least one permanent party medical expert must be on this team and have authority to liaise with VBA, assign VHA medical staff to participate in VBA body system reviews and to coordinate with medical experts. The experiential expertise that VHA professionals will bring to the discussion should prove invaluable and well worth the additional staffing.

We also agree with the Committee's body systems prioritization, beginning with mental health disorders. It is essential that different criteria be formulated to evaluate the various mental disorders under appropriate psychiatric disorders. Criteria for evaluating mental disorders under Title 38, Code of Federal Regulations, Section 4.130 are very ambiguous. One veteran service-connected for schizophrenia and another veteran service-connected for another psychiatric condition, such as an eating disorder, should not be evaluated using the same general formula.

Moving to part two, transition compensation adequacy and sequencing for servicemembers moving to veteran status. DAV supports legislation that offers limited dual entitlement to vocational rehabilitation and employment under Chapter 31 and the Post-9/11 Education Assistance Program under Chapter 33 to ensure disabled veterans are not forced to choose the lesser of two benefits. Such a disparity will ultimately force service-connected dis-

abled veterans with employment handicaps to either utilize less financially supportive programs than their non-disabled counterparts; or even more tragically, opt out of vocational rehabilitation for the more financially beneficial Post-9/11 G.I. Bill.

An area where Congress could act now without having to wait on the next study is by providing increased funding for the Transition Assistance Program and Disabled Transition Assistance Program, TAP and DTAP, respectively. TAP and DTAP were created with the goal of furnishing separating servicemembers with vocational guidance to aid in obtaining meaningful civilian careers. Their continuation is essential to easing some of the problems associated with transition. Unfortunately, the level of funding and staffing is inadequate to support the routine discharges of all the services in a given year.

Congress could enact legislation to eliminate employment barriers impeding the transfer of military job skills to the civilian labor market by requiring the DOD to take appropriate steps to ensure that servicemembers be trained, tested, evaluated, and issued any licensure or certification that may be required in the civilian workforce.

Last, part three addressed quality-of-life compensation. Although close family members are often willing to bear the burden of being primary caregivers for severely disabled veterans, thus relieving VA of that obligation or the cost of institutionalization, they seldom receive sufficient support services or financial assistance from the government. The DAV believes these informal caregivers should receive a comprehensive array of support services, to include respite care, financial compensation, vocational counseling, basic health care, relationship, marriage, and family counseling, and mental health care to address multiple burdens they face.

A caregiver tool kit should be provided to family caregivers to include a concise recovery road map to assist families in understanding and maneuvering through the complex systems of care and Federal, State, and local resources available to them. Policy and planning to better service such caregivers could include statistically representative data from a periodic national survey and individual assessments of family caregivers of severely injured and disabled veterans to address their quality-of-life concerns.

There are other action items that are listed in the Advisory Committee's work. We look forward to working with the VA and Members of Congress on them.

It has been a pleasure to appear before this honorable Committee today, sir.

[The prepared statement of Colonel Wilson follows:]

PREPARED STATEMENT OF JOHN L. WILSON, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS

Mr. Chairman, Ranking Member and Members of the Committee. I am pleased to have this opportunity to appear before you on behalf of the Disabled American Veterans (DAV), to address the report to the Secretary of the Department of Veterans Affairs (VA) by the Advisory Committee on Disability Compensation.

The Advisory Committee focused on the necessity and methodology of updating the VA's Schedule of Rating Disabilities or VASRD; transition compensation adequacy and sequencing for servicemembers moving to veterans' status; and quality of life compensation.

The importance of a systematic review and update of the VASRD, in our view, is a priority, as it is the source of all disability compensation ratings. It is a rating scheme that addresses illnesses and conditions that run into the hundreds, and as such, should reflect the most recent medical findings in each and every case. DAV agrees with the Advisory Committees' assessment that a systematic process is lacking and that one is a necessity. The Committee offered the following recommendations, with all of which we agree:

(1) The Deputy Secretary of the VA should be tasked with providing oversight of the VASRD process, and of ensuring that the Veterans Health Administration (VHA) and Office of the General Counsel (OGC) are fully integrated in the Veterans Benefits Administration's (VBA's) process;

(2) Immediately increase staff at the VBA to 9 full-time employees (FTE) for the purpose of continuously reviewing and updating the VASRD. The staff should include a coordinating administrative person and two sub-teams comprised of one medical expert, two legal specialists, and one administrative support staff each. This staff should be assigned to the Compensation and Pension Service (C&P) for administrative purposes; and

(3) As part of its new role as full partner in the VASRD review process, VHA must establish a permanent administrative staff to participate in VASRD review. The VHA administrative staff should include at least one permanent party medical expert. This staff member should have the authority to liaise with VBA, assign medical staff from VHA to participate in VBA body system reviews, and to coordinate with other medical experts as appropriate.

Staffing within the VHA and VBA must be allocated toward this task. It is a positive step to include the medical expertise from the VHA into this process. Although previous sources of expertise such as the Institute of Medicine contributed to this body of work, the experiential expertise that VHA professionals will bring to the discussion, with a decades-long role in providing medical care to veterans, should prove invaluable to this endeavor and well worth the additional staffing.

The various stakeholders must also have a voice in this process. Such a collaborative effort by all parties helps to dispel any misperceptions and missteps.

Additionally, VA's leadership must ensure oversight and successful implementation of this important recommendation. It was anticipated that VA's commitment to the systematic updating of the VASRD would have carried forward and been reflected in its strategic plan. Is not the VASRD the key source of all disability ratings? However, a search of VA's fiscal year (FY) 2006–2011 Strategic Plan finds no mention of the VASRD. The need for an update of the VASRD is instead referenced in the FY 2008 Performance and Accountability Report, as a result of a U.S. Government Accountability Office (GAO) update to its High-Risk Series (GAO–07–310), *GAO High-Risk Area #1: Modernizing Federal Disability Program*.[1] The VA would be well served to add the very language of this section of the Advisory Committee's report to its Strategic Plan as its map for the systematic updating of the VASRD.

As noted earlier, while we agree that a rewrite of sections of the VASRD is appropriate, DAV would oppose an approach that required a complete revamping of the 1945 Rating Schedule. Generally, the VASRD has served America's disabled veterans quite adequately. It incorporates a policy of "average impairment," and that policy has treated all veterans with like disabilities equally and fairly, in spite of age, education or work experience. It also encourages disabled veterans to seek vocational rehabilitation training in order to become a more productive wage earner without penalty for doing so. Understandably, the VASRD has been modified and upgraded many times when advances in medical science dictates a change in a particular disability rating might be necessary, or additions to the Schedule have been incorporated to cover injuries, infirmities and illnesses unique to some theatre of operations.[2] We agree with the Advisory Committee that the VASRD be updated in a systematic fashion, based on sound medical principles, provided there are no wholesale changes and, when change is necessary, it is based on the above principles.

We also agree with the body system prioritization the Committee offers, beginning with mental health disorders. It is essential that different criteria be formulated to

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[1] High-Risk Series (GAO–07–310), *GAO High-Risk Area #1: Modernizing Federal Disability Program, pages 307 and 309.*

[2] DAV Legislative Program 2010, DAV Resolution No. 098, Oppose A Complete Revamping of the 1945 Rating Schedule.

evaluate the various mental disorders under the appropriate psychiatric disorder.[3] Criteria for evaluating mental disorder under title 38, Code of Federal Regulations, Section 4.130, are very ambiguous. For example, schizophrenia and other psychotic disorders, delirium, dementia, and amnestic and other cognitive disorders, anxiety disorders, dissociative disorders, somatoform disorders, mood disorders, and chronic adjustment disorders, are all evaluated using the same general rating formula for mental disorders. The Diagnostic and Statistical Manual for Mental Disorders (DSM IV) specifically lists different symptoms for Post Traumatic Stress Disorder, schizophrenia, and other psychiatric disorders. One veteran service-connected for schizophrenia and another veteran service-connected for another psychiatric disorder should not be evaluated using the same general formula. Therefore, the DAV supports amendment of title 38, Code of Federal Regulations, section 4.130, to formulate different criteria to evaluate the various mental disorders under the appropriate psychiatric disorder and is pleased to see the Advisory Committee place mental disorders as the first to be considered in this systematic review.

The next area the Advisory Committee addressed was Quality of Life (QOL). While the VASRD focuses its ratings and subsequent compensation as a result of loss of income when compared to civilian contemporaries, QOL is a separate but related category. The Advisory Committee's recommended definition of "An overall sense of well-being based on physical and psychological health, social relationships, and economic factors," is acceptable. Given an acceptable definition, the next question is should a loss of QOL be compensated? We believe the answer is yes. A veteran's quality of life generally decreases as the severity of their disabilities increases. The Advisory Committee reasons that the VA's providing additional monetary assistance through Special Monthly Compensation (SMC) is, at a minimum, an inferred QOL compensation program.

SMC is a rate paid in addition to disability compensation (i.e., SMC (K)). And this compensation can be viewed as an inferred payment for a decrease in quality of life. To qualify, a veteran must be disabled beyond a combined degree percentage or due to special circumstances such as the loss or loss of use of specific organs or extremities. SMCs are referred to by the letters (K) through (R.2). These alphabetic designations follow the paragraph numbering system in title 38, United States Code § 1114.

While following the Advisory Committee's recommendation to change the reference from "Quality of Life" to "non-economic loss," clarifying the definition may prove helpful, DAV agrees that additional benefits/compensation should be provided to veterans. Eligibility criteria for non-economic loss should be clear, precise, and objective in order to reduce uncertainty about the benefit's purpose, inconsistent application of eligibility criteria and perceptions of unfairness. We look forward to working with VA and Congress to create legislation and a framework for controlled growth of this program.

The Advisory Committee has also recommended the use of International Classification of Diseases (ICD) codes being added to the VASRD where there is a direct correlation between an ICD code and a VASRD diagnostic code. The DAV has no resolution on this issue.

The next area for future study has to do with reporting on the inadequacies of the Vocational Rehabilitation and Employment Program. According to a January 2009 GAO report, the "program [has] not fulfilled its primary purpose, which is to ensure that veterans obtain suitable employment."

The GAO Report summary noted:

> "In 2004, the Veterans Affairs' Vocational Rehabilitation and Employment (VR&E) program was reviewed by a VR&E Task Force. It recommended numerous changes, in particular focusing on employment through a new Five-Track service delivery model and increasing program capacity. Since then, VR&E has worked to implement these recommendations. To help Congress understand whether VR&E is now better prepared to meet the needs of veterans with disabilities, GAO was asked to determine (1) how the implementation of the Five-Track Employment Process has affected VR&E's focus on employment, (2) the extent to which VR&E has taken steps to improve its capacity, and (3) how program outcomes are reported. GAO interviewed officials from VR&E, the 2004 Task Force, and veteran organizations; visited four VR&E offices; surveyed all VR&E officers; and analyzed agency data and reports."

[3] DAV Legislative Program 2010, DAV Resolution No. 135, Support Amendment of Title 38, Code of Federal Regulations, Section 4.130, Schedule of Ratings, to Formulate Different Criteria to Evaluate the Various Mental Disorders Under the Appropriate Psychiatric Disorders.

"By launching the Five-Track Employment Process, VR&E has strengthened its focus on employment, but program incentives have not been updated to reflect this emphasis. VR&E has delineated its services into five tracks to accommodate the different needs of veterans, such as those who need immediate employment as opposed to those who need training to meet their career goal. However, program incentives remain directed toward education and training. Veterans who receive those services collect an allowance, but those who opt exclusively for employment services do not. While VR&E officials said they believed it would be helpful to better align incentives with the employment mission, they have not yet taken steps to address this issue. VR&E has improved its capacity to provide services by increasing its collaboration with other organizations and by hiring more staff, but it lacks a strategic approach to workforce planning. Although there have been staff increases, many of VR&E's regional offices still reported staff and skill shortages. The program is not addressing these workforce problems with strategic planning practices that GAO's prior work has identified as essential. For example, VR&E officials have not fully determined the correct number of staff and the skills they need to serve current and future veterans. VA does not adequately report program outcomes, which could limit understanding of the program's performance. Specifically, it reports one overall rehabilitation rate for veterans pursuing employment and those trying to live independently. Computing each group's success rate for fiscal year 2008, GAO found a lower rate of success for the majority seeking employment and a higher rate of success for the minority seeking independent living than the overall rate. GAO also found that VR&E changed the way it calculates the rehabilitation rate in fiscal year 2006, without acknowledgments in key agency reports. VA noted the change in its fiscal year 2006 performance report, but did not do so for its fiscal year 2007 and 2008 reports, or for its fiscal year 2008 and 2009 budget submissions. Such omissions could lead to misinterpretation of program performance over time." [4]

While VA has contracted a study with Economic Systems, Inc. to review the VRE program and plans to complete a study workforce planning study in FY 2010, DAV and others have commented previously that the VR&E subsistence allowance is insufficient, which causes veterans to avoid entering the program or exiting it prematurely.

DAV supports legislation that offers limited dual entitlement to vocational rehabilitation and employment chapter 31, and the post-9/11 education assistance program under chapter 33 in order to ensure that disabled veterans are not forced to choose the lesser of two benefits.[5] Our nation established veterans' programs to repay or reward veterans for their extraordinary service and sacrifices on behalf of their fellow citizens, especially those veterans disabled as a result of military service. These programs include the VR&E program for service-connected disabled veterans with employment handicaps as well as the post-9/11 GI Bill under title 38, United States Code, chapter 33 (GI Bill). The GI Bill currently provides a more financially lucrative subsistence allowance than does the current VR&E Chapter 31 program. Such a disparity will ultimately force service-connected disabled veterans with employment handicaps to either utilize a program less financially supportive to them and their families than their non-disabled counterparts, or opt out of vocational rehabilitation for the more financially beneficial post-9/11 GI Bill.

Subsistence allowances must be comparable, regardless of program, to ensure maximum participation and maximum benefit, whether it is assisting veterans in finding employment, participation in vocational rehabilitation or other services. The basis of that decision must never be based on its financial incentives when compared to various VA programs.

The issue of the transition from active duty status to veteran status is also a subject of future study and we look forward to participating in these discussions as well. DAV notes that there are existing programs that prove invaluable during this transition period, but are in need of additional funding. An area where Congress could act now is by providing increased funding for the Transition Assistance Pro-

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[4] VA Vocational Rehabilitation and Employment: Better Incentives, Workforce Planning, and Performance Reporting Could Improve Program, GAO–09–34 January 26, 2009.

[5] DAV Legislative Program 2010, DAV Resolution No. 002, Support For Limited Dual Entitlement To Vocational Rehabilitation And Employment Chapter 31, And The Post-9/11 Education Assistance Program Under Chapter 33 In Order To Ensure That Disabled Veterans Are Not Forced To Choose The Lesser Of Two Benefits.

gram (TAP) and the Disabled Transition Assistance Program (DTAP).[6] The transition from military service to civilian life is very difficult for most veterans, who must overcome many obstacles to successful employment. TAP and DTAP were created with the goal of furnishing separating servicemembers with vocational guidance to aid them in obtaining meaningful civilian careers and their continuation is essential to easing some of the problems associated with transition. Unfortunately, the level of funding and staffing is inadequate to support the routine discharges per year from all branches of the Armed Forces.

Additionally, Congress could enact legislation supporting licensure and certification of active duty personnel.[7] The Department of Defense (DOD) provides some of the best vocational training in the Nation for its military personnel. DOD establishes, measures, and evaluates performance standards for every occupation within the Armed Forces. There are many occupational career fields in the Armed Forces that can easily translate to a civilian occupation but there are many occupations in the civilian workforce that require a license or certification. The Armed Forces occupational standards meet or exceed the civilian license or certification criteria yet many former military personnel, certified as proficient in their military occupational career, are not licensed or certified to perform a comparable job in the civilian workforce. This situation creates an artificial barrier to employment upon separation from military service. A study by the Congressional Commission on Servicemembers' and Veterans' Transition Assistance identified several military professions in which civilian credentialing is required for employment in the private sector. Congress could enact legislation to eliminate employment barriers that impede the transfer of military job skills to the civilian labor market by requiring the DOD to take appropriate steps to ensure that servicemembers be trained, tested, evaluated, and issued any licensure or certification that may be required in the civilian workforce. Simultaneously, Congress could amend legislation and make GI Bill eligibility available to pay for all necessary civilian license and certification examination requirements, including necessary preparatory courses to increase the civilian labor market's acceptance of the occupational training provided by the military.

Another area for Congressional action could come with modification of the Omnibus Budget Reconciliation Act of 1982 (Public Law 97–253, now title 38, United States Code 511), which currently prohibits disability compensation payments until the first day of the second month after the VA grants a disability rating. A rewrite would allow the newest veterans to receive disability compensation at the end of the first month after discharge.

In reference to family care-giver support, the Advisory Committee noted the Veterans Disability Benefits Commission (VDBC) cited gaps in services when servicemembers leave active duty and transfer to VA under title 38, United States Code. The VDBC recommended that Congress should authorize and fund VA to establish and provide support services for the families of severely injured veterans similar to those provided by DOD. In a separate but related issue, under the issue heading Services as a Disability Benefit, it noted that VA could directly provide respite services for family members of severely disabled veterans who provide daily aid and attendance and indirectly provide services such as seed or grant money to encourage individuals, groups, and/or non-profit organizations to develop and implement programs for veterans and their families. Additionally, VA could establish a clearinghouse for identification, referral, and support of existing and newly emerging programs.

DAV supports legislation to create a comprehensive program through which family members of severely wounded veterans can receive VA training, certification, counseling, respite, a family allowance and health coverage under CHAMP VA. The Advisory Committee is focusing on two aspects of disability compensation as it pertains to family care-giving. These are the impact on families when the servicemember transfers from DOD to VA, and the long-term roles and needs of family caregivers.

DAV has testified before the House Veterans' Affairs Subcommittee on Health on June 4, 2009[8] and on February 28, 2008[9] regarding the issue of family caregivers.

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[6] DAV Legislative Program 2010, DAV Resolution No. 258, Provide Increased Funding for the Transition Assistance Program and the Disabled Transition Assistance Program

[7] DAV Legislative Program 2010, DAV Resolution No. 046, Support Licensure And Certification Of Active Duty Service Personnel

[8] Meeting the Needs of Caregivers, Statement of Adrian Atizado, Assistant National Legislative Director of the Disabled American Veterans before the Subcommittee on Health Committee on Veterans' Affairs, U.S. House Of Representatives June 4, 2009

[9] Providing care, support and mental health programs for caregivers of seriously disabled veterans, Statement of Joy J. Ilem, Assistant National Legislative Director of the Disabled Amer-

Informal caregivers play a critical role in facilitating recovery and maintaining the veteran's independence and quality of life while residing in their community, and are an important component in the delivery of health care by the VA. These family members, relatives, or friends are motivated by empathy and love, but the very touchstones that have defined their lives—careers, love relationships, friendships, and their own personal goals and dreams—have been sacrificed, and they face a daunting lifelong duty as caregivers. Research has found that all too often the role of informal caregiver exacts a tremendous toll on that caregiver's health and well-being.

Family caregiving has been associated with increased levels of isolation, depression and anxiety, higher use of prescription medications, compromised immune function, poorer self-reported physical health, and increased mortality. Research also suggests that caregiver support services can help to reduce adverse health outcomes arising from caregiving responsibilities and can improve overall health status.

Despite these documented physical and psychological hardships and knowledge of effective interventions against caregiver burden, family caregivers of disabled veterans receive little support from VA, compromising their ability to provide care to their loved one. Accordingly, the delegates to our most recent National Convention, held in Denver, Colorado, August 22–25, 2009, approved a resolution calling for legislation that would provide comprehensive supportive services, including but not limited to financial support, health and homemaker services, respite, education and training and other necessary relief, to immediate family member caregivers of veterans severely injured, wounded or ill from military service.[10]

The last area to be addressed has to do with the relationship between level of Individual Unemployability (IU) and VR&E. Modern concepts of disability largely preclude the concept of "unemployable" except in the case of the most catastrophically disabled. For that reason, the Committee is considering whether a finding of IU should occur only after or in conjunction with some level of the VR&E services. DAV's position is that determinations of IU are the province of medical professionals familiar with their patients' history. VR&E personnel, although skilled in their areas of expertise, do not have the medical perspective essential to the proper determination as to whether a veteran should be diagnosed as unemployable.

CONCLUSION

DAV looks forward to a continuing dialog on the issues of the necessity and methodology of updating the VASRD, transition compensation adequacy and sequencing for servicemembers moving to veteran status and QOL compensation that were the focus of the Advisory Committee. As we move forward it is a necessity that a transparent process be set in place to address each of these sensitive issues. We should not have to offer reminders this late in the game about the important perspective that veterans service organizations bring to discussions on topics such as these. Talking openly and discussing potential changes will help resolve the understandable angst about these complex and important questions. The time to act is now—our Nation's veterans deserve no less than our best effort.

Thank you, Mr. Chairman and Members of the Committee for allowing DAV to share our views on this critical topic.

Chairman AKAKA. Thank you very much, Colonel.

You heard General Scott state that the Advisory Committee is now of the opinion that quality-of-life loss should be limited to those with serious disabilities. I am posing this to all of our witnesses on this panel. Quality-of-life loss should be limited to those with serious disabilities. Do you agree? Let me ask Ms. Neas to begin.

Ms. NEAS. You won't be surprised that I don't agree. I think we have seen with these last conflicts that people with Traumatic Brain Injury and PTSD have had very challenging times returning to the workforce. In our own work at Easter Seals, we are working with employers to help them understand what it means to have

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ican Veterans before the Subcommittee on Health Committee on Veterans' Affairs, U.S. House Of Representatives, February 28, 2008

[10] DAV Legislative Program 2010, Resolution No. 242, Support Legislation to Provide Comprehensive Support Services for Caregivers of Severely Wounded, Injured and Ill Veterans

these conditions and how it affects the veteran's work. Someone who may have lost several limbs might be considered as having a much more significant disability than one who had a brain injury.

I also think that from our experience in working with returning veterans—those that didn't have a formal diagnosis of brain injury, because so many of these individuals have been exposed to explosions that have affected their brains, for lack of a more likely term—that we are going to see more people needing help down the line who may not have had a formal diagnosis of a brain injury but who, in fact, have had a brain injury.

So, I think limiting these to people who have what is only considered at a moment in time a serious disability would be very inappropriate.

Chairman AKAKA. Thank you.

Ms. Prokop?

Ms. PROKOP. I think—well, I would echo Ms. Neas's comments and note that the exchange that occurred earlier about asking the veterans themselves for a perspective of what their consideration of quality-of-life is is probably a key ingredient in ascertaining that. I got the impression that that sort of came late in the process in this study in terms of actually—and echoing the "Nothing about us without us" philosophy of the broader disability movement, that you would really need to talk to or gain a sense from a wide variety of veterans with disabilities as to what exactly they feel quality-of-life loss is for them, because it can be very subjective.

Chairman AKAKA. Colonel Wilson?

Colonel WILSON. Thank you, Senator. I would have to say that Ms. Neas certainly said it quite well, I think, and I would agree with her comments. I think the current situation of economic loss that deals with things such as how this is going to impact your capability to earn a living over an extended period of time does not—the quality-of-life loss—does not deal with the current economic compensation; and it does not factor in pain and suffering, changes in lifestyle as a result of being placed into a wheelchair, having to have hooks now in order to manipulate a door, to drive a vehicle, to play baseball, or fishing with my child.

I think Senator Tester was absolutely correct. You ask a number of veterans and they will tell you exactly what they think about an appropriate level of compensation or what is not; and they should be actively involved in the process from the very beginning.

Chairman AKAKA. Thank you.

Colonel WILSON. Yes, sir.

Chairman AKAKA. This next question is for everyone on the panel. Do you have any suggestions for outside expertise that VA should engage with while contemplating reform of the system? Ms. Neas?

Ms. NEAS. Absolutely. I think our three organizations, which are in communities working with individuals every day, are people who should be involved in this, though first and foremost, veterans and their families. They know what they need. They are the only ones who can dictate the quality of their lives. They are the only ones who can tell you what it was like to try to get a job and be turned down because you look different or you act different than you did before you were injured.

One of the things that has been wonderful about working for Easter Seals all these years is many of the families that come to us have been told by a variety of different systems and professionals what they can't do. Until they came to us, no one was asked what they want to do and have us figure out a way to make it happen. I think that is a perspective that is really important to have go forward with this. Let us not talk to you about all the things you are never going to be able to do, because quite frankly, nobody knows what that is. What we need to do is help veterans figure out what they want to do and what is going to be necessary to get them there. And unless you talk to them directly and know the communities from which they come, we are not going to be successful.

Chairman AKAKA. Thank you.

Ms. Prokop?

Ms. PROKOP. One of the benefits that PVA has is that it has joined Easter Seals and other disability advocacy organizations in a broader coalition, the Consortium for Citizens with Disabilities, that enables us to see disability issues from a broader perspective, and from that coalition we are able to talk with our allies in the disability community and learn from them about quality-of-life issues and studies and evaluations of disability programs that are often tailored to or focused on the Social Security disability system, but at the same time raise many of the same issues that were being talked about in this context.

So, there are studies, there are reports and evaluations—such as from the National Council on Disability and elsewhere—that speak to broader disability program features and issues that the VA committee might be able to learn from, as well.

Chairman AKAKA. Thank you.

Colonel Wilson?

Colonel WILSON. Just briefly, sir, I would think that the Veterans Health Administration professionals who have been doing such a fine job of taking care of veterans for these past many decades certainly have an excellent perspective to provide. They will be beneficial to updating the VASRD and moving this whole process forward. And, of course, the Veterans Service Organizations are pleased. We look forward to working with this particular committee and the VA to move ahead on this particular process.

Chairman AKAKA. Thank you.

This question is also for all of the panelists. The question of whether to compensate for loss of quality-of-life has a potential to change veterans disability compensation considerably. Do you believe that VA should work on changes to the rating schedule before addressing whether loss of quality-of-life should also be compensated?

Colonel WILSON. If I could, Mr. Chairman, I would say, absolutely, yes. The first priority is to address the VASRD, look at it. The Disability Committee offered a viable option on how to go about doing this. I would like to see it adopted as soon as possible. I will believe that the VA is serious about moving ahead on this particular issue once I see it appear in their strategic plan. Being 33 years in the military, I find them very useful to determine where an organization is going. I look for that; I will review it.

The new administration has inherited this product from previous years, but I have yet to see this issue—which has been discussed by this Committee in other studies that the Ranking Member talked about earlier—but has never been incorporated into a change plan. There is no mention of the VASRD being reviewed in the strategic plan. There is no tactical application of how to go about doing this strategic business to the tactical level of making it happen at all, despite the many discussions, despite the many committee hearings, despite the many publications. Once I see that happen, then I know the leadership—and this new administration, I am sure, will move in that direction—will be moving properly to update the VASRD, followed closely by the quality-of-life issues.

Chairman AKAKA. Any other comments? Ms. Prokop?

Ms. PROKOP. Mr. Chairman, I don't feel qualified to answer that question because that is an issue that many of my other colleagues at PVA have dealt with and worked on over many, many years. If there is something specific you would like us to answer on that question, we would be happy to do so in writing.

Ms. NEAS. Yes. And Mr. Chairman, I don't feel qualified to answer that question, either.

Chairman AKAKA. Thank you. This question, again, is for the panel. If VA compensation is modified to incorporate a specific element for quality-of-life, do you believe that each disabled veteran would require an individual assessment that was mentioned, or would it be feasible to develop averages for the impact on quality-of-life of specific disabilities? Ms. Neas?

Ms. NEAS. I think you really—quality-of-life is such a personal issue. I don't know how you could do that without having maybe some broad criteria from which you could gain that information. But, I think really making that determination would have to be left up to each individual.

Chairman AKAKA. Ms. Prokop?

Ms. PROKOP. Based on what I have heard from our folks in PVA's Veterans Benefits Department, I suspect they would say that would need to be an individual assessment—that you really do need to consider each person's specific circumstances.

Ms. NEAS. Mr. Chairman, if I could add, I used to work for a Member of the Senate who had a brother who was deaf. His brother was told that deaf people could only be printers, cobblers, or bakers, because at the time when he went to our State School for the Deaf, that was what was determined for someone who was deaf; those were the choices that were appropriate to that disability.

I use that sort of extreme example because we don't want to have the VA have a system that says, if you have a spinal cord injury or if you have Traumatic Brain Injury, the only things you can do or the only things you should consider being available to you are a limited set of jobs or circumstances or support. So, I really do think it needs to be individualized and we don't need to go back to those days where, if you had a specific disability or condition, that that put you on a track that you could never otherwise get off.

Chairman AKAKA. Colonel Wilson?

Colonel WILSON. I will be glad to provide a comment in writing on that rather complex question, sir.

Chairman AKAKA. Thank you.

I want to thank you for your responses. As you know, we specifically asked you to join us here in this hearing so that we could get responses from groups outside of VA, and I want to thank you very much for providing responses from your experiences. So, thank you very much for appearing today.

We know that there are many challenges to providing disability benefits in the 21st century. Deciding how to best compensate our Nation's disabled veterans is a sensitive and complicated issue. We heard many options on how to calculate and implement disability compensation for the future and we can all agree that reforming the current system is imperative.

My goal is to ensure that this is done in an accurate and timely manner.

The Committee, along with the administration and those who advocate on behalf of veterans, intend to do all we can to improve the current system. To bring optimal change to a process as complicated and important as this, we must be deliberative, focused, and open to input from all who are involved in this process.

The Committee has held a number of hearings on this matter in the past and will continue to work diligently until this issue is resolved.

I want to again thank you all for being here today. This hearing is adjourned.

[Whereupon, at 11:42 a.m., the Committee was adjourned.]

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