THE U.S. DEPARTMENT OF VETERANS AFFAIRS SCHEDULE FOR RATING DISABILITIES

HEARING

BEFORE THE

SUBCOMMITTEE ON DISABILITY ASSISTANCE AND MEMORIAL AFFAIRS

OF THE

COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

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THE U.S. DEPARTMENT OF VETERANS AFFAIRS SCHEDULE FOR RATING DISABILITIES

TUESDAY, FEBRUARY 26, 2008

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
SUBCOMMITTEE ON DISABILITY ASSISTANCE
AND MEMORIAL AFFAIRS,
Washington, DC.

The Subcommittee met, pursuant to notice, at 2:02 p.m., in Room 334, Cannon House Office Building, Hon. John J. Hall (Chairman of the Subcommittee) presiding.

Present: Representatives Hall, Rodriguez, Lamborn, and Bilirakis.

OPENING STATEMENT OF CHAIRMAN HALL

Mr. HALL. Good afternoon. The Committee on Veterans' Affairs, Subcommittee Disability Assistance and Memorial Affairs, hearing on the U.S. Department of Veterans Affairs (VA) Schedule for Rating Disabilities will come to order.

Before I begin my opening statement, I would like to call attention to the fact that the American Medical Association (AMA) has asked to submit a written statement for the hearing record. If there is no objection, I ask for unanimous consent that this statement be entered for the record. Hearing no objection, so entered.

[The statement of the American Medical Association appears on p. 110.]

Mr. HALL. Could we all please rise for the Pledge of Allegiance. Flags are at both ends of the room.

[Pledge of Allegiance.]

Thank you and thank you for being here. We will be expecting Congressman Bilirakis at some point to be joining us. Minority Counsel is here and we are going to proceed with his agreement to go ahead and hope to get through as much of this hearing as possible without putting it on autopilot.

This is the third hearing of the Subcommittee regarding the VA's claims processing system. As we have discussed before, this system has not lived up to expectations and has left many disabled veterans without proper and timely compensation and other benefits.

At the heart of this system is the VA Schedule for Rating Disabilities or VASRD. The rating schedule as we know it today is divided into 14 body systems, which incorporate approximately 700 codes that describe illness or injury symptoms and levels of severity. Ratings range from zero to 100 percent and are in increments

of ten. This schedule was uniquely developed for use by the VA, but the U.S. Department of Defense (DoD) has also mandated its use when the service branches conduct evaluation boards on servicemembers who are unfit for duty. Otherwise, it is not used by any other governmental agencies or private-sector disability plans.

In its study, the Veterans' Disability Benefits Commission (VDBC) concluded that the VA rating schedule had not been comprehensively updated since 1945. Although sections of it have been modified, no overall review has been satisfactorily conducted, leaving some parts of the schedule out of date, relying on arcane medical practices, and not in sync with modern disability concepts.

The notion of a rating schedule was first crafted in 1917, so that returning World War I veterans would be cared for when they could no longer function in their pre-war occupations.

At the same time, the American economy was primarily agricultural based and labor intensive. Today's economy is different and the effects of disability are understood to be greater than the average loss of earning capacity.

Many disability specialists agree that quality of life, functionality, and social adaptation are just as important.

Our Nation's disabled veterans deserve to have a system that is based on the most available and relevant medical knowledge.

There are several issues pertaining to the rating schedule I hope to have us discuss today. First would be the need to remove out-of-date and archaic criteria that are still part of the schedule for some conditions and replace them with current medical and psychiatric evaluation instruments for determining and understanding disabilities.

The medical community relies on codes from the International Classification of Disease (ICD) and the Diagnostic and Statistical Manual of Mental Disorders (DSM). Should the Veterans Benefit Administration (VBA) be relying on these and other AMA Guides as well?

Individual Unemployability, IU, as a rating gives VA an alternative means by which to compensate veterans who cannot sustain gainful occupation, but might not otherwise be rated 100 percent.

The U.S. Government Accountability Office (GAO) found that the use of IU was ineffective and inefficient since it relies on old data, outdated criteria, and lacks guidance.

[See "VA Benefits: Fundamental Changes to VA's Disability Criteria Need Careful Consideration," GAO–03–1172T, Testimony Before the Senate Committee on Veterans' Affairs, September 23, 2003, Statement of Cynthia A. Bascetta, Director, Education, Work force, and Income Security Issues, U.S, General Accounting Office, which appears on p. 114.]

The VDBC, Institute of Medicine (IOM), and the Center for Naval Analyses (CNA) Corp., also studied IU and expressed their concerns over how it is utilized instead of scheduled ratings. I look forward to hearing from them today.

The criteria for psychiatric disabilities, especially for post traumatic stress disorder or PTSD, are in dire need of expansion. The current rating schedule has only one schedule for all of mental

health which is based on the Global Assessment of Functioning scale, or GAF.

The IOM noted that one of the many problems with GAF is that it was developed for schizophrenia, and therefore, not as accurate for other disorders, and recommended that VA replace it as a diagnostic tool. I am especially concerned about this issue and how it pertains to PTSD and other mental disorders.

The VDBC also recommended that traumatic brain injury or TBI, in case you have not had enough initials yet, be a priority area of concentration, and for VA to improve the neurological criteria for TBI, which has become one of the signature injuries of this war.

I know there has been much discussion on how to compensate veterans for their quality of life losses. Both the VDBC and Dole-Shalala reports recommended that this be a new category added to the rating schedule in some fashion, but they did not necessarily agree or provide clear guidance on how to do this or whether the current system does so implicitly. So next steps are still needed.

Presumptions have had a major impact on VA compensation over the last few decades for conditions related to ionizing radiation, Agent Orange, and the Gulf War. The IOM, therefore, engaged in a lengthy study for the VDBC on presumptions and recommended that there be evidence-based criteria which could impact the rating schedule.

I commend Secretary Peake for changing the regulation on PTSD, but we might also want to add a presumption that combat-zone service is a stressor when evaluating PTSD.

I look forward to the testimony today on these complex rating schedule issues. I know there is a lot to be done to improve the VA claims processing system. But with the rating schedule at the core of the process, it seems that the centerpiece is in need of immediate comprehensive repair, which we intend to advocate.

I look forward to working with Ranking Member Lamborn and the Members of the Subcommittee in providing oversight for the VA's schedule for rating disabilities. The VA needs the right tools to do the right thing so our Nation's disabled veterans get the right assistance.

[The prepared statement of Chairman Hall appears on p. 53.]

Mr. Lamborn, our Ranking Member, was unable to be here. Will he have a statement for the record?

Mr. LAWRENCE. Yes.

[The prepared statement of Congressman Lamborn appears on p. 54.]

Mr. HALL. It will be made a part of the record. Whenever Mr. Bilirakis arrives, then he will be afforded the chance to make an opening statement and also to ask questions.

I would like to first of all welcome our panels, all of our panelists today, and to remind you that your complete written statements have been made part of the hearing record.

Please limit your remarks so that we can have sufficient time to followup with questions once everyone has had the opportunity to provide their testimony.

Joining us on our first panel is Vice Admiral Dennis Vincent McGinn, Member of the Veterans' Disability Benefits Commission.

Admiral McGinn, I first want to express my deepest sympathies to you, the rest of the Commission, and its staff on the passing of Commissioner Butch Joeckel. Butch was a true American hero, a great Marine, and a veterans' advocate to the end, who understood all too well why we are here today trying to improve the qualify of life for our disabled veterans.

I understand that Butch was known for saying, "You just have to do the right thing." And I think it is apropos that we keep that spirit in mind as we move forward on improving the VA claims processing system.

We also welcome Dr. Lonnie Bristow, Chair of the Committee on Medical Evaluation of Veterans for Disability Benefits for the Institute of Medicine; Dr. Dean Kilpatrick, Member of the Committee on Veterans' Compensation for Post Traumatic Stress Disorder for the Institute of Medicine; Dr. Jonathan Samet—is that the correct pronunciation?

Dr. SAMET. Samet.

Mr. HALL. Samet. Thank you. Dr. Jonathan Samet, Chair of the Committee on Evaluation of Presumptive Disability, Decision-Making Process for Veterans for the Institute of Medicine; and Dr. Joyce McMahon from the Center for Health Research and Policy of the CNA Corp.. Thank you all for joining us.

And, Admiral McGinn, you are now recognized for 5 minutes.

STATEMENTS OF VICE ADMIRAL DENNIS VINCENT MCGINN, USN (RET.), MEMBER, VETERANS' DISABILITY BENEFITS COMMISSION, ON BEHALF OF LIEUTENANT GENERAL JAMES TERRY SCOTT, USA (RET.), CHAIRMAN; LONNIE BRISTOW, M.D., CHAIR, COMMITTEE ON MEDICAL EVALUATION OF VETERANS FOR DISABILITY BENEFITS, BOARD ON MILITARY AND VETERANS HEALTH, INSTITUTE OF MEDICINE, THE NATIONAL ACADEMIES; DEAN G. KILPATRICK, PH.D., MEMBER, COMMITTEE ON VETERANS' COMPENSATION FOR POSTTRAUMATIC STRESS DISORDER, INSTITUTE OF MEDICINE, THE NATIONAL ACADEMIES, AND DISTINGUISHED UNIVERSITY PROFESSOR AND DIRECTOR, NATIONAL CRIME VICTIMS RESEARCH AND TREATMENT CENTER, MEDICAL UNIVERSITY OF SOUTH CAROLINA, CHARLESTON, SC; JONATHAN M. SAMET, M.D., M.S., CHAIRMAN, COMMITTEE ON EVALUATION OF THE PRESUMPTIVE DISABILITY, DECISION–MAKING PROCESS FOR VETERANS, BOARD ON MILITARY AND VETERANS AFFAIRS, INSTITUTE OF MEDICINE, THE NATIONAL ACADEMIES, AND, PROFESSOR AND CHAIRMAN, DEPARTMENT OF EPIDEMIOLOGY, JOHNS HOPKINS BLOOMBERG SCHOOL OF PUBLIC HEALTH, JOHNS HOPKINS UNIVERSITY, BALTIMORE, MD; AND JOYCE MCMAHON, PH.D., MANAGING DIRECTOR, CENTER FOR HEALTH RESEARCH AND POLICY, CENTER FOR NAVAL ANALYSES (CNA) CORPORATION, ALEXANDRIA, VA

STATEMENT OF VICE ADMIRAL DENNIS VINCENT MCGINN, USN (RET.)

Admiral MCGINN. Thank you, Mr. Chairman and Members of the Committee. I am pleased to appear before you today on behalf of the Chairman of the Veterans' Disability Benefits Commission,

General Terry Scott, to discuss the findings, conclusions, and recommendations of the Commission related to revising the VA rating schedule.

The Commission was tasked to examine and make recommendations concerning the appropriateness of benefits, the appropriateness of the level of benefits, and appropriate standards for determining whether a disability or death of a veteran should be compensated. We completed our work and submitted our report on the 3rd of October 2007.

Mr. Chairman, I appreciate your comments concerning Commissioner Joeckel. You may note that we dedicated our report to him and he was the conscience of our Commission and a continuous reminder of the tremendous debt our Nation owes to disabled veterans.

For almost 2½ years, the Commission conducted an extensive and comprehensive examination of issues related to veterans' disability benefits. This was the first time that the subject had been studied in depth by an independent body since the Bradley Commission in 1956.

We identified 31 key issues for study and made every effort to ensure that our analysis was evidence based and data driven. And we engaged two well-known organizations to provide medical expertise and analysis. First the Institute of Medicine of the National Academies and the CNA Corporation. Both of those organizations are represented today in this panel.

Of the many issues the Commission examined, one of the most important was determining the effectiveness of the VA rating schedule.

You will be hearing from four panels today, including to my left Drs. Bristow, Kilpatrick, Samet representing their IOM Committees, and Dr. McMahon from CNA, independent experts, Veteran Service Organizations, and later Admiral Dan Cooper and Mr. Mayes representing the Department of Veterans Affairs.

I will keep my remarks brief and focus on the conclusions and recommendations of our Commission related to the rating schedule.

Our Commission is most appreciative of the outstanding work of the IOM Committees and CNA. We believe that their efforts were exceptionally complementary of each other and that the results were remarkably consistent.

The Commission's report summarizes the analysis and recommendations of CNA and the IOM Committees in some detail. However, the reports to the Commission are rich in detail with extensive analysis and each should be carefully reviewed by the Committee.

I would like to highlight a few of their key findings that our Commission found especially helpful. For example, Dr. Bristow's Committee emphasized that the rating schedule should achieve horizontal and vertical equity.

Vertical equity means that the VA ratings of severity of disability assigned in 10 percent increments from zero to 100 percent should be accurately assigned so that those assigned more severe ratings should be those veterans whose disabilities impact their earnings more than those assigned less severe ratings.

CNA's comparison of the earnings of veterans who are not service disabled with service-disabled veterans demonstrated that disability causes lower earnings in employment at all levels of severity and types of disabilities and that the earnings loss of the disabled veteran increases as the percent rating increases. Thus, VA ratings using the rating schedule are generally achieving vertical equity.

Horizontal equity means that assigning ratings of severity should reflect average loss of earnings among the nearly 800 diagnostic codes and across the 16 body systems. CNA's analysis generally confirmed horizontal equity as well. Overall, their analysis confirmed that the VA rating schedule and VA's assignment of ratings using the rating schedule results in compensation paid to veterans that is generally adequate to offset average impairment of earnings.

Taken as a whole, the rating schedule is doing its job reasonably well. The detailed and comprehensive analysis demonstrated that even veterans with less severe ratings do, in fact, have loss of earnings.

However, the key word in the aforementioned paragraph is generally. The CNA analysis also identified very pronounced disparities for some veteran cohorts in which vertical and horizontal equity are not being achieved.

The amount of compensation is not sufficient to offset loss of earnings for three specific groups of veterans, those whose primary disability is post traumatic stress disorder, PTSD, or other mental disorders, those who are severely disabled at a young age, and those who are granted maximum benefits because their disabilities make them unemployable.

For these veteran groups, horizontal and vertical equity is not being achieved. Those severely disabled at a young age have greater loss of earning, especially over their remaining lives since they did not have established civilian careers or transferable job skills and have more of the normal working years ahead of them.

The analysis also clearly demonstrates that veterans with PTSD and other mental disorders experience much greater loss of employment and earnings than those with physical disabilities, particularly those more severely disabled.

These disparities should be addressed by a careful but prompt revision to the rating schedule leading to a more equitable level of payment to disabled veterans in the severely disabled category.

Concerning PTSD and mental disorders, the reasons for insufficient compensation may lie partly in the criteria in the rating schedule itself and partly in how the VA raters interpret or apply the criteria.

The rating schedule was revised a few years ago to eliminate separate criteria for diagnoses such as PTSD and in order to have a single set of criteria for all 67 diagnoses contained in the body system known as mental disorders.

The Commission asked the IOM to provide advice as to whether a single set of criteria is effective. IOM recommended that separate criteria should be established for PTSD and CNA's survey of VA raters and VSO service officers found agreement with that advice.

Concerning the interpretation of the criteria by raters, the Commission learned that almost ½ of 223,000 veterans granted indi-

vidual unemployability or IU as being unable to work due to their service-connected disabilities had a primary diagnosis of PTSD, that would constitute 31 percent, or other mental disorders, 16 percent.

To be granted IU, the veteran must be rated at 60 to 90 percent disabled and also be found unable to work due to the service-connected disability.

Mr. HALL. Excuse me, Admiral.

Admiral MCGINN. Yes.

Mr. HALL. I am sorry. Could you summarize, please?

Admiral MCGINN. I certainly will. Yes, sir.

Our Commission concluded that there has been an implied but unstated congressional intent to compensate disabled veterans for impairment to quality to life due to their service-connected disabilities. And this is a key area that the Committee can make a real difference.

I would also like to point out before I make my concluding remarks that since the reports of the IOM that indicated the need to update the rating schedule, there has been very, very limited progress by the VA. And this should be looked at both in terms of what is the sense of urgency and other adequate resources available to do this rating schedule update as a matter of priority.

As I reflected in my written statement and partially in the oral statement I have just made, only by keeping the rating schedule current with the best up-to-date medical knowledge and by adjusting the payment levels to offset both loss of earnings and quality of life can we be assured that disabled veterans and their families are adequately compensated.

This was the clear consensus of our Commission. The specific recommendations in our report should be used to guide needed legislative actions by Congress as well as the policy and resource allocations by the departments and agencies needed to update and improve disabled veterans' benefits.

Mr. Chairman, I would be glad to answer any questions the Committee may have.

[The prepared statement of Admiral McGinn appears on p. 54.]

Mr. HALL. Thank you, Admiral.

And next, Dr. Bristow, you are recognized for 5 minutes.

STATEMENT OF LONNIE BRISTOW, M.D.

Dr. BRISTOW. Thank you. Good afternoon, Chairman Hall and Ranking Member Lamborn and Members of the Committee.

My name is Lonnie Bristow. I am a physician and I have served as the President of the American Medical Association. And I am joined this day on this panel by Drs. Dean Kilpatrick and Jonathan Samet who will introduce themselves shortly.

But on their behalf, we want to thank you for the opportunity to testify about the work of our Institute of Medicine Committees, our three Committees from the IOM.

My task today is to present to you the recommendations of the IOM Committee, which I chair, which was asked to evaluate the VA's schedule for rating disabilities and related matters.

Dr. Kilpatrick will follow me to speak about his Committee's work which focused on post traumatic stress disorder, a particular

challenge for the VA to evaluate. And Dr. Samet will conclude our panel's presentation from the IOM by briefing you on the findings of his Committee which was asked to offer its perspective on the scientific considerations underlying the question of whether a health outcome should be presumed to be connected to military service.

We submitted testimony, written testimony for the record and we will summarize our presentations here. I only have a few minutes, so let me quickly list our key findings and recommendations concerning the VA rating schedule. And I will be glad to go into more detail about any of them during the question period.

Our Committee found that the statutory purpose of disability compensation which is to compensate for an average loss of earning capacity is, in fact, an unduly restrictive rationale for the program and it is inconsistent with the current modern models of disability.

The Committee recommends that the VA compensate for three consequences of service-connected injuries and diseases. First, for work disability which it currently does. And, second, however, for loss of ability to engage in usual life activities other than work, what disability experts today call functional limitations. And, third, for loss in quality of life.

Concerning the rating schedule, the Committee found that the schedule is not as current medically as it could be or should be. The relationship of the rating levels to average loss of earning capacity is not known at the time of our evaluation. The schedule does not evaluate impact on a veteran's ability to function in everyday life and the schedule does not evaluate for loss in quality of life.

The Committee, therefore, recommends that VA immediately update the current rating schedule medically beginning with those body systems that have gone the longest without a comprehensive update and adopt a system for keeping that schedule up to date medically.

Second, establish an external Disability Advisory Committee to provide advice during the updating process.

And, third, as a part of updating the schedule, we recommend moving to the ICD and DSM diagnostic classification systems.

Fourth, we recommend investigating the relationship between the ratings and actual earnings to see the extent to which the rating schedule is compensating for loss of earnings on average and make adjustments in the rating criteria to reduce any disparities that are found.

Fifth, compensate for functional limitations on usual life activities to the extent that the rating schedule does not.

And, sixth, develop a method of measuring loss of quality of life and where the schedule does not adequately compensate for it, VA should adopt a method for doing so.

The Committee also reviewed individual unemployability or IU and our main finding concerning IU is that it is not something that can be determined on medical grounds alone. Therefore, the Committee recommends that the VA conduct vocational assessments as well as medical evaluations whenever they are determining IU eligibility.

This concludes my remarks. And I want to thank you again for the opportunity to testify, and I will be happy to address any questions you might have about our report.

[The prepared statement of Dr. Bristow appears on p. 58.]

Mr. HALL. Thank you, Doctor.

And as you heard, the bell buzzer was sounding indicating that votes have been called. So I am going to have to ask you to be patient once again, and this Subcommittee will be in recess until this stack of votes are over.

[Recess.]

Mr. HALL. The Subcommittee is called back to order. And we apologize for the delay. You will be happy to know our legislative business is over for this afternoon, so we will be able to continue uninterrupted.

Dr. Kilpatrick, your written statement is in the record. You are now recognized for 5 minutes, please.

STATEMENT OF DEAN G. KILPATRICK, PH.D.

Mr. KILPATRICK. Thank you very much, and I appreciate the opportunity to testify on behalf of the Committee on Veterans' Compensation for PTSD.

Last June, our Committee completed its report entitled "PTSD Compensation and Military Service," which addresses several potential revisions to the schedule for rating disabilities in the context of a larger review of how the VA administers its PTSD compensation program. Our Committee's review of the scientific literature led it to draw the following conclusions:

First, there are two primary steps in the VA's disability compensation process. The first of these is a compensation and pension or C&P exam.

Testimony presented to our Committee indicated that clinicians often feel pressured to limit the time they devote to conducting a PTSD C&P exam, sometimes to as little as 20 minutes, even though the protocol suggested in a best practice manual developed by the VA National Center for PTSD can take 3 hours or more to complete.

Our Committee felt very strongly that the key to a proper administration of the VA's PTSD compensation program is a thorough C&P clinical examination conducted by experienced mental health professionals. Many of the issues that arise could be dealt with nicely if the resources needed for a thorough examination were provided.

The Committee also recommended that a system-wide training program be implemented for the clinicians who conduct these exams in order to promote uniformity and consistent evaluations.

The second step in the VA compensation process is rating the level of disability associated with service-connected disorders. This rating is performed by a VA employee using information gathered in the C&P exam and the criteria set forth in the schedule for rating disabilities.

Currently the same set of criteria are used for rating all mental disorders and they primarily focus on symptoms from schizophrenia, mood and anxiety disorders.

The Committee found that these criteria are, at very best, a crude and it is an overly general instrument for the assessment of PTSD disability. We recommend that the new criteria be developed and applied that specifically address PTSD symptoms and that are firmly grounded in the standards set out in the DSM used by mental health professionals.

A third point is that our Committee suggested that the VA take a broader and more comprehensive view of what constitutes disability for PTSD. There is a special emphasis and some might say a total emphasis on occupational impairment in the current criteria that unduly penalizes veterans who may be capable of working but who are significantly symptomatic or impaired in other dimensions and, thus, the current system may serve as a disincentive to both work and recovery.

Under this framework, the psychosocial and occupational aspects of functional impairment would be separately evaluated and the claimant would be rated on the dimension upon which he or she is more affected.

In order to promote more accurate, consistent, and uniform PTSD disability ratings, the Committee recommended that the VA establish a specific certification program for raters who deal with PTSD claims and to have training along with that as well.

Finally, at the VA's request, the Committee addressed whether it would be advisable to establish a set schedule for reexamining veterans receiving compensation for PTSD. The Committee concluded that this was not appropriate to require across-the-board, periodic reexaminations and instead recommended that it be done on a case-by-case basis when there is some reason to believe that maybe the disability status had changed.

Our reasoning for that was that the resources that the VA has are finite and they would be better spent focusing on doing a really first-class and timely initial evaluation than diverting the resources to do periodic rereviews.

The second point about that is that if only PTSD is singled out, it says to the veteran that there is something suspect about this so that we have to reexamine you over and over again. And we did not find any data that suggests that there was a need for that.

I realize that there has been some differences of opinion between various committees about the extent to which reexamination should happen and I think honest people could disagree on that. And we would just urge that, you know, the Congress as well as that the VA, consider carefully the merits of each of those approaches.

And, finally, I really would say, and this is my opinion, but I think it is consistent with what our Committee thought, that if we are going to do periodic PTSD reexaminations and we are going to implement that, we should not do so until there are adequate resources to ensure that every veteran gets a first-rate initial C&P exam that is done in a timely fashion.

We have several other recommendations in our report. I understand that each of you have that, and so I would be happy to answer any questions when the time comes.

[The prepared statement of Mr. Kilpatrick appears on p. 66.]

Mr. HALL. Thank you, Doctor.

Dr. Samet, you are now recognized for 5 minutes.

STATEMENT OF JONATHAN M. SAMET, M.D., M.S.

Dr. SAMET. Thank you. Good afternoon. I am pleased to speak with you today on behalf of our 16-member Committee about the report, improving the presumptive disability, decisionmaking process for veterans. You have the report and we have also made the executive summary available.

We were charged with describing the current process for how presumptive decisions are made for veterans and with proposing the scientific framework for making such presumptive decisions in the future.

As you know, presumptions are made in order to reach decisions in the face of unavailable or incomplete information. And presumptions have been made since 1921 around matters of exposure and causation.

To address our charge, we met with the full range of involved stakeholders. We completed a series of ten in-depth case studies to look at lessons learned from past presumptions. We also looked at how information is obtained on the health of the veterans and how exposures during military service are evaluated and potentially linkable to health events in the future. We also looked at how scientists synthesize information to judge what is known about association and causation.

To the first part of our charge, the present approach to presumptive disability, decisionmaking largely flows from the "Agent Orange Act of 1991." In that law, Congress asked the VA to contract with an independent organization to review scientific evidence for Agent Orange, that organization being the Institute of Medicine.

The Institute of Medicine provides its reports to the VA which then acts with its own internal decisionmaking process to determine if a presumption is to be made.

Our case studies pointed to a number of difficulties in this current approach that need to be addressed in any future approach, lack of information on exposures received by military personnel, insufficient surveillance of veterans for service-related illness, gaps in information because of secrecy, varying approaches to bringing information together, and variation in classification of evidence in different presumptions sometimes around association and sometimes around causation, and a general lack of transparency of aspects of the process.

We proposed a new approach that we feel will address these deficiencies when implemented. We call for an approach that is outlined in the figure attached to my testimony. Elements of this approach include an open process for nominating exposures and health conditions for review involving all stakeholders who are interested in the outcome of the presumptive disability, decisionmaking process.

We recommend a revised process for evaluating scientific information on whether a given exposure causes a health condition in veterans. We offer a new set of categories to assess the strength of evidence for causation and propose that in a second step of the scientific evaluation of the evidence, an estimate be made of the numbers of exposed veterans who are at risk from the exposure.

We call for a consistent and transparent decisionmaking process by the VA and a system for tracking the exposures of military personnel and for monitoring health conditions while in service and after separation and an organizational structure to support this process.

Two elements of the organizational process include creating two panels. One we called the Advisory Committee would be advisory to the VA. This Committee would monitor information as it comes in on the exposures and health of veterans. It would assess nominations made for consideration for presumptions and give recommendations to the VA.

The second panel would be a Science Review Board, an independent body that would evaluate the evidence, the strength of the evidence, and do the quantitative estimations if appropriate. The recommendations of this group would go to the VA as well.

We propose a set of principles, including stakeholder inclusiveness, evidence-based decisions, a transparent process, flexibility and consistency, and, finally, use of causation and not just association as the target for decisionmaking.

We offer a set of categories around how certain the evidence is for causation and suggest that for the purpose of causation that the benefit always goes to the veterans and that the evidence should be at least 50 percent or more pointing toward causation for making presumptive decisionmaking.

This implementation of this approach will call for action by Congress. Legislation would be needed to create the two panels and the resources would be needed to create and sustain exposure and health tracking for service personnel and veterans.

Elements of this system we recommend could be implemented at present even as steps are taken to move the DoD and VA toward implementing the full model.

Thank you.

[The prepared statement of Dr. Samet appears on p. 71.]

Mr. HALL. Thank you, Doctor.

Dr. McMahon, you are now recognized.

STATEMENT OF JOYCE MCMAHON, PH.D.

Ms. MCMAHON. Thank you. Chairman Hall, Representative Lamborn, and distinguished Members, I appreciate the opportunity to testify before the House Subcommittee on Disability Assistance and Memorial Affairs of the House Committee on Veterans' Affairs today on the subject of revising the VA schedule for rating disabilities.

This testimony is based on the findings reported in the CNA final report for the Veterans' Disability Benefits Commission.

We were asked to provide analysis to the Commission regarding the appropriateness of the current benefits program for compensating for loss of average earnings and degradation of quality of life resulting from service-connected disabilities for veterans.

Pertinent to today's topic is that we were asked to examine the evidence regarding the individual unemployability rating, to evaluate the quality of life findings for disabled veterans, and to conduct surveys of raters and Veterans Service Officers with regard to how they perceive the process of rating claims and assisting applicants.

Our primary task was to focus on how well the VA compensation benefits served to replace the average loss in earnings capacity for service-disabled veterans. We defined subgroups of disabled veterans by body system of the primary disability and on the total combined disability rating in four groups, 10 percent, 20 to 40 percent, 50 to 90 percent, and 100 percent disabled.

Within this, we further stratified the 50—to 90-percent disabled group into those with and without individual unemployability status.

Our overall finding is that for male veterans, there is general parity overall at the average age of entry. When we looked at various subgroups, we found some differences as has been mentioned before. In particular, those with a primary mental disability have lower earnings ratios than those with a primary physical disability and many of the rating subgroups for those with a primary mental disability had earnings rates below parity. In addition, entry at a young age with severe disability is associated with below parity earnings ratios.

We were asked to look at veterans' quality of life degradation, and we did this by conducting a survey using health-related questions taken from a standardized bank of questions used to survey the general population. This allowed us to compare results for service-disabled veterans to widely used population norms.

We found that as the degree of disability increased, generally overall health declined, and that there were differences between those with physical and mental primary disabilities. Physical disability led to lower physical health, but in general did not lead to lowered mental health except for the most severely disabled.

On the other hand, mental disability led not only to lower mental health scores but was also associated with lower physical health in general. For those with a primary mental disability, physical scores were well below the population norms for all rating groups and lowest for those with PTSD.

In general, we did not find that there were any implicit quality of life payments being made to the disabled veteran population since most veterans were at parity with the exception of the subgroups we have mentioned. Overall, there is no quality of life payment implicitly being provided by the current compensation schedule.

There are groups that are below parity and these would include those entering as severely disabled veterans at a young age and, in particular, those with a mental primary disability. Since these people are below parity, that implies a negative implicit quality of life payment for these groups. However, it is worth noting that in general the loss of quality of life appears to be the greatest for those with a mental primary disability.

Turning to the survey of raters and Veterans Service Officers that we conducted, I will make a few points quickly. Many raters indicated that the criteria for IU are too broad and that more specific decision criteria or evidence regarding IU would be helpful in deciding IU claims.

They reported that claims are becoming more complex, that mental claims are harder to evaluate than physical claims, and that

they would appreciate more specific criteria to help them resolve mental health issues, especially PTSD.

Turning to IU, we were asked specifically to look at this in the context of the system and how it works. We have a figure that 8 percent of those receiving VA disability compensation have IU, but 31 percent of those with PTSD as their primary diagnosis have IU status. This may indicate that the rating schedule does not work well for PTSD.

We were asked to comment on the rapid growth in the number of disabled veterans categorized as IU from 2000 to 2005. The data suggests that the vast majority of the increase in the IU population is explained by demographic changes, specifically the aging of the Vietnam cohort.

We also looked at mortality rates to determine if there were clinical differences for those with IU, and we found that those with IU status have higher mortality rates than those who were rated 50 to 90 percent disabled without IU. IU mortality rates were, however, less than was observed for those who are 100 percent disabled.

Finally, we would make a couple of comments about rating system implications. If the purpose of the IU designation is primarily related to employment, there could be a maximum eligibility age reflecting typical retirement patterns. But if it is to correct for rating schedule deficiencies, an option might be to simply correct the rating schedule so that fewer disabled veterans would need to be classified as IU.

In particular, I do not think you will ever find that you can get away from the rating system using an IU designation completely, but you might well be able to limit the number of veterans who receive this designation each year by changing the schedule or considering other options such as a greater use of retraining programs.

Thank you.

[The prepared statement of Ms. McMahon appears on p. 75.]

Mr. HALL. Thank you, Doctor.

Thank you to all of our panelists.

At this time, I want to acknowledge Congressman Rodriguez and Congressman Bilirakis who have joined us.

I will ask a few questions first. Admiral McGinn, as a Member of the Commission and participant in its deliberations, what is your sense of the priority of revising the rating schedule from the perspective of the veteran? In other words, what do veterans need most?

Admiral MCGINN. I think the comments by some of my colleagues at the panel here reflected the priority that should be placed on PTSD, TBI or traumatic brain injury, and other mental conditions as areas in which the VA should start their review of the rating schedule. Those are all very, very compelling in terms of numbers and the effects it has on veterans and their families. And from a veteran's perspective, that is a good place to start.

That said, the entire rating schedule should be approached, and updated with a much greater sense of urgency. And if that requires more resources, those should be applied.

Thank you, sir.

Mr. HALL. In your testimony, you called for VA's response to be urgent and expedient, but then pointed out that this has never been the case with the VA's reaction to recommendations such as those made by Omar Bradley's Commission in 1956.

So if we want this done now, what is the best way for Congress to ensure your call to action?

Admiral MCGINN. I know we made a recommendation in our report on establishing an oversight group comprised of DoD and the VA to track the progress of the various recommendations that we made.

I will say that given the fact that we are at war, we are seeing terribly injured veterans come back and into the system, tremendous effect on their families, and various spotlights have been put on how we treat those veterans.

The VA and DoD, for example, have made tremendous progress, more in the past couple of months, 6 months say, than in the previous 10 years on addressing the so-called seamless transition from uniform member to disabled veteran.

I think that same type of focus needs to be applied in updating the rating schedule and we will see the results that we need.

Mr. HALL. And would you consider the 25-percent quality of life payment as recommended by the Commission sufficient to correct the horizontal and vertical equity issues described by CNA? Should the maximum payment of 25 percent only pertain to the most severely disabled or for the three groups you described as below parity?

Admiral MCGINN. I think that horizontal and vertical equity issues should be dealt with separately than quality of life. And quality of life should be applied as we are developing standards for measuring quality of life or decrement to quality of life and what appropriate compensation should be.

I think that immediately those veterans who are most severely disabled should benefit first from a quality of life increase.

Mr. HALL. Thank you.

Dr. Bristow, could the rating schedule be simplified and still be an effective tool for VA to use in compensating veterans?

Dr. BRISTOW. That is a very difficult question, Mr. Chairman. I believe the rating system needs to be clarified. I am not sure if simplified is the term that I would use. But I think it certainly needs to be clarified so that it has logic.

It currently fails to have the sort of logic, at least from the point of view or from the perspective of medicine or science, that it should have and can have. It has a lack of logic because it has not progressed during the last five decades at the rate that it should have. In some areas, it has been abysmally behind the times. Others, there have been fitful starts in an effort to become more modernized. But its problem is a lack of being up to date rather than being too complex.

Mr. HALL. Do you agree with the Commission's recommendation to begin with mental health, specifically PTSD and TBI?

Dr. BRISTOW. Yes, sir, although my Committee recommended that the updating take place approaching those particular systems that have had the longest lag of inattention.

This actually dovetails with the Commission's recommendation, particularly if you look at traumatic brain injury, which is a part of the neurological system, which would be one of the first systems that needs to be upgraded.

The addition of PTSD that the Commission is recommending for early and urgent attention, I think, is based on pragmatism and it makes eminently good sense. And I am quite certain that no one on my Committee would disagree or dispute or find fault with that.

Mr. HALL. Thank you.

In a hearing last month, Dr. Randy Miller from Vanderbilt University testified that the rating schedule was too vague and ambiguous. He suggested that if it had better definitions and clear-cut key words, it could be automated.

What is your opinion on these observations and would you advocate for the automating of the rating schedule using software, artificial intelligence, et cetera?

Dr. BRISTOW. I think it is key that the rating system begin to use as rapidly as can be accomplished DSM and ICD codes. The reason is because that would bring the greatest clarity to what the medical condition or surgical condition is of a particular individual. And clarity is essential if you are going to do any sort of epidemiologic approach to a given population.

The rating system currently has been using only 700 plus codes and whenever a condition does not fit a particular code, the raters are encouraged or advised that they should use an analogous code. That is a matter of administrative convenience. But when one attempts to look back and decide what is going on with a given population of diseases or injuries, there is a mishmash that has been created in that fashion.

And so it is important that although the ICD codes are far more numerous, parenthetically, we are talking about an alternative with the potential use, the use of potentially anywhere from 14 to 17,000 different codes as opposed to 700 plus, they would bring a great deal more clarity and make the information that the VA is collecting much more useful in terms of how to allocate resources, in terms of how to develop programs, and provide the sort of the services that the entire Nation wishes our veterans to have.

Mr. HALL. Thank you.

And my 7 minutes have just gone flying by.

Congressman Rodriguez.

Mr. BILIRAKIS. I have one question.

Mr. HALL. Mr. Bilirakis.

Mr. BILIRAKIS. One question. Thank you.

Dr. McMahon, how might the VA adjust the rating schedule so that it more accurately reflects the consequences of PTSD?

Ms. MCMAHON. Well, I am not a clinical expert. We approach this at CNA from a point of analysis of what the rating schedule showed. I would say that the information with regard to individual unemployability suggested that there was an inability to rate the person in terms of the fullness of the disability. In other words, many people were unable to work and were granted individual unemployability who did have PTSD.

One way to address that would be to rate them at a higher rating for PTSD instead of at their current rating level. So part of it

may be a systematic rating that does not properly assess the degree of disability associated with PTSD. But that gets into some more clinical issues which I do not really feel I should address. The IOM is more appropriate for that.

We certainly could see, however, that, overall, the earnings capability of those people who had a primary disability of mental disability or PTSD was much lower than for someone who had a physical disability. There was a sharp discrepancy between physical disability and mental disability in terms of how people fared.

This was true with regard to earnings and it was also true with quality of life. Those with mental primary disabilities tended to earn less than people with a physical disability at the same rating level, and they tended to have a lower quality of life when you compared both their mental and physical quality of life in the scales that we calculated.

The story becomes consistent that they do not earn as much and they have a lower quality of life. I think that could be reflected in terms of how the schedules are applied. But the actual clinical way in which that could be done, I am not prepared to answer.

Mr. BILIRAKIS. Thank you.

Mr. HALL. Mr. Rodriguez.

Mr. RODRIGUEZ. Yes. Thank you very much.

Dr. Kilpatrick or maybe anyone else that might know, what are your thoughts on the possibility of delayed onset of PTSD and how would the Department of Veteran Affairs detect where we have missed that.

I am referring to as they arrive, the importance of picking up on them as quickly as possible, but then—and this is an additional question, how do we distinguish between those veterans that have been out there maybe from Vietnam and the duration of PTSD and the onset? Have we been able to come to grips with that?

Mr. KILPATRICK. Yes. In fact, our Committee report addresses that at some length. And a CliffsNotes version of what we found was that basically there is ample evidence that you can get delayed responses of PTSD.

And that can occur for a number of reasons, one of which is it may be that people are symptomatic and they have been symptomatic for a long period of time and all of a sudden, it gets to a threshold where they recognize that there is a problem or more commonly a family member or a co-worker or somebody like that recognizes that they have a problem, brings them to the attention of mental health professionals and whatnot, and then they get diagnosed.

The other aspect of what you are saying is that there is a strong belief on the part of many servicemembers when they get out that they will be fine when they go back home. In other words: "I have been in a dangerous war zone situation. All I need is to get back to my family and to my civilian life and I will be fine."

In many cases, it turns out that not to be the case, so that it takes a while for them to understand that this is not going away. It is here and maybe I need to do something about it.

For mental health, PTSD specifically, but also with a lot of mental disorders, there are ample epidemiological data suggesting that probably the majority of people who have PTSD or mental health

problems do not seek treatment out for some of these reasons. There is still a lot of stigma.

In fact, you know, my previous testimony about why we did not want to have a reexam mandated was that if it is just for PTSD and not for anything else, it is telling people with PTSD that you have a suspect condition here and we are concerned that might, in fact, deter people from being willing to come forward for treatment.

Mr. RODRIGUEZ. Do we know a little bit in terms of the condition because I know and I have given the example of schizophrenia where the worse the person acts as the prognosis, they are better for prognosis because they are reacting to their illness? Do we have any indication that post traumatic stress works in the same way, that those where the onset is very slow, their prognosis may be less? Or are we still researching that? Where their prognosis is more evident initially, do we have any information in that?

Mr. KILPATRICK. Well, I think that is a complicated question and so I will give you a somewhat complicated answer, not too complicated, I hope.

But the thing is is that some people if they are just totally unable to function, in other words, if they are, you know, very, very, very disturbed very soon afterward and it comes to other people's attention, they are more likely to have a severe case perhaps.

But the number of people who basically may have subthreshold PTSD or who may actually meet all the diagnostic criteria, but they keep it to themselves, I would suggest the Ken Burns movie that came out on PBS fairly recently in which one of the most moving things to me was seeing these World War II veterans, many of whom had functioned incredibly well for 50 or 60 years and who now are tearing up.

And, you know, military people do not tear up very much. That is not what they are supposed to do. And these people had functioned very well throughout life, but it had taken a toll to the point that they still had a great deal of difficulty talking about things.

So that I think there are two groups that we are talking about. One group is people that you can see what is going on and it is obvious that they are very disturbed. There is another group that may through their force of will and their character and everything else be striving to work and striving to have relationships, but who are still, it has taken a toll on them and, you know, it takes a while for it to become obvious to everybody else.

Mr. RODRIGUEZ. And I know, if I can followup with another question, I know psychiatrists that will tell you that there is a clear distinction. But have we been able to get a clear distinction between the people that have been diagnosed with personality disorders versus having post traumatic stress disorders?

Mr. KILPATRICK. There are people who have PTSD who can have personality changes, but I would argue that someone who is a competent mental health professional who knows something about PTSD would not make the mistake of diagnosing somebody as having a personality disorder when, in fact, it is an outcome of PTSD.

For example, one of the symptoms of PTSD is, you know, maybe angry outbursts and things like that. So if you are still in the military and you are telling, you know, your superior officers to do something or you are getting in fights and maybe you are drinking

a lot to try to cope maladaptively with some of the PTSD symptoms, that may look a little like a personality disorder. But anybody who knows something about PTSD and knows how to assess people should not make the mistake of saying this is primarily a personality disorder versus this is PTSD.

Mr. RODRIGUEZ. Yes. I was bringing that up because I know, I think it was DoD that had identified some 20,000 soldiers with personality disorders. And that makes a big difference in terms of benefits for one when it comes to the VA.

If on the personality disorders, if they are picked up and allowed to participate in the military with a personality disorder, you would think that that trait would come up pretty quickly. At what point do you think that personality disorder reveals itself as such and not as PTSD?

Mr. KILPATRICK. Well, I would say that most people think that most personality disorders might, in fact, predate, I mean just in terms of time of onset, would predate, you know, entry into service. Now, most of us get worse under stress and so if you had a personality disorder, maybe that would be get worse under stress too.

But the key is that if you can look at military trauma, sexual trauma, other kinds of trauma, you can look at things that happened during the military and then you look at that to see how that relates to the specific PTSD symptoms.

Mr. RODRIGUEZ. Okay. I am out of time. Thank you.

Mr. HALL. Thank you.

I would like to ask a couple more questions, if I may.

Dr. Kilpatrick, the rating schedule for mental health is very much based on the Global Assessment of Functioning or GAF scale, which a different IOM Committee found to be ineffective and recommended that it should be replaced.

What do you think that says about the rating schedule itself and should the same conclusion apply?

Mr. KILPATRICK. Well, I believe our Committee did, in fact, reach that conclusion. The problem with it is that it was not designed to capture the specific types of disabilities that go along with and difficulties in functioning that go along with PTSD. And so the items and the anchors in it do not really fit PTSD very well. So there are better measures there.

And if anybody wants chapter and verse on that, there is a long discussion of it in, you know, our report. But the Committee really felt like that there were better ways to capture that than a rating system that is based on the GAF.

Mr. HALL. You mentioned that the current rating schedule serves as a disincentive for both recovery and work for those with PTSD who might also be able to work.

Should VA allow veterans with mental disabilities to be rated 100 percent and for them to be employable just like with physical disabilities?

Mr. KILPATRICK. Well, I think if you were interested in parity, that would be something that would appear to be attractive. Again, this is my personal opinion.

But I think the Committee also felt that encouraging people to work and not setting up a system that provides a disincentive to do that is probably not what you would want to do if you were

wanting to encourage people to, you know, get vocational services and other kinds of things that would enable them to be productive.

There are clearly people who are 100-percent disabled for a physical disability, but who if they go to work, they do not have to give up the disability. And it seems to me that parity would suggest that, you know, that you try to do the same thing for people with PTSD specifically, but also for other mental disorders.

Mr. HALL. Thank you.

Dr. Samet, it sounds like the causal effect level of evidence that your Committee proposes is very stringent and would make it even more difficult for veterans to achieve service connection on a presumptive basis.

Is that really the intention and does that really serve our veterans best?

Dr. SAMET. Several comments. The four-level categorization of evidence has a point of balance between 50 percent certainty that there might be a causal association or less. And we suggest that, in fact, the 50 percent and above level of certainty be used for compensation.

I do not know that this is necessarily more stringent than the current approach. We also call for a more holistic approach to evidence evaluation, making certain that the latest understanding of how exposures received in the military might cause disease or incorporate it into the decision making.

We also suggest that when the evidence does not meet that balance point, action still might be taken. For one, research might be developed to fill the gaps that are there so that the level of certainty can be higher.

I think this is a point for an important discussion because, as I pointed out, our case studies show that, in fact, sometimes judgments have been made on the standard of association and sometimes on causation. We think that this should be uniform. It should be clear. It should be transparent.

And as the decision is made about what is the right approach, there should be a weighing of how many potential presumptions might be made when the evidence is not there yet, a false positive, and then also how often an association, a causal association might be missed, a false negative.

We want a system that assures that we do not miss those conditions that are actually linked to exposures in the military and at the same time does not let some through where there is no association. It is a difficult balancing and we propose a system that we hope will do the right job.

Mr. HALL. Thank you.

The Committee recommended the creation of a VA Presumption Advisory Committee and a Scientific Review Board to consider and review scientific evidence. But developing this level of evidence as described in your report could take years.

What should we do about getting veterans their benefits in the meantime?

Dr. SAMET. You know, I think embedded in your question is an important point. Scientific evidence will always be accumulating and first we call for the accumulation of the best stream of evidence possible on the health of veterans.

I mean, going back to the question about PTSD, if we did have the right public health surveillance approaches in place, some of the questions that were posed would be answerable.

So we think that while evidence is accumulating, judgments have to be made. The evidence needs to be looked at serially. When there are gaps, they need to be targeted. If there are questions about delayed onset of PTSD, there should be a focused investigation. And I think the VA needs the capacity to do that.

An Advisory Committee would have the role of providing guidance on what evidence is needed and how it might be obtained. And, again, if perhaps evidence is unobtainable, then it is best to know that and to make a decision with acknowledgment of the uncertainty.

Mr. HALL. Thank you.

Dr. McMahon, the data you have presented is compelling and it seems that the groups who suffer the most from service disabling injuries and illnesses are those who are younger, more severely injured, those with mental health issues, and those who are unemployable.

If VA were able to augment those whose disabilities were more impairing with a quality of life loss schedule, do you think that would improve the financial parity for those veterans or is there a need to change the rates of compensation or the levels of severity?

Ms. MCMAHON. Well, I would think that you would want to address these issues separately. I would have to say that while I can identify the quality of life degradation pretty sharply by some of the criteria that you mentioned, I am not able to put a dollar figure on exactly how much would be appropriate for a quality of life adjustment.

We did look in some of our analysis at some of the steps that other countries took with regard to quality of life adjustments. Some of those countries dealt with it with a lump sum payment, for example. I am not suggesting that that is the way we would want to go.

I do think that these are separable issues. One of them is a matter of compensation and whether a person is unable to work in the accustomed area or maybe has not been able to be retrained into another line of work. That is a matter of fairness. You have lost something compared to what you started with. You have not been able to keep up with your peer group.

The issue of a loss of quality of life is something different and I think that needs to be dealt with separately rather than merged together in a single payment because that gives you a cleaner way of dealing with the situation.

Mr. HALL. Thank you.

I want to thank you all for your testimony.

We were talking before about the various resources that are available that are more up to date than the VA's rating schedule. This DSM manual from the American Psychiatric Association, which has a section on post traumatic stress disorder in it, it is copyrighted in 1994 and updated through 1997 with new codes and so on.

I am hopeful that all of us together with the testimony that you have provided us and with what the other panels will be providing

us, we can help VA move from the fifties or sixties or wherever they last were into the present and future in terms of clarifying this and making this a more logical system and one that serves our veterans better.

Thank you all so much for you patience and for testifying before the Subcommittee today, and the first panel is now excused.

And we will ask our second panel, Mark Hyman, M.D., American Academy of Disability Evaluating Physicians (AADEP); Sidney Weissman, M.D., member of the American Psychiatric Association; Ronald Abrams, Joint Executive Director of the National Veterans Legal Services Program (NVLSP), to join us please.

Thank you also for your patience. As usual, your full written statement will be entered in the record and you will each be recognized for 5 minutes. So feel free to summarize or deviate from it in whichever way you choose.

Dr. Hyman, you are now recognized for 5 minutes.

STATEMENTS OF MARK H. HYMAN, M.D., FAADEP, PRESENTER, AMERICAN ACADEMY OF DISABILITY EVALUATING PHYSICIANS, AND MARK H. HYMAN, M.D., INC., F.A.C.P., F.A.A.D.E.P., LOS ANGELES, CA; SIDNEY WEISSMAN, M.D., MEMBER, COMMITTEE ON MENTAL HEALTHCARE FOR VETERANS AND MILITARY PERSONNEL AND THEIR FAMILIES, AMERICAN PSYCHIATRIC ASSOCIATION; AND RONALD B. ABRAMS, JOINT EXECUTIVE DIRECTOR, NATIONAL VETERANS LEGAL SERVICES PROGRAM

STATEMENT OF MARK H. HYMAN, M.D.

Dr. HYMAN. Thank you very much, Mr. Hall, Members, and staff.

I read the Institute of Medicine report and do wish to align my recommendations from the private sector experience.

In the community, if we have an injured person, they file a claim within a recognized jurisdiction, usually at the State level. This triggers a claims handling by either a private insurance entity or a State mandated agency. Records are obtained and the patient is then referred to a physician for evaluation.

A report is prepared in the format required by the jurisdiction and the findings of the evaluation are then translated into an impairment rating which then triggers subsequent administrative actions.

Implementation of the recommendations in the report would bring our veterans system in a closer approximation to what I have just described. In particular, I must strongly underscore the need for a common language and the process which emanates from already existing national standards, including the AMA Guides, the ICD, and the DSM.

These resources are the products of multiple leaders throughout the world. The AMA Guides began in 1958 in response to the developing field of disability evaluation. The mission has always been to bring the soundest possible reasoning to the impairment process. The Guides have become the community standard in the majority of the States within our country. In essence, the Guides are the tools and the rules of the disability trade.

We have just produced the sixth edition of this seminal work and there are many companion books that go with this. These have been provided to your staff and I have copies of them here. Together these books represent the efforts of experts around the country who regularly work in the disability field.

There is also a mechanism of updating this information through an Advisory Board that we have and we also do major revisions when it is warranted.

Through this mechanism that is used in the private sector, we can thoroughly describe and categorize the range of human injury. We are able to develop a fair, equitable, consistent rating on an individual's impairment, small or large.

Further, the Guides are aligned with the World Health Organization's (WHO's) standards of disablement which are called the International Classification of Functioning, Disability, and Health.

As with all jurisdictions, once an impairment rating process has occurred, then, like all other jurisdictions, specific unique coding or administrative concerns can then be added to the process.

Indeed, in many jurisdictions, the evaluators may not even fully know all of the subsequent claims processing that their impairment rating triggers.

In the current VA example, raters could take this report from the medical evaluation and cohesively apply a disability rating with good reproducibility. They can add whatever modifiers they feel are necessary or unique to the VA system.

The use of these resources will allow for a transition to an electronic health record which is currently the standard for the veterans health system on the medical side. Tracking of the data then becomes much easier.

To accomplish this process, all shareholders from the VA system must have a seat at round-table discussions and have input into recommendations from the Advisory Committee. The Advisory Committee must be charged and funded to meet at least once yearly with quarterly telephonic meetings in order to ensure implementation, assess outcomes, and ensure proper education.

I cannot underscore enough the importance of education as this field is one that is not covered heavily or extensively in standard medical training and has many unique aspects.

By using the resources which I have identified as central to this process, the common language of impairment and disability will be broadened to all personnel involved in the process. I personally, as a citizen of this country and our organization that I am representing today, AADEP, offer assistance to you in furthering this project.

Finally, based on briefly some comments I heard today, I want you to know that there is data that works for the vast majority of people and these resources cover the vast majority of concerns.

In looking at your reporting from the Institute of Medicine, the three most common difficulties, orthopedic, hearing, psychiatric, are all covered in the AMA Guides. The best way to get this done is through the AMA Guides. The research already exists. You do not have to reinvent the wheel. The resources are already regularly examined and updated. These resources cover matters of concern to you.

There is no perfect book. There will never be a perfect book to describe the entire human condition. But the AMA Guides is the closest we have to equanimity and I strongly recommend it.

Thank you for allowing me to help our country, but, in particular, for giving me a chance to help those men and women who have provided for our security that we can meet here today and try to repay their effort. May God bless you in your deliberations.

[The prepared statement of Dr. Hyman appears on p. 79.]

Mr. HALL. Thank you, Dr. Hyman.

Dr. Weissman, now you are recognized for 5 minutes.

STATEMENT OF SIDNEY WEISSMAN, M.D.

Dr. WEISSMAN. Thank you, Mr. Chairman.

I am Sidney Weissman and I am here to represent the American Psychiatric Association which is the publisher of the DSM which has been spoken about this afternoon.

The American Psychiatric Association published the current DSM in 1994 and you noted some of the revisions.

As publisher, we have a vital interest in the work of the Subcommittee and particularly in the interest of expanding the criteria for psychiatric disability, especially for veterans suffering from post traumatic stress disorder.

I would like to say I share the Chairman's concern that we have instruments for assessing the disability of our members who have served us so well, but I would also, though, disagree that the GAF as has been reported and commented on by a number of people does not do that job.

The GAF or the global assessment of functioning of the DSM is designed to look at all mental health disorders. And what I think has been confusing to some people is that as it describes varying levels of functioning, it has references or it will say EG, for example. What is confusing is that the for examples frequently refer to schizophrenia or depressive disorders, but in point of fact, the broad categories themselves can be used to apply for all mental health disorders and could as readily be designed to respond to post traumatic stress disorder. We at the APA or myself would be glad to work on some models of that.

I should also note that I would like to agree with the Institute of Medicine for the need for the establishment of broad criteria and the training of Veterans Administration's physicians and evaluators to a standardization of the criteria and the terms in which all mental health diagnoses are made.

Four years ago, I had the opportunity as a psychiatrist working for Veteran Integrated Services Network (VISN) 12 to review how PTSD was diagnosed and treated in the Veterans Administration hospitals in the Great Lakes. To my amazement, there was no universal agreement. The treatment you got or the diagnosis you received depended totally on which hospital you attended. There was no comparability. One hospitalized everybody for a month. One treated everybody in a day treatment center and one treated everybody as an outpatient. This will not do.

It's not surprising that categorization of assessment tools do not work if the people filling them out and completing them have no standardization.

I should note that all mental disorders ranging from mild depression to schizophrenia to PTSD vary in the degree of disability associated with them. The questions of disability not only affect veterans and active-duty military personnel, but they affect civilians in Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI).

We believe it is important that clinical research, insurance claims management, and government use of mental disorders diagnosis all have a common frame of reference and a common diagnostic set of tools.

The DSM is that common reference point and it is used throughout the world to accomplish this, not just in the United States, but in all sectors of the world. It has been used and worked on by World Health Organization. And on the basis of that work, for the past 26 years, we have been working then to reassess and redevise and reexamine and reformulate the DSM.

I should note that the DSM is used by all mental health practitioners, psychologists, social workers, counselors, mental health administrators. And the need for a common language has been noted by some of my colleagues. In the absence of a common language and standards, epidemiological surveys and studies of mental health practice patterns cannot be made. Practice guidelines for clinicians to improve and standardize patient care could not be made.

Our concern is that we not fragment our system of assessment by introducing new forms which could be idiosyncratic, but that we use a standardized form. We can work to modify the for examples used for the global assessment functioning be changed to respond to PTSD and refer specifically to PTSD.

We should also note in closing that all forms of the U.S. Government from TRICARE to Champus to Medicaid and Social Security all use the DSM.

In closing, I should also note that we are in the process of developing a new DSM or DSM–V. The Chair of the work group to develop the DSM–V apropos of PTSD is Dr. Matthew Freedman. He is a psychiatrist and Executive Director of the U.S. Department of Veterans National Center for Post Traumatic Stress, so he brings a critical perspective to the review of the DSM. And a particular focus of this DSM–V work group will be the reevaluation of the relationship between mental disorder and disability.

And I close as did my colleague of our need to ensure the adequate and responsible acknowledgment of the needs of the men and women who have served our country so well.

Thank you.

[The prepared statement of Dr. Weissman appears on p. 83.]

Mr. HALL. Thank you, Doctor.

I should have acknowledged our Ranking Member, Congressman Lamborn, who obviously you noticed his presence, but I am acknowledging it officially and thanking him for being here.

And now we will turn to Mr. Abrams who is recognized for 5 minutes.

STATEMENT OF RONALD B. ABRAMS

Mr. ABRAMS. Thank you, Mr. Chairman and Members. I am pleased to have the opportunity to submit this testimony on behalf of NVLSP.

I would like to point out that many parts of the rating schedule have been updated, amended, and changed. Some have been helpful. Some of the changes have been helpful. Some have been harmful. If you want to look at a bad one, go look at the way they changed the back condition evaluations.

As someone with a severe back condition, I can tell you that the current rules on evaluating back conditions where you have to be in bed for so many weeks really hurts people with those conditions and they ought to do something about that and fix that.

Of course, NVLSP would want the rating schedule updated, modernized, and otherwise improved. However, we want to caution that improving the rating schedule is not a cure all. In our opinion, there is no amount of money that would adequately compensate any veteran for the loss or loss of use of a body part, permanent cognitive impairment, or the loss of a creative organ. We should be asking not how much is the disability worth, but how much can this Nation afford to pay.

I want to stress that our priority is the evaluation of mental conditions and we believe that for a long time, the VA has tended to under-evaluate mental disabilities. This has occurred at the same time that our society has evolved from one dominated by manual labor to a work environment that emphasizing intellectual endeavors.

We really cannot compare the impact of a mental condition today to the impact of a mental condition in 1947 where we had more of a farm economy than we do today.

I also want to stress that veterans with mental conditions are handicapped. While vets with heart conditions, lung conditions, and other conditions can get 100-percent schedule or evaluation, a veteran with a severe mental condition who is lucky enough to find some kind of minimal work cannot work and get the 100-percent evaluation. We do not think that is fair.

Also, we would like to stress that we agree with the current VA rating policy on individual unemployability or IU. We reject any recommendation that would require the VA to implement a periodic evaluation or review of veterans in receipt of IU benefits. They tried this in the eighties. I worked for the VA at that time. And we ended up being pushed as employees to cut off as many veterans as we could.

At one time, the rolls went from, I believe, 180,000 vets getting IU to under 80,000. I do not think you want to go there. That is not the way to go.

This longstanding policy about paying people unable to perform substantial gainful employment because of their service-connected conditions without considering nonservice-connected conditions, without considering age should not be changed.

We have already talked about at other hearings our views on traumatic brain injury, so I will leave that for you to talk about later.

And we also want to stress that the current association standard regarding presumptive service-connected conditions should not be changed. The causal effect would be almost impossible for vets who come back from Vietnam after being exposed to Agent Orange to win benefits unless science can determine what is a causal effect.

Do not go there. This is not working. We are getting benefits for people when statistically we can see an association between being in a terrible place in the world where we send our troops and then later getting hypertension and other terrible conditions, lung cancers.

Thank you very much.

[The prepared statement of Mr. Abrams appears on p. 85.]

Mr. HALL. Thank you, Mr. Abrams.

It is true I was noticing reading the pages in the part of the DSM on post traumatic stress and anxiety disorder that a substantial number of our former panelists said numbers of the population at large, civilians, exhibit these symptoms depending on exposure to robberies or muggings or volcanic events, I am sure there are quite a few residents of the New Orleans area who were exhibiting symptoms because of Hurricanes Katrina and Rita and so on.

Now we are hearing from Iraq and Afghanistan that our Diplomat Corps and their families are reporting symptoms that would probably qualify as PTSD.

I wanted to ask Dr. Hyman, based on your testimony, it seems you are advocating for the use of the current WHO standard as encompassed in the AMA Guides.

Can you give us an example so we can better understand the difference between disability and impairment?

Dr. HYMAN. Yes, Mr. Hall.

Let me give you an example from my own private practice. I take care of a conductor for the Philharmonic in my city. And he called me 1 day and said, you know, Mark, there is something wrong with my ear and I cannot hear very well.

Now, hearing loss, which is one of the three most common conditions that are in the claims for the veterans, would be evaluated with specific hearing tests. And one would generate an impairment rating. In other words, how impaired, how much loss of use of that hearing has somebody obtained.

But that loss of hearing for my conductor patient could translate into 100-percent disability because he is not able to work as a conductor because hearing is so critical to his work, whereas for another worker where that level of hearing acuity is not necessary to perform their essential job functions would have a lower disability.

Another example might be in that same type of field a concert violinist. If somebody injures their finger and they happen to be performing janitorial services and it happens to be their fourth digit and it is a partial amputation, they could probably fulfill all the job requirements of their janitorial duties. And in that respect, they would have no disability from their job. But a concert violinist is now 100-percent disabled.

They both have the same injury. They both have the same impairment. They are both evaluated in the same manner and are given a very fair, appropriate, understandable impairment rating,

which is then translated by the impairment rating process and the disability process into their ultimate effects.

Mr. HALL. Dr. Weissman, the issues with mental health and PTSD have been complex. Could we have your opinion on these as well? For instance, what is your reaction to the IOM study on PTSD and compensation?

Dr. WEISSMAN. It is interesting because I think they are not unlike my colleague's comments vis-&-vis what your tasks are and what your jobs are. I think that we have probably underestimated for varying reasons the significance of PTSD and its disabling effect on people.

I think that as is the case in all mental disorders, it can be so totaling disabling and marginally disabling. I think that the need for a thorough diagnostic assessment of someone with PTSD is the aid and the assistance in making that determination, but I believe that we have probably underestimated the significance of it because, as you noted, we frequently think in terms of mental disorders of schizophrenia and, again, a global notion of it.

So I would agree with the Institute of Medicine report. It is understated. It is more complex and we need to do a much better job in assessing veterans who suffer from it.

Mr. HALL. What do you think of the VA's reliance on the GAF and should that be changed, especially as the basis of the rating schedule?

Dr. WEISSMAN. If one went to the GAF, I have my DSM also, and where it says EG, it will say every ten points, there is a statement and then it is EG. If I started on the top at 90, I suspect any number of people here are at 100, but we will not quibble about our scores, not myself, but I believe you could take the GAF, use as the EGS, which means for example, elements of the symptomatology and behaviors observed in PTSD and as you would go down the GAF scores, the EGS, would describe more intensive intrusion into functioning. One could make the GAF an extremely effective agent for assessing PTSD as you could for any number of other mental disorders as it is used, by the way, around the world.

Mr. HALL. Would this fall into your comment about common language and standards? Is that specific enough and simple enough to be part of a rating system which could be automated, which could be computerized?

Dr. WEISSMAN. I would not want to computerize the diagnostic assessment of the man or woman who has served our country.

Mr. HALL. I am not saying computerize the assessment. I am saying that once a psychiatrist has diagnosed a particular level on the scale and that it could be entered in assuming—both the Ranking Member and I have an interest in moving toward, as much as we can, toward artificial intelligence for the purpose of rating and processing claims.

Dr. WEISSMAN. Assuming we went through the DSM and the GAF down the line and used as our example now, for our for example, PTSD and the varying elements of it, then I believe you could do just what you said. So, I have seen the patient with an extensive diagnostic interview and I have given him a rating of 55 and that scale should fit.

But I would also want to make sure that we have then done what the IOM also reported or asked for, which is a training schedule so that you certify people and that there is some inter-rater reliability because if there is no inter-rater reliability, then the number doesn't mean anything.

Mr. HALL. Mr. Abrams, would you be so kind as to give us in writing, at your earliest convenience, specifically how we should change the evaluation for back conditions.

Mr. ABRAMS. I would be happy to.

Mr. HALL. Thank you. I am personally interested in that as well.

Mr. ABRAMS. As someone who suffers from severe spinal stenosis, I would not get much if I could apply for my back condition. And I can tell you that I am lucky to have a job that I can do where I can sit, not stand, where I do not have to walk. And I truly believe that if I applied for Social Security, I would get it if I was not working. But in VA, I might get ten percent.

I do want to add something to what Dr. Weissman said. The GAF score would be a wonderful tool if the VA followed it and all they have to do is say—in fact, they are obligated to do it now. We take many cases to the Court of Appeals for Veterans Claims where the GAF is not consistent with the symptomatology and the VA under-evaluates the veteran's mental condition.

We feel that if the VA was encouraged to either accept the GAF score, I mean, we have seen people with 40 GAF scores get a 30 percent evaluation. That is just nuts. If they do not think the GAF score is right, the VA should send it back to the examiner and ask them to explain why such a score was assigned. And we win those cases on a routine basis at the court.

And so you do have a common language there if you can just get the VA to buy into that and do it, but we see that as a consistent error. In fact, if you look at our American Legion quality checks, you will see that is many of the errors that we found in the Regional Offices.

Mr. HALL. Thank you.

Mr. Lamborn, you are recognized for 5 minutes.

Mr. LAMBORN. Thank you, Mr. Chairman.

Dr. Weissman, will you briefly summarize for us the findings of the planning conference on PTSD from June of 2005? For example, what were the specific recommendations for research and will these be included in the DSM revision due in 2011?

Dr. WEISSMAN. Well, in one of my other roles, I happen to be a trustee of the American Psychiatric Association. We are in the very early form of developing a number of task forces to look at the totality of the psychiatric diagnostic system.

So I cannot tell you explicitly what that conference was other than to say that that was to form the framework of beginning to put together people from around the world to create the new DSM–V, which will not be published until 2011 and 2012. So this is the formative period. It will use all of this data.

I would hope that as my friend here, I will sound like one of the candidates, I believe that if we work on the common language, use it effectively, understand language from as follows, that will then be able to inform not just for veterans, men and women who have experienced combat. But, as Mr. Hall says, PTSD is not simply a

disorder of the military. It is a disorder for all of us. All of us have family members who have experienced traumatic situations. And I dare say all of us could find members of our families who have some degree of PTSD.

But that is the formative period for the task force and the work groups to establish the DSM–V and one element that one of the task force works on these issues.

Mr. LAMBORN. Thank you.

Mr. HALL. Thank you, Mr. Lamborn. And——

Dr. HYMAN. Mr. Chairman.

Mr. HALL. Yes.

Dr. HYMAN. One brief comment. In reflecting on some of the comments here, I do hear an understandable concern as the mechanisms of bringing the science to the patient. And I think these resources have that process built into them. And I said, there will never be a perfect scale for many of these conditions, but this is the state of where we are at and we will always get better.

What I think is very important is to have the mechanisms in place of using these standard references. And as an example, I want you to know that in California where I am now at, we have the country's largest workers' compensation system and we passed a law to put into place the AMA Guides. And that process took 8 months.

This is not something that, requires a long period of startup and evaluation in order to accomplish what is doable. And that could be something for your deliberations as far as putting something in place that can begin to bear on the benefits for these veterans that are needed and over time, work on the associated issues.

Mr. HALL. Thank you.

Dr. Weissman, I wanted to ask you, would you say that if a veteran is diagnosed with PTSD, it would be safe to assume that the stressor occurred in a combat zone even if the veteran did not have a combat action ribbon or some other combat related award?

Dr. WEISSMAN. One could serve in the military and experience a traumatic situation, which is not in the combat zone. A woman, and we know this is the case, could be sexually abused and assaulted and experience PTSD that is not combat related. One could be in an accident.

So the existence of PTSD in a veteran or an active-duty soldier does not in and of itself tell me that that was obtained in a combat zone.

Mr. HALL. Your comment that each VA hospital that you studied handled PTSD differently, diagnosed it differently, treated it differently is disturbing to me and not surprising based on some of the other testimony that this Subcommittee has heard.

Other than the common language and common standards, can you get more specific than that in terms of how you would suggest that we approach this?

Dr. WEISSMAN. I would take and work using the GAF, for example, work it through to each of those points where it says EG, develop a model that fits PTSD. I would then view the cases or interviews of men and women with PTSD and I would have a number of people observe those interviews, assess that data so that I could get a standardization.

And then after I have obtained a standardization and inter-rater reliability from my people developing the standardization—we have wonderful ways now of communicating that instantly around the country. With the web, I would then develop a training program to be taken by all VA psychiatrists or mental health workers who would assess someone for a mental disorder, for PTSD so that there would then be an agreement that if I was evaluated in Milwaukee or at Hines VA or Jesse Brown or in Tomah, Wisconsin, these are some of the places we looked at it, I would have the same rating.

However, I could warn you that when you do this, the inter-rater reliability fails after a time. The three of us could take the training and agree and very quickly, he goes to California and I go to Chicago, my friend, I am not sure where you are going, you have to make sure that the training is repeated, that we redo the training. This is a constant process. The VA is not always effective at constant processes.

It is not one where you get your transfer punched and it is good for the lifetime. You have to do this repeatedly. And I am convinced if we did that, we could develop a scale that works and I could ensure you, Mr. Chairman, and the American people that a vet evaluated in Milwaukee or Chicago or Los Angeles or Washington would get a comparable evaluation and be treated fairly. And he would not or she would not have to go somewhere else.

Mr. HALL. Thank you, Doctor.

Dr. Weissman, Dr. Hyman, Mr. Abrams, thank you all for your testimony and you have been very helpful to us. And thank you again for your patience. This panel is excused. Have a lovely evening.

Would our third panel please come to the table, Dean Stoline, the Assistant Director of the National Legislative Commission, the American Legion; Kerry Baker, Associate National Legislative Director of Disabled American Veterans (DAV); and Gerald T. Manar, Deputy Director, National Veterans Service of the Veterans of Foreign Wars (VFW) of the United States.

Gentlemen, thank you. Your full written statements have been entered as is customary into the record, so your oral testimony may be as brief or lengthy as you would like it to be. Hopefully not more than 5 minutes.

Mr. Stoline, you are recognized now.

STATEMENTS OF DEAN F. STOLINE, ASSISTANT DIRECTOR, NATIONAL LEGISLATIVE COMMISSION, AMERICAN LEGION; KERRY BAKER, ASSOCIATE NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS; AND GERALD T. MANAR, DEPUTY DIRECTOR, NATIONAL VETERANS SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES

STATEMENT OF DEAN F. STOLINE

Mr. STOLINE. Thank you, Mr. Chairman, Mr. Lamborn, and Members of the Subcommittee. My name is Dean Stoline. I am Assistant Director for the National Legislative Commission of the American Legion.

Thank you for this opportunity to present the American Legion's views on revising the Department of Veterans Affairs schedule for rating disabilities.

My statement includes the American Legion's views on this subject and also our views on recommendations contained in the Veterans' Disability Benefits Commission.

The VA should update the current rating schedule and begin with body systems that evaluate post traumatic stress disorder and other mental disorders such as traumatic brain injury. This revision process should be completed within 5 years and a published system of keeping the rating schedule up-to-date should be devised.

The American Legion cautions that revision of the rating schedule should be put into its proper perspective as the Committee conducts its work.

While we agree with the need for a new schedule, the problem for veterans is getting service connection on their claims. The rating schedule is a downstream issue a veteran contends with after the award of service connection.

In addition, the rating schedule is not the major cause of problems in the VA process. While updating disabilities that have not been properly reviewed is a good idea, the real problems veterans face are the inadequate staffing, the inadequate funding, the ineffective quality assurance, the premature adjudications, and the inadequate training that plague the VA, especially in the Regional Offices.

For example, what good is a new rating schedule if the veteran who files a claim waits for years going through a series of VA denials, remands, appeals, requests for submission of new evidence, and hearings before finally receiving the service connection award?

Only after service connection is the rating schedule relevant. And in the rating schedule, if the disability is lower than it should be, the veteran must appeal that decision through the same process all over again.

What good is a new rating schedule to Reservists and National Guardsmen who submit claims only to have them denied because the VA decides the disability did not occur or have its onset when they were serving on active duty? As with the prior example, the Reservist must appeal and face many years of fighting and waiting before a service connection is awarded. Only then will the rating schedule be relevant.

The Committee should note VA's lack of proper review of Reserve component servicemembers' claims will become more exacerbated as this Nation continues with the Global War on Terrorism.

Recent VA figures indicate that while the conflicts in Afghanistan and Iraq may be an active-duty war, they are also a citizen-soldier fight. Only 48 percent of the veterans from Afghanistan and Iraq have been active-duty servicemembers. Fifty-2 percent are Reserve and National Guard members.

Clearly VA and DoD must be held accountable to properly ensure Reserve component servicemembers are getting the proper documentation while in active service for review of potential disability claims.And the Committee must ask how a seamless transition for Reserve component servicemembers from DoD to VA can ever be made if the citizen-soldiers are not given an end-of-service medical

examination. This DoD examination would be the one piece of medical evidence Reserve component servicemembers would need most for a VA claim to succeed.

Clearly these problems will not be resolved by a new rating schedule. The American Legion emphasizes the solution of those problems must be a major focus to reform the adjudication process.

Getting back to improving the schedule, the American Legion first stresses that we are a Nation at war. Therefore, no injury or disability to any current servicemember should receive less compensation because of an update to the rating schedule.

The American Legion believes evaluations for some disabilities, for example, amputations, loss of use of limb, loss of use of creative organ, are under-compensated because they fail to consider the impact of those disabilities on a veteran's quality of life and other disabilities such as mental conditions fail to adjust to changing American work environments over time. The American Legion welcomes changes to the rating schedule to take care of these inequities.

I will skip the PTSD and IU subjects because they were adequately covered in prior testimony by NVLSP.

I will move on to the periodic evaluation of IU eligible veterans. VA should authorize only a gradual reduction of their compensation for those returning to substantial gainful employment rather than abruptly terminating payments to them at an arbitrary level of earnings.

The American Legion opposes part of the Commission's recommendation that would be interpreted as requiring consideration of age in determining eligibility. It is inherently unfair to punish an older veteran who would not be able to work at any age because of a service-connected condition and award the benefit to a similarly disabled younger veteran.

The schedule is based on the average impairment in earning capacity. If the veteran cannot work because of service-connected disabilities, then IU should be awarded.

With regard to TBI, VA proposes a regulation to amend the current criteria. The American Legion commends the VA for recognizing the situation and for making an effort to revise the current criteria.

Last, the proposed regulation does not discuss consideration of the history of the disability on TBI. TBI symptoms wax and wane for some veterans. Therefore, some veterans may be under-evaluated if the history of their symptomatology is not considered.

With regard to the evaluation of cognitive impairment, we believe that "moderately impaired" and "severely impaired" should also be defined in the regulation.

With regard to applicability date, the VA contends the proposed rule should be applicable to claims received on or after the effective date. The American Legion disagrees. It does not make sense to apply the old rating criteria to a claim that has not been initially adjudicated or is pending readjudication due to an appeal simply because the claim was received prior to the effective date of the new rule.

With regard to presumptions, the Commission made recommendations regarding the replacement of the current association standard with its causal effect standard in the presumptive dis-

ability, decisionmaking process. The American Legion does not support those recommendations because the association standard currently used in the presumption determination process is consistent with a nonadversarial and liberal nature of the VA disability process.

For example, for 1991 Gulf War veterans, specific or reliable exposure data is not available due to improper recordkeeping. So for Operations Desert Storm and Desert Shield veterans, there is insufficient information to properly determine their exposure to the numerous environmental and other hazards found in that conflict. This lack of data clearly diminishes the value and reliability of a causation standard. It should be noted that despite its recommendation, the Commission did state that it was concerned that causation rather than association may be too stringent and encourage further study of the matter.

In closing, I thank you again, Mr. Chairman, for allowing the American Legion to present its comments on these important matters. As always, the American Legion welcomes the opportunity to work closely with you and your colleagues. I stand ready for any questions you may have of me.

[The prepared statement of Mr. Stoline appears on p. 89.]

Mr. HALL. Thank you, sir, and we appreciate your testimony. We will have questions in a minute.

But, first, Mr. Baker is recognized.

STATEMENT OF KERRY BAKER

Mr. BAKER. Mr. Chairman and Members of the Subcommittee, on behalf of the DAV, I am pleased to offer my testimony to address the VA disability rating schedule.

The present rating schedule was developed in 1945. By 1961, there had been no less than 15 revisions. In fact, since the beginning 1990, there have been no less than 28 sections of the rating schedule updated to some degree.

I am providing this information in response to most of the rhetoric that VA must completely revise its entire compensation system. The majority of support for such rhetoric stems from speechless proposals that VA's compensation system is over 60 years. It is not. VA's disability system in 1945 was but a shell of today's system.

In no previous war was there a need to recreate VA's disability system nor does such a need currently exist. However, the DAV agrees that portions of the rating schedule must be updated such as but not limited to traumatic brain injury or TBI and residuals and the mental health rating criteria.

The problem with the mental health criteria is the weak nexus between severity of symptoms and degree of disability. Another problem is the proclivity for VA decisionmakers to deny increased rating claims based on failure to demonstrate symptoms required for a higher rating and the lack of such symptoms is not at all associated with a condition. Therefore, any update to the mental health disorders rating schedule should be condition specific rather than a one-size-fits-all criteria.

Essentially the DAV supports the Veterans' Disability Benefits Commission or VDBC recommendation that VA update the rating

schedule, keep it up-to-date, and establish an Advisory Committee to assist in the updating process.

With respect to ratings for individual unemployability or IU, the VDBC asked the CNA Corp. to conduct an analysis of veterans receiving IU. The central focus of their work was to determine whether the increase in IU was due to veterans manipulating the system.

The CNA Corp. discovered that the growth in the IU population is a function of demographics and that disabilities are worsening as veterans age. The CNA Corp. concluded that the increase in IU is not due to veteran manipulation.

We realize the need to help unemployed veterans return to work when feasible. Most desire to lead productive lives rather than attempt to survive only on VA compensation. Nonetheless the slightest misinterpretation by VA employees of a change in law regarding entitlement to benefits under this program will result in a large number of veterans receiving an unlawful denial of benefits or worse a revocation of benefits.

We ask that you realize that no single disability will ever affect two veterans in the same manner. What may render one unemployable may simply not the other.

With respect to quality of life, the VDBC recommended that Congress increase compensation rates up to 25 percent for loss of quality of life. The DAV fully supports this recommendation.

Through comprehensive research, the Commission determined that compensation at most helps some groups of disabled veterans achieve parity with their nondisabled counterparts, but only with respect to loss of earnings due to disability. However, other groups were found to be below parity when compared to nondisabled veterans.

These findings show that VA compensation replaces only the average in lost earnings for many veterans, but much less for others. In no event are veterans being overcompensated. The question then arises of how, not if, VA should develop a way to compensate for each. I believe that question is simply yet to be answered.

In conclusion, we know that society has laws that are evolutionary. The founders took great care in assuring that change does not come easy, but still provided for its evolvement. Some ignore this by acting hastily, attempting to push legislative agendas aimed at more conserving the bottom line than conserving the benefits that disabled veterans spent the last 100 years fighting for.

Some of these agendas would pit veterans against veterans or worse pit veterans against their government. We simply urge caution. We support a vast majority of the VDBC's recommendations because they are well-researched, carefully planned suggestions with the potential of improving what is already a good system.

Once again, however, we urge Congress to resist hastily laid plans designed to do more undoing than doing or else the next battle we will fight will be the one against unintended consequences.

Mr. Chairman, thank you for inviting the DAV to testify today. I will be happy to answer any of your questions.

[The prepared statement of Mr. Baker appears on p. 93.]

Mr. HALL. Thank you, Mr. Baker.

Mr. Manar, you are now recognized.

STATEMENT OF GERALD T. MANAR

Mr. MANAR. Thank you. Chairman Hall, thank you for this opportunity to present the views of the 2.3 million veterans and auxiliaries of the Veterans of Foreign Wars of the United States on the state of the VA's schedule for rating disabilities.

Today I am going to talk about the rating schedule, individual unemployability, and presumptions. We address other topics in our testimony, and we hope that you have an opportunity to review it.

We have heard today about the history of the development of the rating schedule. I think it was you yourself who mentioned that there was a rating schedule that was created in 1917. Certainly there was one in 1921, 1925, 1933, and 1945.

The interesting thing about the 1925 rating schedule is that it attempted to do what one of your earlier witnesses advocates and that is to tailor individual evaluations based on the profession or the occupation of the individual veteran.

While it is a laudable goal, it is in our view, unworkable. Certainly the VA found that it was, in fact, unworkable and they reverted to an earlier scheme in 1933.

The VA has, as my colleague here from the DAV has said, continuously updated bits and pieces of the rating schedule since 1945. They have not ignored it.

The problem is that as time has passed, they have been able to, in our view, devote fewer and fewer resources to it. And as a consequence, the changes have flowed less frequently.

And, in fact, as they have made changes, they have incorporated some problems into the rating schedule that might have been avoided had they been able to devote more resources and more experts to the process.

Now, the Institute of Medicine, the Dole-Shalala Commission and the Veterans' Disability Benefits Commission all found that the rating schedule is filled with terminology that is archaic, had criteria for evaluating disabilities that needs to be refined. Medical knowledge has advanced to the point where much of the rating schedule needs to be rearranged and reformed.

Everybody has an alternative approach to doing this. Under Dole-Shalala, they would simply throw it out and start fresh. In our view, their proposals would have a new rating schedule in a very short period of time, formulated in a back room of a bureaucracy, reviewed and modified by the Office of Management and Budget, and then presented to the world for their consideration.

If left alone, the VA also will continue reviewing and fixing bits and pieces of the rating schedule. But they are doing so with the resources that they have at hand. So we will get what we have already got in that respect.

The Veterans' Disability Benefits Commission, on the other hand, has made recommendations that build on those from the Institute of Medicine. It is the only plan to create a process for the logical, methodical, measured review in updating of the rating schedule.

We do not agree with everything the Institute of Medicine recommended, but we do support their structured approach. They have presented a blueprint for change. They advocate the creation of an Advisory Committee, which would be staffed with experts in

medical care, disability evaluation, functional and vocational assessment and rehabilitation, representatives from health, health policy, disability law, and from the veterans community.

Our view of its function is somewhat different from what the Veterans' Disability Benefits Commission and the Institute of Medicine have recommended. We think this Committee should perhaps look at, as an example, the Defense Health Board and see how that has worked for the Defense Department.

We think that this Advisory Committee needs to be separately funded and not directly under the Compensation and Pension Service. We expect that it would meet several times a year and work in the open. We view this as very important. And it would provide guidance and direction to the VA. We expect that it would make changes based on data and research.

In our view, individual unemployability is not broken. You have heard testimony earlier today from the Center for Naval Analysis that the increase in the grants of individual unemployability over the last 10 years is almost certainly related to defects or problems with the rating schedule rather than any other single individual cause.

Understanding why there is something like individual unemployability is very important. The rating schedule is very mechanical. If you can only raise your arm to your shoulder level, you get a certain evaluation. If you can only raise it to your waist level, you get a higher evaluation. It is very uniform.

The regulations allowing the grant of individual unemployability allows the VA in this one instance to exercise flexibility to address the inequities in the rating schedule and differences among individuals. It allows the rating specialists to look at education, vocational skills, job history, and experiences of the individual.

If the VA grants individual unemployability for certain conditions more than others, it may be an indication that the rating criteria is not appropriate and should be changed.

[The prepared statement of Mr. Manar appears on p. 100.]

Mr. HALL. Thank you, Mr. Manar.

Mr. MANAR. Thank you.

Mr. HALL. Thank you all.

Mr. Stoline, your comment that 48 percent of Operation Iraqi Freedom/Operation Enduring Freedom soldiers are active duty and the remainder Guard and Reserve is a striking one.

One of our earlier hearings, we had a witness testify that we should approach this—well, he was specifically talking about educational benefits, but I believe he would say the same for disabilities or for medical benefits. Same service, same battlefield, same benefits.

And in this case, it is just a reminder to me that we are using our Guard and Reserve today in a way that perhaps they have historically not been used.

And also your comment about, I was not sure if you said it was turning into a system soldier fight or if we want——

Mr. STOLINE. Citizen soldiers fight because the Reserve——

Mr. HALL. Citizen. Excuse me. I heard you wrong. Citizen soldiers fight, right.

Mr. STOLINE. I think the Nation looks upon what they see on the news as the active duty of the President's force. But when you look at the statistics, which are VA statistics, not American Legion, you rapidly see it is the folks who are the part-time soldiers who are paying the price and not the price just on the battlefield but the price after the war because when they get back to the VA, the VA is not able to understand. Even though the health problems are the same, they do not think because it is a Reservist they suffered it under active-duty conditions and it is just a real struggle.

And that is why in my testimony I said it is a DoD as well as a VA problem. They have to have the proper documentation, especially that end-of-service documentation. Otherwise, citizen-soldiers just lose out with the VA. And a rating schedule, no matter how good, will not change that.

Mr. HALL. Okay. All right. Thank you for clearing that up for me.

Timeliness issues seem to be a priority concern with the veterans I have spoken with, especially older veterans who have waited years for decisions and younger veterans who are just now leaving the military and do not have months of financial reserves to fall back on while waiting for VA to rate a claim.

Would it not be better to get these veterans paid in 45 days as opposed to months or years later?

Mr. STOLINE. Is that to me?

Mr. HALL. Yes.

Mr. STOLINE. Yes. I would think it would be. We understand the nature that VA has to protect the public, but the law is quite clear that it is to be liberally applied and the veteran should get the benefit of the doubt.

And I think there is ample opportunity for the VA to relook back at the record after they have made a decision because it is in the law that they can rectify a decision that was erred too much to the side of the veteran. But as you see, most of the time, it errs too much to the side of the government.

Mr. HALL. As CNA studied and found, but most of us believe to be true, that the veterans are not massively trying to rip off the government. And I think that most people would expect that to be the case.

What I hear from my constituents and people I meet around the country and especially in these hearing rooms is that we should be presuming more on the side of the veteran and not asking them to clear a high bar or jump through hoops.

You have expressed concern in your testimony over the presumption standard proposed by the IOM and the VDBC. After hearing your testimony today that explains the need to create a model to develop better scientific and medical data, do you not think it would be in the best interest of veterans to know more about the environmental and occupational hazards that they are exposed to during military service and could that not also mean better treatment and recovery? And I would also like to hear DAV and VFW's thoughts on this subject.

Mr. STOLINE. Well, mine, of course, we talked about and used the Gulf War as an example is that the military does not keep proper

records. How are you ever going to be able to scientifically study what the exposures were? And I think that speaks for itself.

Mr. BAKER. I can probably add a little bit to what Mr. Stoline said. I mean, I cannot speak to the military's recordkeeping process as far as the Gulf War is concerned. I am sure it could have been better. But they do have records of what they know was there.

I was there extensively. They know the things in the atmosphere as far as oils and some of the chemicals and some of the biological agents. But they still have not been able to point a finger of any of those things to any particular symptom from any of the veterans that have been sick after they returned from the Gulf War.

And that is why I think if you try to structure the presumptions around some of the ways that the IOM suggested, you are never going to get to that answer. The same thing applies to Vietnam veterans with dioxin exposure. A statistical relationship is all that has ever been shown.

I believe one of the gentlemen mentioned you would give the presumption at least when it is 50 percent or more that a specific condition is related to a specific exposure, whatever it may be. But if you cannot prove one way or the other, I do not see how you get past that 50 percent. If it is inconclusive results, it is inconclusive results.

But if you know that 80 percent of the veteran population that were exposed as opposed to 80 percent that were unexposed are getting sick, well, then I think you have to rely on that statistical information if you have no other route to go down.

Mr. HALL. Mr. Manar.

Mr. MANAR. Both my colleagues have pointed out first the real difficulty is in gathering data on a battlefield or in every-day occupations. You can imagine somebody at an airfield being exposed to gasoline fumes, toxic chemicals of all kinds and perhaps not even know it.

It would probably be an overwhelming task for the military to accumulate data on every possible exposure. So knowing that it is impossible, I think the law has to take into account that we have to know that there are some things we are not going to know fully or we might not know for many years to come.

So that is why, of course, there are presumptions and that is why we oppose any proposal that would raise the bar, whether it is legal or scientific, to ensure that veterans receive healthcare and compensation.

We believe that the current standard of association is appropriately high enough and to make veterans wait years, perhaps even die while they are waiting for science to catch up with and make a decision as to whether there is a causation between something that occurred in service and a current disability is too high.

Mr. HALL. Thank you.

Mr. Manar, in your testimony, you stated that Compensation and Pension Service has fewer than 140 people. However, VA reports that its C&P direct labor full-time equivalent (FTE) for 2008 is about 10,304.

Are you suggesting that more of the FTE be directed to the Central Office rather than in the field?

Mr. MANAR. You direct more people in the Central Office, fewer claims get rated or processed. But at the same time, this is a $30 billion plus program or set of programs and VA needs to dedicate adequate resources to administer it.

As I mentioned earlier, the rating schedule has slowly eroded or fallen into disrepair because not enough resources were allocated to keeping it up to date and keeping it current. Had the VA done so, many of the problems that veterans face today would not exist.

So I think that, yes, there should be more people in Central Office. As difficult as it is to recruit and find qualified people to come to Washington, a high-cost area, they need to make the effort because this is too important to let go on as it has in the past.

Mr. HALL. Thank you.

And just one more question to Mr. Baker. I understand that DAV is cautious in changing the way VA does business since there are components of the process that do work. I thank you for your extensive review of rating schedule revisions.

But as staunch veterans' advocates, you must see that the system the way it is needs serious repair and cannot continue to rely on antiquated medical concepts, outdated tools, and ineffective business practices.

Has the DAV explored how to improve the system beyond resources and training which we have heard? What else would you suggest to make this a better rating system for disabled veterans?

Mr. BAKER. We only give the impression that we are against updating the rating schedule. We are certainly not. Anything that is outdated, we support 100-percent updating that.

What we are opposed to is recreating the system. The system that VA works within is very good. And over the years, if you look at the 1945 schedule and the 1945 system and compared it to today, you would find a lot of holes that veterans can fall through in the 1945 system that have been accounted for now. And if you recreate that, you are going to recreate those holes and I think you are going to recreate some problems.

We all in DAV have some ideas about some large policy changes, maybe some small policy changes that we think could make some very good improvements in the system. I would suggest looking at all aspects from the top down or bottom up, however you wanted to start, looking at practices of the Court of Appeals for Veterans Claims. There are issues there that could be very cost effective, that could be changed, that would support the court more, the veteran more, and help the VA more.

The same thing with the Board of Veterans Appeals. Same thing with developmental procedures at the Regional Offices.

Everybody is looking at IT technology. I think it is important to focus that IT technology in the right place. What is taking the longest in developing these claims? Well, the development is. It is not the rating decision. So focus the IT technology to the development process. That is currently taking the longest time. It is about 90 percent of the whole timeframe to decide a case.

Once a case is ready to rate, it is not taking that long. You can develop an automated system for rating once you focus on the larger problem.

There are other smaller things, changes in small regulations or maybe statutes that, you know, I would be happy to submit for the record in writing so I can give you a little bit more detailed answer without getting into the weeds too much here.

But we are certainly not opposed, you know, to updating anything. We want to see the updates. We just do not want to recreate the system that has served veterans pretty good for a very long time.

Mr. HALL. Thank you very much, sir.

Thank you all for your service to our country and to our veterans. Thank you for your patience. Thank you for your testimony this afternoon, and you are now excused.

And changing of the guard, we will ask our fourth panel to join us, Brad Mayes, the Director for Compensation and Pension Service of the Veterans Benefits Administration, U.S. Department of Veterans Affairs; accompanied by Tom Pamprin, Deputy Director for Policy, Compensation and Pension Service, Veterans Benefits Administration; Steven H. Brown, M.D., M.S., Director for Compensation and Pension Exam Program, the Veterans Health Administration; Patrick Joyce, M.D., Chief Occupational Health Clinic, Veterans Health Administration; Richard Hipolit, Assistant General Counsel for Department of Veterans Affairs; Joseph Kelley, M.D., Deputy Assistant Secretary of Defense for Clinical and Program Policy, U.S. Department of Defense; and Horace Carson, M.D., Senior Medical Advisor, Air Force Review Boards Agency, Department of Defense. Thank you all for being with us. Thank you for your patience also. This has been a long afternoon. Somehow it always turns out that way.

And, Director Mayes, your statement is in the record, as you submitted it, and you are given 5 minutes to address us however you choose.

STATEMENTS BRADLEY G. MAYES, DIRECTOR, COMPENSATION AND PENSION SERVICE, VETERANS BENEFITS ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY TOM PAMPRIN, DEPUTY DIRECTOR FOR POLICY, COMPENSATION AND PENSION SERVICE, VETERANS BENEFITS ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; STEVEN H. BROWN, M.D., M.S., DIRECTOR, COMPENSATION AND PENSION EXAMINATION PROGRAM, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; PATRICK JOYCE, M.D., CHIEF, OCCUPATIONAL HEALTH CLINIC, AND CHIEF PHYSICIAN, COMPENSATION AND PENSION PROGRAM, WASHINGTON, DC, VETERANS AFFAIRS MEDICAL CENTER, VETERANS HEALTH ADMINISTRATION U.S. DEPARTMENT OF VETERANS AFFAIRS; RICHARD HIPOLIT, ASSISTANT GENERAL COUNSEL, OFFICE OF GENERAL COUNSEL, U.S. DEPARTMENT OF VETERANS AFFAIRS; AND MAJOR GENERAL JOSEPH E. KELLEY, M.D., USAF (RET.), DEPUTY ASSISTANT SECRETARY OF DEFENSE FOR CLINICAL AND PROGRAM POLICY (HEALTH AFFAIRS), U.S. DEPARTMENT OF DEFENSE; ACCOMPANIED BY HORACE CARSON, M.D., SENIOR MEDICAL ADVISOR, AIR FORCE REVIEW BOARDS AGENCY, U.S. DEPARTMENT OF DEFENSE

STATEMENT OF BRADLEY G. MAYES

Mr. MAYES. Thank you. Mr. Chairman, Mr. Rodriguez, I am pleased to appear before you today to speak on the subject of revising the Department of Veterans Affairs VA schedule for rating disabilities.

As you noted, I am accompanied by Dr. Patrick Joyce, Chief of the Occupational Health Clinic and Chief Physician, Compensation and Pension Program at the Washington, DC, VA Medical Center; Dr. Steven Brown, Director of the Compensation and Pension Examination Program Office, Veterans Health Administration; Mr. Tom Pamperin, Deputy Director for Policy, Compensation and Pension Service; and Mr. Richard Hipoli, VA Office of General Counsel.

I would like to briefly highlight some points made in my written statement, which was submitted for the record. Before I begin, however, Mr. Chairman, I want to apologize for getting the statement to the Committee so late.

We spent a great deal of time preparing for this hearing, to include my statement, because we know this subject is of such great importance. I regret, however, that you may not have had sufficient time to review what was submitted for the record and I hope that you have an opportunity to do so. I described, in some detail, the history of VA's rating schedule and how we got where we are today, much of which we have heard from the previous panels.

With that, let me say that the VA rating schedule has truly evolved over time and continues to evolve. It has served literally millions of veterans throughout much of this Nation's great history.

There are some fundamental underpinnings to VA's disability compensation program that bear mentioning. First, it is a system designed to compensate disabled veterans for lost earnings capacity.

The system is modeled after workmen's compensation programs developed at the turn of the 20th century and still in use by society today.

The system is based on the "average man" concept so that individuals are not penalized because they may be able to overcome their disability.

And, finally, the system generally relies on degree of anatomic loss and functional loss to approximate those lost earnings, with the exception of mental disorders where there is consideration of social and economic impacts.

Fundamentally, I believe we need to ask two questions. Does the VA rating schedule meet Congress' mandate to compensate veterans for reductions in earning capacity from specific injuries or combinations of injuries and should that mandate be expanded to include compensation for loss in quality of life due to injury or disease in service?

The second part of the question is a broader public policy question that requires study and that is exactly what this administration initiated in recent proposed legislation sent to Congress this past October.

Title 2 of the President's draft bill, "America's Wounded Warriors Act," would require VA to complete a study regarding creation of a schedule for rating disabilities based upon current concepts of medicine and disability, taking into account loss of quality of life and loss of earnings resulting from specific injuries.

VA entered into a contract on January 25th of this year for a study to analyze the nature of specific injuries and diseases for which disability compensation is payable under various disability programs of Federal and State Governments, including VA's own program, and those of other countries.

The study will examine specific approaches and the usefulness of currently available instruments for measuring disabilities' effects on an individual's psychological state, loss of physical integrity, and social inadaptability to include the impact on quality of life. We expect that study will be completed by August of 2008.

Finally, in my written statement, I outline a five-point plan to update the schedule and address various suggestions made by recent commissions and studies. The elements of the plan include the above-mentioned contract for a study, aggressive staff development and possible utilization of further contractor support, continued revisions to the schedule that are already underway, (we recently published a new regulation for evaluation of traumatic brain injury and we are reviewing the mental disorders portion of the rating schedule currently) development of a periodic review process to ascertain the effectiveness of the schedule, and, finally, evaluation of a possible quality of life component to VA's disability compensation scheme.

Mr. Chairman, this concludes my prepared remarks. I and others on the panel would be pleased to answer any questions you and Members of the Subcommittee might have.

[The prepared statement of Mr. Mayes appears on p. 104.]

Mr. HALL. Thank you.

Dr. Kelley, you are recognized for 5 minutes.

STATEMENT OF MAJOR GENERAL JOSEPH E. KELLEY, M.D., USAF (RET.)

Dr. KELLEY. Thank you, Mr. Chairman.

Due to the time constraints, I have submitted a statement and I will summarize the major points of that. And hopefully we will have more time for questions then.

The Administration has made significant efforts to improve the treatment of active-duty servicemembers and veterans. And they have commissioned independent review groups, task forces, Presidential Commissions, and this has culminated in the formation of a Senior Oversight Committee (SOC) chaired by the Deputy Secretary of Defense and the Deputy Secretary of the Department of Veterans Affairs. This has resulted in significant progress in DoD and VA cooperation.

When DoD looks at the issues for the goals for a disability system, they would like to have a fair, consistent, timely, and accurate adjudication of the disabilities which maximizes or incentivizes rehabilitation.

And the components of those that I think we have heard discussed is that it be scientifically based or evidence based, up to date and rapidly modifiable to meet new developments, new types of injuries, illnesses, medical treatments, consistent nomenclature, and that the DoD would have the ability to input when changes are needed in that system.

Recently, there has been great success in that as we have looked at the newly formed and revised standards for traumatic brain injury and burns, which were published in the Federal Register in January of this year. We would like to see that process formalized or institutionalized so that DoD would be involved in the revision of any of those standards as they went forward.

And I would like to also mention the pilot program in the National Capital region where there is an effort to have a single discharge disability evaluation where the DoD is concentrating on determining fitness for duty and all disability ratings are being done by the VA so there is not an inconsistency between the departments.

And that so far has gone well, but we do not have any conclusions from that study which is in progress right now. And we look forward to that and potentially promulgating that throughout the entire system.

Sir, thank you for the opportunity to make a statement and appreciate your comments.

[The prepared statement of Dr. Kelley appears on p. 108.]

Mr. HALL. Thank you, Dr. Kelley.

This is a little bit off topic, but since I have both Dr. Kelley and Mr. Mayes here, I wanted to ask you if you are consistent with nomenclature and the electronic transition or transfer of records that we all want to see happen.

I heard in Landstuhl from the Commander of the hospital there in October that he thought it was going to start happening in December, where the onion, as he described it of electronic information coming back with each wounded service man or woman from the field of battle, which would have added to it a layer in Balad, and again in the plane on the way to Germany, and again in Ger-

many and the Landstuhl Medical Center, and then, every step of the way, there would be the medication, the treatment, the surgeries, whatever, starting with the diagnosis and any continued additions or changes in the diagnosis or diagnoses and then again on the plane back to the States to Walter Reed or Bethesda or whichever DoD facility they were in and the entire onion would then be able to be handed off to the VA.

And when Deputy Under Secretary Walcoff was with us last week, I asked him if he knew how close we were to that happening and he was not able to say, but I wondered if you could give us any update, based on your knowledge as to how close we are. We are not talking about a rating schedule here as much as we are IT, but the compatibility of technology between the two departments. How close are we?

Dr. KELLEY. Sir, if I could make a comment, I would like to take that and give you a more detailed answer later.

But just a summary statement is that we do have what we call the Joint Patient Tracking Application which goes through the system. It captures that data that you were talking about from the far forward front, bringing it back in the system. And it is not visible at all VA facilities at this time, but it is visible at the VA facilities where there are major treatment centers. And we plan to expand that broader to encompass the entire system so that those who have the need to know have that.

So it is partially in place, what you describe, but it is not completely available. And that goes along with increasing cooperation. We are developing a common methodology for our next generation of electronic medical records.

Mr. HALL. Just do not call it Next Gen, okay? We will get confused.

Dr. KELLEY. And so we are making progress and it is going on and it is becoming present at more and more facilities as we go on.

Mr. HALL. That is good to hear. Thank you.

And please update us as it progresses because it is something the Subcommittee and the full Committee are very interested in, and concerned with.

Director Mayes, you said that the revision of the rating schedule has actually been underway since the nineties, which seems like a long time to get this done. Realizing, of course, that as the battle changes and the weapons change and the circumstances change that, maybe it will never be done, but it seems you are still working on recommendations, some recommendations anyway, from 1956 and ones that never materialized in 1971.

Have you been doing one code at a time or why does it appear this way? Would it not be better accomplished by an established editorial panel that constantly updates the Codes?

Mr. MAYES. Mr. Chairman, I think you are right on point. We agree with the Institute of Medicine and with the Disability Benefits Commission, there has to be an ongoing systematic approach to revising the schedule. You really are never going to finish because medical science advances.

We have gone through 12 of the 15 body systems. We take it a body system at a time. That has been our approach. We begin looking at that body system which will have multiple diagnostic codes

and we begin reviewing the criteria looking for obsolete codes or obsolete evaluation criteria, engaging our partners in the Veterans Health Administration, and then we propose changes similar to what we did recently with the traumatic brain injury revisions to the schedule. They are published for notice and comment so that our stakeholders have an opportunity to weigh in. And we got lots of comments on the proposed TBI regs and we are in the process of assimilating those comments.

So, I agree. One of the elements of my five-point plan is to put in place this regular schedule so that it is continuous. And we are building the capacity to be able to do that.

Mr. HALL. That is very encouraging and I commend you for that.

It seems that the private sector relies on some codes and guides that work well for them that are simpler than the VA's rating schedule. I am just curious if you had the observation and if you considered adopting what is already in existence in terms of disability ratings in the private schedule as opposed to going through this process of what some would call reinventing the wheel.

Would it take a shorter time to revise the rating schedule if we did that?

Mr. MAYES. A couple of comments on that. I guess one could argue the VA has been revising that schedule since 1917, you know, in reality. I would say that we are interested in hearing what the American Medical Association has to say, as well as the World Health Organization.

As a matter of fact, next week, we are meeting with Dr. Rondinelli to discuss their compensation scheme. We are open to considering other alternatives.

I would say, though, I was struck by Dr. Bristow's comment regarding the International Classification of Disease system. I think he mentioned 14,000 to 17,000 codes. The VA rating schedule right now has in excess of 700 codes.

Mr. HALL. They should adopt your schedule then.

Mr. MAYES. Yes, sir. I do not know that we want to get more complex. What we want to do is make sure that we have a system that accurately compensates veterans for earnings loss and quality of life if that becomes the mandate.

And I believe that there is the possibility to cross walk that system with the International Classification of Disease system which, as I understand it, was primarily set up for identifying diseases and for billing purposes.

We are trying to come up with a system and particular codes that will provide for evaluation criteria to compensate veterans. I think that makes it a little bit different than the ICD scheme.

Mr. HALL. Right. I would also assume that the World Health Organization and other organizations have to consider some genetic syndromes and diseases that, may not be something that would be service related. They could be if you happened to be serving in an area where a rare pathogen was at work, but that some of them could be ruled out.

I wanted to ask you, does VHA already evaluate veterans for their quality of life? Is that not what the SF36 scale is designed to indicate?

Mr. MAYES. I am aware of that standard form and I do believe that they administer that, but I personally am not familiar with how frequently or who they administer that instrument to.

Mr. HALL. Can you explain why according to the VDBC report so many veterans with PTSD are rated with IU instead of a 100-percent schedule rating?

Mr. MAYES. I cannot unequivocally explain that, although I would take the opportunity to echo what some of the previous panel members from the Veteran Service Organizations said.

The IU benefit was created in 1934, and it was set up to provide VA with the ability to compensate a veteran for an unusual disability picture that the schedule may not have been able to deal with when that disability precluded employment. And that was the purpose of the IU benefit.

I would agree with some of the previous panel members. It may be that we have a higher percentage of PTSD recipients who are having difficulty securing and maintaining gainful employment. Therefore, we have exercised that discretion and granted the IU benefit. And that is precisely why we are beginning to tackle the mental disabilities portion of the rating schedule.

Mr. HALL. In 2006, VA agreed with the GAO recommendation to establish procedures for rating specialists to request Vocational Rehabilitation and Employment to conduct vocational assessments of IU claimants "as appropriate." But VA has never acted on its concurrence.

Why is this?

Mr. MAYES. The purposes of the vocational rehabilitation program is to assimilate veterans back into the work force. The vocational rehabilitation assessment was designed to assist our voc rehab employees with developing a rehabilitation plan. And the whole construct for that program was to evaluate and to try to transition those servicemembers or veterans back into the workforce.

I do not have a short answer for you. I think that we talked about it. I do not believe we were resourced. I do not want to say that we were not resourced. But our distribution of resources would have been challenging because we had never done that for IU. The decision was made to continue on that path.

Tom, do you want to add to that? I know you were here during those discussions.

Mr. PAMPERIN. Yes, sir. We looked at it extensively. And I think there is value in looking at the potential for rehabilitation when considering individual unemployability.

There are, however, a couple of immediate barriers that have to be confronted. This would require a vocational assessment for everyone who claimed individual unemployability or whose disability picture was such that it reasonably raised IU as an issue.

And when we were looking at the numbers, this is in excess of 80,000 people a year who would have to be assessed through vocational rehabilitation. And whether or not we are positioned to deal with that level of workload and still deliver rehabilitation services to people who want them is a real challenge.

There is also the question as to whether or not legally that could be done without legislation.

Mr. HALL. Thank you.

Mr. Mayes, you were asked to discuss presumption in your testimony today, but you only mentioned it as it was applied in 1921 for tuberculosis.

Is there a further VA response to the recent IOM report on presumptive disability decisionmaking?

Mr. MAYES. We are still evaluating the IOM study. I do not have a formal position regarding their recommendations at this point, although I would say that it seems that the causation standard would be a high standard.

Mr. HALL. Maybe you could send us a message when you come to a further conclusion.

I keep hearing that there are three simple things needed to establish service connection, the diagnosis, eligible military service, and a nexus between the two.

Can you explain the overwhelming need for evidence? How much evidence is enough and why does VA require so much documentation from a veteran?

Mr. MAYES. Ultimately I believe that we want to make sure that we collect all of the evidence that is available so that we render an accurate decision and a decision that favors the veteran to the extent possible.

Further, we do have certain statutory requirements, a duty to assist, a duty to notify. Those requirements are very specific that we must attempt to obtain any and all evidence that is referenced by the claimant.

Those records that are in our constructive custody, we must obtain those unless the custodian of those records tell us that they do not exist. That truly is a statutory requirement, and we want to help the veteran.

Mr. HALL. Thank you.

Dr. Kelley, you mentioned that since National Defense Authorization Act of 2008 (NDAA) and the creation of the Senior Oversight Committee (SOC), many of the issues between the two departments on the application and revisions of the VASRD are now being worked in a collaborative and productive manner, unquote.

Can you tell me what those applications and revisions are and how did you communicate your input on the VASRD prior to the SOC?

Dr. KELLEY. Let me let Dr. Carson answer that first.

Mr. HALL. Sure.

Dr. CARSON. Mr. Chairman, thank you for the opportunity.

My current role as an appellate review physician at our Air Force Review Boards Agency, I am prefacing my remarks with this statement so that you will understand a bit about how we communicate with our sister services and the VA.

We have established communication that is via the Disability Advisory Council, which is a Department of Defense Committee, where there is cross talk, communication, discussion on issues. It is also attended by a Department of Veterans Affairs representative. So that forum has been and will be a principal entity for the type of communication that you are referring to.

I will say that as recent as this past Friday, the Department of Veterans Affairs and the Air Force Personnel Center at Randolph

Air Force Base initiated an initial conference call to discuss variances in methodologies in ratings.

Also, the Department of Veterans Affairs has offered training as soon as March of this year and April of this year designed to train our adjudicators on VA methodologies.

Additionally, the NDAA 2008 has been reviewed top to bottom and all disability-related matters have been looked at carefully. And we are in the process as of the execution date of that Act in looking at applications and our current policy under Department of Defense instruction 1332.39, which is our principal document that we use along with the VASRD in rating disabilities.

And we are identifying those areas that we are now prohibited from utilizing in rating disabilities that may result in a reduction or a deduction or a rating less than the VA absent the existence of this policy.

This is ongoing. And as of even yesterday, we received at our agency an initial inventory of records that have recently been adjudicated so that immediate disability rating corrections, or adjustments, may be made as necessary, in the context of current law; specifically, the NDAA that become effective on January 28, 2008.

[The following information was subsequently received:]

> The specific implementation methods for services to review ALL cases previously rated at "less than 30 percent dating to "9/11," is still in the planning phase. This item will be followed-up to assure it is addressed at the next Disability Advisory Council meeting.

Dr. CARSON. I will pause at this point and allow Dr. Kelley to speak.

Dr. KELLEY. Yes, sir. So I think Dr. Carson mentioned that we are having the combined training. Each of the services will have their senior physician that does the disability processes going to that training in April. And there are some on the personnel side that are also going to that training in April.

Dr. Carson mentioned the Disability Advisory Council. There is also a review in the H–E-C, which we call the HEC, which is the Health Executive Council. That is chaired by the Assistant Secretaries for Health on both sides, as well as the JEC, which is the Joint Executive Council, which reviews both the health and the personnel issues. And that is at the Under Secretary that is chaired.

And then the example that I cited in my summary where we have had a working group that worked extensively with the VA on the TBI and the burn revisions that were just published. And so that is moving forward.

Mr. HALL. Well, that is encouraging. If you guys keep working together like that, we might not have anything to do.

Mr. PAMPERIN. Sir, could I add something?

Mr. HALL. Yes.

Mr. PAMPERIN. Because I, like Dr. Carson, am on the Disability Advisory Council. Based upon the conversations we had at the last session, DoD did submit to us concerns or issues or recommendations on about four items in the rating schedule that we took under advisement and provided them with a response to. I believe it was last week.

Mr. HALL. Thank you.

And if you could keep the Committee in the loop or the Subcommittee because you are a little bit of a moving target. We are trying to figure out what to do or what we might need to do or what would be helpful for us to do legislatively.

And I am happy to hear that these working groups and conversations and cross talk is going on because we all think that it is essential certainly to the accuracy and the timeliness of the ratings and the provision of benefits to the veterans who deserve them.

And, Dr. Kelley, the Veterans' Disability Benefits Commission found in their study that there were variances in the way DoD rates disabilities and compares them to the way VA does them. As you probably know, VA has also had its own issues with variances between raters and Regional Offices.

What steps beside the training that you mentioned would you recommend to gain more consistency in rating disabled veterans regardless of where or who did the rating?

Dr. KELLEY. Well, I think that the training is important as a first step. I think that there needs to be a greater understanding of the exact nature of why those differences occur which we need to discuss and adjust so that we understand so that there are some—we have heard several other panel members talk about how a specific illness or injury could affect different people depending on their occupation differently.

And the DoD when they do a fitness for duty, they determine a fitness to work in the particular job. It is not a general fitness for duty. And so because of that and the VA is doing a general and total evaluation, there are some differences.

I think that we need to have the common nomenclature so that we are all talking the same way, and that, again, has been mentioned earlier, so that we can interpret the rating systems in the same way on both sides.

Mr. HALL. You mentioned that in your oral testimony, "consistent nomenclature." I think that would be a helpful step among other things in terms of getting closer to a system that could do a substantial number of ratings electronically with artificial intelligence.

You mentioned the Disability Advisory Committee. When did that group start interacting with the VA and do they or are you discussing the rating schedule as part of those discussions? What would make the rating schedule a better tool from DoD's standpoint besides consistent nomenclature?

Dr. KELLEY. I will get back to you on when the VA actually started working in the Disability Advisory Committee.

Mr. HALL. Dr. Carson.

Dr. CARSON. I can assure you that since my entry into the system in 1998, I know you have a decade of it at least, and I am sure it is many, many years before that.

Mr. HALL. Good.

From your statement, Dr. Kelley, it sounds as if DoD is already preparing to implement the findings of the disability evaluation system pilot that is ongoing with VA.

What steps are being taken to prepare for this transition to a single system for evaluating disabilities?

Dr. KELLEY. We are looking forward to doing that and we are not prepared to do that right now. So we do not have a complete strategic plan of how we will do that because we are waiting for some of the results or the results of the lessons learned from that pilot.

We are working with the VA. We have issues to work out on the resources that are going to be required, who is going to do the exams. There are certain locations. For example, having the VA do the exams would work, but there are no VA facilities overseas.

And so we have to work out those details of the specific cases. Some places we have bases and there is only clinics that do not have the VA capability of providing many services. Other places the VA has much better facilities than the military does.

And so we think that it is probably going to require a mapping process for each specific site and then when we bring in the Reserves and the Guards, that is going to make that a much more difficult conclusion or solution for that. And so we have to work those out, but are looking for the lessons learned as we go along so that we can apply that.

Mr. HALL. Difficulty aside or taken into account, do you have a time frame in mind that you think this can be done in?

Dr. KELLEY. I do not, sir. I will get back to you if we have one.

Mr. HALL. Somewhere between 2 and 10 years?

Dr. KELLEY. Sir, we are looking in terms of short term rather than long term.

[Followup information from Dr. Kelly was supplied in the post-hearing questions and responses for the record, which appear on p. 138.]

Mr. HALL. We will all be grateful for that.

Last, I have a question from Ranking Member Lamborn to Mr. Mayes. Your testimony suggests that the revision of the rating schedule has been underway since the nineties.

I recently became aware of a case of a veteran who is completely deaf in one ear, yet he only receives the minimum level of compensation. I was unable to explain to him why the rates for hearing loss are at such a seemingly paltry level.

I understand that *The Independent Budget* has a longstanding resolution calling for a compensable rating for anyone with a hearing aid. It seems reasonable to me that the required use of a prosthetic device would easily warrant compensation, especially when one considers the high noise environment inherent to military service.

Has any consideration been given to revising the rates for hearing loss?

Mr. MAYES. Specifically, consideration has been given to compensation for veterans who are in need of a hearing aid. We have had those discussions in our policy shop and have contemplated moving forward with that.

As far as changing the diagnostic criteria for hearing loss, there is nothing currently in the works to change that diagnostic criteria.

Mr. HALL. What about for other prosthetic devices?Mr. MAYES. For other prosthetic devices?

Mr. HALL. Right. The question was specifically about hearing aids, but I would also ask the question about——

Mr. MAYES. Typically a veteran in need of prosthetic devices is going to have an amputation. There is already a compensation scheme in place for amputation. It is very detailed and lays out the criteria, whether it be, for example, a below-knee amputation, above-knee amputation, below the elbow, above the elbow, etc.

I am not sure that there is the difficulty or maybe the perception that I am hearing about the hearing loss——

Mr. HALL. It is more concrete and easily identified than hearing loss?

Mr. MAYES. Exactly. We hear this because veterans are service-connected because there is some impairment, but it is not at a level sufficient for us to pay disability compensation based on the evaluation criteria. VHA will issue them a hearing aid. We understand that and we have had discussions regarding that.

Mr. HALL. Thank you.

I want to thank you all very much for your testimony, for your dedication to our Nation's veterans, for your patience this afternoon waiting to be the fourth but greatest panel.

And we thank everyone for their interesting and informative statements this afternoon. We look forward to working with you on this very important topic and improving the VA claims process system.

This hearing now stands adjourned.

[Whereupon, at 6:20 p.m., the Subcommittee was adjourned.]

APPENDIX

Prepared Statement of the Honorable John J. Hall
Chairman, Subcommittee on Disability Assistance and Memorial Affairs

This is the third hearing this Subcommittee has held regarding VA's claims processing system. As we have discussed before, this system has not lived up to expectations and has left many disabled veterans without proper and timely compensation and other benefits.

At the heart of this system is the VA Schedule for Rating Disabilities (or VASRD). The Rating Schedule, as we know it today is divided into 14 body systems, which incorporate approximately 700 codes that describe illness or injury symptoms and levels of severity. Ratings range from 0 to 100 percent and are in increments of 10. This schedule was uniquely developed for use by VA, but the Defense Department has also mandated its use when the service branches conduct evaluation boards on servicemembers who are unfit for duty. Otherwise, it is not used by any other governmental agencies or private sector disability plans.

In its study, the Veterans' Disability Benefits Commission (VDBC) concluded that the VA Rating Schedule has not been comprehensively updated since 1945. Although sections of it have been modified, no overall review has been satisfactorily conducted leaving some parts of the schedule out of date, relying on arcane medical practices, and not in sync with modern disability concepts. The notion of a Rating Schedule was first crafted in 1917, so that returning World War I veterans could be cared for when they could no longer function in their pre-war occupations. At the time, the American economy was primarily agricultural based and labor intensive. Today's economy is different and the effects of disability are understood to be greater than the average loss of earning capacity. Many disability specialists agree that quality of life, functionality, and social adaptation are just as important. Our Nation's disabled veterans deserve to have a system that is based on the most available and relevant medical knowledge.

There are several issues pertaining to the Rating Schedule I hope to have us discuss today:

First would be the need to remove out-of-date and archaic criteria that is still part of the schedule for some conditions and replace them with current medical and psychiatric evaluation instruments for determining and understanding disabilities. The medical community relies on codes from the International Classification of Diseases and the Diagnostic and Statistical Manual of Mental Disorders. Should the VBA be relying on these and other AMA guides as well?

Individual Unemployability (IU) as a rating gives VA an alternative means by which to compensate veterans who cannot sustain gainful occupation, but might not otherwise be rated 100 percent. The Government Accountability Office found that the use of IU was ineffective and inefficient since it relies on old data, outdated criteria, and lacks guidance. The VDBC, IOM, and CNA also studied IU and expressed their concerns over how it is utilized instead of scheduled ratings. I look forward to hearing more from them today.

The criteria for psychiatric disabilities, especially for Post Traumatic Stress Disorder (PTSD) are in dire need of expansion. The current Rating Schedule has only one schedule for all of mental health, which is based on the Global Assessment of Functioning Scale (GAF). The IOM noted that one of the many problems with GAF is that it was developed for Schizophrenia, therefore not as accurate for other disorders and recommended that VA replace it as a diagnostic tool. I am especially concerned about this issue and how it pertains to PTSD and other mental disorders.

The VDBC also recommended that traumatic brain injury (TBI) be a priority area of concentration, and for VA to improve the neurological criteria for TBI, which has become one of the signature injuries of this war.

I know there has been much discussion on how to compensate veterans for their quality of life losses. Both the VDBC and the Dole/Shalala Reports recommended that this be a new category added to the Rating Schedule in some fashion. But, they

did not necessarily agree or provide clear guidance on how to do this or whether the current system does so implicitly. So, next steps are still needed.

Presumptions have had a major impact on VA compensation over the last few decades for conditions related to Ionizing Radiation, Agent Orange and the Gulf War. The IOM therefore engaged in a lengthy study for the VDBC on presumptions and recommended that there be evidence-based criteria, which could impact the Rating Schedule. I commend Secretary Peake for changing the regulation on PTSD, but we also might want to add a presumption that combat zone service is a stressor when evaluating PTSD.

I look forward to the testimony today on these complex Rating Schedule issues. I know there is a lot to be done to improve the VA claims processing system, but with the Rating Schedule at the core of the process, it seems that the centerpiece is in need of immediate comprehensive repair, which I intend to advocate.

I look forward to working with Ranking Member Lamborn and the Members of this Subcommittee in providing oversight for the VA Schedule for Rating Disabilities. VA needs the right tools to do the right thing, so our Nation's disabled veterans get the right assistance.

Prepared Statement of Hon. Doug Lamborn
Ranking Republican Member

Thank you Mr. Chairman for yielding.

I look forward to hearing our witnesses' testimony and I am pleased to have this opportunity for a collective discussion on the Department of Veterans Affairs', Schedule for Rating Disabilities.

The VA Rating Schedule provides the basis for determining the level of compensation that is appropriate for veterans' disabilities.

It is a complex schedule that is unparalleled by any other disability benefits system.

The schedule is complex, because the human body is complex.

It may seem a paradox that the complexity of the rating schedule favors veterans, but this is due to the fact that each rating is as specific to individual injuries as possible.

The result is more than 700 diagnostic codes that pertain to each body system.

While the VA has made adjustments over the course of many decades, it is still obviously important that this Committee confer with VA and its stakeholders to ensure that the rating schedule is as accurate and up-to-date as possible.

Veterans must be assured that the compensation they receive for disabilities is based on information that is both credible and fair.

Recent Congressional and Administrative Commissions have questioned the validity of the rating schedule in as much as it is unclear how well quality-of-life and loss-of-earnings are taken into consideration.

Perhaps further study is needed to analyze these points, and also to look at the rating schedule from a contemporary perspective with regard to today's job market.

I want to make clear; the purpose in doing such a study is to ensure veterans are justly compensated for their sacrifices.

I have read the statements that have been submitted, and I understand veterans' service organizations have rightly expressed concern that the schedule should not be subject to arbitrary tampering.

I commend VSOs for their protective posture regarding veterans' disability compensation, and want to emphasize that their stance is precisely why we need them to be active participants in any effort to examine and update the schedule.

Mr. Chairman, I thank you for yielding, and I look forward to working with you on this issue in the favorable, bipartisan manner we have established on this Subcommittee.

I yield back.

Statement of Vice Admiral Dennis Vincent McGinn, USN (Ret.)
Member, Veterans' Disability Benefits Commission on behalf of
Lieutenant General James Terry Scott, USA (Ret.), Chairman

Chairman Hall, Ranking Member Lamborn, Members of the Committee, I am pleased to appear before you today on behalf of the Chairman of the Veterans' Dis-

ability Benefits, General Terry Scott, to discuss the findings, conclusions, and recommendations of the Commission related to revising the VA Rating Schedule.

The Commission was created by Public Law 108–136 and Commissioners were appointed by the President and the four leaders of Congress to study the benefits and services that are provided to compensate and assist veterans and their survivors for disabilities and deaths attributable to military service. Specifically, the Commission was tasked to examine and make recommendations concerning:

- The appropriateness of such benefits;
- The appropriateness of the level of such benefits; and
- The appropriate standards for determining whether a disability or death of a veteran should be compensated.

The Commission completed its work and submitted its report on October 3, 2007.

My statements today are my own and do not necessarily represent the views of the Commission.

For almost 2½ years, the Commission conducted an extensive and comprehensive examination of issues relating to veterans' disability benefits. This was the first time that the subject has been studied in depth by an independent body since the Bradley Commission in 1956. We identified 31 key issues for study. We made every effort to ensure that our analysis was evidence based and data driven, and we engaged two well-known organizations to provide medical expertise and analysis:

- the Institute of Medicine (IOM) of the National Academies, and
- the CNA Corp. (CNAC).

Both of those organizations are represented today at this hearing.

Of the many issues the Commission examined, one of the most important was determining the effectiveness of the VA Rating Schedule. You will be hearing from four panels today including Drs. Bristow, Kilpatrick, and Samet representing their IOM Committees, Dr. McMahon from CNAC, independent experts, veteran service organizations, and Admiral Cooper and Mr. Mayes representing the Department of Veterans Affairs. I will keep my remarks brief and focus on the conclusions and recommendations of our Commission relative to the Rating Schedule.

Our Commission is most appreciative of the outstanding work of the IOM Committees and CNAC. Our intent was to complete a data-driven and evidenced-based analysis of disability benefits and IOM and CNAC enabled us to do exactly that. We believe that their efforts were exceptionally complimentary of each other and that their results were remarkably consistent with each other. The Commission's report summarizes the analysis and recommendations of CNAC and the IOM Committees in some detail, however, the reports to the Commission are rich in detail, with extensive analysis, and each should be carefully reviewed.

I would like to highlight a few of their key findings that the Commission found especially helpful. For example, Dr Bristow's Committee emphasized that the Rating Schedule should achieve horizontal and vertical equity. Vertical equity means that VA ratings of severity of disability, assigned in 10 percent increments from 0 to 100 percent, should be accurately assigned so that those assigned more severe ratings should be those veterans whose disabilities impact their earnings more than those assigned less severe ratings. CNAC's comparison of the earnings of veterans who are not service disabled with service disabled veterans demonstrated that disability causes lower earnings and employment at all levels of severity and types of disabilities and that the earnings loss of the disabled increases as the percent rating increases. Thus VA ratings, using the Rating Schedule, are **generally** achieving vertical equity. Horizontal equity means that assigned ratings of severity should reflect average loss of earnings among the nearly 800 diagnostic codes and across the 16 body systems. CNAC's analysis **generally** confirmed horizontal equity as well. Overall, CNAC's analysis confirmed that the VA Rating Schedule, and VA's assignment of ratings using the Rating Schedule, results in compensation paid to veterans that is **generally** adequate to offset average impairment of earnings. Taken as a whole, the Rating Schedule is doing its job reasonably well. The detailed and comprehensive analysis demonstrated that even veterans with less severe ratings do, in fact, have loss of earnings.

However, the key word here is **generally**. CNAC's analysis also identified very pronounced disparities for some veteran cohorts in which vertical and horizontal equity are not being achieved. The amount of compensation is not sufficient to offset loss of earnings for three groups of veterans:

- those whose primary disability is post traumatic stress disorder (PTSD) or other mental disorders,
- those who are severely disabled at a young age, and

- those who are granted maximum benefits because their disabilities make them unemployable.

For these veterans, horizontal and vertical equity is not being achieved.

Those severely disabled at a young age have greater loss of earnings, especially over their remaining lives, since they did not have established civilian careers or transferable job skills and have more of their normal working years ahead of them. The analysis also clearly demonstrates that veterans with PTSD and other mental disorders experience much greater loss of employment and earnings than those with physical disabilities, particularly those more severely disabled. These disparities should be addressed by a careful but prompt revision to the Rating Schedule, leading to a more equitable level payment to disabled veterans in this severely disabled category.

Concerning PTSD and mental disorders, the reasons for insufficient compensation may lie partly in the criteria in the Rating Schedule itself, and partly in how the VA raters interpret or apply the criteria. The Rating Schedule was revised a few years ago to eliminate separate criteria for diagnoses such as PTSD and in order to have a single set of criteria for all 67 diagnoses contained in the body system known as mental disorders. The Commission asked the IOM to provide advice as to whether a single set of criteria is effective. IOM recommended that separate criteria should be established for PTSD and CNAC's survey of VA raters and VSO service officers found agreement with that advice.

Concerning the interpretation of the criteria by raters, the Commission learned that almost one half of 223,000 veterans granted Individual Unemployability (IU) as being unable to work due to their service-connected disabilities had primary diagnoses of PTSD (31 percent) or other mental disorders (16 percent.) To be granted IU, the veteran must be rated 60 to 90 percent disabled and also be found unable to work due to the service-connected disability. The criteria for all mental disorders require that the veteran be unable to work due to the disorder in order to be rated 100 percent. Yet, these veterans are not rated 100 percent. They are rated 70 percent and assigned IU status and paid at the 100-percent rate. The Commission did not understand why these veterans were not rated 100 percent according to the Rating Schedule. Our Commission recommended that as the Rating Schedule is revised, every effort should be made to reduce the need to rely on the IU category. That said, we agreed that in some cases, there will continue to be some need for the IU category.

The IOM reports on PTSD Diagnosis, PTSD Compensation, and PTSD Treatment together provide a solid analysis of this disability and the problems associated with diagnosis, examination, treatment, and compensation. The report on PTSD Treatment was completed after our report and, therefore, could not be reflected in our report. Our Commission considered the diagnosis and compensation Committee reports and they weighed heavily in our deliberations. Ultimately, we recommended a course of action for PTSD somewhat different from the IOM: a holistic approach that couples treatment, compensation, and vocational assessment along with reevaluation every 2–3 years to gauge treatment effectiveness and encourage wellness. We felt that veterans with PTSD would not be well served by simply providing compensation without continuing follow up and incentives to seek treatment.

Our Commission concluded that there has been an implied but unstated Congressional intent to compensate disabled veterans for impairment to quality of life due to their service-connected disabilities. Our conclusion was reflected in our consideration of question 2 of our 31 research questions. The Commission addressed this quality of life question in two ways. First, we asked the IOM to suggest specific measures for assessing the impact of disability on quality of life. Second, we requested that CNAC conduct an extensive survey of a representative sample of disabled veterans to ascertain the extent of the impact. IOM concluded that limiting veterans' compensation to only address work disability or earnings loss would be too restrictive and inconsistent with current models of disability. IOM recommended compensating veterans for the loss of some ability to engage in usual life activities, other than work, and for loss in overall quality of life. The results of the extensive CNAC survey of disabled veterans and their families demonstrated that disabilities diminish quality of life at all levels of ratings and, further, that the impact is greater for those with mental rather than physical disabilities. Together, the IOM and CNAC findings provide a sound philosophical and research based justification for compensating veterans for the impact of their service-connected disabilities on quality of life. That is what the Commission's considerable deliberations about loss of quality of life reflect.

In addition, CNAC's survey analysis demonstrated that current compensation payments do not provide payment above that required to offset earnings loss. There-

fore, there is currently no compensation for the impact of disability on quality of life for most veterans. As a result, our Commission recommended that current compensation payments should be increased up to 25 percent, with priority to the more seriously disabled, while permanent quality of life measures are developed and implemented. We understand that VA has contracted for an additional study to address how to properly compensate for the impact of disability on quality of life.

Regarding the current determination of presumptive conditions, when there is considerable evidence that a condition is experienced by a sufficient cohort of veterans, a "presumption" is established that the condition is the likely result of military service. This has been done for radiation exposure, Agent Orange defoliant in Vietnam, and other conditions. The Commission asked the IOM to review the existing process for making these decisions and IOM recommended a detailed, comprehensive, and transparent framework based on better and consistent use of scientific principles. Dr. Samet will address this subject in greater depth. Our Commission believes that his presumption determination framework will significantly improve the process and result in better outcomes for both the veterans and the VA. Moving forward, there is some concern over the "causal effect" standard that Dr. Samet's IOM Committee recommended be implemented. The Committee proposed that this standard be used instead of the existing standard based on "association". In our report, the Committee cautions that Congress should weigh this aspect of the IOM recommendations carefully.

Despite the evidence that the Rating Schedule generally results in veterans being compensated adequately for average loss of earnings except for PTSD and other mental disorders, those severely disabled at younger ages, and those currently compensated as IU, there are significant problems with the Rating Schedule that need to be addressed in an urgent manner. Dr. Bristow and Dr. Kilpatrick will address these problems in much greater detail but let me summarize the Commission's thoughts.

The Commission concluded that the current VA Rating Schedule has not been adequately revised. IOM found that 47 percent of the 798 disability codes organized in 16 body systems have been revised since 1990, but 35 percent have not been revised since 1945 and only 18 percent were revised between 1945 and 1989. We recommended that the Rating Schedule be updated as soon as possible but certainly within the next 5 years. We disagreed somewhat with IOM's recommendation in that we felt that priority should be placed on specific criteria for the evaluation and rating of traumatic brain injury (TBI) and all mental disorders, especially PTSD. IOM recommended beginning with those diagnostic codes that have been the longest without update. We both agree that the revision should be accomplished as quickly as possible.

By any reasonable standard, VA has not paid sufficient attention to keeping the Rating Schedule up to date. Dr. Bristow will, I'm sure, address the medical aspects of the criteria. I noted that his Committee compared the VA resources and staffing levels to those that the Social Security Administration has devoted to keeping their equivalent of the rating schedule current. VA's staffing does not compare well. It is very clear that VA must devote increased staff to this important task. As Dr. Bristow's Committee recommended, VA should create an ongoing process for keeping the Rating Schedule up to date, including publishing a timetable, and creating an advisory Committee for revising the medical criteria for each body system.

As I understand the current status of revisions, VA published a notice revising the Rating Schedule criteria for TBI and the comment period ended February 4, 2008. I further understand that a draft revision for PTSD rating criteria is nearing completion. While these actions are welcome, I would point out that Dr. Bristow's Committee report was released in June of 2007. Revisions to 2 of 798 diagnostic codes in 8 months is not a satisfactory pace for review. This may indicate that VA still needs a stronger sense of urgency and the application of adequate resources to conduct the Rating Schedule revision at a faster pace.

In summary, the Veterans' Disability Benefits Commission found that although the Rating Schedule generally enables service-disabled veterans to receive adequate compensation for average loss of earnings capacity, the Schedule falls short for those with PTSD and other mental disorders, those severely disabled at younger ages, and those needing IU. It does not provide any compensation for loss of quality of life.

It is somewhat ironic and certainly relevant to today's deliberations, that the Bradley Commission in 1956, only 11 years after the major revision of the Rating Schedule in 1945, found that the schedule had not been updated sufficiently. Now, 50 years later, our Commission and the IOM arrived at the same conclusion. This situation needs to be corrected expeditiously.

The Bradley report also recommended extensive analysis on an ongoing basis to assess the adequacy of payments and the effectiveness of the Rating Schedule. Until

our Commission was constituted in 2004, only one attempt to review the Rating Schedule was made in the seventies and the results of that analysis were discarded. Our Commission recommended that Congress should grant statutory authority to VA and DoD to obtain and analyze data from the Social Security Administration in order to periodically assess program outcomes at the diagnostic code level and adjust compensation levels accordingly.

As I have reflected in the foregoing statement, only by keeping the Rating Schedule current with the best, up-to-date, medical knowledge and by adjusting the payment levels to offset both loss of earnings and quality of life can we be assured that disabled veterans and their families are adequately compensated. These conclusions were the clear consensus of our Commission. The specific recommendations in our report should be used to guide needed legislative actions by Congress as well as the policy and resource allocations by the Departments and Agencies needed to update and improve disabled veterans' benefits.

Statement of Lonnie Bristow, M.D., Chair
Committee on Medical Evaluation of Veterans for Disability Benefits
Board on Military and Veterans Health, Institute of Medicine
The National Academies

Good afternoon, Chairman Hall, Ranking Member Lamborn, and Members of the Committee. My name is Lonnie Bristow. I am a physician and a Navy veteran, and I have served as the president of the American Medical Association. I'm joined on this panel by Drs. Dean Kilpatrick and Jonathan Samet, who will introduce themselves shortly. On their behalf, thank you for the opportunity to testify about the work of our Institute of Medicine (IOM) Committees. Established in 1970 under the charter of the National Academy of Sciences, the IOM provides independent, objective advice to the Nation on improving health.

My task today is to present to you the recommendations of the IOM Committee I chaired, which was asked to evaluate the VA Schedule for Rating Disabilities and related matters. Dr. Kilpatrick will follow me to speak about his Committee's work, which focused on post-traumatic stress disorder, which is a particular challenge for the VA top evaluate. Dr. Samet will conclude our panel's presentation by briefing you on the findings of his Committee, which was asked to offer its perspective on the scientific considerations underlying the question of whether a health outcome should be presumed to be connected to military service.

I had the great pleasure and honor of chairing the IOM Committee on Medical Evaluation of Veterans for Disability Compensation, which was established at the request of the Veterans' Disability Benefits Commission and funded by the Department of Veterans Affairs (VA).

Updating the Basis for Disability Compensation

Our report, *A 21st Century System for Evaluating Veterans for Disability Benefits*, which was issued last July, makes a number of important recommendations regarding the VA Rating Schedule and related matters. Our first recommendation is to broaden the purpose of the VA disability compensation program, which currently is to compensate for average loss of earning capacity, or work disability. We recommend that VA also compensate for loss of ability to engage in the usual activities of everyday life other than work and, if possible, for diminished quality of life. We recognize that legislative action will be required to change the statutory purpose of the disability compensation program, but doing so would bring the compensation program in line with our current understanding that disability has broad effects (see attached figure 4–1 from the report).

Assessing the Rating Schedule

When the Committee reviewed the Rating Schedule, we found that:

- Although it is called the Schedule for Rating Disabilities, it currently evaluates degree of impairment (i.e., loss of a body part or function) rather than degree of disability (i.e., limits on a person's ability to function at work or in life).
- Even in rating degree of impairment, the Schedule is not as current medically as it could and should be.
- The relationship of the rating levels to average loss of earning capacity is not known.

- The Schedule does not evaluate impact on a veteran's ability to function in everyday life.
- The Schedule does not evaluate loss of quality of life.

Accordingly, we made a series of recommendations to update and revise the Rating Schedule.

Updating the Rating Schedule

First, the Committee recommends that VA should immediately update the current Rating Schedule, beginning with those body systems that have gone the longest without a comprehensive update (i.e., the orthopedic part of the musculoskeletal system, the neurological system, and the digestive system). Revisions of the remaining systems could be done on a rolling basis, several a year, after which VA should adopt a system for keeping the Schedule up to date medically. Also, VA should establish an external disability advisory Committee to provide advice during the updating process.

As part of updating the Rating Schedule, VA should move to the International Classification of Diseases (ICD) and Diagnostic and Statistical Manual of Mental Disorders (DSM)diagnostic classification systems that are used in today's healthcare systems, including VA's.

Evaluating Traumatic Brain Injury

We were asked by your staff about improving the criteria for traumatic brain injury, or TBI. TBI is an excellent example of where the rating criteria in the Schedule need to be updated in accord with current medical knowledge and practice.

TBI is rated under diagnostic code 8045, "Brain disease due to trauma," which was last updated substantively in 1961. Today, we understand much better how concussions from blast injuries can affect cognition even though there is no evident physical injury. In Iraq, many servicemembers have been subjected to multiple improvised explosive device blasts. The current criteria emphasize physical manifestations, such as paralysis and seizures. The Rating Schedule recognizes that symptoms such as headache, dizziness, and insomnia are common in brain trauma but limits them to a 10 percent rating. It is time to review how to properly evaluate and rate TBI in light of current medical knowledge, along with the rest of the neurological conditions, most of which have not been revised since 1945.

Relating the Rating Schedule to Average Loss of Earnings

In addition to updating the Schedule medically, VA should investigate the relationship between the ratings and actual earnings to see the extent to which the Rating Schedule as revised is compensating for loss of earnings on average. This would build on the analyses done by the CNA Corp. at the body system level but use samples large enough to study the most prevalent conditions being rated. Just 38 conditions account for two-thirds of the compensation rating decisions. If VA finds disparities in average earnings, for example, that veterans with a mental disorder rated 70 percent earn substantially less on average than veterans rated 70 percent for other kinds of disabilities, it could adjust the rating criteria to narrow the gap.

Compensating for Non-Work-Related Functional Limitations

The Committee recommends that VA compensate for non-work disability, defined as functional limitations on usual life activities, to the extent that the Rating Schedule does not. To do this, VA should develop a set of functional measures—e.g., ADLs (activities of daily living), IADLs (instrumental activities of daily living)—and specific performance measures, such as time to ambulate a certain distance, or ability to do specific work-related tasks in both physical domains (e.g., climbing stairs or gripping) and cognitive domains (e.g., communicating or coordinating with other people). After the measures are validated in the disability compensation population, VA should conduct a study of functional capacity among applicants to see how well the revised Rating Schedule compensates for loss of functional capacity. There may be a close correlation between the rating levels based on impairment and degree of functional limitations (i.e., the higher the rating, the more functional capacity is limited), in which case the Rating Schedule compensates for both impairment and functional loss. But if the correlation is not high or does not exist, VA should develop a mechanism to compensate for loss of function that exceeds degree of impairment. This could be done by including functional criteria in the Rating Schedule or by rating function separately, with compensation based on the higher of the two ratings.

Compensating for Loss of Quality of Life

The Committee also recommends that VA compensate for loss of quality of life. We realize that quality-of-life assessment is relatively new and still at a formative stage, which makes this recommendation conditional on further research and development. VA should develop a tool for measuring quality of life validly and reliably in the veteran population, then VA should conduct research to determine the extent to which the Rating Schedule might already account for loss in quality of life. We might find that veterans with the lowest quality of life already have the highest percentage ratings, but if not, VA should develop a procedure for evaluating and rating loss of quality of life of veterans with disabilities where it exceeds the degree of disability based on impairment and functional limitations determined according to the Rating Schedule.

Evaluating Individual Unemployability

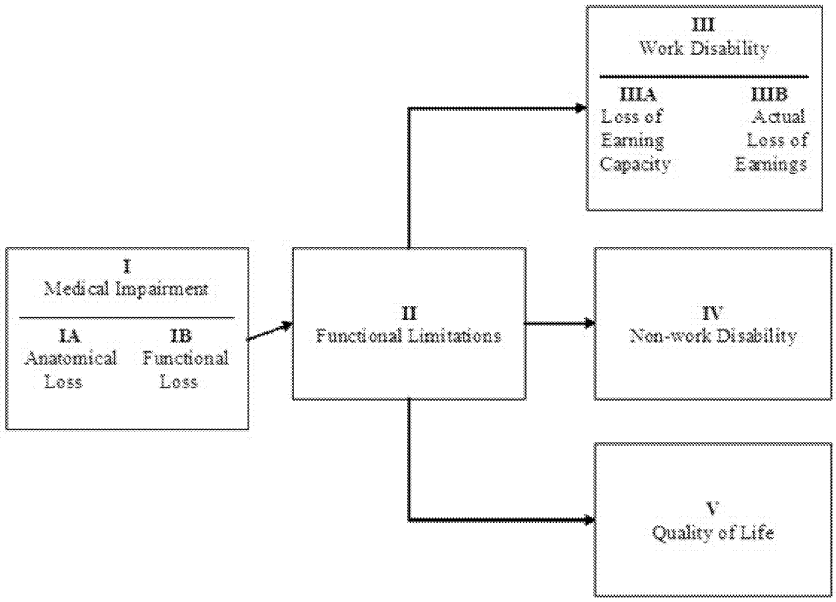
The Committee also reviewed individual unemployability, or IU, which has been a fast-growing part of the compensation program. Our main finding concerning IU is that it is not something that can be determined on medical grounds alone. IU is based on an evaluation of the individual veteran's capacity to engage in a substantially gainful occupation, rather than on the Rating Schedule, which is based on the average impairment of earnings concept. Thus the determination of IU must consider occupational as well as medical factors. To analyze IU claims, raters have medical evaluations from medical professionals and other medical records but usually they do not have comparable functional capacity or vocational evaluations from vocational experts. Therefore, the Committee recommends that, in addition to medical evaluations by medical professionals, VA require vocational assessment in the determination of eligibility for individual unemployability benefits. Raters should receive training on how to interpret findings from vocational assessments for the evaluation of individual unemployability claims.

Other Recommendations

The Committee made additional recommendations on issues other than the VA Schedule for Rating Disabilities, which I am not reviewing today. They can be found in our report and our recommendations for improving the medical examination and rating processes were presented to you by our staff director, Michael McGeary, on February 14 (for example, mandating the use of the online medical examination templates and having medical consultants to advise the raters on medical evidence).

This concludes my remarks. Thank you for the opportunity to testify. I would be happy to address any questions the Subcommittee might have.

FIGURE 4–1 The consequences of an injury or disease.



From: *A 21st Century System for Evaluating Veterans for Disability Benefits. National Academies Press, 2007.*

INSTITUTE OF MEDICINE OF THE NATIONAL ACADEMIES

REPORT BRIEF • NOVEMBER 2007

"A DUTY TO UPHOLD: MODERNIZING THE VETERANS' BENEFIT SYSTEM"

In times of war, the United States puts great demands on the men and women of our Armed Forces. We ask that they risk life and limb for our country, and they do so, willingly.

We honor our troops by providing them with the best medical support possible. Today, thanks to advances in battlefield medicine and logistics, a wounded soldier can be off the battlefield in minutes, in surgery within an hour, and recovering in the U.S. within days.

Surviving the initial trauma, however, is only half the battle. The impact of service-related injuries can last years, and indeed, a lifetime. And while our on-the-ground medical treatment is a model of science and efficiency, our system for handling veterans' disabilities is often mired in outmoded procedures. Worse, it is sometimes mired in World War II-era medical science.

This does not reflect a lack of will: Our Nation is unwavering in its commitment to honor those who serve, and to compensate them for the sacrifices they make. But our benefits system does not currently measure up to this ideal.

Recognizing these disparities, the Congressionally established Veterans' Disability Benefits Commission asked the Institute of Medicine (IOM) to provide guidance in two critical areas:

- How veterans are evaluated and compensated for disability benefits; and
- How we determine if a veteran's disability was caused by their service to our country.

A 21st CENTURY SYSTEM FOR EVALUATING VETERANS FOR DISABILITY BENEFITS

Nearly three million veterans of the U.S. Armed Forces receive compensation for disabilities incurred as a result of their service. The financial burden of this compensation is significant: $30 billion per year, with dependents and survivors receiving an additional $5 billion. The system for managing this compensation is necessarily large and complex: In 2006, the Veterans Administration (VA) received over 650,000 claims for disability compensation, and made decisions on nearly 630,000.

The efficiency suggested by those numbers, however, is illusory. The average time to process a claim is 177 days, and appeals—some 100,000 annually—take almost 2 years. These delays come with significant costs to deserving veterans, creating frustration and hardship from those who most deserve our support.

EVALUATING THE CURRENT SYSTEM

The most critical component in deciding whether a veteran is eligible for benefits is the "VA Schedule for Rating Disabilities," better known as the "Rating Schedule," or simply the "Schedule." The Schedule is a list of more than 700 diagnostic codes, each with criteria for determining the extent of impairment in a particular limb, organ, or body system. A soldier who is shot in the arm, for instance, may see a 10 percent, 50 percent, or other percentage impairment in the use of that arm.

Clinical professionals medically evaluate claimants and provide assessments to a group of nonclinical professionals, who then apply the Schedule to determine a disability rating between a and 100 percent, in 10-percent increments. Veterans with a service-connected disability receive monthly payments tied to their ratings, currently ranging from $115 a month for a 100-percent rating to $2,471 per month for a 100-percent rating.

In principle, the VA disability benefits program is designed to compensate individuals for their loss in earning power. It's only fair: A soldier should not have to "pay" for their injuries by having their income reduced throughout their life. In practice, Congress and the VA have also recognized and compensated veterans for non-economic losses since the disability program was put in place at the end of World War I.

These targets, however, have been approached inconsistently. There has been no systematic attempt to evaluate the connections between medical conditions and actual earnings potential since the seventies, and no effort to move beyond an ad hoc link between quality of life and benefit ratings. Moreover, the Schedule itself has lagged substantially behind changes in modem medicine.

In 2004, the Veterans' Disability Benefits Commission, an independent group created by Congress for the sole purpose of assessing the veterans' disability program, charged the IOM to study and recommend improvements in the rating system. The research agenda featured dozens of areas for investigation, including:

- How well does the current system evaluate and compensate losses of both quality-of-life and earnings capacity?
- How well does the system provide additional benefits (such as adapted housing and rehabilitation) where these benefits would be beneficial?
- Does the existing set of ratings and their application accurately reflect a veteran's ability to make a living?

The IOM established a Committee to review these and other issues and has published its findings in *A 21st Century System for Evaluating Veterans for Disability Benefits (2007)*.

A CALL TO ACTION

The Committee called for immediate action. It found the current system to be out-of-date and out-of-touch with both modem medicine and our modem understanding of disability.

The most urgent finding was a call to reassess the fundamental link between disability and compensation, and to bring our understanding of the impact of different disabilities into the 21st century.

The Rating Schedule is predicated on compensating veterans for a loss of income related directly to their injury. And yet, there is no comprehensive process in place to ensure that the Schedule reflects an accurate connection between the two. Moreover, there is no system to systematically update this connection to reflect changes in jobs, lifestyles, healthcare, or living arrangements.

The Committee noted that the entire Schedule needs an immediate update, beginning with those sections not systematically updated since World War II, and that the VA should establish an expert advisory Committee to manage the change process. The sections that have not been overhauled since 1945 include the orthopedic (e.g., amputations), neurological (e.g., traumatic brain injury), and digestive (e.g., ul-

cers) sections. Most of the other sections, such as mental (e.g., PTSD) and endocrine (e.g., diabetes), have not been comprehensively updated for more than 10 years.

The very construction of the Schedule also needs to be re-evaluated. Currently, the Rating Schedule focuses on discrete body systems: A veteran may be 50 percent disabled in one leg and 30 percent disabled in one arm, etc. Today, we understand disability to be driven by the whole person, and that the interplay of disabilities has an important impact on a person's level of functioning. Moreover, a comprehensive system needs to be put in place to account for additional, non-medical factors like age, experience, education and location when evaluating individual disabilities. A person may face different challenges, after all, if they are a 50-year-old teacher living in New York City than if they are a corn farmer living in Ames, Iowa.

At a minimum, the Rating Schedule needs to be aligned with the work done in the International Classification of Diseases (ICD) codes and the Diagnostic and Statistical Manual of Mental Disorders (DSM). Simply aligning codes and descriptions will help bridge a substantial gap between the existing schedule and the current medical understanding of injuries and diseases and their impacts on a person's ability to function.

While updating the evaluation process is a start, it is not enough to bring the VA disability system into the 21st century. In a truly modem disability program, veterans should be compensated for their difficulties in pursuing a fulfilling life apart from work; for a loss in the quality of their lives. While we have done this in practice historically, the current ad hoc process of accounting for reduced quality of life should be systematized and driven by research and science.

A FUNDAMENTAL CHANGE

These changes will not come easily, and the VA needs to make a commitment to ongoing research. This shift in perspective-from a simple "the postman cannot walk" mentality toward a true, holistic model of the human experience and the effect of disability is fundamental. It implies, and the Committee recommends, that healthcare professionals be made accessible throughout the benefits process for consultation and advice. It also requires constant updating to keep pace with continued changes in medicine and the workplace.

The motivations of the VA benefits program are noble and no change in intent or focus could possibly be desired. What is needed is not a change in motivation, but a commitment to continuous improvement; a commitment to being veteran-focused; a commitment to refining and modernizing processes, criteria and tools; and a commitment to evidence-based decisionmaking.

The Committee's full report outlines myriad ways in which these commitments can be met. To access a copy, visit www.iom.edu.

IMPROVING THE PRESUMPTIVE DISABILITY DECISION–MAKING PROCESS FOR VETERANS

When a veteran applies for disability benefits, the VA has to make several decisions. The first step, outlined above, is to examine the individual and quantify their level of disability—work-related or otherwise. But this is only half of the equation. In order to receive benefits, a veteran's disability must be related to their military service. While these connections can be obvious (a battlefield wound), they can also be murky and complex (as with most environmental exposures).

Since the 1920s, the VA Administrator (now Secretary) and Congress having had the power to establish "presumptions": conditions that, if present, are "presumed" to be the result of military service. These presumptions are, important because they streamline the process of providing benefits to veterans in need. When a "presumption" is made, veterans do not have to prove that their particular disability or illness was caused by their service; if the served in a particular capacity and developed a particular ailment, they are entitled to benefits.

The best-known example is Agent Orange. In 1991, Congress passed law (the 1991 Agent Orange Act) requiring the VA to investigate the health impacts of Vietnam-era exposure to the herbicide Agent Orange. The VA asked the IOM to review the evidence, and on the basis of an IOM recommendation, decided that any soldier setting foot on Vietnamese soil during the war may have been exposed to Agent Orange. Moreover, a range of medical problems (including Hodgkin's disease and prostate cancer) were linked to this exposure. Therefore, any veteran developing these conditions after serving on Vietnamese soil was entitled to benefits, as it was "presumed" that their service led to these conditions.

Today, nearly 150 health conditions have been codified, allowing veterans to receive benefits based on presumptive service connection. However, the current system for determining presumptions has not been standardized.

In order to ensure that future decisions are based on sound science and evidence, the Veterans' Disability Benefits Commission asked the IOM to examine the current process and propose a framework for establishing presumptions in the future. The IOM appointed a Committee experts from fields including epidemiology, toxicology, and industrial hygiene.

In its report, *Improving the Presumptive Disability Decision-Making Process for Veterans* (2007), the Committee finds that the current process has met most noble goal: the VA has consistently given the benefit of the doubt to disabled veterans, in an effort to ensure that no veteran who *might* have been affected by their service is denied compensation. But this apparent generosity has come not from policy as much as from an inadequate process. Congress has been inconsistent in giving guidance when asking for assessments, and the VA has lacked clarity in its requests to IOM Committees evaluating individual cases. There has been an inconsistent burden of proof: in some cases, Congress has required a causal link between a certain exposure and a cert health risk; at other times, only an "association" was required. In many cases, the Department of Defense has been unable to provide health and exposure data to inform the decisionmaking process.

Such a system cannot help but lead to flaws—granting benefits where disabilities are not service-connected or denying benefits to those entitled to them. Perhaps more damaging, the ad hoc and ill-defined process undermines veterans' confidence in the VA system, fostering discontent and confusion among those who have sacrificed for their country.

A CALL FOR STRUCTURE

The Committee's findings are clear: What the system needs is structure. This structure must ensure that presumptive decisions are based on evidence, not emotion, and that decisions are made quickly, transparently, and consistently. Such a system must have the flexibility to grow and change as science advances, and cannot be a top-down government program: It needs the input and cooperation of all potential stakeholders to function well.

Toward this end, the Committee took the unusual step of making broad recommendations to Congress, the Department of Veterans Affairs, and the Department of Defense, both individually and collectively. It is rare to make recommendations to multiple organizations, but in this case, cooperation and coordination are critical.

The Committee laid out the structure in careful detail. It envisions a new system, created by Congress, consisting of two parts: an Advisory Committee and a Science Review Board. The Advisory Committee would be made up of stakeholders from government, the scientific community, veterans groups, and others. Its task would be to consider potential exposures, illnesses and circumstances that might require the establishment of presumptions. Based on this Advisory Committee's recommendations, the VA Secretary would then charge the Science Review Board—a completely independent group-to examine the evidence and provide recommendations.

The Science Review Board is the linchpin of this new system. Relying on evidence-based decisionmaking, the Board will consider how strong the link is between a given exposure and a particular medical ailment, classifying that connection into four categories:

1. **Sufficient:** A causal relationship exists.
2. **Equipoise and Above:** A causal relationship is at least as likely as not.
3. **Below Equipoise:** Either a causal relationship is unlikely, or there is insufficient information to make a scientifically informed judgment.
4. **Against:** The evidence suggests the lack of a causal relationship.

When the evidence permits, the Board would estimate how many veterans were exposed, to what extent, and what fraction of their medical condition was due to this exposure. These findings would then be delivered to the VA, which would determine if a presumptive ruling is merited.

This kind of structure will not be put into place overnight, and substantial work remains to be done. For instance, the VA needs to develop and publish a formal process for how these presumptions will be made. This must be consistently applied, and needs to be transparent from start to finish, documenting all evidence collected and the reasoning behind each decision—pro or con. But most importantly, the DoD and the VA need to make a commitment to work together. For example, evaluating causality is only possible for the VA if the DoD has accurate medical records, reports on pre-existing conditions, and information on what time individual veterans spent operating in different military theaters. The Committee's report provides many recommendations, from strategic planning to computer data interfaces, where

a commitment to joint research, knowledge-sharing, and resource allocation will be required. Without this cooperation, no new structure will succeed.

A COMMITMENT RENEWED

America remains steadfast in its commitment to the men and women of our Armed Forces, whether they still wear the uniform or have re-entered private life. The Department of Veterans Affairs, in recognizing the need for research and change, has shown its commitment to extending this commitment for as long as is necessary to support those harmed in the line of duty.

The way in which we compensate our disabled veterans is far from broken—millions of veterans rely on it and more are granted benefits every day. But it can and should be as effective as possible. Our veterans deserve nothing less.

FOR MORE INFORMATION . . .

Copies of *A 21st Century System for Evaluating Veterans for Disability Benefits and Improving the Presumptive Disability Decision-Making Process for Veterans* are available from the National Academies Press, 500 Fifth Street, N.W., Lockbox 285, Washington, DC 20055; (800) 624–6242 or (202) 334–3313 (in the Washington metropolitan area); Internet, www.nap.edu. The full text of this report is available at www.nap.edu.

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Statement of Dean G. Kilpatrick, Ph.D.
Member, Committee on Veterans' Compensation for Posttraumatic Stress Disorder, Institute of Medicine, The National Academies, and Distinguished University Professor and Director
National Crime Victims Research and Treatment Center
Medical University of South Carolina, Charleston, SC

Good afternoon, Mr. Chairman and Members of the Committee. My name is Dean Kilpatrick and I am Distinguished University Professor in the Department of Psychiatry and Behavioral Sciences and Director of the National Crime Victims Research and Treatment Center at the Medical University of South Carolina. Thank you for the opportunity to testify on behalf of the Members of the Committee on Veterans' Compensation for Post Traumatic Stress Disorder. This Committee was convened under the auspices of the National Research Council and the Institute of Medicine. Our Committee's work was requested by the Department of Veterans Affairs, which provided funding for the effort. Its work was also presented to and used by the congressionally constituted Veterans Disability Benefits Commission.

Last June, our Committee completed its report—entitled *PTSD Compensation and Military Service*—which addresses potential revisions to the Schedule for Rating Disabilities in the context of a larger review of how VA administers its PTSD compensation program. I am pleased to be here today to share with you the content of that report, the knowledge I've gained as a clinical psychologist and researcher on traumatic stress, and my experience as someone who previously served as a clinician at the VA.

I will begin with some background information on post traumatic stress disorder. Briefly described, PTSD is a psychiatric disorder that can develop in a person after

a traumatic experience. Someone is diagnosed with PTSD if, in response to that traumatic experience, he or she develops a cluster of symptoms that include:

- ***reexperiencing*** the traumatic event as reflected by distressing recollections, memories, nightmares, or flashbacks;
- ***avoidance*** of anything that reminds them of the traumatic event;
- ***emotional numbing*** or feeling detached from other people;
- ***hyperarousal*** as reflected by trouble sleeping, trouble concentrating, outbursts of anger, and having to always be vigilant for potential threats in the environment; and
- ***impairment*** in social or occupational functioning, or clinically significant distress.

PTSD is one of an interrelated and overlapping set of possible mental health responses to combat exposures and other traumas encountered in military service. It has been described as one of the signature wounds of the most recent Iraq conflicts. Although PTSD has only been an official diagnosis since the 1980's, the symptoms associated with it have been reported for centuries. In the U.S., expressions including *shell shock, combat fatigue,* and *gross stress reaction* have been used to label what is now called PTSD.

Our Committee's review of the scientific literature regarding PTSD led it to draw some conclusions that are relevant to this hearing. It found abundant evidence indicating that PTSD can develop at any time after exposure to a traumatic stressor, including cases where there is a long time interval between the stressor and the recognition of symptoms. Some of these cases may involve the initial onset of symptoms after many years of symptom-free life, while others may involve the manifestation of explicit symptoms in persons with previously undiagnosed PTSD. The determinants of delayed-onset PTSD are not well understood. The scientific literature does not identify any differences material to the consideration of compensation between these delayed-onset or delayed-identification cases and those chronic PTSD cases where there is a shorter time interval between the stressor and the recognition of symptoms.

Our review also identified several areas where changes to VA's current practices might result in more consistent and accurate ratings for disability associated with PTSD.

There are two primary steps in the disability compensation process for veterans. The first of these is a compensation and pension, or C&P, examination. These examinations are conducted by VA mental health professionals or outside professionals who meet certain education and licensing requirements. Testimony presented to our Committee indicated that clinicians often feel pressured to severely constrain the time that they devote to conducting a PTSD C&P examination—sometimes to as little as 20 minutes—even though the protocol suggested in a best practice manual developed by the VA National Center for PTSD can take 3 hours or more to properly complete. The Committee believes that the key to proper administration of VA's PTSD compensation program is a thorough C&P clinical examination conducted by an experienced mental health professional. Many of the problems and issues with the current process can be addressed by consistently allocating and applying the time and resources needed for a thorough examination. The Committee also recommended that a system-wide training program be implemented for the clinicians who conduct these exams in order to promote uniform and consistent evaluations.

The second primary step in the compensation process for veterans is a rating of the level of disability associated with service-connected disorders identified in the clinical examination. This rating is performed by a VA employee using the information gathered in the C&P exam and criteria set forward in the Schedule for Rating Disabilities. Currently, the same set of criteria are used for rating all mental disorders. They focus on symptoms from schizophrenia, mood, and anxiety disorders. The Committee found that the criteria are at best a crude and overly general instrument for the assessment of PTSD disability. We recommended that new criteria be developed and applied that specifically address PTSD symptoms and that are firmly grounded in the standards set out in the *Diagnostic and Statistical Manual of Mental Disorders* used by mental health professionals.

Our Committee also suggested that VA take a broader and more comprehensive view of what constitutes PTSD disability. In the current scheme, occupational impairment drives the determination of the rating level. Under the Committee's recommended framework, the psychosocial and occupational aspects of functional impairment would be separately evaluated, and the claimant would be rated on the dimension on which he or she is more affected. We believe that the special emphasis on occupational impairment in the current criteria unduly penalizes veterans who

may be capable of working, but significantly symptomatic or impaired in other dimensions, and thus it may serve as a disincentive to both work and recovery. This recommendation is consistent with the Dole-Shalala Commission's suggestion to add quality of life payments to compensation.

Research reviewed by the Committee indicates that disability compensation does not in general serve as a disincentive to seeking treatment. While some beneficiaries will undoubtedly understate their improvement in the course of pursuing compensation, the scientific literature suggests that such patients are in the minority, and there is some evidence that disability payments may actually contribute to better treatment outcomes in some programs. The literature on recovery indicates that it is influenced by several factors, and the independent effect of compensation on recovery is difficult to disentangle from these.

Determining ratings for mental disabilities in general and for PTSD specifically is more difficult than for many other disorders because of the inherently subjective nature of symptom reporting. In order to promote more accurate, consistent, and uniform PTSD disability ratings, the Committee recommended that VA establish a specific certification program for raters who deal with PTSD claims, with the training to support it, as well as periodic recertification. Rater certification should foster greater confidence in ratings decisions and in the decisionmaking process.

At VA's request, the Committee addressed whether it would be advisable to establish a set schedule for re-examining veterans receiving compensation for PTSD. We concluded that it is not appropriate to require across-the-board periodic reexaminations for veterans with PTSD service-connected disability. The Committee instead recommended that reexamination be done only on a case-by-case basis when there are sound reasons to expect that major changes in disability status might occur. These conclusions were based on two considerations. First, there are finite resources—both funds and personnel—to conduct C&P examinations and determine disability ratings. The Committee believes that resources should be focused on the performance of uniformly high-quality C&P clinical examinations. It believes that allocating resources to such examinations—in particular, to initial C&P evaluations—is a better use of resources than periodic, across-the-board reexaminations. Second, as the Committee understands it, across-the-board periodic reexaminations are not required for other mental disorders or medical conditions. The Committee's review of the literature on misreporting or exaggeration of symptoms by PTSD claimants yielded no justification for singling out PTSD disability for special action and thereby potentially stigmatizing veterans with the disability by implying that their condition requires extra scrutiny.

I understand that the Veterans Disability Benefits Commission subsequently recommended that VA should conduct PTSD reevaluations every 2–3 years to gauge treatment effectiveness and encourage wellness. Since the Commission report was released after the end of our work, my Committee did not address the disparity in our recommendations. I know that our Committee and the Commission both want veterans to receive fair treatment and the finest care, and I consider this to be an honest difference of opinion on how to best achieve those goals. There are advantages and disadvantages to the approaches that our two groups put forward, and the important thing is for VA to give these careful consideration when they formulate their policy. I believe that—if periodic reexaminations are implemented—this should not be done until there are sufficient resources to insure that every veteran gets a first-rate initial C&P exam in a timely fashion.

To summarize, the Committee identified three major changes that are needed to improve the compensation evaluation process for veterans with PTSD:

- First, the C&P exam should be done by mental health professionals who are adequately trained in PTSD and who are allotted adequate time to conduct the exams.
- Second, the current VA disability rating system should be substantially changed to focus on a more comprehensive measure of the degree of impairment, disability, and clinically significant distress caused by PTSD. The current focus on occupational impairment serves as a disincentive for both work and recovery.
- Third, the VA should establish a certification program for raters who deal with PTSD clams.

Our Committee also reached a series of other recommendations regarding the conduct of VA's compensation and pension system for PTSD that are detailed in the body of our report. I have provided copies of this report as part of my submitted testimony.

Thank you for your attention. I will be happy to answer your questions.

INSTITUTE OF MEDICINE OF THE NATIONAL ACADEMIES

REPORT BRIEF • JULY 2007

"PTSD COMPENSATION AND MILITARY SERVICE"

The scars of war take many forms: the limb lost, the illness brought on by a battlefield exposure, and, for some, the psychological toll of encountering an extreme traumatic event. The mission of the Department of Veterans Affairs (VA) "to care for him who shall have borne the battle" is met through a series of benefits programs for veterans and their dependents. One of these programs-compensation to veterans whose disability is deemed to be service-connected-has risen in the public eye over the past few years. While several factors have contributed to this development, three that are particularly prominent are the increase in the number of veterans seeking and receiving benefits, the corresponding increase in benefits expenditures, and the prospect of a large number of veterans of Operation Iraqi Freedom and Operation Enduring Freedom entering the system.

Compensation claims for post traumatic stress disorder (PTSD) have attracted special attention. PTSD is a psychiatric disorder that can develop in a person who experiences, witnesses, or is confronted with a traumatic event, often one that is life-threatening. PTSD is characterized by a cluster of symptoms that include:

- reexperiencing—intrusive recollections of a traumatic event, often through flashbacks or nightmares;
- avoidance or numbing-efforts to avoid anything associated with the trauma and numbing of emotions; and
- hyperarousal—often manifested by difficulty in sleeping and concentrating and by irritability.

PTSD is one of an interrelated and overlapping set of possible mental health responses to combat exposures and other traumas encountered in military service. While the term "post traumatic stress disorder" has only been part of the lexicon since the 1980's, the symptoms associated with it have been reported for centuries. In the U.S., expressions including shell shock, combat fatigue, and gross stress reaction have been used to label what is now called PTSD.

Against this backdrop, VA's Veterans Benefits Administration (VBA) asked the National Academies to convene a Committee of experts to address several issues surrounding its administration of veterans' compensation for PTSD. The resulting report, *PTSD Compensation and Military Service*, identifies several areas where changes might result in more consistent and accurate ratings for disability associated with PTSD.

THE PTSD COMPENSATION AND PENSION EXAMINATION

There are two major steps in the disability compensation process for veterans. The first is a compensation and pension (C&P) examination. These are conducted by VA clinicians or outside professionals who meet certain education and licensing requirements. Clinicians often feel pressured to severely limit the time that they devote to conducting a PTSD C&P examination-to as little as 20 minutes-even though the protocol suggested in a best practice manual developed by the VA National Center for PTSD can take 3 hours or more to properly complete. The Committee believes that the key to proper administration of VA's PTSD compensation program is a thorough C&P clinical examination conducted by an experienced mental health professional. Many of the problems and issues with the current process can be addressed by consistently allocating and applying the time and resources needed for a thorough examination. The Committee also recommends the implementation of a system-wide training program for the clinicians who conduct these exams in order to promote uniform and consistent evaluations.

THE EVALUATION OF PTSD DISABILITY CLAIMS

The second major step in the compensation process is a rating of the level of disability associated with service-connected disorders. This rating is performed by a VA employee using the information gathered in the C&P exam. The Committee found that the criteria used to evaluate the level of disability resulting from service-connected PTSD were, at best, crude and overly general. It recommends that new criteria be developed and applied that specifically address PTSD symptoms and that are firmly grounded in the standards set out in the *Diagnostic and Statistical Manual of Mental Disorders* used by mental health professionals. As part of this effort, the committee suggested that VA take a broader and more comprehensive view of what constitutes PTSD disability. In the current scheme, occupational impairment drives the determination of the rating level. However, the Committee believes that

this unduly penalizes veterans who may be capable of working but are impaired in other capacities, and might thus be a disincentive to both work and recovery. Under the committee's recommended framework, the applicant's rating would be based on evaluations of both the psychosocial and occupational aspects of functional impairment.

Determining ratings for mental disabilities in general and for PTSD specifically is more difficult than for many other disorders because of the inherently subjective nature of symptom reporting. In order to promote more accurate, consistent, and uniform PTSD disability ratings, the Committee recommends that VA establish a specific certification program for raters who deal with PTSD claims, with the training to support it, as well as periodic recertification. Rater certification should foster greater confidence in ratings decisions and in the decisionmaking process.

SPECIAL ISSUES FOR WOMEN VETERANS

Female veterans are less likely to receive service connection for PTSD, which could be because of the difficulty of validating exposure to non-combat traumatic stress-notably, military sexual assault (MSA). The Committee believes that it is important to gain a better understanding of the sources of this disparity and to better facilitate the validation of MSA-related traumas in both women and men. It therefore recommends that VBA gather more detailed data on the determinants of service connection and ratings level for MSA-related PTSD claims, including the gender-specific coding of MSA-related traumas for analysis purposes; and develop and disseminate reference materials for raters that more thoroughly address the management of MSA related claims. Training and testing on MSA-related claims should be a part of the certification program the Committee recommends for raters who deal with PTSD claims.

FINAL OBSERVATIONS

The Committee is acutely aware that resource constraints-on both funds and staff-limit the ability of VA to deliver services and force difficult decisions on allocations among vital efforts. It believes that increases in the number of veterans seeking and receiving disability benefits for PTSD, the prospect of a large number of veterans of Operation Iraqi Freedom and Operation Enduring Freedom entering the system, and the profound impact of the disorder on the Nation's veterans make changes in PTSD C&P policy a priority deserving of special attention and action by VA and the Congress.

FOR MORE INFORMATION . . .

Copies of *PTSD Compensation and Military Service* are available from the National Academies Press, 500 Fifth Street, N.W., Lockbox 285, Washington, DC 20055; (800) 624–6242 or (202) 334–3313 (in the Washington metropolitan area); Internet, http://www.nap.edu. The full text of this report is available at http://www.nap.edu.

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COMMITTEE ON VETERANS' COMPENSATION FOR POST TRAUMATIC STRESS DISORDER

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Statement of Jonathan M. Samet, M.D., M.S.
Chairman, Committee on Evaluation of the Presumptive Disability Decision-Making Process for Veterans, Board on Military and Veterans Affairs, Institute of Medicine, The National Academies, and Professor and Chairman, Department of Epidemiology, Johns Hopkins Bloomberg School of Public Health, Johns Hopkins University Baltimore, MD

Good afternoon Congressman Hall and Members of the Subcommittee on Disability Assistance and Memorial Affairs of the House Committee on Veterans' Affairs. I am pleased to speak with you today about the Institute of Medicine report, *Improving the Presumptive Disability Decisionmaking Process for Veterans*. I am Jonathan Samet, the Chair of the Committee. I represent my colleagues on the Committee, a multidisciplinary group of 16 people that covered the broad range of expertise needed to take on this important, but very challenging topic. The Subcommittee has access to the report and a copy of the Executive Summary is attached to my testimony.

Our Committee was charged with describing the current process for how presumptive decisions are made for veterans who have health conditions arising from military service and with proposing a scientific framework for making such presumptive decisions in the future. Presumptions are made in order to reach decisions in the face of unavailable or incomplete information. They address the gaps in evidence that introduce uncertainty in decisionmaking. Presumptions have been made with regard to exposure and causation. In trying to assess whether a particular health problem in veterans can be linked to their exposures in the military, a presumption might be needed because of missing information on exposures of the veterans to the agent of concern or because of uncertainty as to whether the exposure increases risk for the health condition. A presumption might also be made with regard to the link between an exposure and risk for a disease, while the evidence is still uncertain or accumulating as to whether the exposure causes the disease.

Presumptions have long been made; in fact, the first were established in 1921. More recently, a number of presumptions have been made with regard to the consequences of Agent Orange exposure during service in Vietnam and most recently

they have been made around the health risks sustained by military personnel in the Persian Gulf War.

To address its charge, the Committee met with the full range of involved stakeholders: past and present staffers from Congress, the Veterans Administration (VA), the Institute of Medicine, veteran's service organizations, and individual veterans. The Department of Defense (DoD) gave the Committee information about its current activities and its plans to track exposures and health conditions of personnel. The Committee attempted to formally capture how the current approach works and completed a series of case studies to identify "lessons learned" that would be useful in proposing a new approach. The Committee also considered how information is obtained on the health of veterans and how exposures during military service can be linked to any health consequences via scientific investigation. It gave substantial attention to how information can best be synthesized to determine if an exposure is associated with a risk to health and whether the association is causal.

The present approach to presumptive disability decisionmaking largely flows from the Agent Orange Act 1991, which started a model for decisionmaking that is still in place. In that law, Congress asked the VA to contract with an independent organization, —the Institute of Medicine—to review the scientific evidence for Agent Orange. Subsequently, the Institute of Medicine has produced reports on Agent Orange, evaluating whether there is evidence that Agent Orange is associated with various health outcomes. The Institute of Medicine provides its reports to the VA, which then acts through its own internal decisionmaking process to determine if a presumption is to be made.

The case studies conducted by the Committee probed deeply into this process. The case studies pointed to a number of difficulties that need to be addressed in any future approach:

- Lack of information on exposures received by military personnel and inadequate surveillance of veterans for service-related illnesses.
- Gaps in information because of secrecy.
- Varying approaches to synthesizing evidence on the health consequences of military service.
- In the instance of Agent Orange, classification of evidence for association but not for causation.
- A failure to quantify the effect of the exposure during military service, particularly for diseases with other risk factors and causes.
- A general lack of transparency of the presumptive disability decisionmaking process.

The Committee discussed in great depth the optimum approach to establishing a scientific foundation for presumptive disability decisionmaking, including the methods used to determine if exposure to some factor increases risk for disease. This assessment and the findings of the case studies led to recommendations to improve the process:

- As the case studies demonstrated, Congress could provide a clearer and more consistent charge on how much evidence is needed to make a presumption. There should be clarity as to whether the finding of an association in one or more studies is sufficient or the evidence should support causation.
- Due to lack of clarity and consistency in congressional language and VA's charges to the Committees, IOM Committees have taken somewhat varying approaches since 1991 in reviewing the scientific evidence, and in forming their opinions on the possibility that exposures during military service contributed to causing a health condition. Future Committees could improve their review and classification of scientific evidence if they were given clear and consistent charges and followed uniform evaluation procedures.
- The internal processes by which the VA makes it presumptive decisions following receipt of an IOM report have been unclear. VA should adopt transparent and consistent approaches for making these decisions.
- Adequate exposure data and health condition information for military personnel (both individuals and groups) usually have not been available from DoD in the past. Such information is one of the most critical pieces of evidence for improving the determination of links between exposures and health conditions. Approaches are needed to assure that such information is systematically collected in an ongoing fashion.

All of these improvements are feasible over the longer term and are needed to ensure that the presumptive disability decisionmaking process for veterans is based on the best possible scientific evidence. Decisions about disability compensation and related benefits (e.g., medical care) for veterans should be based on the best possible

documentation and evidence of their military exposures as well as on the best possible information. A fresh approach could do much to improve the current process. The Committee's recommended approach (see Figure GS–1 attached) has several parts:

- an open process for nominating exposures and health conditions for review; involving all stakeholders in this process is critical;
- a revised process for evaluating scientific information on whether a given exposure causes a health condition in veterans; this includes a new set of categories to assess the strength of the evidence for causation, and an estimate of the numbers of exposed veterans whose health condition can be attributed to their military exposure;
- a consistent and transparent decisionmaking process by VA;
- a system for tracking the exposures of military personnel (including chemical, biological, infectious, physical and psychological stressors), and for monitoring the health conditions of all military personnel while in service and after separation; and
- an organizational structure to support this process.

To support the Committee's recommendations, we suggest the creation of two panels. One is an Advisory Committee (advisory to VA), that would assemble, consider and give priority to the exposures and health conditions proposed for possible presumptive evaluation. Nominations for presumptions could come from veterans and other stakeholders as well as from health tracking, surveillance and research. The second panel would be a Science Review Board, an independent body, which would evaluate the strength of the evidence (based on causation) which links a health condition to a military exposure and then estimates the fraction of exposed veterans whose health condition could be attributed to their military exposure. The Science Review Board's report and recommendations would go to the VA for its consideration. The VA would use explicit criteria to render a decision by the VA Secretary with regard to whether a presumption would be established. In addition, the Science Review Board would monitor information on the health of veterans as it accumulates over time in the DoD and VA tracking systems, and nominate new exposures or health conditions for evaluation as appropriate.

This Committee recommends that the following principles be adopted in establishing this new approach:

1. Stakeholder inclusiveness
2. Evidence-based decisions
3. Transparent process
4. Flexibility
5. Consistency
6. Causation, not just association, as the target for decisionmaking.

The last principle needs further discussion, as it departs from the current approach. In proposing causation as the target, the Committee had concern that the approach of relying on association, particularly if based on findings of one study, could lead to "false-positive" presumptions. The Committee calls for a broad interpretation of evidence to judge whether a factor causes a disease in order to assure that relevant findings from laboratory studies are adequately considered. The Committee also recommends that benefits be considered when there is at least a 50 percent likelihood of a causal relationship, and does not call for full certainty on the part of the Science Review Board.

The Committee suggests that its framework be considered as the model to guide the evolution of the current approach. While some aspects of the approach may appear challenging or infeasible at present, feasibility would be improved by the provision of appropriate resources to all of the participants in the presumptive disability decisionmaking process for veterans and future methodological developments. Veterans deserve to have these improvements accomplished as soon as possible.

The Committee recognized that action by Congress will be needed to implement its proposed approach. Legislation to create the two panels is needed and Congress should also act to assure that needed resources are available to create and sustain exposure and health trackingfor service personnel and veterans. Many of the changes proposed by the Committee could be implemented now, even as steps are taken to move the DoD and VA toward implementing the model recommended. Veterans deserve to have an improved system as soon as possible.

Thank you for the opportunity to testify. I would be happy to address any questions the Subcommittee might have.

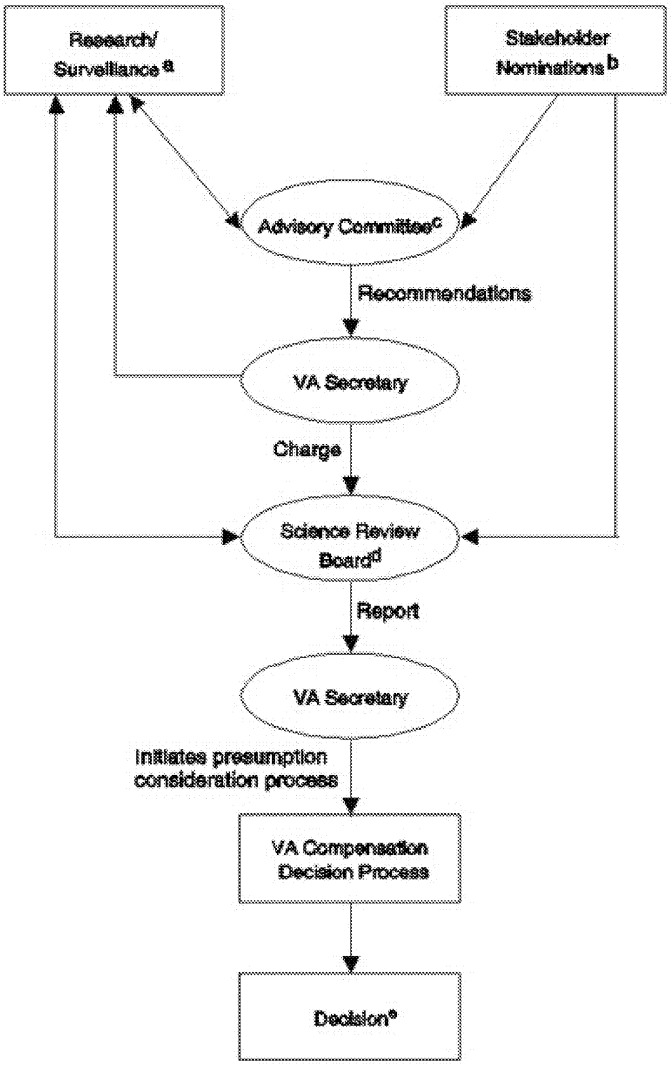


FIGURE GS–1 (IOM 2007) Proposed Framework for Future Presumptive Disability Decision-Making Process for Veterans.

[a] Includes research for classified or secret activities, exposures, etc.
[b] Includes veterans, Veterans Service Organizations, Federal agencies, scientists, general public, etc.
[c] This Committee screens stakeholders' proposals and research in support of evaluating evidence for presumptions and makes recommendations to the VA Secretary when full evidence review or additional research is appropriate.
[d] The board conducts a two-step evidence review process (see report text for further further detail).
[e] Final presumptive disability compensation decisions are made by the Secretary, Department of Veterans Affairs, unless legislated by Congress.

Statement of Joyce McMahon, Ph.D.
Managing Director, Center for Health Research and Policy
Center for Naval Analyses (CNA) Corp., Alexandria, VA

Chairman Hall, Representative Lamborn, distinguished Members, I appreciate the opportunity to testify before the House Subcommittee on Disability Assistance and Memorial Affairs of the House Committee on Veterans' Affairs today on the subject of Revising the VA Schedule for Rating Disabilities. This testimony is based on the findings reported in *Final Report for the Veterans' Disability Benefits Commission: Compensation, Survey Results, and Selected Topics*, by Eric Christensen, Joyce McMahon, Elizabeth Schaefer, Ted Jaditz, and Dan Harris, of the CNA Corp. (CNA). Details on the specific findings discussed here can be found in the report, which is available at http://www.cna.org/domestic/healthcare/. The report also includes reference sources.

The Veterans' Disability Benefits Commission (the Commission) asked CNA to help assess the appropriateness of the benefits that the Department of Veterans Affairs (VA) provides to veterans and their survivors for disabilities and deaths attributable to military service. Specifically, the Commission was charged with examining the standards for determining whether a disability or death of a veteran should be compensated and the appropriateness of benefit levels. The overall focus of our effort was to provide analyses to the Commission regarding the appropriateness of the current benefits program for compensating for loss of average earnings and degradation of quality of life resulting from service-connected disabilities for veterans.

- Pertinent to today's topic of Revising the VA Schedule for Rating Disabilities is that we were asked to:
- Examine the evidence regarding the individual unemployability (IU) rating.
- Evaluate Quality of Life findings for disabled veterans.

Conduct surveys of raters and Veterans Service Officers (VSOs) with regard to how they perceive the processes of rating claims and assisting applicants.

The evaluation of IU was, to some extent, embedded in our evaluation of earnings parity and quality of life assessments from the disabled veterans' survey.

Earnings comparisons for service-disabled veterans

Our primary task was to answer the question of how well the VA compensation benefits serve to replace the average loss in earnings capacity for service-disabled veterans. Our approach identified target populations of service-disabled veterans and peer or comparison groups (non-service-disabled veterans) and obtained data to measure earned income for each group. We also investigated how various factors such as disability rating, type of disability, and age impact earned income. Finally, we compared lifetime earned income losses for service-disabled veterans to their lifetime VA compensation, adjusting for expected mortality and discounting to present value terms, to see how well VA compensation replaces lost earning capacity.

Congressional language indicates that the intent of VA compensation is to provide a replacement for the average impairment in earning capacity. The VA compensation program is not an individual means tested program, although there are minor exceptions to this. Therefore, we focused on average losses, first for all service-disabled veterans and then for subgroups. We defined the subgroups of disabled veterans, through consultation with the Commission, on the body system of the primary disability (16 in all) and on the total combined disability rating (10 percent, 20–40 percent, 50–90 percent, and 100 percent disabled).

In addition, we further stratified the 50–90-percent disabled group into those with and without individual unemployability (IU) status. To receive IU status, a veteran must have at least one disability that is rated 60 percent or more or one disability rated at least 40 percent and a combined disability rating of 70 percent or more. In addition, the veteran must be unable to engage in substantial gainful employment as a result of service-connected disabilities. Those with IU status receive VA compensation as if they were 100-percent disabled, which results in a substantial increase in VA compensation.

To make earnings comparisons over a lifetime, it is necessary to have a starting point. In other words, a young service-disabled veteran will have a long period of lost earnings capacity during prime wage-earning years, while a veteran who enters into the VA disability compensation system at an older age will face reduced earnings capacity for a smaller number of years. If a veteran first becomes eligible for VA compensation at age 65 or older, the average expectation of lost earnings is very low, because a large share of individuals are retired or planning to retire soon by this age. The data show that the average age of entry into the VA compensation system is about 55 years, although many enter at a younger or older age. Also, the

average age of entry varies somewhat across the body systems of the primary disability and combined degree of disability.

Looking at average VA compensation for all male service-disabled veterans, we find that they are about at parity with respect to lost earnings capacity at the average age of entry. To calculate expected earnings parity, we take the ratio of service-disabled earned income plus VA compensation divided by the present value of total expected earnings for the peer group. This figure is 0.97, which is very close to parity. A ratio of exactly 1 would be perfect parity, indicating that the earnings of disabled veterans, plus their VA compensation, gives them the same lifetime earnings as their peers. A ratio less than one would mean that the service-disabled veterans receive less than their peers on average, while a ratio greater than one would mean that they receive more than their peers.

We also evaluated the parity of earned income and VA compensation for service-disabled veterans compared to the peer group by disability rating group and age at first entry into the VA compensation system. Our findings indicate that it is important to distinguish whether the primary disability is a physical or a mental condition. We found that there is not much difference in the results among physical body systems (e.g., musculoskeletal, cardiovascular), and for mental disabilities, it does not matter much whether the disability is for PTSD or some other mental disability.

If we only look at those with a physical primary disability, our findings indicate that service-disabled veterans are generally at parity at the average age of first entry into VA compensation system (50 to 55 years of age). This is true for each of the rating groups. However, we observed earnings ratios substantially below parity for service-disabled veterans who were IU, and slightly below parity for those who were 100-percent disabled, who entered at a young age (age 45 or less).

For those with a mental primary disability, our findings indicate that their earnings ratios are generally below parity at the average age of entry, except for the severely disabled (IU and 100-percent disabled).

We find that the severely disabled who enter at a young age are substantially below parity.

To summarize the earnings ratio findings for male veterans, there is general parity overall. However, when we explored various subgroups, we found that some were above parity, while others were below parity. The most important distinguishing characteristic is whether the primary disability is physical or mental. In general, those with a primary mental disability have lower earnings ratios than those with a primary physical disability, and many of the rating subgroups for those with a primary mental disability had earnings rates below parity. In addition, entry at a young age is associated with below parity earnings ratios, especially for severely disabled subgroups.

Veterans' quality-of-life survey results

The second principal tasking from the Commission was to assess whether the current benefits program compensates not just for loss of average earnings, but also for veterans' quality-of-life degradation resulting from service-connected disability. Addressing this issue required collecting data from a representative sample of service-disabled veterans, which would allow us to estimate their average quality of life. To do this, we constructed, in consultation with the Commission, a survey to evaluate the self-reported physical and mental health of veterans and other related issues. CNAC's subcontractor, ORC Macro, conducted the survey and collected the data. As with the earned income analysis, we designed the survey to collect data by the major subgroup. We defined subgroups by the body system of the primary disability and combined disability rating. We also characterized the survey results by IU status within the 50- to 90-percent disabled subgroup.

The survey utilized 20 health-related questions taken from a standardized bank of questions that are widely used to examine heath status in the overall population. The questions allowed us to calculate a physical health summary score (physical component summary, or PCS) and a mental health summary score (mental component summary, or MCS). As this approach is widely used to measure health status, it allowed us to compare the results for the service-disabled veterans to widely published population norms.

For evaluating the survey, we analyzed the results by subgroup similar to the strategy we used for comparing earnings ratios. We looked at those with a primary physical disability and those with a primary mental disability separately. We also examined the PCS and MCS scores for additional subgroups within those categories. For the population norms, the PCS and MSC averages are set at 50 points.

For service-disabled veterans with a primary physical disability, we found that their PCS measures were below population norms for all disability levels, and that the scores were in general lower as the disability level increased. In addition, having

a primary physical disability was not generally associated with reduced mental health as measured by MCS. Mental health scores for those with a primary physical disability were close to population norms, although those who were severely disabled had slightly lower mental scores.

For service-disabled veterans with a primary mental disability, we found that both the physical and mental component summary scores were well below population norms. This was true for each of the rating groups. This was a distinction from those with a primary physical condition, who (except for the severely disabled) did not have MCS scores below population norms.

To summarize our overall findings, as the degree of disability increased, generally overall health declined. There were differences between those with physical and mental primary disabilities in terms of physical and mental health. Physical disability did not lead to lowered mental health in general. However, mental disability did appear to lead to lowered physical health in general. For those with a primary mental disability, physical scores were well below the population norms for all rating groups, and those with PTSD had the lowest PCS values.

Combining earnings and quality-of-life findings for service-disabled veterans

The quality-of-life measures allow us to examine earnings ratio parity measures in the context of quality-of-life issues. In essence, the earnings parity measures allow an estimate of whether the VA compensation benefits provide an implicit quality-of-life payment. If a subgroup of service-disabled veterans has an earnings ratio above parity, they are receiving an implicit quality-of-life payment. At parity, there is no quality-of-life payment, and those with a ratio less than parity are effectively receiving a negative quality-of-life payment. We turned next to considering the implicit quality-of-life payment in the context of the veterans' self-reported health status.

With regard to self-reported quality of life, we had multiple measures to consider, such as the PCS and MCS measures, and a survey question on overall life satisfaction. In addition, there is no intrinsic valuation of a PCS score of 42 compared to a score of 45. We know that a score of 45 reflects a higher degree of health than a score of 42 does, but we have no precise way to categorize the magnitude of the difference. To simplify the analysis, we combined the information from the PCS and MCS into an overall health score, with a population norm of 100 points (each scale had a norm of 50 points separately). Then we calculated the population percentile that would be attributed to the combined score. For example, for a score of 77 points, we know that 94 percent of individuals in the age range 45 to 54 would score above 77. This gave us a way to calibrate our results, in terms of how the overall physical and mental health of the service-disabled veterans compared to population norms. By construction, the 50th percentile is the population norm of this overall measure.

The results of this analysis confirmed our earlier finding that there are more significant health deficits for those with a primary mental disability than a primary physical disability. We found that overall health for those with a mental primary disability is generally below the 5th percentile in the typical working years for those who are 20 percent or more disabled (this would represent a combined score of 77). Even for the 10-percent group, the overall health score is generally below the 20th percentile (a combined score of 83).

This approach lets us compare the implicit quality-of-life payment, based on the parity of the earnings ratio, to the overall health percentile and the overall life satisfaction measure (the percentage of respondents who say that they are generally satisfied with their overall life). We investigated this by rating group and average age at first entry, separately for those with a physical primary disability compared to a mental primary disability.

For those with a physical primary disability, the average age at first entry varies from 45 to 55, rising with the combined degree of disability. For 10-percent and 20- to 40-percent disability, there is a negative quality-of-life payment, although their overall health percentile ranges from 28 to 15 percent. For these groups, the overall life satisfaction ranges from 78 to 73 percent. For higher disability groups, there is a modest positive quality-of-life payment, ranging as high as $2,921 annually for the 100-percent disabled group. For the 100-percent disabled group, the overall health percentile is 4, meaning that 96 percent of the population would have a higher health score than the average score for this subgroup, and the overall life satisfaction is only 60 percent.

In evaluating the service-disabled veterans with a mental primary disability, we found that there was an implicit negative quality-of-life payment for veterans of all disability levels except for those receiving IU. Also, for these subgroups, the overall

health percentile was at the 13th percentile for 10-percent disabled and at the 6th percentile for 20- to 40-percent disabled. In fact, for the higher disability groups, the overall health score was at or below 1 percent, meaning that 99 percent of the population would have a higher overall health score. Overall life satisfaction, even for the 10-percent disability level, was only 61 percent. For disability levels 50- to 90-percent, IU, and 100-percent disabled, the overall life satisfaction measure hovered around 30 percent.

With regard to the existence of implicit quality-of-life payments, we found positive quality-of-life payments for those with a physical primary disability at a combined rating of 50 to 90 percent or higher (except for IU). For those with a mental primary disability, we found that there is a positive quality-of-life payment only for the IU subgroup. In comparing overall health percentiles and life satisfaction, however, we found that for all rating groups, those with a mental primary disability have lower overall health percentiles, and substantially lower overall life satisfaction, than those with a physical primary disability. Those with a mental primary disability have lower health and life satisfaction compared to those with a physical primary disability, but receive less in implicit quality-of-life payments.

To summarize, we found that VA compensation is about right overall relative to earnings losses based on comparison groups for those at the average age at first entry. But the earnings ratios are below parity for severely disabled veterans who enter the system at a young age and more generally below parity among subgroups for those with a mental primary disability. Earnings ratios tend to be above parity for those who enter the VA system at age 65 or older. On average, VA compensation does not provide a positive implicit quality-of-life payment. Finally, the loss of quality of life appears to be greatest for those with a mental primary disability.

Raters and VSOs survey: pertinent results

With regard to the benefits determination process, the Commission asked us to gather information by conducting surveys of VBA rating officials and accredited veterans service officers (VSOs) of National Veterans Service Organizations (NVSOs). The intent was to gather insights from those who work most closely with the benefits determination and claims rating process. Through consultation with the Commission, we constructed separate (but largely parallel) surveys for raters and VSOs. The surveys focused on the challenges in implementing the laws and regulations related to the benefits determination and claims rating process and perspectives on how the process performs.

The content of the surveys looked at issues involving training, proficiency on the job, and resource availability and usage. Respondents were asked about what they considered to be their top three job challenges. They were also asked about how they decided or established specific criteria related to a claim, how smoothly the rating process went, and the perceived capabilities of the various participants in the process.

The overall assessment indicated that the benefits determination process is difficult to use by some categories of raters. Many VSOs find it difficult to assist in the benefits determination process. In addition, VSOs reported that most veterans and survivors found it difficult to understand the determination process and difficult to navigate through the required steps and provide the required evidence. Most raters and VSOs agreed that veterans had unrealistic expectations of the claims process and benefits.

Raters and VSOs noted that additional clinical input would be useful, especially from physicians and mental health professionals. Raters felt that the complexity of claims is rising over time, and that additional resources and time to process claims would help. Some raters felt that they were not adequately trained or that they lacked enough experience. They viewed rating mental disorder claims as more problematic than processing physical condition claims. They viewed mental claims, especially PTSD, as requiring more judgment and subjectivity and as being more difficult and time-consuming compared to physical claims.

Specific to the topics of this hearing, many raters indicated that the criteria for IU are too broad and that more specific decision criteria or evidence regarding IU would help in deciding IU claims. In addition, we asked raters and VSOs whether they thought it would be helpful or appropriate to separately rate the impact of a disability on quality of life and lost earnings capacity for disabled veterans applying for benefits. Separating the rating of quality of life from the earnings impact was not supported by a majority of either raters or VSOs. Raters did indicate that more specific criteria for rating and deciding mental health issues – especially PTSD – would be useful.

IU issues and mortality

The Commission asked us to conduct an analysis of those receiving the individually unemployable (IU) designation. This designation is for those who do not have a 100-percent combined rating but whom VA determines to be unemployable. The designation enables them to receive disability compensation at the 100-percent level.

Overall 8 percent of those receiving VA disability compensation have IU, but 31 percent of those with PTSD as their primary diagnosis have IU status. Ideally, if the rating schedule works well, the need for something like IU will be minimal because those who need 100-percent disability compensation will get it from the ratings schedule. The fact that 31 percent of those with PTSD as their primary condition have IU is an indication that the ratings schedule does not work well for PTSD.

Another issue is the rapid growth in the number of disabled veterans categorized as IU—from 117,000 in 2000 to 223,000 in 2005. This represents a 90-percent increase, an increase that occurred while the number of disabled veterans increased 15 percent and the total number of veterans declined by 8 percent. The specific issue is whether disabled veterans were taking advantage of the system to get IU status to increase their disability compensation.

The data suggest that this is not the case. While there has been some increase in the prevalence of getting IU status for certain rating-and-age combinations, the vast majority of the increase in the IU population is explained by demographic changes (specifically the aging of the Vietnam cohort) in the veteran population.

There have also been concerns that individual veterans may be taking advantage of the system to inappropriately gain IU benefits. We can use mortality rates to shed light on this issue. The question is whether those with IU have higher mortality rates than those without IU. If so, this would seem to provide evidence that there is a clinical difference between those with and without IU. We found that there are differences. Those with IU status have higher mortality rates than those rated 50–90 percent without IU, but the IU mortality rates are less than for the 100-percent disabled.

Rating system implications for IU

Many individuals receive the IU designation because they are unemployable. If the purpose of this designation truly relates to employment, there could be a maximum eligibility age reflecting typical retirement patterns. If the purpose is to correct for rating schedule deficiencies, an option is to correct the ratings schedule so that fewer need to be artificially rated 100-percent through IU. This would reduce the administrative burden of individual means testing associated with IU.

In addition, as noted above, almost a third of those with PTSD as their primary disability condition have IU status. This may be an indication that the ratings schedule does not work well for PTSD.

It is unlikely that changes to the rating schedule would be able to completely alleviate the need for the IU designation. There will always be instances in which a disabled veteran will be rated at less than 100 percent, but will be unable to continue working at the job customarily performed. However, rating schedule changes might lead to reductions in the number of veterans that apply for IU. In addition, the VA may want to consider whether putting more emphasis on retraining programs might prove useful to veterans designated as IU.

Statement of Mark H. Hyman, M.D., FAADEP
Presenter, American Academy of Disability Evaluating Physicians, and Mark H. Hyman M.D., Inc., F.A.C.P., F.A.A.D.E.P., Los Angeles, CA

On behalf of the American Academy of Disability Evaluating Physicians, (AADEP), a duly constituted AMA delegated non-profit specialty society, I have prepared the following remarks. Having reviewed the document, *A 21st Century System for Evaluating Veterans for Disability Benefits*, I wish to stress the following points in support of changes to the Veterans Disability System:

1. I am a strong advocate for the adoption of national standards that are currently in use for the majority of jurisdictions in our country, including the AMA *Guides to the Evaluation of Permanent Impairment*, ICD and DSM codes. Importantly, the legislation should clearly provide for automatically incorporating updates for these resource standards when new editions are published.

2. Additional resources that will directly aid in this process include the AMA books-*A Physician's Guide to Return to Work, Guides to the Evaluation of Disease and Injury Causation*, as well as other resources soon to be released.
3. A secondary benefit of promulgating these same current national standards and medical textbooks is that all evaluating parties will be speaking a common medical language. This also aids in teaching, as well as recruitment of personnel who are involved in the evaluation process.
4. Any unique aspects of the Veteran's claims experience can then be applied to the impairment rating process so that any perceived area of inadequacy is addressed.
5. I advocate the formation of the recommended advisory Committee to be constituted by representatives of both private and governmental sectors to monitor implementation, assess changes and provide direction to incorporate evolving concepts. The advisory Committee must have at minimum, once yearly face-to-face meetings to carry out their duties. The Advisory Committee must have recognized Subcommittees that review education and training of personnel and another to review administrative claims handling including outcomes research. Important decisions regarding how the Veteran's system chooses to define disability will need to be explored.
6. All claims and evaluations must be migrated to an electronic health record.
7. Consideration will need to be given to presumptive conditions which may streamline some of the claims processing.
8. A roundtable discussion is necessary in the upcoming months to further crystallize specific recommendations by all shareholders in the process, with continued outside input from private sector entities being essential.
9. AADEP stands ready to provide educational support and intellectual resources to guide any transition process.
10. AADEP is prepared to offer special accommodations for any active duty military personnel, reserve personnel, Veteran Affairs Staff, as well as governmental workers to our educational programs and academy.

I have read the Institute of Medicine report, and do wish to outline my recommendations from a private sector experience. In the community, an injured person files a claim within a recognized jurisdiction-usually at a state level. This triggers a claims handling by either a private insurance entity or a state mandated agency. Records are obtained and the patient is then referred to a physician for evaluation. A report is prepared in the format required by that jurisdiction. The findings on evaluation are then translated into an impairment rating, with subsequent administrative actions pursued.

Implementation of the recommendations of the report would bring our veterans system in a closer approximation to what I have just described. In particular, I must strongly underscore the need for a common language in this process which emanates from using already existing national standards including the AMA Guides, ICD and DSM coding. These resources are the product of multiple leaders throughout the world. The AMA Guides began in 1958 in response to the developing field of disability evaluation. The mission has always been to bring the soundest possible reasoning to the impairment process. The Guides have become the community standard in the majority of states within our country. In essence, the Guides are the tools and rules of the disability trade. We have just produced the 6th edition of this seminal work and there are many companion books that go with this resource. Together, these books represent the efforts of experts around the country who regularly work in the disability field. There is also a mechanism of updating this information through a newsletter until there is the need for a more major revision. Through this mechanism that is used in the private sector, we can thoroughly describe and categorize the range of human injury. We are able to develop a fair, equitable, consistent rating on an individual's impairment, small or large. Further, the Guides are aligned with the World Health Organization model of disablement termed the International Classification of Functioning, Disability and Health.

As with all jurisdictions, once an impairment rating process has occurred, then, like all jurisdictions, any specific, unique, coding or administrative concerns can then be added to the process. Indeed, in many jurisdictions, the evaluators may not even fully know all the subsequent claims processing above their impairment rating. In the current VA example, raters could take this report from the medical evaluation, and cohesively apply the disability rating with good reproducibility.

The use of these resources will allow for transition to an electronic health record system, which is currently the standard for the Veterans health system on the medical side. Tracking of data then becomes much easier.

To accomplish this process, all shareholders form the VA system must have a seat at preliminary roundtable discussions and have input into the recommendations from the advisory Committee. The advisory Committee must be charged and funded to meet at least once yearly, with quarterly telephonic meetings, in order to ensure implementation, assess outcomes and ensure proper education. I can not underscore enough the importance of education as this field is one that is not covered well or extensively in standard medical training and has many unique aspects which must be understood. By using the resources which I have identified as central to this process, the common language of impairment and disability will be broadened to all personnel involved in the process. I personally, as a citizen of this great country, and our organization AADEP that I am representing today, offer assistance to you in furthering this project.

Thank you for allowing me to help our country, but in particular, for giving me a chance to help those men and women who have provided for our security, that we can meet here today and try to repay their effort in some way. May God bless you in your deliberations.

2007 Annual Report
AADEP: Doctors Teaching What They Do Best
21 Years
AADEP Fact Sheet

HISTORY

The Chicago-based American Academy of Disability Evaluating Physicians (AADEP) is a multi-disciplinary, collegial organization, which transcends the many specialties of its Fellows and Members. Founded by Orthopaedic Surgeons in 1987, the Academy celebrated its 20th Anniversary in 2006 in St. Petersburg, Florida. Just 75 physicians met at the First Annual Scientific Session in Detroit to hear 8 hours of continuing medical education. The 2008 meeting will offer more than 25 CME hours to 300 physicians. Nearly 2000 physicians have achieved Fellow status, the only enhanced credential for those physicians who evaluate disabilities or rate impairments. Nearly 300 have achieved a CEDIR (Certification in Evaluation of Disability and Impairment Rating). The Academy's mission is quality CME and its vision is to be the pre-eminent authority in disability evaluation. That mission stretched to Dublin and Amsterdam with EUMASS (European Union of Medical Assurance in Social Security) in June 2006, and to Majorca in 2007.

MEMBERSHIP

Membership has more than doubled since inception, AADEP now stands at 1050, 90 percent are Fellows and 37 percent are AMA Members. Members represent 23 ABMS specialties, predominantly:

26 percent Orthopaedic Surgery
14 percent PM&R
13 percent Family/General Practice
10 percent Occupational Medicine
and are from all 50 states, Puerto Rico and 6 countries.

ASSOCIATE MEMBERSHIP

Fellows approved Associate Membership for all others on the evaluation team in 2003—a major step toward an inclusion perspective. Associate Members make up 3 percent of the total.

CONTINUING MEDICAL EDUCATION

AADEP has trained nearly 20,000 physicians since its founding. The Academy now provides advanced educational offerings to at least 2000 physicians annually. AADEP maintains its integrity and credibility as an educator with 45 volunteer faculty teaching more than 300 segments with average ratings of 4.5 on a 5.0 scale. AADEP is also an approved provider for mandated courses in Texas, Ohio and Pennsylvania. With publication of the AMA *Guides to Evaluation of Permanent Impairment*, 5Mh Edition, the need for impairment rating courses will grow. The real growth will be the disability focus, using Evidence Based Medicine skills and tools. Web based guidelines require additional education.

ACADEMY HALLMARKS

- Single Source of Focused Disability Evaluation Education
- High Energy Network of Experts
- Access to Physician Resources on Complex Issues
- Disability Medicine Standard Bearers
- Unique Certification (CEDIR)
- Clearinghouse of Best Available Evidence and EBM tools
- Practice Improvement with Evidence-Based Medicine

AMERICAN ACADEMY OF DISABILITY EVALUATING PHYSICIANS
223 West Jackson Boulevard
Suite 1104
Chicago, IL 60606–6900
Telephone: 1/800–456–6095

AADEP PROVIDES EXPERTS

- To Develop Resources
- To Create/Edit New Publications
- To Testify for Fairer Adjudication
- To Teach Best Practices
- To Fulfill Individual Physician Needs
- To Improve Injured Worker Outcomes
- To Consult with Physician Learners

AADEP PROVIDES PRE–EMINENT CME

- Outstanding Annual Scientific Session with internationally recognized faculty
- Customized Impairment Rating Courses
  - Texas (5–7 annually)
  - Ohio (one annually)
  - Pennsylvania (as mandated)
  - Washington (as requested)
  - Other States

AADEP PROVIDES ADDITIONAL CME

- 2–4 AMA *Guides* Impairment Rating Courses
- 5–6 MDA*/ODG** Courses
- Customized ODG Courses (as requested)
- Functional Capacity Exam Courses
- Customized Courses for Medical Associations/Healthcare Institutions
- At least 15–18 Live CME Activities Annually

* Medical Disability Advisor (MDA)
** Official Disability Guidelines (ODG)

AADEP DESIGNATES FELLOWS

- Recruits Members
- Provides Annual Comprehensive Education Course (Austin, TX 2008)
- Peer Reviews Reports
- Evaluates Credentials
- Has Designated Nearly 2000 Nationally and Internationally

AADEP CERTIFIES EXPERTS

- Provides Specific Certification Exams (states, editions of Guides) – since 2002
- Certifies at Least 75 Annually as CEDIR (Certification in Evaluation of Disability and Impairment Rating (CEDIR)
- Approved Certification Provider in Texas
- Offers Exam at All Live CME Activities

AADEP EDUCATES

- Physicians
- Attorneys

- Psychologists
- Insurance Co. Representatives
- Industrial Health Services Groups
- Occupational Health Nurses
- Certified Claims Managers
- Certified Vo-Rehab Consultants
- All Members of the Disability Arena

AADEP TESTIFIES

- For Institute of Medicine Committee on Social Security
- Before House Subcommittee on Veterans' Affairs
- AMA Committees
- Before State Boards of Inquiry
- As Expert or Peer Review Witnesses in Courts of Highest Jurisdiction on Legal Issues of Disability

AADEP VOLUNTEERS

- As Resource Authors
- As Contributing Authors
- As Reference Work Editors
- As Board Members
- As Researchers
- As Faculty for AADEP and Other Aligned Organizations

AADEP COLLABORATES

- With AMA as Member of House of Delegates
- With governmental Bureaus/Agencies
- With Allied Product Developers
- With AMA Press
- With Affiliated Specialty Societies
- With Universities
- With Medical Practices

AADEP HEADQUARTERS IN CHICAGO

- Organized as Illinois not-for-profit in 1989
- Accredited CME Provider since 1991
- Provided Hundreds of CME Activities—Both Live and Distance Learning
- 1050 MD/DO Members
- 950 Fellows
- 50 Associate Members

AADEP INFORMS

- Reach by e-mail aadep@aadep.org
- Check website www.aadep.org
- Call 1/800/456–6095
- Inquire of Headquarters for "hot line" to AADEP Fellows
- Talk to the Executive Director at Ext. 21

Statement of Sidney Weissman, M.D.
Member, Committee on Mental Healthcare for Veterans and Military Personnel and Their Families, American Psychiatric Association

Good afternoon. I am Sid Weissman M.D., and am pleased to have this opportunity meet with you representing the American Psychiatric Association, the medical specialty organization which represents over 37,000 psychiatrists, their patients and families. My professional experience includes serving as a psychiatric physician for the United States Air Force and 6 years with the Department of Veterans Affairs.

The American Psychiatric Association (APA) is responsible for the preparation, publication, and maintenance of the Diagnostic and Statistical Manual of Mental Disorders, which is now in its fourth edition (DSM–IV). Thus, we have a vital inter-

est in the work of this Subcommittee, and particularly the interest in "expanding the criteria for psychiatric disabilities, especially for Post Traumatic Stress Disorder (PTSD)."

As you have heard from many experts, there is a long history of examining responses to stress, beginning early in this century, with the notion of "shell shock" in World War I and the analytic concept of "traumatic neurosis." During WW II Roy Grinker and John Spiegel published *War Neurosis in North Africa and Men under Stress* addressing the stresses experienced by Army Aviators. Their work ushered in the era of scientific study of stress which extends to the present. This work has expanded to address all severe psychologically traumatizing life events in addition to those experienced in wartime in combat. The extensive scientifically informed work over the past 50-plus years has resulted in a professional consensus, based increasingly on a rigorous scientific base, of the explicit clinical characteristics of PTSD, its prevalence, and its responsiveness to appropriate treatment.

We understand that the Committee has an interest in the utilization of the diagnosis of PTSD in active duty and discharged military personnel and the impact of this diagnosis on the determination of health benefits and compensation for service-induced disability.

Need for a Definition Reference Point

All mental disorders – ranging from mild depression to schizophrenia to PTSD – vary in the disability associated with each particular diagnosis. Hence, questions of disability and severity are at the heart of compensation assessments for SSDI and SSI in the civilian governmental sector. Because of the broad use of diagnostic criteria, it is important for all clinical, research, insurance claims management, and governmental use of mental disorder diagnoses to have a common frame of reference for diagnostic assessments. Without such a common reference point, the potential for the development of idiosyncratic diagnostic systems may lead to a dysfunctional and non-cumulative research base and to misuse of diagnostic approaches for financial or political purposes.

I hope it will be helpful to the Committee to have some additional background information about the development of diagnosis criteria and reporting of mental disorders in the U.S. and internationally. After the development of the United Nations in the late 1940's, each signatory to the UN Charter agreed to use the World Health Organization (WHO) International Classification of Diseases (ICD) for all morbidity and mortality recording—to assure comparable international health statistics. Within the U.S., there has been a Clinical Modification (CM) of the ICD codes since about 1977 when the ninth revision (ICD–9) was issued by the WHO. Although there was a list of mental disorder definitions included in the ICD–9-CM, the NIMH supported research community began using a much more detailed set of explicit Research Diagnostic Criteria (RDC) to obtain greater homogeneity of research subjects. In 1980, the APA proposed a third edition of the Diagnostic and Statistical Manual (DSM–III) that was based heavily on the RDC prototype of explicit diagnostic criteria, that could be seen as testable hypotheses for their validity in predicting clinical course, treatment response, and eventual etiological information such as genetics or environmental exposure.

This diagnostic prototype was almost immediately adopted by the international psychiatric community, convened by the WHO Division of Mental Health in a historic 1982 Copenhagen conference. The WHO then worked jointly with the APA and NIMH over the next decade, using the DSM–III as a common reference point, to develop almost identical diagnostic criteria for ICD–10 and subsequently DSM–IV. Unfortunately, the U.S. has not yet adopted the ICD–10–CM and continues to use ICD–9-CM diagnostic codes for required Medicare claims submissions by the Centers for Medicare & Medicaid services (CMS) (and by private insurance carriers as well). However, for the past 26 years, mental health and other healthcare practitioners have been using an alternative set of "descriptors" for ICD–9-CM codes, provided in successive editions of the DSM by the American Psychiatric Association (APA).

This alternative classification system for mental disorders is the Diagnostic and Statistical Manual of Mental Disorders, now in its 4th edition (called DSM–IV). Even though the American Psychiatric Association publishes the DSM–IV, psychologists, social workers, counselors, mental health administrators, and policy planners use it routinely for clinical management, recordkeeping and communication. Epidemiological surveys and studies of mental health practice patterns use DSM–IV definitions for ascertainment of appropriate case inclusion. Practice guidelines for clinicians to improve and standardize patient care are keyed to the DSM definitions. Virtually all research studies on mental disorders define study populations in terms of the DSM categories. Students of medicine, law, psychiatry, psychology, social

work, and all other mental health professions rely on textbooks that describe mental disorders based on the DSM definitions.

Furthermore, DSM–IV is the *de facto* official code set for various Federal agencies and for virtually all states. Indeed, there are over 650 Federal and state statutes and regulations that rely on or directly incorporate DSM's diagnostic criteria. For example, the Department of Veterans Affairs disability program uses the diagnostic criteria in DSM–IV to assess whether an applicant qualifies for disability on the basis of a mental disorder [38 CFR § 4.125]. In addition, CHAMPUS required that the "mental disorder must be one of those conditions listed in the DSM–III" [32 CFR § 199.2]; and Medicaid beneficiaries who apply for admission to nursing facilities because of a mental disorder must meet diagnostic criteria set out in DSM [42 CFR § 483.102]. In California, Medicaid reimbursement to hospitals is keyed to the DSM–IV [9 CCR §§ 1820.205(a)(1)(B) and 1830.205(b)(1)(B)], while in Tennessee, the mental health qualifications to serve as a police officer incorporate by statute DSM [Tenn. Code Ann. § 38–8-106], as do the driver's license provisions of Pennsylvania law [67 Pa. Code § 83.5].

APA is in the process of assessing the evidence base for PTSD and all other mental disorders in anticipation of a revision of the DSM scheduled for publication in 2011. In June 2005, APA, with the collaboration of the World Health Organization and grant support from the National Institutes of Health, convened an international research planning conference on stress-induced and fear circuitry disorders, a diagnostic grouping that subsumes PTSD.

A key product of the APA/WHO/NIH conference was the compilation of specific recommendations for research, based on a critical assessment of the existing science base and our identification of near-, intermediate-, and longer term opportunities for diverse studies and analyses. In early March of last year, the APA appointed an official DSM–V Revision Task Force which includes a workgroup on stress-related disorders, including PTSD, which will recommend any modifications to the diagnostic criteria that are supported by the science base. The chair of the workgroup is Dr. Matthew Friedman. He is a psychiatrist and Executive Director of the U. S. Department of Veterans Affairs National Center for Post Traumatic Stress Disorder (PTSD) so he brings a critical perspective to the review of the DSM. A particular focus of this DSM–V workgroup is the reevaluation of the relationship between mental disorders and disability. Research exploring disability and impairment may benefit from the diagnosis of mental disorders being uncoupled from a requirement for impairment or disability in order to foster a more vigorous research agenda on the etiologies, courses, and treatment of mental disorders as well as disabilities and to avert unintended consequences of delayed diagnosis and treatment.

The APA welcomed the IOM's intensive review of the VA disability ratings process and how it related to the DSM. Any additional information that is specific to the Veteran's population from emerging from your review will certainly be most welcome by the DSM–V task force Committee.

In closing, we hope that knowledge gained from working with our Veterans population will be incorporated into the U.S. and international diagnostic conventions for mental disorders rather than be used to develop into an idiosyncratic diagnostic system unique to the VA or to the Department of Defense. Likewise, we would hope that there will be a similar interaction with experts convening to study mental health disorder disability assessment, treatment, management and compensation programs which are supported by the Social Security Administration. One instructive source for these and other expert groups may be found in the work and decisions of the United Nations Compensation Commission, a subsidiary of the U.N. Security Council. The Commission was established in 1991 to process claims and pay compensation – including compensation to claimants who suffered personal injury and mental pain and anguish – resulting from Iraq's invasion and occupation of Kuwait. A common goal for both civilian and military populations is to structure the most effective strategies for maximizing treatment response and functional capacity in those impacted by disability associated with a mental disorder.

Thank you very much.

Statement of Ronald B. Abrams
Joint Executive Director, National Veterans Legal Services Program

Mr. Chairman and Members of the Subcommittee:

I am pleased to have the opportunity to submit this testimony on behalf of the National Veterans Legal Services Program (NVLSP). NVLSP is a nonprofit veterans service organization founded in 1980 that has been assisting veterans and their ad-

vocates for 28 years. We publish numerous advocacy materials that thousands of advocates for veterans regularly use as practice tools to assist them in their representation of VA claimants. NVLSP also recruits and trains volunteer attorneys, trains service officers from such veterans service organizations as The American Legion and Military Order of the Purple Heart in veterans benefits law, and conducts quality reviews of the decisionmaking of the VA regional offices on claims for VA benefits on behalf of The American Legion.

In addition, NVLSP represents veterans and their families on claims for veterans benefits before VA, the U.S. Court of Appeals for Veterans Claims (CAVC), and other Federal courts. Since its founding, NVLSP has represented over 1,000 claimants before the Board of Veterans' Appeals and the Court of Appeals for Veterans Claims (CAVC). NVLSP is one of the four veterans service organizations that comprise the Veterans Consortium Pro Bono Program, which recruits and trains volunteer lawyers to represent veterans who have appealed a Board of Veterans' Appeals decision to the CAVC without a representative.

In General

Obviously, updating, modernizing, and otherwise improving the rating schedule would be beneficial to veterans. NVLSP would like to caution, however, that improving the rating schedule should not be considered as cure-all. For example, there is no amount of money that would adequately compensate anyone for the loss of (or loss of use) of a body part, permanent cognitive impairment, or loss of a creative organ. Ideally, in dealing with severe service-connected disability, we should not ask how much is the disability worth, we should ask how much we can this Nation afford to pay.

NVLSP suggests that the rating schedule be amended so that it would more accurately reflect both the impact on the average impairment in earning capacity and the negative impact of the disability on the veteran's lifestyle. The current special monthly compensation rules which are intended in some respects to reflect adverse changes in lifestyle, (*see* 38 U.S.C. 1114 and 38 C.F.R. § 3.350) are complicated, confusing, and do not accurately reflect the negative impact of mental disorders on a veteran's industrial capacity and lifestyle.

The fact that some veterans are not adequately compensated for their service-connected mental disabilities does not mean that the VA should reduce the evaluation of some physical disabilities. This is not a zero-sum game. Also, we caution that no change to the rating schedule should adversely impact any current servicemember.

Evaluation of Mental Conditions

For a long time, the VA has tended to under-evaluate mental disabilities. This has occurred at the same time that our society has evolved from one dominated by manual labor to a work environment that emphasizes intellectual endeavors. Therefore, the adverse impact of a mental disability on the average worker has increased over time. That impact should not be constrained to whether the average person suffering from a mental disability could work on the type of farm that existed in 1947.

The VA should adopt new criteria for rating the degree of disability for all mental conditions that reflect the adverse impact that severe mental disabilities have on an individual in the civilian world today. In addition, the rating schedule for mental disorders should be amended to remove the unfavorable disability rating criteria that apply to veterans suffering from mental disorders when compared to veterans suffering from physical disorders. The rating schedule permits veterans with 100 percent scheduler evaluations for all conditions other than mental conditions to be evaluated as 100 percent disabled even if they are gainfully employed.

Veterans who suffer from severe mental disabilities and cannot perform any work can be evaluated as 100 percent disabled. But veterans suffering from a mental disorder cannot be rated 100 percent disabled if they are engaged in any employment, despite the severity of their mental condition. In the experience of NVLSP, some severely mentally disabled veterans can be lucky enough to find a job where they can be somewhat productive. They should not be penalized for trying to do some work while other veterans with physical disabilities are receiving compensation at the 100 percent disability level and earn a full-time salary as a productive worker. This does not mean that there should not be some connection between earned income and the evaluation of mental conditions. We just suggest that the connection be not so absolute.

Total Disability Based on Individual Unemployability (IU)

NVLSP agrees with the current VA rating policy regarding IU. Veterans who are so unlucky to suffer from both severe service-connected disabilities and severe non-service-connected disabilities should not be punished because they have multiple disabilities. If a veteran's service-connected conditions would cause him or her to be

unable to perform substantial gainful employment, that veteran should be awarded total disability based on individual unemployability.

NVLSP rejects any recommendation that would require the VA to implement a periodic and comprehensive evaluation (or review) of veterans in receipt of IU benefits. As a VA employee in the eighties, I had to perform some of these reviews. They tend to become witch hunts. While NVLSP has no problem with the VA reviewing grants of disability benefits on a case-by-case basis, we oppose any systematic review of IU benefits. Also, age should never be any factor in the award or evaluation of compensation benefits. With Supreme Court justices regularly working well past age 80, and candidates for President over age 70, age should not be considered as a positive or negative factor.

38 C.F.R. § 3.340 states:

> (a) Total disability ratings—(1) General. Total disability will be considered to exist when there is present any impairment of mind or body which is sufficient to render it impossible for the average person to follow a substantially gainful occupation. Total disability may or may not be permanent.

The longstanding policy should not be changed. It is fair and compassionate. *See also*, 38 C.F.R. § 4.16(b).

Improving rating criteria for Traumatic Brain Injury

NVLSP commends the efforts of the Department of Veterans Affairs' (VA) to revise the current evaluation criteria for TBI. The current diagnostic code (DC 8045) is very restrictive and promotes inadequate evaluations. The current DC is unfair because subjective symptoms of TBI are limited to a 10 percent evaluation without any consideration to the frequency and severity of these symptoms. (The current DC provides that "*[P]urely subjective complaints such as headache, dizziness, insomnia, etc., recognized as symptomatic of brain trauma, will be rated as 10 percent disabling and no more. . . . [without a diagnosis of multi-infarct dementia associated with the brain trauma].*"

Addressed below are specific comments regarding the following provisions of the proposed rule:

Evaluation of Symptom Clusters

The VA proposes to replace the subjective guidelines under DC 8045 with new evaluation levels of 20, 30 and 40 percent. The subjective symptoms are now lumped into a category described by the VA as *symptom clusters*.

While the proposed regulation is an improvement, the Legion and NVLSP believe that veterans who suffer from TBI should not be required to satisfy the narrow criteria for an extra-schedular evaluation in order to receive a total disability rating. Veterans who suffer from frequent and severe "symptom clusters" are unlikely to be able to obtain substantial gainful employment. Those who are unable to obtain substantial gainful employment due to a service-connected disability should be entitled to a 100 percent disability rating. But VA's proposed rule places a significant roadblock to a 100 percent disability rating for "symptom clusters."

Under VA's proposal, a veteran is entitled to no more than a 40 percent schedular disability rating, no matter how frequent or severe the following "symptom clusters" are:

headaches, dizziness, fatigue, malaise, sleep disturbance, cognitive impairment, difficulty concentrating, delayed reaction time, behavioral changes, emotional changes, tinnitus or hypersensitivity to sound or light, blurred vision, double vision, decreased sense of smell and taste, and difficulty hearing in noisy situations in the absence of hearing loss,

The general pathway a veteran must travel to obtain a total disability rating for individual unemployability ("TDIU") is to obtain at least a 70 percent schedular rating and satisfy the requirements for TDIU under 38 C.F.R. § 4.16(a). But under VA's proposal, veterans suffering from "symptom clusters" would be unable to obtain any schedular rating higher than 40 percent, no matter how frequent or severe the symptom clusters are. This means that the only pathway to a 100 percent disability rating is if VA grants an extra-schedular rating under 38 C.F.R. § 4.16(b). Because very few extra-schedular ratings are issued by VA, (especially an extra-schedular grant of total disability based on individual unemployability) this is highly unfair.

The VA indicates that the current diagnostic code 8045 is 45 years old and reflects a view that the various symptoms associated with TBI could be due to malingering or hysteria. It appears this comment was inserted to explain the current rating policy.

Under the proposed rule, there must be at least three of the above listed symptoms present for a compensable evaluation to be assigned. The disability percentage would be based on a specific number of symptoms present (40 percent—9 or more

symptoms; 30 percent—5–8 symptoms; 20 percent—3 or 4 symptoms). The proposed regulation wrongly fails to credit the frequency and severity of these symptoms.

NVLSP appreciates that VA now has recognized that these symptoms could be due to subtle brain pathology. Because, however, the VA proposes to replace the current 10 percent maximum evaluation with rating levels of 20, 30, and 40 percent, NVLSP is concerned that this rating formula would continue to promote unfair adjudications because just as in the current DC 8045, the frequency and severity of the symptoms are ignored.

Also, the proposed regulation does not discuss how and when the longitudinal history of the disability should be considered. For some veterans the symptoms of TBI may wax and wane. Therefore, some veterans may be under evaluated if the history of their symptomatology is not considered.

Evaluation of Cognitive Impairment

While the proposed regulation does attempt to define mild impairment for the purposes of evaluating cognitive impairment, the proposed regulation does not define the terms "moderately impaired" and "severely impaired." We strongly urge VA to define these terms with specificity to promote consistency and fairness in adjudication.

The formula used by the proposed regulation to evaluate the 11 common major effects of cognitive impairment would encourage much unfair adjudication. The proposed regulation is unfair because the formula does not fairly capture the impact of some of the major effects of cognitive impairment. For example suppose a veteran has a score of three because his or her TBI causes the veteran to require assistance with the activities of daily living some of the time (but less than half of the time). If the veteran had only zero scores in the other major effects of cognitive impairment, the veteran would be evaluated as only 10 percent disabled. This is patently unfair, especially given the fact that veterans with a mental condition that causes just mild memory loss could arguably receive a 30 percent evaluation under 38 C.F.R. § 4.130 (see the 9400 diagnostic code series).

Applicability Date

VA proposes that the provisions of this proposed rule would be applicable only to claims for benefits received by VA on or after the effective date of the rule. Therefore, pending claims would have to be adjudicated under the current unfavorable rule.

It does not make sense to apply the old rating criteria to a claim that has not been initially adjudicated, or is pending re-adjudication due to an appeal, simply because the claim was received prior to the effective date of the new rule. NVLSP urge you to amend this portion of the proposed rule to require claims and appeals filed prior to the effective date of the rule, but pending at the time the rule takes effect, to be adjudicated under the new rule.

Emotional and Behavioral Dysfunction and Comorbid Mental Disorders

It is clear, as admitted by VA in its comments, that many veterans who suffer from TBI also suffer from secondary depression (or other mental illnesses such as PTSD). Therefore, the proposed rule should be amended to require the VA to consider whether the record reasonably raises the issue whether service-connection is warranted for mental disorders (especially mental disorders secondary to the TBI) whenever service connection is granted for TBI, and, if so, to adjudicate such a separate claim. This should be done because it is fair and because many veterans with mental disorders at a disadvantage when it comes to prosecuting their claims.

Presumptions

The current "association" standard **should not**, as proposed by the Veterans' Disability Benefits Commission (VDBC), be replaced with a "causal effect" standard. Any move away from the "benefit of the doubt" standard would have a negative impact on all veterans. If we send our troops into dangerous places, and if we put our servicemembers into dangerous situations, our Nation must make certain to at least maintain the non adversarial nature of the VA claims process and protect the "benefit of the doubt" standard. The cost of compensating veterans who suffer from disabilities that are presumptive in nature is a cost of war.

Thank you for permitting NVLSP to testify on such an important issue.

Statement of Dean F. Stoline
Assistant Director, National Legislative Commission, American Legion

Mr. Chairman and Members of the Subcommittee:

Thank you for this opportunity to present The American Legion's views on revising the Department of Veterans Affairs (VA) Schedule for Rating Disabilities (VASRD). This statement will focus on the issues outlined in the Subcommittee's hearing invitation letter.

Rating Schedule (General)

The Veterans' Disability Benefits Commission (Commission or VDBC) specifically recommended the following with respect to the VASRD:

VA should immediately begin to update the current Rating Schedule, beginning with those body systems addressing the evaluation and rating of post-traumatic stress disorder and other mental disorders and of traumatic brain injury. Then proceed through the other body systems until the Rating Schedule has been comprehensively revised. The revision process should be completed within 5 years. VA should create a system for keeping the Rating Schedule up to date, including a published schedule for revising each system. **(Recommendation 4.23; Chapter 4, section I.5)**

While The American Legion does not disagree with the need to ensure an up-to-date VASRD, by removing out-of-date and archaic criteria and using current trends in medicine, science, and technology to evaluate disabilities, the issues with the Rating Schedule should be put in proper perspective. In fact, most major body systems in the Rating Schedule have been updated over the last several years.

In the opinion of The American Legion, the Rating Schedule is not the major cause of problems with the VA disability compensation process. The American Legion supports the updating of conditions such as traumatic brain injury (TBI) that have not been recently updated, but problems such as inadequate staffing, inadequate funding, ineffective quality assurance, premature adjudications, and inadequate training that plague the VA regional offices will not be resolved by an overhaul of the rating schedule and must be the major focus of any attempts to reform the adjudication process.

The American Legion must stress that we are a Nation at war. Therefore, no injury or disability to any current servicemember should receive less compensation because of an update to the Rating Schedule. Also, The American Legion believes the evaluations for some disabilities (for example: amputations, loss of use of a limb, loss of use of a creative organ) are under-compensated because these ratings fail to consider the impact of the disability on the veteran's quality of life. Other disabilities, such as mental conditions, are under-compensated because they fail to adjust to the changing work environment. The American Legion welcomes positive changes to the Rating Schedule to cure these inequities.

Evaluation of Post Traumatic Stress Disorder

The VDBC made the following recommendation regarding the evaluation of post-traumatic stress disorder (PTSD):

VA should develop and implement new criteria specific to post-traumatic stress disorder in the VARD. VA should base those criteria on the *Diagnostic and Statistical Manual of Mental Disorders* and should consider a multidimensional framework for characterizing disability due to post-traumatic stress disorder. **(Recommendation 5.28; Chapter 5, section III.3)**

The Rating Schedule currently uses one set of rating criteria for all mental disorders. There are unique aspects of PTSD that are not properly evaluated by the current rating criteria and The American Legion supports the development of rating criteria that addresses the specific symptoms involved with PTSD.

The VDBC further recommended:

VA should establish a holistic approach that couples post-traumatic stress disorder treatment, compensation and vocational assessment. Reevaluation should occur every 2–3 years to gauge treatment effectiveness and encourage wellness. **(Recommendation 5.30; Chapter 5, section III.3)**

While The American Legion supports a holistic approach to the treatment and compensation of PTSD that encourages wellness, we are concerned that a mandatory reevaluation every 2–3 years could result in undue stress among PTSD service-connected veterans. These veterans may be fearful that the sole purpose of such reevaluations would be to reduce compensation benefits. This perception could undermine the treatment process. We would, therefore, encourage study and review of possible unintended consequences regarding this portion of the Commission's recommendation.

Individual Unemployability

The VDBC made the following recommendations regarding the use and evaluation of total ratings based on Individual Unemployability (IU):

Eligibility for Individual Unemployability should be consistently based on the impact of an individual's service-connected disabilities, in combination with education, employment history, and medical effects of an individual's age or potential employability. VA should implement a periodic and comprehensive evaluation of Individual Unemployability-eligible veterans. Authorize a gradual reduction in compensation for Individual Unemployability recipients who are eligible to return to substantially gainful employment rather than abruptly terminating disability payments at an arbitrary level of earning. **(Recommendation 7.4; Chapter 7, section II.3)**

Recognizing that Individual Unemployability is an attempt to accommodate individuals with multiple lesser ratings, but who remain unable to work, the Commission recommends that as the VASRD is revised, every effort should be made to accommodate such individuals fairly within the basic rating system without the need for an Individual Unemployability rating. **(Recommendation 7.5; Chapter 7, section II.3)**

Although The American Legion supports the provision calling for the gradual reduction in compensation benefits for IU recipients who are able to return to substantially gainful employment, we strongly oppose the portion of the recommendation that could be interpreted as requiring the consideration of age in determining eligibility to IU. It is inherently unfair to punish an older veteran, who would not be able to work at any age because of a service-connected condition, while awarding the benefit to a similarly disabled younger veteran. The current rule states (in essence) that the impact of a service-connected condition on a veteran cannot be evaluated to a higher degree because the veteran is old (38 C.F.R. § 3.341(a)). The schedule is based on the average impairment in earning capacity. If the veteran cannot work because of service-connected disability(ies), then IU should be awarded.

Additionally, The American Legionis extremely leery of any recommendation that would encourage the elimination of a specific benefit program on the anticipation of a revised Rating Schedule that would supposedly eliminate the need for that benefit. The current policy as enunciated by 38 C.F.R. § 3.340 states, "[T]otal disability will be considered to exist when there is present any impairment of mind or body which is sufficient to render it impossible for the average person to follow a substantially gainful occupation." This policy is fair and consistent with the non-adversarial nature of the VA claims process. Therefore, this policy should not be altered. Veterans should not be punished because they are so unfortunate to suffer from both service-connected and nonservice-connected disabilities, either of which could cause unemployability.

38 C.F.R. § 4.16(b) states: ***It is the established policy of the Department of Veterans Affairs that all veterans who are unable to secure and follow a substantially gainful occupation by reason of service-connected disabilities shall be rated totally disabled.***

The bottom line is that veterans who are unable to work due to service-connected disability should be compensated at the 100 percent level, whether it be based on a scheduler evaluation (either single service-connected disability or a combined scheduler evaluation) or based on Individual Unemployability. This has been a longstanding VA policy and we see no need to change it. *See* 38 C.F.R. § 3.340.

Improving rating criteria for Traumatic Brain Injury

On January 3, 2008, VA published in the Federal Register a proposed regulation to amend the current criteria for the evaluation of Traumatic Brain Injury (TBI). The current diagnostic code (DC 8045) is very restrictive and promotes inadequate evaluations. In fact, VA specifically noted that the current DC 8045 is 45 years old and reflects a view that the various symptoms associated with TBI could be due to malingering or hysteria. The American Legion commends VA for recognizing this situation and for making an effort to revise the current evaluation criteria for TBI.

Symptom Clusters

The current criteria limit subjective TBI symptoms to a 10 percent rating evaluation without any consideration to the frequency and severity of these symptoms. Although the new criteria under the proposed regulation allow for ratings up to 40 percent for symptom clusters, frequency and severity of the symptoms are still not considered. Under the proposed rule, there must be at least three of the listed symptoms present for a compensable evaluation to be assigned. These symptom clusters include headaches, dizziness, fatigue, malaise, sleep disturbance, cognitive impairment, difficulty concentrating, delayed reaction time, behavioral changes, emotional changes, tinnitus or hypersensitivity to sound or light, blurred vision, double vision,

decreased sense of smell and taste, and difficulty hearing in noisy situations in the absence of hearing loss. The disability percentage would be based on a specific number of symptoms present (40 percent—9 or more symptoms; 30 percent—5–8 symptoms; 20 percent—3 or 4 symptoms).

The American Legion appreciates that VA now recognizes that these symptoms could be due to subtle brain pathology. Unfortunately, because VA proposes to replace the current 10 percent maximum evaluation with rating levels of 20, 30, and 40 percent, we are concerned that this rating formula would continue to promote unfair adjudications because, just as in the current DC 8045, the frequency and severity of the symptoms are ignored. This means that the maximum rating allowed would be 40 percent no matter how severe or frequent the symptom clusters. This 40 percent maximum rating makes it extremely difficult for a veteran to receive a total rating based on IU due to TBI symptom clusters because the proposed revised rating criteria do not allow for a rating of 60 percent, which is required to satisfy the scheduler requirements for IU under 38 C.F.R. § 4.16(a). This means that the only pathway to a 100 percent disability rating is if VA grants an extra-scheduler rating under 38 C.F.R. § 4.16(b). Because very few extra-scheduler ratings are issued by VA (especially an extra-scheduler grant of total disability rating based on IU), this proposed change is highly unfair.

Last, the proposed regulation does not discuss the consideration of the longitudinal history of the disability. For example, TBI symptoms for some veterans may wax and wane. Therefore, some veterans may be under evaluated if the history of their symptomatology is not considered.

Evaluation of Cognitive Impairment

While the proposed regulation does attempt to define mild impairment for the purposes of evaluating cognitive impairment, it does not define the terms "moderately impaired" and "severely impaired." We strongly recommend that VA define these terms with specificity to promote consistency and fairness in adjudication.

In the opinion of The American Legion and the National Veterans Legal Services Program (NVLSP), the formula used by the proposed regulation to evaluate the 11 common major effects of cognitive impairment would encourage much unfair adjudication. The proposed regulation is unfair because the formula does not fairly capture the impact of some of the major effects of cognitive impairment. For example, suppose a veteran has a score of three because his or her TBI causes the veteran to require assistance with the activities of daily living some of the time (but less than half of the time). If the veteran had only zero scores in the other major effects of cognitive impairment, the veteran would be evaluated as only 10 percent disabled. This is patently unfair, especially given the fact that veterans with a mental condition that causes just mild memory loss could arguably receive a 30 percent evaluation under 38 C.F.R. § 4.130 (see the 9400 diagnostic code series).

Applicability Date

VA contends that the provisions of this proposed rule would be applicable only to claims for benefits received by VA on or after the effective date of the rule. Therefore, pending claims would have to be adjudicated under the current unfavorable rule.

It does not make sense to apply the old rating criteria to a claim that has not been initially adjudicated, or is pending re-adjudication due to an appeal, simply because the claim was received prior to the effective date of the new rule. VA should amend this portion of the proposed rule to require claims and appeals filed prior to the effective date of the rule, but pending at the time the rule takes effect, to be adjudicated under the new rule.

Emotional and Behavioral Dysfunction and Comorbid Mental Disorders

It is clear, as admitted by VA in its comments, that many veterans who suffer from TBI also suffer from secondary depression (or other mental illnesses such as PTSD). Therefore, the proposed rule should be amended to require the VA to consider whether the record reasonably raises the issue whether service-connection is warranted for mental disorders (especially mental disorders secondary to the TBI) whenever service-connection is granted for TBI, and, if so, to adjudicate such a separate claim. This should be done because it is fair and because many veterans with mental disorders are already at a disadvantage when it comes to prosecuting their claims.

Presumptions

The VDBC made the following recommendations regarding the replacement of the current "association" standard with a "causal effect" standard in the presumptive disability decisionmaking process:

The goal of the presumptive disability decisionmaking process should be to ensure compensation for veterans whose diseases are caused by military service and this goal must serve as the foundation for the work of the Science Review Board. The Committee recommends that the Science Review Board implement its proposed two-step process. **[Institute of Medicine (IOM) Rec. 4] (Recommendation 5.11; Chapter 5, section II.1)**

The Science Review Board should use the proposed four-level classification scheme, as follows, in the first step of its evaluation. A standard should be adopted for "causal effect" such that if there is at least as much evidence in favor of the exposure having a causal effect on the severity or frequency of a disease as there is evidence against, then a service-connected presumption will be considered. **[IOM Rec. 5] (Recommendation 5.12; Chapter 5, section II.1)**

- Sufficient: The evidence is sufficient to conclude that a causal relationship exists.
- Equipoise and Above: The evidence is sufficient to conclude that a causal relationship is at least as likely as not, but not sufficient to conclude that a causal relationship exits.
- Below Equipoise: The evidence is not sufficient to conclude that a causal relationship is at least as likely as not, or is not sufficient to make a scientifically informed judgment.
- Against: The evidence suggests the lack of a causal relationship.

When the causal evidence is at equipoise and above, an estimate also should be made of the size of the causal effect among those exposed. **[IOM Rec. 7] (Recommendation 5.14; Chapter 5, section II.1)**

The American Legion does not support these recommendations because the "association" standard currently used in the presumption determination process is consistent with the non-adversarial and liberal nature of the VA disability claims process. Moreover, as is the case of the 1991 Gulf War, there is often a lack of specific or reliable exposure data. Due to improper recordkeeping, resulting in a lack of reliable exposure data, during Operations Desert Shield and Desert Storm, there is insufficient information to properly determine servicemember exposure to the numerous environmental and other hazards U.S. troops were exposed to in the Southwest Asia Theater of Operations during the war. A lack of such data would clearly diminish the value and reliability of a "causation" standard as recommended by the IOM. It should also be noted by this Subcommittee that despite its recommendation, the Commission stated that it was concerned that "causation rather than association may be too stringent" and encouraged further study of the matter.

Evaluating Quality of Life

The American Legion supports specifically addressing in the evaluation process the impact of a service-connected disability on a veteran's quality of life. We do realize, however, that properly evaluating and compensating for the impact of a service-connected disability on an individual's quality of life is not an easy task and we welcome further study on this matter, including the study VA has recently commissioned that will address qualify of life matters.

Closing

Thank you again, Mr. Chairman, for allowing The American Legion to present comments on these important matters. As always, The American Legion welcomes the opportunity to work closely with you and your colleagues to reach solutions to the problems discussed here today that are in the best interest of America's veterans and their families.

Statement of Kerry Baker
Associate National Legislative Director, Disabled American Veterans

Mr. Chairman and Members of the Subcommittee:

I am pleased to have this opportunity to appear before you on behalf of the Disabled American Veterans (DAV), to address the Department of Veterans Affairs' (VA) Schedule for Rating Disabilities (Rating Schedule).

The VA Rating Schedule is a key component in the process of adjudicating claims for disability compensation. The Rating Schedule consists of slightly more than 700 diagnostic codes organized under 14 body systems, such as the musculoskeletal system, organs of special sense, and mental disorders. For each code, the schedule provides criteria for assigning a percentage rating. The criteria are primarily based on loss or loss of function of a body part or system, as verified by medical evidence; although, the criteria for mental disorders are based on the individual's "social and industrial inadaptability." The schedule also includes procedures for rating conditions that are not among the 700 plus diagnostic codes. Ratings are combined into a single overall rating when a veteran has more than one disability.

It is critical that the Rating Schedule be as accurate as possible so that rating decisions based on it are valid, reliable, and fair. The Rating Schedule is valid when it reflects accurately a veteran's degree of disability. Likewise, it is reliable when veterans with the same disability receive the same rating or when two raters would give the same veteran the same rating. Additional factors, however, include the quality and relevance of medical information, accuracy and ease of use of information systems, training and experience of raters, effectiveness of the quality review system, and number of raters and other personnel involved in the claims adjudication process.

The present Rating Schedule was developed in 1945 and was based on revisions of schedules dating from 1917, 1925, and 1933. According to statute, the Secretary "shall from time to time readjust this schedule of ratings in accordance with experience" (38 U.S.C. § 1155). The 1945 Rating Schedule became effective on April 1, 1946. The first revision, or "extension," was issued on July 14, 1947. By 1956, when the President's Commission on Veterans Pensions (Bradley Commission) reported, there had been 14 extensions, most of them revising a specific section.

In 1961, VA addressed a part of the Rating Schedule largely dating from 1933. The designers of the 1945 schedule had kept the classifications and nomenclature for mental disorders from the 1933 schedule. The 1961 revision adopted four classifications of mental disorders: psychotic disorders, organic brain disorders, psychoneurotic disorders, and psychophysiologic disorders. The 1961 revision also updated the nomenclature; added up-to-date diagnoses from the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), such as dissociative, conversion, phobic, obsessive-compulsive, and depressive reactions; and dropped outmoded diagnoses.

In 1988, the General Accounting Office (GAO)—now the Government Accountability Office—issued the report *Need to Update Medical Criteria Used in VA's Disability Rating Schedule* based on medical reports that a major overhaul was needed: citing outdated terminology; diagnostic classifications that were outdated, ambiguous, or missing; evaluation criteria made obsolete by medical advances, and out-of-date specifications of laboratory tests. In response to the 1988 GAO report, VA published its intent to update the entire Rating Schedule in a series of Advance Notices of Proposed Rulemaking (ANPRM) in the *Federal Register* beginning in August 1989. The ANPRM indicated that other body systems would be subsequently scheduled for review until the medical criteria in the entire rating schedule had been analyzed and updated. The ANPRM also stated that this was "the first step in a comprehensive rating schedule review plan which will ultimately be converted into a systematic, cyclical review process." (ANPRM, 54 Fed. Reg. 34,531 [August 21, 1989]).

In preparing proposed and final versions of the sections of the Rating Schedule, VA considered the views of Veterans Health Administration clinicians, Veterans Benefits Administration raters, groups of non-VA medical specialists assembled by a contractor, and comments received in response to the ANPRM and Notice of Proposed Rule Making (NPRM). Revisions of nine body systems and the muscle injury part of the musculoskeletal system were made final and published in the *Federal Register* between 1994 and 1997. The audiology part of the special senses was finalized in 1999, and a 10th body system, the "skin," was finalized in 2002. In addition to the foregoing, individual sections of the Rating Schedule that have been updated since the beginning 1990 include, but are not limited to, the following:

Rating Schedule Part "A"

38 C.F.R. § 4.13:	Effect of change of diagnosis	October 1996
38 C.F.R. § 4.16:	Total disability ratings for compensation based on unemployability	August 1990 July 1993 October 1996
38 C.F.R. § 4.29:	Ratings for service-connected disabilities requiring hospital treatment	May 2006
38 C.F.R. § 4.30:	Convalescent ratings	May 2006
38 C.F.R. § 4.31:	Zero percent evaluations	October 1993

Rating Schedule Part "B"

38 C.F.R. § 4.55:	Principles of combined ratings for muscle injuries	June 1997
38 C.F.R. § 4.56:	Evaluation of muscle disabilities	June 1997
38 C.F.R. § 4.71a:	Schedule of ratings—musculoskeletal system	May 1996 July 2002 August 2002 August 2003 June 2004
38 C.F.R. § 4.73:	Schedule of ratings—muscle injuries	June 1997
38 C.F.R. § 4.84a:	Schedule of ratings—eye	June 1992
38 C.F.R. § 4.85:	Evaluation of hearing impairment	May 1999
38 C.F.R. § 4.86:	Exceptional patterns of hearing impairment	May 1999
38 C.F.R. §4.87:	Schedule of ratings—ear	May 1999 May 2003
38 C.F.R. § 4.88a:	Chronic fatigue Syndrome	November 1994
38 C.F.R. § 4.88b:	Schedule of ratings—infectious diseases, immune disorders and nutritional deficiencies	July 1996
38 C.F.R. § 4.96:	Special provisions regarding evaluations of Respiratory conditions	September 1996
38 C.F.R. § 4.97:	Schedule of ratings—respiratory system	September 1996 May 2006
38 C.F.R. § 4.104:	Schedule of ratings—cardiovascular system	December 1997 July 1998.
38 C.F.R. § 4.113:	Weight loss	May 2001
38 C.F.R. § 4.114:	Schedule of ratings—digestive system	May 2001
38 C.F.R. § 4.115:	Nephritis	January 1994

Rating Schedule Part "B"—Continued

38 C.F.R. § 4.115a:	Ratings of the genitourinary system—dysfunctions	Jan, Mar 1994
38 C.F.R. § 4.115b:	Ratings of the genitourinary system—diagnoses	Jan, Mar, Sep 1994
38 C.F.R. § 4.116:	Schedule of ratings—gynecological conditions and disorders of the breast	April 1995 May 2002
38 C.F.R. § 4.117:	Schedule of ratings—hemic and lymphatic system	September 1995
38 C.F.R. § 4.118:	Schedule of ratings—skin	July, Sep 2002
38 C.F.R. § 4.119:	Schedule of ratings—endocrine system	May 1996
38 C.F.R. § 4.124a:	Schedule of ratings—neurological conditions convulsive disorders	January 1990 October 1991 June 1992 December 2005

The foregoing list is not all-inclusive. Nonetheless, some of the dates of changes listed incorporated only minor substantive changes or substantially revised *portions* of a rating section rather than an entire section. Still, others incorporated significant substantive changes to rating sections.

The above information is provided in response to most of the popular rhetoric of the past year in that VA must completely revise its Rating Schedule and/or its entire disability compensation system. The vast majority of support for such rhetoric stems from specious propositions that VA's Rating Schedule, and essentially its entire rating system, is well over 60-years old—it is not. VA's disability system in 1945 was but a shell of today's system—one that has evolved, as it should, with an ever-growing knowledge base of war's effect on human life.

Each major war of the 20th century brought with it new challenges to VA's disability compensation system. The end of World War II brought about the advent of atomic veterans; the Korean war resulted in thousands of severely frostbitten veterans; the Vietnam War left tens of thousands struggling with sickness and disease 30 years after the War's end due to the effects of dioxin; the Persian Gulf War brought Gulf-War Syndrome; and now the current War is shedding new light on traumatic brain injuries (TBI). In no previous war was there a need to recreate VA's disability compensation system from scratch, nor does such a need currently exist. The fluid nature of the law is such that it is made to evolve when needs arise; VA's benefits delivery system is no different. However, the DAV agrees that portions of VA's Rating Schedule must be updated, such as, but not limited to, TBI residuals and the mental health rating criteria under the General Rating Formula for Mental Disorders.

Removing out-of-date Criteria, Traumatic Brain Injury, and Post Traumatic Stress Disorder

The Institute of Medicine (IOM) recently conducted a study of the Rating Schedule for the Veterans Disability Benefits Commission (VDBC). The IOM report identified examples of conditions in need of updating, including craniocerebral trauma (because, for example, a number of chronic effects are not included), neurodegenerative disorders (because some currently known disorders are not included while some disorders now known to be autoimmune are included), spinal cord injury (because it relies on an outmoded classification system), post traumatic arthritis (because it requires x ray rather than more up-to-date imaging techniques that provide much more information, such as computerized tomography [CT] and magnetic resonance imaging [MRI]), and mental disorders (because the rating criteria are based on sets of symptoms that do not apply to all mental disorders).

Another IOM report reached a similar conclusion regarding post traumatic stress disorder (PTSD), namely, that the rating criteria were not appropriate for PTSD because they included some symptoms consistent with other mental disorders but not PTSD. The problem with evaluating disability caused by PTSD stems from the decision in the 1996 revision of the mental disorders section of the Rating Schedule to

use a single rating formula to rate all mental conditions except eating disorders. The 1961 revision of the mental disorders section had increased the classifications of disorders from two to four; the 1996 revision reclassified the conditions into eight categories to "conform more closely to the categories in DSM–IV, thus making it easier for rating specialists to correlate the diagnoses given on VA and non-VA exams with the conditions in the rating schedule" (Proposed Rule: Schedule for Rating Disabilities; Mental Disorders, 60 Fed. Reg. 54,825 [(October 26, 1995]). But in place of three rating formulas in the 1961 revision—for psychotic disorders, organic mental disorders, and psychoneurotic disorders—VA implemented a single rating formula with the intent of "providing objective criteria based on signs and symptoms that characteristically produce a particular level of disability."

The fundamental problem with the general rating formula for mental disorders is the weak nexus between severity of symptoms and degree of social and occupational disability, which make the inclusion of symptoms in the criteria problematic in terms of determining disability. The mixing of symptoms and functional measures is also a weakness of the Global Assessment of Functioning Scale, which was criticized in the IOM report, *PTSD Compensation and Military Research*, which recommends looking at symptoms, function, and other dimensions of PTSD separately. Another problem with the general formula is the propensity for VA decisionmakers to deny claims for increased ratings based on a veteran's failure to demonstrate certain symptoms required for a higher rating, PTSD for example, when the *lack* of symptoms on which VA bases a denial are not associated with PTSD at all. Therefore, any update to the Rating Schedule with respect to mental disorders should be based on condition-specific symptoms rather than a one-size-fits-all rating criteria.

The IOM found the current criteria under diagnostic code 8045 for rating craniocerebral trauma, or TBI, are not adequate for rating all conditions in this classification, and therefore recommended the criteria be updated. VA added diagnostic code 8045 to the Rating Schedule in 1961 and has not changed it substantively since that time.

TBI, per se, is not rated directly; rather, it is rated according to residual impairments. The guidance under diagnostic code 8045 gives hemiplegia, epileptiform seizures, and facial nerve paralysis, which are physical effects, as examples of conditions that could be rated separately. The guidance limits a rating based on symptoms such as headache, dizziness, and insomnia, to 10 percent. This made sense in 1961 because VA did not thoroughly understand the harmful effects of even mild brain trauma on a person's cognitive and emotional condition or the negative impacts of these effects on social and occupational functioning.

Post-concussion effects are now recognized and under intense study. The proposed clinical management edition of the *International Classification of Diseases*, tenth revision (ICD–10) includes criteria for postconcussional syndrome. The *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (DSM–IV) identifies postconcussional disorder as a potential diagnosis depending on further research. The clinical criteria for postconcussional syndrome in ICD–10 call for a history of TBI and the presence of three or more of the following eight symptoms: (1) headache, (2) dizziness, (3) fatigue, (4) irritability, (5) insomnia, (6) concentration difficulty, (7) memory difficulty, and (8) intolerance of stress, emotion, or alcohol. The DSM–IV criteria are: (1) a history of TBI causing significant cerebral concussion; (2) cognitive deficit in attention, memory, or both; (3) presence of at least three of eight symptoms—fatigue, sleep disturbance, headache, dizziness, irritability, affective disturbance, personality change, or apathy—that appear after injury and persist for 3 months; (4) symptoms that begin or worsen after injury; (5) interference with social role functioning; and (6) exclusion of dementia due to head trauma or other disorders that better account for the symptoms.

Currently, the rating criteria for TBI do not refer to evaluation of cognitive and emotional impacts through structured clinical interviews or neuropsychological testing. Such impacts may be the only manifestations of closed-head TBI. The guide for VA clinicians performing compensation and pension (C&P) examinations and the worksheet for brain and spinal cord examinations do not provide guidance for assessments of the cognitive effects of TBI, but do call for description of psychiatric manifestations. The IOM also recommended that the Rating Schedule should be updated *medically* to ensure that:

- The diagnostic categories reflect the classification of injuries and diseases currently used in healthcare, so that the appropriate condition in the Rating Schedule can be more easily identified and confirmed using the medical evidence;
- the criteria for successively higher rating levels reflect increasing degrees of anatomic and functional loss of body structures and systems (i.e., impairment),

so that the greater the extent of loss, the greater the amount of compensation; and

- current standards of practice in assessment of impairment are followed and appropriate severity scales or staging protocols are used in evaluating the veteran and applying the rating criteria.

VA has proposed to amend the Rating Schedule by "revising that portion of the Schedule that addresses neurological conditions and convulsive disorders, in order to provide detailed and updated criteria for evaluating residuals of TBI." 73 Fed. Reg. 432 (proposed Jan. 3, 2008) (to be codified at 38 C.F.R. § 4.124a (diagnostic code 8045)). The DAV commends VA for its efforts to improve the evaluation of disability residuals for veterans with TBI. We nonetheless have serious concerns or otherwise outright disagreements as to how VA is proposing to structure the rating criteria for TBI. A copy of VA's proposed rule change concerning the rating criteria for TBI as well as DAV's comments can and will be provided immediately upon request.

The IOM's *A 21st Century System for Evaluating Veterans for Disability Benefits* report recommended numerous improvements that were endorsed by the VDBC and that are further supported by the DAV. One of many primary recommendations supported by the DAV states:

> The purpose of the current veterans' disability compensation program as stated in statute currently is to compensate for average impairment in earning capacity, that is work disability. This is an unduly restrictive rationale for the program and is inconsistent with current models of disability. The veterans' disability compensation program should compensate for three consequences of service-connected injuries and diseases: work disability, loss of ability to engage in usual life activities other than work, and loss in quality of life.

See A 21st Century System for Evaluating Veterans for Disability Benefits, Chapter 4, for more specific recommendations on approaches to evaluating each consequence of service-connected injuries and diseases.

Essentially, the DAV supports the VDBC via the IOM's recommendation that VA undertake a comprehensive update of the Rating Schedule, devise a system for keeping it up to date, and establish a disability advisory Committee to assist in the updating process. VA should consider updating the evaluation and rating of mental disorders, especially PTSD, and TBI as its highest priority and first order of business because of their prevalence among veterans currently returning from the Global War on Terror.

To be clear, however, DAV's support does not extend to any plan that would result in temporary or permanent dual compensation systems. Such schemes are inherently dangerous for a multitude of reasons. Likewise, the DAV will adamantly oppose any proposed change in law, whether regulatory or statutory, aimed at, or consequently resulting in, degradation of current benefits and/or rights provided to disabled veterans.

Total Ratings for Compensation Based on Individual Unemployability

The purpose of total ratings for compensation based on individual unemployability ("TDIU" or "IU") is to provide VA with a mechanism for compensating veterans with ratings that do not meet the Rating Schedule's threshold for receiving the 100-percent rate and who are unable to work because of their service-connected disabilities. To provide a service-connected veteran with IU, VA evaluates the veteran's capacity to engage in substantial gainful occupation as the result of his or her service-connected disabilities. The definition for "substantial gainful occupation" is the inability to earn more than the Federal poverty level.

In order to quality for IU, a disabled veteran with only one disability must be rated 60 percent or more. However, if there are two or more disabilities, then at least one disability must be rated at 40 percent or more resulting in a combined 70-percent rating. TDIU is not provided to veterans who receive a 100-percent rating because it is not necessary.

The adjudication of IU claims by VA raters takes into account the veteran's current physical and mental condition and his or her employment status, including the nature of employment, and the reason employment was terminated. Some factors are beyond the scope of inquiry for consideration of TDIU, such as age, nonservice-connected disabilities, injuries sustained post-service, or voluntary withdrawal from the employment market. VA instructs it raters that IU should not be granted if the veteran retired from work for reasons other than for their service-connected disability.

The VDBC asked the CNA Corp. (CNAC) to conduct an analysis of service-connected disabled veterans who are receiving IU. The central focus of CNAC's work revolved around determining whether the increases in IU were due to veterans' manipulation of the system to get additional compensation. To conduct their analysis, CNAC analyzed the mortality rates of those with and without IU and who concurrently receive Social Security Disability Insurance (SSDI) payments.

The CNAC discovered that certain body systems are more likely to receive IU ratings. For example, 28 percent of those with IU have musculoskeletal disorders and 29 percent have PTSD. The CNAC surmised that this may be an area of implicit failure of the Rating Schedule. Second, CNAC discovered that the growth in the IU population is mostly a function of demographic changes. These changes have come about because veterans with service-connected disabilities are facing complications with those disabilities as they age. As a result, CNAC concluded that the increase in IU is *not* due to veteran manipulation.

The VDBC stated that VA should consistently base TDIU decisions on the impact of an individual's service-connected disabilities, in combination with education, employment history, and medical effects of an individual's *age* or potential employability. The VDBC recommended that VA implement a periodic and comprehensive evaluation of IU-eligible veterans, and authorize a gradual reduction in compensation for IU recipients who are able to return to substantially gainful employment rather than abruptly terminating disability payments at an arbitrary level of earning.

The DAV is mindful of a desire to help unemployed disabled veterans return to work when feasible. Most veterans desire to lead productive lives in society rather than attempt to survive on nothing but VA compensation, even when such compensation is paid at the 100-percent rate. Nonetheless, the slightest misinterpretation by VA employees of changes to the law regarding entitlement to and retention of benefits under this program will result in an immeasurable number of unemployable veterans receiving an unlawful denial of benefits, or worse, a revocation of benefits. The DAV opposes the idea of allowing "age" to become a factor in VA decisions regarding claims for entitlement to TDIU. Denials of benefits based merely on age *will* result, and in those cases, relevant evidence *will* be ignored.

The VDBC also recognized that TDIU accommodates individuals with multiple lesser ratings but who remain unable to work. Therefore, the VDBC recommended that as VA revises the Rating Schedule, every effort be made to accommodate such individuals fairly within the basic rating system without the need for TDIU. To that extent, the DAV supports updating the Rating Schedule to reflect the true nature of the disability. For example, a veteran receiving IU because of service-connected PTSD rated at 70 percent, or a spine disability rated 60 percent, may be more accurately rated at 100 percent. In that, we certainly could not oppose revising the Rating Schedule to reflect a veteran as 100-percent disabled when he or she is unable to work because of disability. We nonetheless must emphasize that at the very heart of the necessity for benefits based on IU is that no single disability or group of disabilities will ever affect two veterans in the same manner—what may render one unemployable may not the other.

Evidence-based Criteria for Presumptions

While not in the list of priority recommendations by the VDBC, the issue of VA's establishment of presumptive conditions was addressed by the Commission. The IOM conducted an analysis and recommended a new approach for establishing which disabilities should be presumed related to military service. Presumptions are currently established when there is evidence that a sufficient number of veterans experience a condition and it is reasonable to presume that all veterans in that group who experience the condition acquired the condition due to military service.

The IOM's suggested approach includes using a causal effect standard for decisionmaking rather than a less-precise statistical association. The Commission endorsed the recommendations of the IOM but expressed concern about the causal effect standard. Likewise, the DAV has equal, if not deeper, concerns over this proposal. For example, numerous veterans of the first Gulf War in 1991 receive compensation for disabilities related to service in the theater of operations. Many of those "Gulf War" related diseases are ill defined, undiagnosed, and usually produce a cluster of symptoms that cannot be attributed to a specific etiology. To this day, research has not provided a specific cause and effect analysis for any single symptom, much less the myriad of symptoms experienced by veterans of the 1991 Gulf War.

Veterans of that war would have never received benefits for such disabilities had VA utilized a cause-and-effect standard to determine presumptive disabilities. Science is not exact enough to provide a precise cause for every disability resulting

from combat. A statistical association is the fairest method of determining presumptive disabilities resulting from military service.

Quality of Life

The VDBC recommended, as a priority, that Congress increase the compensation rates up to 25 percent as an interim and baseline future benefit for loss of quality of life, pending development and implementation of quality of life measure in the Rating Schedule. In particular, the Commission recommended the measure take into account the quality of life and other non-work related effects of severe disabilities on veterans and family members. The DAV fully supports this recommendation.

Through lengthy, exacting, and comprehensive research, the CNAC determined that disability compensation, at most, helped disabled veterans achieve parity with their non-disabled counterparts to the extent that compensation substitutes a disabled veterans' "average loss" of earnings due to disability. This was not, however, the case for veterans with mental health disabilities, younger veterans with disabilities, and those with total ratings based on individual unemployability—these three groups were found to be below parity when compared to non-disabled veterans.

These findings are evident that VA compensation replaces only the average in lost earnings for many veterans, but even much less for others. In no event are disabled veterans being overcompensated. The VDBC and other well-known studies have collectively agreed that service-connected disabled veterans are not compensated for the inability to engage in useful life activities that many able-bodied people take for granted, nor does it compensate for reduction in quality of life. All recommendations from such studies and commissions have been for Congress to enact legislation ensuring that veterans are compensated for such losses.

Essentially, the Rating Schedule compensates for work disability, not for a loss in quality of life. It is therefore possible that ratings under the current Rating Schedule and *accurate* quality-of-life measures are not close. If this is so, then the question arises of *how* not *if* VA should develop a way to compensate for each. (*I.e.*, adapting the current Rating Schedule to compensate for both, or creating a separate Rating Schedule for each consequence.) These questions are yet to be decided. Nonetheless, as stated earlier, the DAV opposes recommendations for a dual compensation system.

Conclusion

The VDBC agreed that America has a solemn obligation, expressed eloquently by President Lincoln, "to care for him who shall have borne the battle, and for his widow, and his orphan. . . ." With this in mind, the VDBC stated: "It is the duty of Congress and VA to ensure that the benefits and services for disabled veterans and survivors are adequate and meet their intended outcomes." Based on these obligations, the VDBC identified the following guiding principles.

1. Benefits should recognize the often enormous sacrifices of military service as a continuing cost of war, and commend military service as the highest obligation of citizenship.
2. The goal of disability benefits should be rehabilitation and reintegration into civilian life to the maximum extent possible and preservation of the veterans' dignity.
3. Benefits should be uniformly based on severity of service-connected disability without regard to the circumstances of the disability (wartime v. peacetime, combat v. training, or geographical location.)
4. Benefits and services should be provided that collectively compensate for the consequence of service-connected disability on the average impairment of earnings capacity, the ability to engage in usual life activities, and quality of life.
5. Benefits and standards for determining benefits should be updated or adapted frequently based on changes in the economic and social impact of disability and impairment, advances in medical knowledge and technology, and the evolving nature of warfare and military service.
6. Benefits should include access to a full range of healthcare provided at no cost to service-disabled veterans. Priority for care must be based on service-connection and degree of disability.
7. Funding and resources to adequately meet the needs of service-disabled veterans and their families must be fully provided while being aware of the burden on current and future generations.
8. Benefits to our Nation's service-disabled veterans must be delivered in a consistent, fair, equitable, and timely manner.

These principles served as the moral fiber that directed the VDBC's priorities throughout its work. They are also synonymous with the mission of the DAV—

"Building better lives for America's disabled veterans and their families." Therefore, the DAV strongly suggests that as Congress moves forward in implementing many of the Commission's recommendations, it bears these principles in mind and employs them as its lighthouse to navigate congressional action on the course set by the VDBC.

Society and its laws are evolutionary, and as such, they are slow-moving creatures. The Framers of the Constitution took great care in ensuring that change does not come easy, but nonetheless provided for its evolvement. Some in Congress today ignore this by acting hastily—attempting expeditiously to push legislative agendas aimed more at conserving the bottom line than conserving the benefits for which disabled veterans spent the last 100 years fighting. Some of these agendas would wipe VA's slate clean and force it to start over with the shell of a compensation system it once had in 1933, all while claiming we have come no farther since 1933. Some of these agendas would pit veterans of today's wars against veterans of yesterday's wars—or worse, pit veterans against their government.

We simply urge caution. VA's benefits delivery system must be considered in the larger context of today's views on the rights of individuals with disabilities to live as full a life as possible. It is therefore essential to envision a more comprehensive evaluation of veterans' needs, including medical, educational, vocational, and compensation. We respectfully remind Congress that many of those that came before you did their best to ensure that VA was a pro-claimant, veteran-friendly, non-adversarial system where the disabled veteran received the benefit of the doubt whenever doubt existed.

The DAV supports a vast majority of the VDBC's recommendations because they are well-researched, carefully planned suggestions with a potential of improving what is already a good system that cares for disabled veteran. Once again, however, the DAV urges Congress to resist hastily laid plans designed to do more undoing than doing, or else the next battle we will fight in Congress will be the one against unintended consequences.

We hope the Subcommittee will review the DAV's recommendations and give them consideration for inclusion in your legislative plans. Mr. Chairman, thank you for inviting the DAV to testify before you today.

Statement of Gerald T. Manar
Deputy Director, National Veterans Service
Veterans of Foreign Wars of the United States

CHAIRMAN HALL, RANKING MEMBER LAMBORN AND MEMBERS OF THE COMMITTEE:

Thank you for this opportunity to present the views of the 2.3 million veterans and auxiliaries of Veterans of Foreign Wars of the United States on the state of the VA Schedule for Rating Disabilities.

Schedule for Rating Disabilities

Service connected disabilities are evaluated using criteria contained in Part 4 of title 38 Code of Federal Regulations. The first schedule for rating disabilities was written in 1921. The 1925 revision attempted to adjust evaluations based on the occupation of veterans. That approach proved far too cumbersome and inequitable to be of practical value and the rating schedule was rewritten again in 1933. The last complete revision was published in 1945.

A popular misconception is that the current rating schedule has not been substantively revised since its last major overhaul in 1945. While the Institute of Medicine and the Veterans Disability Benefits Commission found that the rating schedule has been revised, often substantively, since 1945, sections of it have been rarely touched and many parts contain medical terminology and evaluative criteria which are significantly out of date.

VA is charged with administering a compensation program that pays veterans in excess of $30 billion per year for disabilities arising as a result of or coincident with military service. Yet the VBA Compensation and Pension Service has fewer than 140 people including support staff assigned to run this program. When the 26 employees conducting quality reviews of various types are subtracted, along with the 28 people figuring out how to make computer software work more efficiently, the remaining 86 are spread too thin to do most jobs adequately. For many years in the late 1990s only one person was assigned to review, revise and update the rating

schedule. It is little wonder that many sections of the rating schedule are not up to date.

To address this problem, the Commission adopted a number of recommendations advanced by an Institute of Medicine Committee that the Commission had contracted with to study the disability evaluation of veterans. In its report, "A 21st Century System for Evaluating Veterans for Disability Benefits", the IOM suggested that VA should create a permanent "disability advisory committee, "staffed with experts in medical care, disability evaluation, functional and vocational assessment and rehabilitation, and include representatives of the health policy, disability law, and veteran communities." The Advisory Committee would meet regularly and offer direction and oversight to the regular review and updating of the rating schedule. In addition to this Committee, the IOM recommended that VA substantially increase the number of staff members permanently assigned to accomplishing the changes directed by the Advisory Committee.

We support these recommendations and believe that its first task should amend the criteria for evaluating Post Traumatic Stress Disorder. The criteria adopted many years ago by VA were intended to encourage consistency in the evaluation of psychiatric disabilities. Unfortunately, the debilitating symptoms experienced most often by veterans with PTSD are not the same as those shown in the rating schedule. As a consequence, rating specialists have been forced to select an evaluation, based not on the symptoms, per se, but, rather, on how disabling they believed those symptoms were. This led to great frustration on the part of rating specialists and inconsistency in evaluations assigned to veterans. This problem has been known for years. It needs to be corrected now.

At the same time, an Advisory Committee could begin the process of reviewing and suggesting changes to those sections of the Rating Schedule that have not been updated in the last 10 years.

Some critics of the current disability compensation program have suggested that the rating schedule can be thoroughly and completely reviewed and updated in as little as 6 months. While it is true that anyone can revise the rating schedule in a few weeks or months, the result will simply be a different rating schedule, almost certainly not a better rating schedule.

It is our considered belief that it will take years of hard work by a competent staff of medical, vocational and legal experts to devise new rating criteria for all the body systems which allow for the accurate assessment of service connected disabilities.

Revision of the rating schedule cannot be a one-time project. A permanent process must be devised and put in place to ensure that you and your successors, and I and mine, never again have to discuss why the primary tool for assessing veterans disabilities is inadequate and antiquated.

Quality of Life

The Veterans Disability Benefits Commission adopted an Institute of Medicine recommendation to "research and develop a quality of life measurement tool and study ways to determine the degree of loss of quality of life, on average, of disabling conditions in the rating schedule." We concur. Decreases in the quality of life resulting from service-connected disabilities, certainly warrants investigation and research. While VA and Congress have addressed quality of life losses resulting from some disabilities through special monthly compensation, a comprehensive study, or series of studies, should be conducted to determine which disabilities, and level of disability, adversely affect a veteran's quality of life. To the extent that studies show that service connected disabilities limit the quality of life of veterans VA should consider how best to adjust the Rating Schedule to ensure that veterans are adequately compensated.

Individual Unemployability

The Dole/Shalala Commission recommended eliminating individual unemployability. The Veterans Disability Benefits Commission agreed that VA should retain the ability to decide that a veteran's service connected disabilities make them unemployable. It further recommended that the rating schedule be adjusted, allowing more veterans rendered unemployable by their service-connected disabilities, particularly psychiatric disabilities, should be rated 100 percent.

The Center for Naval Analysis found no statistical evidence that veterans were "gaming" the system in order to obtain increased benefits. Increases in the numbers of those receiving individual unemployability are attributed to increasing disabilities as the veteran population ages.

Disability evaluations under the rating schedule are designed to compensate veterans for the average loss of earnings impairment. The rating schedule is not intended to look a veteran's vocation; whether they practiced law, drove trucks, pro-

grammed computers, fixed plumbing or any other occupation prior to or post their disabled. Disability evaluations are assigned based on the severity of disabilities and represent average impairment.

Individual unemployability is the one regulation that allows VA to look at the individual person assessing their education, vocational skills, job history, and experiences to determine whether their service connected disabilities keep them from gainful employment. In our view, this little bit of flexibility allows the VA to adjust evaluations to address any inequities that may result from the automatic application of the rating schedule. This is a good thing. We believe that Individual Unemployability is appropriate, as it currently exists.

It has been suggested that veterans seeking a total evaluation based on Individual Unemployability should be given a vocational assessment. We do not oppose this idea. We agree that it may provide additional information which will help rating specialists make the most correct decision. However, we believe that sufficient resources must be devoted to these assessments so that veterans will experience no delays in entitlement decisions. As we stated in testimony before the Veterans Disability Benefits Commission in July 2007:

> "While we do not oppose an employment assessment for veterans who are applying for total benefits based on Individual Unemployability, we do have some concerns about the implementation of this option.
>
> - It is axiomatic that veterans who apply for IU are either unemployed or marginally employed. Generally, these individuals have been unemployed for many months before they apply for benefits. Whatever economic well-being they enjoyed before becoming unemployed has evaporated and most are in serious financial distress. *Any* action on the part of the government resulting in a delay of a decision on IU should be avoided at all costs. Therefore, we believe that it is absolutely essential that the staff of VR&E be expanded and trained long before a requirement mandating an employment assessment is implemented.
> - Individuals who are denied Individual Unemployability should be offered, at a minimum, vocational counseling and employment services."

Traumatic Brain Injury

VA recently published proposed regulations to amend the criteria for evaluating traumatic brain injury (TBI). We view that proposal as a good first attempt at better assessing the impairments caused by TBI. We understand that VA received significant comments to its proposal.

We suggest that the VA publish its next set of regulations as "interim-final" regulations. Considering the increasing number of veterans suffering from TBI, and the difficulty that exists in writing appropriate rating criteria for this multi-faceted problem, leaving the door open to further adjust this regulation makes perfect sense given the evolving nature of this injury.

Presumptions

In August, 2007, the Institute of Medicine Committee Report titled "Improving the Presumptive Disability Decision-Making Process" released. Our views concerning this report, expressed to the Veterans Disability Benefits Commission on August 22, 2007, are as appropriate today as they were then.

Here we have a seminal work: a report from academicians who took your charge seriously: they analyzed the methodologies used to establish a number of presumptions currently written in law and regulation to help VA determine whether diseases were incurred while on active duty, discussed in depth different approaches used by scientists to determine whether a disability is related to various exposures and recommended a structured approach for determining, in the future, whether a disease is caused by some event experienced by veterans while they performed military service.

We do not disagree with the historical analysis of presumptions; nor do we take issue with the structure recommended by the Committee for creating presumptions in the future. We agree that the government cannot simply throw open the doors of Fort Knox to every person who alleges a disability and has a discharge paper. However, we believe that this IOM Committee may be setting the bar too high for men and women who served their country in both peace and war.

You know that many who left to serve never returned and, of those who did, hundreds of thousands returned with wounds and other injuries of both body and mind. Some of those who apparently returned unscathed did not escape their service wholly intact but, in fact, were often found many years later to have diseases acquired while performing military duty.

These men and women should not have to wait years, perhaps decades, suffering painful, debilitating and often deadly conditions, while scientists ponder whether "the evidence is sufficient to conclude that a causal relationship is at least as likely as not, but not sufficient to conclude that a causal relationship exists."

The Committee acknowledges that causation is a higher standard than association. It states that while the evidence may show that a disability is associated with an event or exposure in military service, it does not mean that the disability was caused by that event or exposure. According to the Committee, determining that an association exists is only "prima facie evidence of causation but is not sufficient by itself for proving a causal relationship between exposure and disease" and they would have veterans endure additional years of pain and suffering before they might receive medical care and compensation for their service "caused" conditions.

Presumptions are a legal tool; they fill an evidentiary gap or shift an evidentiary burden from one party to another. In the area of veteran's benefits, they are created as often to ease the burden on the government as well as the veteran. The government's approach to herbicide exposure in Vietnam and disabilities related to herbicide exposure illustrates these presumptions.

Millions of gallons of herbicides were sprayed over diverse areas of Vietnam from the early 1960's to 1971. It was sprayed by plane, helicopter and by hand. Nearly all uses were designed to deny cover to the enemy. It was an extremely useful tool and doubtless saved hundreds, perhaps thousands of American and allied soldiers' lives.

The Department of Defense maintains records of those areas targeted for defoliation. However, we know that because of weather, poor navigation, mechanical malfunction or aircraft emergencies requiring inaccurate or premature dumping of defoliants, we cannot know with any degree of certainty exactly where all these chemicals were dropped. Further, loss of records, or, in the case of hand spraying, failure to keep accurate records, means that we will never know precisely where and when defoliants were used. Finally, although we may know generally where various units were operating during any given period, the military cannot know where every soldier or Marine performed duty while they were in Vietnam.

Consequently, it is not possible to state with any degree of certainty whether a particular servicemember was exposed to herbicides during their service in Vietnam. Nor is it possible to determine the quantity or level of exposure.

Without a presumption of exposure for those who served in Vietnam, the government would be forced to undertake the Herculean task of determining where each veteran-claimant was located while in Vietnam. As well as, whether patterns and to what degree he or she was exposed to herbicides.

As a consequence of these uncertainties, and to save our government the millions of dollars it would cost to attempt to verify the location of individual veterans and the exposure they received, a presumption was created that conceded that all those who served in Vietnam during certain periods were exposed to herbicides.

Exposure without a disability is simply an exposure; exposure is not a disability under the law. However, we know that Vietnam veterans started experiencing rare cancers and other maladies within a decade of their leaving Vietnam. Casting about for possible causes, these veterans, their advocates and healthcare providers looked for commonalities to explain these departures from normal health. The one constant soon became apparent: service in Vietnam.

The Agent Orange Act 1991 was the law, which created the mechanism used today to determine whether a disease should be considered by the Secretary of Veterans Affairs to be presumptively related to herbicide exposure while in the military service.

So long as presumptions of service connection was created for a few rare cancers no one cared to use the term found in the Committee's report, a few "false positives" were compensated along with veterans whose cancers were caused by exposure to herbicides. However, with the extension of presumptive service connection to lung cancer, prostate cancer and, finally, diabetes, legislators and others became increasingly concerned when thousands of Vietnam veterans sought service connection, medical treatment and compensation for these conditions.

The VFW is not deaf to the cacophony of criticism. The GAO, Members of Congress, and others believe that the presumptions granting medical treatment and compensation to Vietnam veterans with lung cancer, prostate cancer and diabetes are too costly. In these cases, if we wait for evidence of causation most of these veterans would be dead before the evidence is obtained. Further, their survivors would not just suffer the premature loss of the veteran but would also be denied survivors benefits for years, perhaps decades, while scientists study "causation".

We speak about Vietnam presumptions because it is the specter of thousands of Vietnam veterans flooding the VA with claims for benefits and the medical system

that concern our legislators. They are concerned that many of the men and women who volunteer, train, fight, suffer and survive from the conflicts of the present will return asking whether their diseases could somehow be related to their military service.

We should not tell them, as we did in the 1970's, that since there is no medical evidence showing that their disability was "caused" by their military service we cannot help them. We should not deny them healthcare and benefits even when studies show that an association exists between their disability and service. We accept everything in this report except the bar calling for "causation." "Causation" is not a hurdle to jump over; it is a scientific bar to benefits.

We urge that you adopt the standard found in the Agent Orange Act 1991 and use it in the same manner as it is today. We urge that presumptive service connection be granted when the Science Review Board suggested by the IOM Committee finds that an association exists between an exposure in military service and a disease arising after service.

Statement of Bradley G. Mayes
Director, Compensation and Pension Service
Veterans Benefits Administration, U.S. Department of Veterans Affairs

Mr. Chairman and Members of the Subcommittee, I am pleased to appear before you today to speak on the subject of revising the Department of Veterans Affairs (VA) schedule for rating disabilities. I am accompanied by Dr. Patrick Joyce, Chief of the Occupational Health Clinic and Chief Physician, Compensation and Pension (C&P) Program, at the Washington, D.C., VA Medical Center; Dr. Steven Brown, Director of the Compensation and Pension Examination Program Office, Veterans Health Administration; Mr. Tom Pamperin, Deputy Director for Policy, Compensation and Pension Service; and Mr. Richard Hipolit, Office of the General Counsel.

Within VA, the mission of providing C&P disability benefits to veterans relies on the regulatory scheme embodied in 38 Code of Federal Regulations (CFR), Part 4—*Schedule for Rating Disabilities* (rating schedule). This rating schedule serves to provide an organized and coherent system for evaluating disabilities and for providing equitable and consistent compensation for service-connected injuries and diseases to our Nation's veterans. We are aware that the schedule must continue to "evolve," and, as you know, the President has sent to Congress a bill, "America's Wounded Warriors Act," to implement the recommendations of the President's Commission on Care for America's Returning Wounded Warriors, including the Commission's recommendation that VA should update its disability rating schedule to reflect current injuries and modern concepts of the impact of disability on quality of life.

Also, as you noted in your letter inviting us to testify today, the Veterans Disability Benefits Commission (VDBC) has made several recommendations about how to improve the VA rating schedule. In addition, the Center for Naval Analyses (CNA) and the National Academies' Institute of Medicine (IOM) have recently evaluated the rating schedule. We welcome the congressional interest in C&P and the issue of rating schedule improvement because we share the common goal of improving benefits and service to veterans.

Rating Schedule History

The current rating schedule is the product of many years of development and is an expression of our Nation's desire to acknowledge the sacrifices made by veterans and to compensate them for disabilities resulting from military service. Early in our Nation's history, the Continental Congress of 1776 passed the first pension laws and administrative directives for veterans disabled during military service as a means to encourage enlistment and curtail desertion. These laws remained in effect, with some modifications, until after the Civil War, when additional benefits were introduced due to the activity of newly formed veterans organizations. During this period, the basis for pension payment amounts shifted from the veteran's service rank to the degree of disability. Until 1890, pensions were granted only to veterans discharged because of illness or injury resulting from military service. In that year, Congress substantially broadened the scope of eligibility to include veterans incapable of manual labor. In 1912, veterans of the Mexican War and Union veterans of the Civil War became eligible for pension at age 62, even though not sick or disabled.

The War Risk Insurance Act 1917 provided for the first significant rating schedule as well as the idea of compensating veterans for service-connected aggravations of

pre-existing conditions. This legislation introduced compensation based on the average loss of earning capacity. Section 302 of the act stated the following:

"A schedule of ratings of reductions in earning capacity from specific injuries or combinations of injuries of a permanent nature shall be adopted and applied by the bureau [of War Risk Insurance]. Ratings may be as high as one hundred per centum. The ratings shall be based, as far as practicable, upon the average impairments of earning capacity resulting from such injuries in civil occupations and not upon the loss of earning capacity in each individual case, so that there shall be no reduction in the rate of compensation for individual success in overcoming the handicap of permanent injury. The bureau shall from time to time readjust this schedule of ratings in accordance with actual experience."

A 1918 amendment to the Act provided for the presumption of soundness in health for those "examined, accepted, and enrolled in service." In 1921, a Veterans Bureau was established and the first codified rating schedule was drafted. The 1921 Rating Schedule adopted the average loss of earning capacity standard. It also modified the presumption of soundness to exclude defects, disorders, or infirmities recorded at the inception of active service and provided for the first presumptions of service connection for tuberculosis and neuropsychiatric conditions. In addition, local rating boards were established around the country to replace a single rating board in Washington D.C.

The World War Veterans' Act 1924 created a new rating schedule, based on the California workmen's compensation system, which became known as the 1925 Rating Schedule. It provided for disability evaluation percentages in increments of 1 percent and introduced a disability indexing system that became the basis for diagnostic codes. It also departed from the average loss of earning capacity standard and adopted the idea of a disability compensation system based on assumptions about the loss of skills and functions needed for specific occupations. This led to rating decisions, for example, which would compensate a veteran, whose occupation required reading and writing skills, at a higher rate for visual impairment than a veteran engaged in manual labor. This focus on specific occupations provided the initial rational for including an occupational specialist on the rating board. However, the emphasis on specific occupations was short-lived.

The Economic Act 1933 authorized the next version of the rating schedule. Disability percentage evaluations were now determined in 10 percent increments, prior differences between temporary and permanent evaluations were eliminated, and additional compensation was provided for bilateral anatomical loss. Most important, the 1933 Rating Schedule eliminated ratings based on occupational variance and reintroduced the concept of average impairment in civilian occupational earning capacity as the basis for disability compensation.

As a result of medical and technological advances resulting from World War II, the 1945 Rating Schedule was created. This schedule maintained the average loss of earning capacity standard and, with periodic updates of medical evaluation criteria, is the rating schedule in use today.

Elements of the Current Rating Schedule

Development of the current rating schedule is based on the Congressional mandate provided in 38 U.S.C. 1155, *Authority for schedule for rating disabilities*, which states that the "rating shall be based, as far as practicable, upon the average impairments of earning capacity resulting from [specific injuries or combination of specific] injuries in civil occupations." As a result of this directive, the rating schedule compensation system is viewed primarily as a means to replace work-related lost wages resulting from a service-connected disability. The basic elements of the rating schedule are described below.

The current rating schedule brings together more than 700 diagnostic codes representing distinct physical and mental impairments that are grouped by body systems or like symptoms. Covered body systems include the musculoskeletal, visual, auditory, respiratory, cardiovascular, digestive, genitourinary, hemic and lymphatic, skin, and endocrine systems. Also covered are gynecological and breast disorders, neurological and convulsive disorders, dental and oral disorders, and mental disorders. Each diagnostic code is broken down into levels of impairment severity, with disability percentages assigned to each level. These range from less severe to more severe, with higher percentages assigned to more severe levels. Disability percentage numbers range from 0 to 100 percent, in 10 percent increments, throughout the rating schedule, although individual diagnostic codes vary in the incremental progression and the maximum available disability percentage.

If the veteran's impairment is not listed in one of the specific diagnostic codes, it is rated under a hybrid code representing an analogous anatomical location or

symptomatology. When a veteran has more than one service-connected disability, the percentages for each disability are combined, rather than added, under a numerical table provided at 38 CFR 4.25, *Combined Rating Table*. In a case with an exceptional or unusual disability picture where application of the rating schedule does not adequately compensate a veteran for functional loss, the case may be sent to the C&P Service for consideration of an extra-schedular rating. If a veteran's disability cannot be rated at 100 percent under the regular schedule, but the veteran is unable to secure or follow a substantially gainful occupation as a result of the veteran's service-connected disabilities, then an extra-schedular 100 percent can be assigned under the regulation providing for a total disability rating based on individual unemployability. In cases where the veteran's disability is rated at 100 percent, but it is severe enough that a veteran is permanently bedridden or has a regular need for aid and attendance, or where anatomical loss or loss of use is involved, additional special monthly compensation payments are available.

America's Wounded Warriors Act

Title II of the President's draft bill, America's Wounded Warriors Act, would require VA to complete a study regarding creation of a schedule for rating disabilities based upon current concepts of medicine and disability, taking into account loss of quality of life and loss of earnings resulting from specific injuries. The legislation requires VA, within 7 months after entering into a contract for the study, to submit a report to Congress that includes VA's findings and conclusions with respect to the creation of a disability rating schedule based on loss of quality of life and loss of earnings resulting from specific injuries.

The legislative proposal provides the framework for VA to pay disability compensation for the loss of quality of life attributable to an eligible veteran's service-connected disabilities at rates to be determined pursuant to the Secretary's report to Congress. Current law only allows the VA to compensate for loss of earning capacity.

VA Plan for Rating Schedule Improvement

To address the recommendations of the Dole-Shalala Commission, as well as various commissions, organizations, and interest groups that have offered suggestions for improving the current rating schedule, VA has developed the following plan to update the schedule and to adopt various suggestions that have been made.

I. *Contract for Study*

The Department entered into a contract on January 25, 2008, for a study analyzing the nature of specific injuries and diseases for which disability compensation is payable under various disability programs of Federal and State Governments and other countries, including VA's program. The study will examine specific approaches and the usefulness of currently available instruments for measuring disabilities' effects on an individual's psychological state, loss of physical integrity, and social inadaptability. The study will make findings and recommendations on the following: (1) the service-connected disabilities that should be included in the schedule for rating disabilities; (2) the appropriate level of compensation for loss of quality of life and for loss of earnings; and (3) the appropriate standard(s) for determining whether an injury or disease, or combination of injuries and diseases, has caused a loss in a veteran's quality of life or loss of a veteran's earnings. The study will take into account the impact of medical advances on disability functioning. We expect that the study will be completed by August 2008.

II. *C&P Staff Development and Contract Assistance*

Meaningful changes to the rating schedule will require strong leadership and the input of competent personnel who possess the knowledge and skills required to interpret, understand, and write regulations on complex medical concepts. The C&P Service is in the process of recruiting key personnel and expanding our Policy staff. One important aspect of this resource development is our effort to recruit physicians who can bring their medical expertise to improving the rating schedule. Physicians possess the medical knowledge necessary to assist in the effective management of a systematic, ongoing Rating Schedule review process. The hiring of physicians and other qualified individuals is the foundation for the future integration and standardization of this review process. In addition to augmenting the C&P Policy staff as described, we intend to seek assistance from organizations such as the National Academies' Institute of Medicine. We want to leverage the work already accomplished for the Veterans Disability Benefits Commission, and it is important to ensure that our review of the schedule is based on the latest science regarding com-

pensation for disability. The Institute of Medicine already has a process of peer review of literature in place that will help as we move forward in this area.

III. *Continue with Rating Schedule Changes under the Current Construct*

Revision of the rating schedule has actually been underway since the nineties, and will continue. A deliberative process is in place that includes input from sources such as the Veterans Health Administration, non-VA medical experts, and veterans service organizations. The general public has opportunity to comment on proposed changes to the schedule in compliance with the Administrative Procedure Act. To date, 12 of the 16 body system sections in the schedule have been revised, and a 13th is nearing publication. The remaining three body systems are in various stages of development. Major changes that have been made include: addition of new disabilities; deletion of obsolete and rarely used disabilities; updating of medical terminology; and most important, development of more objective criteria based on current medical knowledge. Partial revisions of body systems in the rating schedule are being carried out on an ongoing basis. This process continues.

The VDBC specifically recommended that the C&P Service generate changes to the rating schedule criteria for traumatic brain injury (TBI) and post-traumatic stress disorder (PTSD). The C&P Service created a new set of criteria for evaluating TBI and published proposed criteria in the Federal Register for public comment. New rating criteria for evaluating the severity of PTSD are being developed. The criteria will incorporate the criteria for evaluation PTSD identified in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition*, published by the American Psychiatric Association. These specific criteria will replace the general criteria used for evaluating all mental disorders and will promote equity and consistency in the assignment of disability percentages for PTSD.

IV. *Periodic Reviews of the Rating Schedule*

Periodic reviews and studies of the rating schedule are a valuable source of information for assessment and improvement. We plan to continue supporting the tradition of reviews established by the Bradley Commission in 1956. That commission conducted studies of the rating schedule that included a survey of 169 medical specialists on the currency and validity of the schedule and a survey and comparative analysis of the earnings of 12,000 veterans receiving compensation and 7,000 veterans not receiving compensation. The survey of medical specialists indicated a consensus that the schedule generally did provide an equitable compensation for earning loss but that much of the evaluation criteria had not kept pace with modern medical diagnostic and treatment practices. The comparative study of earnings indicated that compensation was generally equivalent to lost wages. However, the commission reported that further studies were desirable. This commission served as the impetus to update many of the diagnostic codes. Another review, initiated by VA in 1961, was responsible for modernizing the classifications and nomenclature of the rating schedule's mental disorder section, which incorporated diagnoses from the first *Diagnostic and Statistical Manual of Mental Disorders.*

In 1971, VA submitted to Congress an important review and study was conducted by VA, referred to as the Economic Validation of the Rating Schedule (ECVARS). The study was a response to the Bradley Commission's recommendations and recurrent criticism that ratings in the schedule were not accurate. The ECVARS report noted that the 1945 rating schedule was created during a period when most workplace activity involved physical labor, but the "muscle-oriented society of the World War II era no longer exists, and the instrument that served so well as a yardstick to measure disablement in that era must now be updated and refined." An earnings survey of 485,000 veterans receiving compensation and 14,000 veterans not receiving compensation was conducted and analyzed. The results showed that under many diagnostic codes, especially those involving mental disorders, economic loss exceeded compensation. On the other hand, under some musculoskeletal codes, there appeared to be an over-compensation. VA revised the rating schedule based on the ECVARS findings, with higher compensation provided under some codes and lower compensation under others, and submitted it to Congress in 1973. However, VA did not adopt the revised schedule.

After the failure of ECVARS to affect the rating schedule, the VA review and revision process concentrated on improving the clarity, accuracy, and appropriateness of conditions in the schedule rather than attempting to ensure that economic loss compensation for the conditions was validated. In 1988 the General Accounting Office (GAO) [now the Government Accountability Office] published a report on the need to update the medical criteria used in the schedule. This led to the comprehensive revisions described above. In 1997, the GAO published another report on the rating schedule. This report focused on the idea that disability ratings may not re-

flect veterans' actual economic losses. The recent CNA Corp. study provides the foundation for assessing the effectiveness of the VA Rating Schedule in compensating for average loss of earnings as recommended by the GAO in its 1997 review.

The most recent initiative for rating schedule review and research has come from VDBC's report issued in 2007, which included input from CNA, IOM, and other groups. As mentioned, CNA analyzed the effectiveness of VA disability compensation as a replacement for average loss of earning capacity. It was determined that "VA compensation on average is about right relative to earned income losses." ... It is about right given the average age at which service-disabled veterans come into the VA system," i.e., age 50, "and it is about right when we consider all disability types and ratings as a whole." However, the study also found that veterans entering the system at younger ages are generally under-compensated, while those entering at older ages are generally over-compensated. In addition, while those veterans with physical disabilities are properly compensated, those with mental disabilities are under-compensated. This study provides VA with an empirical basis for developing ways to correct rating inconsistencies identified.

The Dole-Shalala Commission, the VDBC, and various other commissions and groups discussed the need for continuous review and updating of the schedules.

As part of our plan for improving the rating schedule, we are committed to responding in a positive manner to recommendations from reviews and studies provided by commissions and organizations concerned with the welfare of veterans. We are also committed to conducting our own reviews and studies as needed to implement improvements in a practical and efficient manner.

V. *Quality of Life Compensation*

In addition to the Dole-Shalala Commission, recent studies and commission reports, have also recommended that compensation should also be provided for losses incurred in other aspects of a veteran's life. These aspects are generally referred to under the term "quality of life" and include losses in the social and psychological realms. As explained, the recent contract awarded by VA will study the alternatives for incorporating a quality of life component into the disability evaluation scheme. In addition, meetings have been scheduled with representatives of the World Health Organization and the American Medical Association to obtain their views on how quality of life is impacted by physical and mental disability. We stand ready to consider any viable and practical compensation construct that would assist disabled veterans in the quality of life realm. However, as noted above, if VA is to comprehensively incorporate diminution of quality of life resulting from disability into the rating schedule as proposed in the Administration's legislation, it will require additional statutory authority from Congress.

Mr. Chairman, this concludes my prepared remarks. I and others on the panel would be pleased to answer any questions you and Members of the Subcommittee might have.

Statement of Major General Joseph E. Kelley, M.D., USAF (Ret.)
Deputy Assistant Secretary of Defense for Clinical and Program Policy (Health Affairs), U.S. Department of Defense

Mr. Chairman, Ranking Member Lamborn, and Members of the Committee, the Administration has worked diligently – commissioning independent review groups, task forces and a Presidential Commission, which have made recommendations concerning the adequacy and application of the Department of Veterans Affairs (VA) Schedule for Rating Disabilities (VASRD). Central to our efforts, a closer partnership between our respective Departments was strengthened by formation of the Senior Oversight Committee (SOC), cochaired by Deputy Secretaries of Defense and Veterans Affairs, to identify immediate corrective actions and to review and implement recommendations of the external reviews. Some of these recommendations were focused on VA's efforts to update and improve the VASRD.

The driving principle guiding SOC efforts is the establishment of a world-class seamless continuum that is efficient and effective in meeting the needs of our wounded, ill, and injured servicemembers, veterans and their families. In short, the SOC brings together on a regular basis the most senior decisionmakers from DoD and VA to ensure wholly informed, timely action. As such, many of the issues between the two Departments on the application and revisions of the VASRD are now being worked in a collaborative and productive manner.

An updated VASRD is critical to the Department of Defense's Disability Evaluation System as it is the rating schedule utilized in the Physical Evaluation Board (PEB) Adjudication. On the basis of a preponderance of the evidence, the PEB determines whether the individual is fit or unfit to perform adequately the duties of their office, grade, rank or rating. As a product of the PEB process and according to title 10, servicemembers found unfit for continued military service will be awarded a disability rating percentage for the military unfitting condition, in accordance with the rating guidance established in the VASRD. This disability rating determines entitlement to separation or retirement benefits. Consistency of application across the Services has sometimes been problematic in the Department. As part of complying with the NDAA for Fiscal Year 2008, the DoD is working with VA to begin joint VASRD training and to develop clarifying guidance for the Services to use in the Department. This training and guidance is important as it provides clarification on how to measure and rate conditions that do not neatly fit the schedules. VA is also providing the Department of Defense with all court decisions related to the VARSD so that the Departments are consistent in the interpretation of the specific schedules. Consistency of decisions and application of ratings across the Departments will synergistically improve as we work on joint development of training programs and reporting mechanisms, especially when it comes to how to apply the ratings in the VASRD.

It cannot be overstated that an updated and clear VASRD is fundamental to consistent application of the Disability Evaluation System. In fact, consistent application is a key criterion in the Disability Evaluation System (DES) Pilot test which was implemented in November 2007 for disability cases originating at the three major military treatment facilities in the National Capitol Region (Walter Reed Army Medical Center, National Naval Medical Center Bethesda, and Malcolm Grow Medical Center). Key features include both a single disability/transition medical examination and single source disability rating by VA experts and fulltime professionals who apply the VASRD to medical conditions. The pilot is testing, along with many other facets, whether the Department of Defense can accept the single-source rating from VA without modification.

The pilot is part of the larger SOC effort including medical research into the signature injuries of the war and the corresponding updating of the VASRD. Proposed regulations to update the VASRD for Traumatic Brain Injury and burns were published in the Federal Register on January 3, 2008. The VASRD, in regard to Traumatic Brain Injury and Burns, is being updated by VA to reflect advances in medical science. The schedule proposes to clearly define VA's rating policies concerning the evaluation of scars, including multiple scars. VA proposes to incorporate "burn scars" into the title of the diagnostic codes most appropriate for evaluating scars. Previously, burn scars were generally rated only if they impacted motion and mobility. The schedule proposes to also provide detailed and updated medical criteria for evaluating residuals of Traumatic Brain Injury (TBI). VA has proposed to change the title, provide guidance for the evaluation of the cognitive, emotional/behavioral, and physical residuals of TBI, direct raters to consider special monthly compensation for problems associated with TBI, and revise the guidance concerning the evaluation of subjective complaints. The Department of Defense lauds VA for this collaborative and diligent effort to ensure the VASRD rates disabilities associated with the war as accurately as possible.

The Departments are also participating in a reenergized Disability Advisory Council (DAC) – a consortium of advisors from the Military Departments, DoD agencies, and the Department of Veterans Affairs. The DAC is a key instrument in the policy formulation, promulgation, and management of the DES. The Departments have made great progress in revitalizing the DAC so that it plays an active and strengthened role in providing a venue to initiate collaborative discussions with VA on VASRD issues, and a pathway for the Department of Defense medical community to provide consultation and inputs for revisions. The DAC, in turn, will inform the collaborative structure of councils (the Benefits Executive Council and Joint Executive Council) on DES and VARSD issues for decisions. These councils are cochaired by senior leadership of both Departments.

One of the most significant recommendations from the task forces and commissions is the shift in the fundamental responsibilities of the Departments of Defense and Veterans Affairs. Among the core recommendations of the Dole/Shalala Commission is the concept of taking the Department of Defense out of the disability rating business so that DoD can focus on the fit or unfit determination, and streamlining the transition from servicemember to veteran. The Department believes this recommendation is very sound. The application of the VARSD is best left to the trained and professional experts who are from VA where the VARSD is developed and refined.

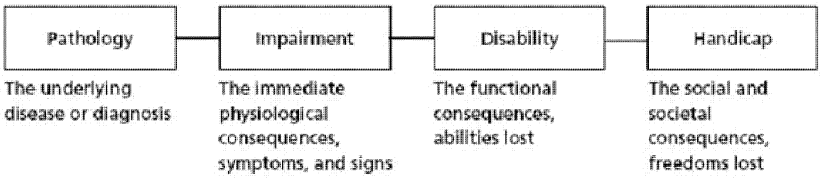
We are pleased with the quality of effort and progress made on the VASRD and understand that there is much more to do. We also believe that the greatest improvement to the long-term care and support of America's wounded warriors and veterans will come from enactment of provisions recommended by Dole/Shalala. We have, thus, positioned ourselves to implement these provisions through the Disability Evaluation System Pilot and continue our collaboration with VA in providing world-class support to our warriors and veterans.

Statement of American Medical Association

The American Medical Association (AMA) appreciates the opportunity to provide the House Committee on Veterans Affairs Subcommittee on Disability Assistance and Memorial Affairs with comments on reforming the Veterans Disability System. Our comments follow our review of the Institute of Medicine's (IOM) 2007 report entitled, *A 21st Ccentury System for Evaluating Veterans for Disability Benefits*, which highlights the significant shortcomings of the current, antiquated veterans disability system.

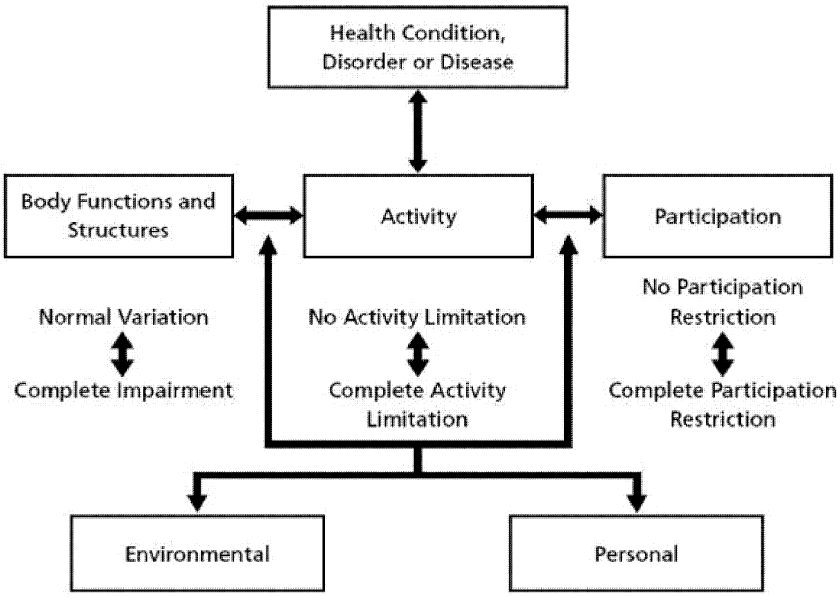
The AMA supports reforms to the Veterans Disability System, as demonstrated in the AMA's *Guides to the Evaluation of Permanent Impairment, Sixth Edition (Guides)*, which was published in December, 2007. This current edition defines a new international standard for impairment assessment. A consistent, well-designed methodology was adopted and applied to each chapter to enhance validity, improve internal consistency, promote greater precision, standardize the rating process, and improve inter-rater reliability. The goal is to provide an impairment rating guide that is authoritative, fair, and equitable to all parties. The editorial process used an evidence-based foundation when possible and a modified Delphi panel approach to consensus building. Additionally, the editorial process was undertaken by a panel of experts and physician specialists in the field of impairment assessment.

The traditional model of disablement was based on the International Classification of Impairments, Disabilities and Handicaps (ICIDH). This was a unidirectional model that does not address all facets of an injury experience.



The AMA *Guides* methodology applies the current state of the art terminology and adopts an analytical framework based on the World Health Organization's International Classification of Functioning, Disability and Health (ICF):

ICF Model of Disablement



In evaluating the severity of an illness or injury, a physician four basic points:

(1) what is the problem (diagnosis); (2) what symptoms and resulting functional difficulty does the patient report; (3) what are the physical findings pertaining to the problem; and (4) what are the results of clinical studies. These same considerations are used by physicians to evaluate impairment and, therefore, are used as a guiding construct for the *Guides*. The Sixth Edition is designed to encourage attention to, and documentation of, functional consequences of the impairment as a part of each physician's detailed history, to clarify and delineate key physical findings, and to underscore essential clinical test results where applicable.

Based on the efforts of the AMA process, Diagnosis-based grids were developed for each organ system. These grids arrange diagnoses into five classes of impairment severity, according to the consensus-based dominant criterion. The functionally based history, physical findings, and broadly accepted clinical test results, where applicable, are then integrated to determine severity grade and provide a corresponding impairment value. Ratings are transparent, clearly stated, and reproducible. The basic template of the diagnosis-based grid is common to each organ system and chapter; thus, there is greater internal consistency, facilitating the application of this new method.

CLASS	CLASS 0	CLASS 1	CLASS 2	CLASS 3	CLASS 4
IMPAIRMENT RATING (%)	0	Minimal %	Moderate %	Severe %	Very Severe %
SEVERITY GRADE (%)		(ABCDE)	(ABCDE)	(ABCDE)	(ABCDE)
HISTORY OF CLINICAL PRESENTATION[a]	No current symptoms *and/or* intermittent symptoms that do not require treatment	Symptoms controlled with continuous treatment *or* intermittent, mild symptoms despite continuous treatment	Constant mild symptoms despite continuous treatment *or* intermittent, moderate symptoms despite continuous treatment	Constant moderate symptoms despite continuous treatment *or* intermittent, severe symptoms despite continuous treatment	Constant severe symptoms despite continuous treatment *or* intermittent extreme symptoms despite continuous treatment
PHYSICAL EXAMINATION OR PHYSICAL FINDINGS[b]	No current signs of disease	Physical findings not present with continuous treatment *or* intermittent, mild physical findings	Constant mild physical findings despite continuous treatment *or* intermittent moderate findings	Constant moderate physical findings despite continuous treatment *or* intermittent severe findings	Constant severe physical findings despite continuous treatment *or* intermittent extreme findings
CLINICAL STUDIES OR OBJECTIVE TEST RESULTS[c]	Testing currently normal	Consistently normal with continuous treatment *or* intermittent mild abnormalities	Persistent mild abnormalities despite continuous treatment *or* intermittent moderate abnormalities	Persistent moderate abnormalities despite continuous treatment *or* intermittent severe abnormalities	Persistent severe, abnormalities despite continuous treatment *or* intermittent extreme abnormalities

[a, b] Descriptors will be disease-specific; mild, moderate, severe, and extreme need to be defined.

[c] Descriptors will be disease-specific and based on the number of abnormalities found.

The following is used as a grade modifier in the musculoskeletal chapters:

FUNCTIONAL HISTORY[d]	Asymptomatic	Pain/symptoms with strenuous/vigorous activity; Able to perform self-care activities independently	Pain/symptoms with normal activity; Able to perform self-care activities with modification but unassisted	Pain/symptoms with less than normal activity (minimal); Requires assistance to perform self-care activities	Pain/symptoms at rest; Unable to perform self-care activities

[d] Based on self-report or scores from the PDQ, QuickDASH, Lower Limb Outcomes Questionnaire, or other self-report tool.

The following will be added in selected chapters when compliance with treatment minimizes objective evidence of organ dysfunction but results in a significant compromise in ADLs:

BURDEN OF TREATMENT COMPLIANCE*	None	Will be based on factors such as number and route of medications taken or the need to regularly undergo diagnostic tests or invasive procedures if *not* already considered in the preliminary rating

* Based on information in Appendix B; depending on the score, the examiner can opt to add 1 to 3 percentage points.

Each chapter in the *Guides* was written by a group of specialty-specific, expert contributors, developing their respective chapter within the scope of this established framework. The Sixth Edition of the *Guides* reflects a significant revision and includes changes to all chapters. The three most common organ system claims seen in the Veterans Disability system— Orthopedics, Psychiatry, and Hearing—are all completely covered by the respective AMA *Guides* chapters. Further, these specialty-specific chapters do not use any separate specialty-specific resource outside of the *Guides* in their fields. As an example, the common psychiatric claims for Post Traumatic Stress Disorder (PTSD), other anxiety disorders, traumatic brain disorders, depressive disorders, psychotic disorders, are all evaluated with the use of the AMA *Guides*.

To assess impairment using the Mental and Behavioral Disorders chapter of the Sixth Edition, the clinician must first make a definitive diagnosis using standard psychiatric criteria, including history, and adjunctive psychological, neuroradiological, or laboratory testing. The Sixth Edition also supports the use of well-standardized psychological tests that may improve accuracy and support the existence of a mental disorder. The diagnosis (with the associated factors of prognosis and course) will form the basis by which one assesses the severity and predicts the probable duration of the impairment. The *Guides* Sixth Edition also uses three scales by which mental and behavioral impairment is rated: 1) the Brief Psychiatric Rating Scale (BPRS), 2) the Global Assessment of Functioning Scale (GAF), and 3) the Psychiatric Impairment Rating Scale (PIRS). The BPRS measures major psychotic and nonpsychotic symptoms in patients with major psychiatric illnesses. The GAF evaluates overall symptoms, occupational and social function. The PIRS assesses behavioral consequences of psychiatric disorders within various areas of functional impairment. The purpose of including all three of these scales is to provide a broad assessment of the patient with mental and behavioral disorders as the individual scales focus on symptom severity and/or function. The objective of making a reliable diagnosis and coupling it with the assessment of these three scales is to arrive at a strongly supportable impairment rating.

Any model used to determine disability for veterans will require a comprehensive, regularly updated, commonly accepted rating method to diagnose medical impairments and link them to basic functional limitations. The AMA *Guides* offers a methodology to achieve this. Any physician trained and experienced in *Guides* methodology within or external to the VA can provide these assessments. This information is a necessary first step in the comprehensive integrated determination of work disability, non-work disability, individual unemployability, and quality of life.

One of the most important changes to the *Guides* development process was the establishment of the *Guides* Advisory Committee. This advisory Committee is composed of representatives from certification organizations, teaching organizations, workers' compensation systems, or are members of the AMA's policymaking body known as the House of Delegates (HOD), which is comprised of representatives from 109 national medical specialty societies and all the state medical societies.

The *Guides* Advisory Committee is ongoing and meets annually to discuss items of mutual concern and current issues in impairment and disability. The Advisory Committee's primary objectives are to:

- serve as a resource to the *Guides* Editorial Panel by giving advice on impairment rating as relevant to the member's specialty;
- provide documentation to staff and the Editorial Panel regarding the medical appropriateness of changes under consideration for inclusion in the *Guides*;
- assist in the review and further development of relevant impairment issues and in the preparation of technical education material and articles pertaining to the *Guides*; and
- promote and educate the Membership of representative organizations on the use and benefits of the *Guides*.

The *Guides* Advisory Committee will receive all recommendations for changes to future editions of the *Guides*. Based on current scientific and clinical evidence, the Advisory Committee Members will help determine the scientific merit of each recommendation and use these to form the foundation for subsequent editions of the *Guides*. The goals of the new approach are to obtain broad input from stakeholders and to develop a process for defining impairment that is supportable, high-quality, efficient, and effective. If the Guides were to be used within the VA system, the AMA would solicit representation from the Veterans Administration to ensure our responsiveness to any particular Veterans Administration need.

In conclusion, there are significant shortcomings of the current, antiquated veterans disability system as highlighted by the IOM. The current international science of disability places the World Health Organization model as the centerpiece to approaching this discipline. The AMA *Guides* has been specifically developed to be at the forefront of the rating process and addresses the IOM reforms and virtually all of the recommended enhancements to the impairment rating process. As with all needed reforms to any aspect of our Nation's healthcare systems, the AMA is prepared to offer the resources of our organization to assist in the ongoing dialog of implementation and improvement.

United States General Accounting Office, GAO–03–1172T
Testimony Before the Committee on Veterans' Affairs, U.S. Senate
Statement of Cynthia A. Bascetta, Director
Education, Workforce, and Income Security Issues
Tuesday, September 23, 2003
VA Benefits: Fundamental Changes to VA's Disability Criteria Need Careful Consideration

Mr. Chairman and Members of the Committee:

I am pleased to be here to discuss our past reviews of the Department of Veterans Affairs (VA) disability programs as you consider the fundamental issue of eligibility for benefits and the related issue of concurrent receipt of VA disability compensation and Department of Defense (DoD) retirement pay. Our work has addressed these issues in addition to identifying significant program design and management challenges hindering VA's ability to provide meaningful and timely support to disabled veterans and their families. It is especially fitting, with the continuing deployment of our military forces to armed conflict, that we reaffirm our commitment to those who serve our Nation in its times of need. Therefore, effective and efficient management of VA's disability programs is of paramount importance.

As you know, in January 2003, we designated VA's disability compensation programs, as well as other Federal disability programs including Social Security Disability Insurance and Supplemental Security Income, as high-risk areas.[1] We did this to draw attention to the need for broad-based transformation of these programs, which is critical to improving the government's performance and ensuring accountability within expected resource limits. In March 2003, we cautioned that the proposed modification of concurrent receipt provisions in the military retirement system would not only have significant implications for DoD's retirement costs but could also increase the demands placed on the VA claims processing system. This would come at a time when the system is still struggling to correct problems with quality assurance and timeliness. Moreover, we testified that it would be appropriate to consider the pursuit of more fundamental reform of the disability programs as the Congress and other policy makers consider concurrent receipt.

Today, as you requested, I would like to highlight the findings of our related past work on VA's disability programs, including our 1989 report on veterans receiving compensation for disabilities unrelated to military service. My comments are based on numerous reports and testimonies prepared over the last 15 years as well as our broader work on other Federal disability programs. (See Related GAO Products.):

In summary, VA needs to modernize its disability programs. In particular, VA relies on outmoded medical and economic disability criteria in adjudicating claims for disability compensation. In addition, VA has longstanding problems providing veterans with accurate, consistent, and timely benefit decisions, although recent efforts have made important improvements in timeliness. However, complex program design features, including eligibility, have developed over many years, and solutions to the current problems will require thoughtful analysis to ensure that efficient, effective, and equitable solutions are crafted. Moreover, these solutions might need to take into account a broader perspective from other disability programs to ensure sound Federal disability policies across government programs and to reduce the risks associated with the current programs.

Background

VA provides disability compensation to veterans with service-connected conditions, and also provides compensation to survivors of servicemembers who died while on active duty. Disabled veterans are entitled to cash benefits whether or not employed and regardless of the amount of income earned. The cash benefit level is based on the percentage evaluation, commonly called the "disability rating," that represents the average loss in earning capacity associated with the severity of physical and mental conditions. VA uses its Schedule for Rating Disabilities to determine, based on an evaluation of medical and other evidence, which disability rating to assign to a veteran's particular condition. VA's ratings are in 10 percent increments, from 0 to 100 percent.

Although VA generally does not pay disability compensation for disabilities rated at 0 percent, such a rating would make veterans eligible for other benefits, including healthcare. About 65 percent of veterans receiving disability compensation have disabilities rated at 30 percent or lower, and about 8 percent are 100 percent disabled.

[1] U.S. General Accounting Office, High-Risk Series: An Update, GAO–03–119 (Washington, D.C.: Jan. 1, 2003).

Basic monthly payments range from $104 for a 10 percent disability to $2,193 for a 100 percent disability.

VA's Disability Criteria Are Outmoded

In assessing veterans' disabilities, VA remains mired in concepts from the past. VA's disability programs base eligibility assessments on the presence of medically determinable physical and mental impairments. However, these assessments do not always reflect recent medical and technological advances, and their impact on medical conditions that affect potential earnings. VA's disability programs remain grounded in an approach that equates certain medical impairments with the incapacity to work.

Moreover, advances in medicine and technology have reduced the severity of some medical conditions and allowed individuals to live with greater independence and function more effectively in work settings. Also, VA's rating schedule updates have not incorporated advances in assistive technologies—such as advanced wheelchair design, a new generation of prosthetic devices, and voice recognition systems—that afford some disabled veterans greater capabilities to work.

In addition, VA's disability criteria have not kept pace with changes in the labor market. The nature of work has changed in recent decades as the national economy has moved away from manufacturing-based jobs to service-and knowledge-based employment. These changes have affected the skills needed to perform work and the settings in which work occurs. For example, advancements in computers and automated equipment have reduced the need for physical labor. However, the percentage ratings used in VA's Schedule for Rating Disabilities are primarily based on physicians' and lawyers' estimates made in 1945 about the effects that service-connected impairments have on the average individual's ability to perform jobs requiring manual or physical labor. VA's use of a disability schedule that has not been modernized to account for labor market changes raises questions about the equity of VA's benefit entitlement decisions; VA could be overcompensating some veterans, while undercompensating or denying compensation entirely to others.

In January 1997, we suggested that the Congress consider directing VA to determine whether the ratings for conditions in the schedule correspond to veterans' average loss in earnings due to these conditions and adjust disability ratings accordingly. Our work demonstrated that there were generally accepted and widely used approaches to statistically estimate the effect of specific service-connected conditions on potential earnings. These estimates could be used to set disability ratings in the schedule that are appropriate in today's socioeconomic environment.[2]

In August 2002, we recommended that VA use its annual performance plan to delineate strategies for and progress in periodically updating labor market data used in its disability determination process.[3] We also recommended that VA study and report to the Congress on the effects that a comprehensive consideration of medical treatment and assistive technologies would have on its disability programs' eligibility criteria and benefit package. This study would include estimates of the effects on the size, cost, and management of VA's disability programs and other relevant VA programs and would identify any legislative actions needed to initiate and fund such changes.

Some Veterans Are Compensated For Disabilities Not Related To Military Service:

A disease or injury resulting in disability is considered serviceconnected if it was incurred or aggravated during military service. No causal connection between the disability and actual military service is required. In 1989, we reported on the U.S. practice of compensating veterans for conditions that were probably neither caused nor aggravated by military service.[4] These conditions included diabetes unrelated to exposure to Agent Orange,[5] chronic obstructive pulmonary disease, arteriosclerotic heart disease, and multiple sclerosis. A review of case files for veterans receiving compensation found that 51 percent of compensation beneficiaries had disabilities due to injury; of these, 36 percent were injured in combat, or otherwise performing a military task. The remaining 49 percent were disabled due to disease; of these,

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[2] U.S. General Accounting Office, VA Disability Compensation: Disability Ratings May Not Reflect Veterans' Economic Losses, GAO/ HEHS–97–9 (Washington, D.C.: Jan. 7, 1997).

[3] U.S. General Accounting Office, SSA and VA Disability Programs: Re— Examination of Disability Criteria Needed to Help Ensure Program Integrity, GAO–02–597 (Washington, D.C.: Aug. 9, 2002).

[4] U.S. General Accounting Office, VA Benefits: Law Allows Compensation for Disabilities Unrelated to Military Service, GAO/ HRD–89–60 (Washington, D.C.: July 31, 1989).

[5] In May 2001, VA issued a regulation identifying Type 2 diabetes as a service-connected disability for veterans who served in Vietnam, based on presumed exposure to Agent Orange.

17 percent had disabilities probably caused or aggravated by military service; 19 percent probably did not have disabilities related to service; and for 13 percent, the link between disease and military service was uncertain. We suggested that the Congress might wish to reconsider whether diseases neither caused nor aggravated by military service should be compensated as service-connected disabilities.

In March 2003, the Congressional Budget Office (CBO) reported that, according to VA data, about 290,000 veterans received about $970 million in disability compensation payments in fiscal year 2002 for diseases identified by GAO as neither caused nor aggravated by military service. CBO estimated that VA could save $449 million in fiscal years 2004 through 2008, if disability compensation payments to veterans with several nonservice-connected, disease-related disabilities were eliminated in future cases. In August 2003, we also identified this as an opportunity for budgetary savings if the Congress wished to reconsider program eligibility.[6]

Because of the complexities involved in a potential change in eligibility, the details of how such a change would be implemented and its ramifications are important to the Congress, VA, veterans, and other stakeholders. For example, service connection is linked with eligibility for other VA benefits, such as healthcare and vocational rehabilitation. Moreover, efforts to change VA disability programs, including eligibility reform, would benefit from consideration in the broader context of fundamental reform of all Federal disability programs.

Mr. Chairman, this concludes my prepared remarks. I would be happy to answer any questions that you or Members of the Committee might have.

Contact and Acknowledgments

For further information, please contact me at (202) 512–7101 or Irene Chu at (202) 512–7102. Greg Whitney also contributed to this statement.

Related GAO Products

Opportunities for Oversight and Improved Use of Taxpayer Funds: Examples from Selected GAO Work. GAO–03–1006. Washington, D.C.: August 1, 2003.

Department of Veterans Affairs: Key Management Challenges in Health and Disability Programs. GAO–03–756T. Washington, D.C.: May 8, 2003.

High-Risk Series: An Update. GAO–03–119. Washington, D.C.: January 1, 2003.

Major Management Challenges and Program Risks: Department of Veterans Affairs. GAO–03–110. Washington, D.C.: January 1, 2003.

Veterans' Benefits: Quality Assurance for Disability Claims and Appeals Processing Can Be Further Improved. GAO–02–806. Washington, D.C.: August 16, 2002. SSA and VA Disability Programs: Re-Examination of Disability Criteria Needed to Help Ensure Program Integrity. GAO–02–597. Washington, D.C.: August 9, 2002.

Veterans' Benefits Claims: Further Improvements Needed in Claims— Processing Accuracy. GAO/HEHS–99–35. Washington, D.C.: March 1, 1999.

VA Disability Compensation: Disability Ratings May Not Reflect Veterans' Economic Losses. GAO/HEHS–97–9. Washington, D.C.: January 7, 1997.

VA Benefits: Law Allows Compensation for Disabilities Unrelated to Military Service. GAO/HRD–89–60. Washington, D.C.: July 31, 1989.

[6] U.S. General Accounting Office, Opportunities for Oversight and Improved Use of Taxpayer Funds: Examples from Selected GAO Work, GAO–03–1006 (Washington, D.C.: Aug. 1, 2003).

QUESTIONS FOR THE RECORD

Committee on Veterans' Affairs
Subcommittee on Disability Assistance and Memorial Affairs
Washington, DC.
February 29, 2008

Vice Admiral Dennis Vincent McGinn, USN (Ret.)
Veterans' Disability Benefits Commission
U.S. Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Dear Admiral McGinn:

In reference to our Subcommittee hearing on The VA Schedule for Rating Disabilities on February 26, 2008, I would appreciate it if you could answer the enclosed hearing questions by the close of business on April 2, 2008.

In an effort to reduce printing costs, the Committee on Veterans' Affairs, in cooperation with the Joint Committee on Printing, is implementing some formatting changes for materials for all Full Committee and Subcommittee hearings. Therefore, it would be appreciated if you could provide your answers consecutively on letter size paper, single-spaced. In addition, please restate the question in its entirety before the answer.

Due to the delay in receiving mail, please provide your response to Ms. Orfa Torres by fax at (202) 225–2034. If you have any questions, please call (202) 225–3608.

Sincerely,

JOHN J. HALL
Chairman

Veterans' Disability Benefits Commission
Established Pursuant to Public Law 108–136
Sunset December 1, 2007
March 31, 2008

Hon. John J. Hall
Subcommittee on Disability Assistance and Memorial Affairs
335 Cannon House Office Building
Washington, DC 20515

Dear Mr. Chairman:

As a follow up to my testimony on behalf of Commission Chairman Scott before the Subcommittee on Disability Assistance and Memorial Affairs on February 26, 2008, enclosed for the record are my written responses to your post-hearing questions. Both my testimony and the enclosed answers reflect my point of view and, where appropriate, my understanding of the considerations. We used to reach consensus as a Commission. As you know, we completed our work and submitted our report in October 2007, closing the Commission's operations at the end of November.

I hope the Subcommittee finds my testimony, the enclosed responses to your questions, and the body of work produced by the Commission, and the Institute of Medicine and the CNA Corp. on behalf of the Commission, useful as you proceed with legislation and oversight aimed at improving the disability compensation system for our Nation's veterans and their families.

Sincerely,

Dennis Vincent McGinn VADM USN (Ret)
Member

Enclosure

RESPONSE TO QUESTIONS FOR THE RECORD BY DENNIS VINCENT MCGINN, VADM USN (RET), MEMBER VETERANS' DISABILITY BENEFITS COMMISSION March 31, 2008

The answers I am providing reflect my views and not necessarily those of all of the Members of the Veterans' Disability Benefits Commission since the Commission completed its work in October 2007 and submitted its report at that time.

Question 1: Presumption seems to be a contentious issue that will require years of research to establish a scientific standard. Did the Commission consider what we should do in the meantime for some of these types of conditions?

Response: The Commission did not discuss in any detail an interim approach to presumptions but we also did not envision that the changes recommended by IOM would require years to implement. If there is one immediate step that should be taken, I would recommend that VA document the existing process and ensure that every effort is made to make the process more transparent. IOM found that "VA (1) has no formal published rules governing this process, (2) does not thoroughly disclose and discuss what "other" medical and scientific information it considered, and (3) publishes abbreviated and insufficiently informative explanations of why a presumption was or was not granted."[1] This situation should not continue.

Question 2: The Commission also differed with the IOM on PTSD re-evaluation. Why did it think it necessary to make such a recommendation when IOM and the VSOs saw it as "discriminatory" and "stressful" for those with mental health issues?

Response: The Commission was mindful of IOM's thoughts on the subject of re-examination and was respectful of IOM's recognized expertise. However, the Commission found that there is insufficient monitoring and coordination between Veterans Benefits Administration (VBA) and Veterans Health Administration (VHA) for veterans experiencing PTSD. Very little is done to monitor these veterans and encourage them to receive treatment. The mental health community generally believes that PTSD can be successfully treated yet the IOM concluded in a study of PTSD treatment[2] completed after our report that the evidence is inadequate to determine efficacy of treatment modalities except for exposure therapy. IOM further stated that they did not intend to imply that other modalities are inefficacious. IOM also found that there is not even an agreed-upon definition of recovery.

Our Commission concluded that veterans with PTSD are not well served by simply providing compensation without follow up and treatment and without incentives to seek treatment. That is why we recommended a holistic approach that couples compensation, treatment, and vocational assessment and requires re-examination every 2 to 3 years to gauge treatment effectiveness and encourage wellness.

Question 3:. According to the Commission's report, the recommended Executive Oversight Group should be formed to oversee implementation of the Commission's recommendations. Should this group's authority be extended beyond your Commission to other Commissions and task forces?

a. How does the Commission envision the Executive Oversight Group to function that is different from the Joint Executive Council (JEC) that is already co-chaired by VA and DoD?

Response: Yes, if properly constituted, the Executive Oversight Group should be granted authority to oversee the implementation of appropriate recommendations by other commissions and task forces. As an illustrative example of how this might work, Chairman Terry Scott briefed the DoD/VA Senior Oversight Committee (SOC) last December on some of our key recommendations. He was in turn briefed on the SOC's efforts to ensure that the recommendations of our Commission, the Dole-Shalala Commission and the other commissions and task forces are acted upon. The SOC is presently tracking all recommendations and has assigned each one to a line of action Subcommittee for action and is monitoring progress on a frequent basis. While the SOC, currently cochaired by Deputy Secretary of Defense England and Deputy Secretary of Veterans Affairs Mansfield, is making real progress, it may not continue in operation after the upcoming change of administration. Its progress reflects the results that are possible when the attention of the two Departments is applied at the highest levels.

My understanding of the Joint Executive Council (JEC) is that it is statutorily mandated and could reasonably be expected perform the oversight role envisioned by our Commission to ensure prompt and appropriate action. However, I recommend strong involvement and oversight on a regular and consistent basis by Committees of Congress, namely the Armed Services and Veterans' Affairs Committees of the Senate and House of Representatives. The momentum and enthusiasm to properly care for our disabled Veterans and their families must not be allowed to diminish. Collectively, the several reports issued over the past year illuminate the path of necessary improvements for disabled servicemembers and veterans and their families.

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[1] Institute of Medicine (IOM), *Presumptive Disability Decision-Making*, 12–10.

[2] Institute of Medicine (IOM), Treatment of Post Traumatic Stress Disorder: An Assessment of the Evidence, 2008.

In this sense, they also reflect the will of the people of this Nation to our duty to fulfill our moral obligation to those who defend our freedom.

Committee on Veterans' Affairs
Subcommittee on Disability Assistance and Memorial Affairs
Washington, DC.
February 29, 2008

Lonnie Bristow, M.D.
Chair
Committee on Medical Evaluation of Veterans
For Disability Benefits
Institute of Medicine
500 5th Street, NW
Washington, DC 20001

Dear Dr. Bristow:

In reference to our Subcommittee hearing on The VA Schedule for Rating Disabilities on February 26, 2008, I would appreciate it if you could answer the enclosed hearing questions by the close of business on April 2, 2008.

In an effort to reduce printing costs, the Committee on Veterans' Affairs, in cooperation with the Joint Committee on Printing, is implementing some formatting changes for materials for all Full Committee and Subcommittee hearings. Therefore, it would be appreciated if you could provide your answers consecutively on letter size paper, single-spaced. In addition, please restate the question in its entirety before the answer.

Due to the delay in receiving mail, please provide your response to Ms. Orfa Torres by fax at (202) 225–2034. If you have any questions, please call (202) 225–3608.

Sincerely,

JOHN J. HALL
Chairman

Questions of the Honorable John J. Hall and Responses of Lonnie Bristow, M.D., Following the Hearing on the VA Schedule for Rating Disabilities Held February 26, 2008

Question 1: At the hearing there was discussion of implicitly including a loss of quality of life component or scale into the Rating Schedule based on your Committee's findings. Can you give me some idea as to how VA could measure quality of life and what instruments are already available that might be useful to achieve this goal in the short-term?

Response: The Committee I chaired noted that the modern conceptualization of disability can include loss of quality of life (QOL) as well as impairment and functional limitations. We recommended that VA expand the basis for disability compensation to explicitly include limitations on ability to function in everyday life and loss of quality of life, in addition to degree of medical impairment, which is currently the basis of the Rating Schedule. Measures of functional limitations, such as Activities of Daily Living and Instrumental Activities of Daily Living, are well developed and commonly used in the healthcare system. Measures of health-related QOL are also widely used—the Veterans Health Administration uses a version of the tool called the SF–36 that has been normed to the VA population (the SF–36V)—but more work needs to be done to further develop and refine this into a tool that can be used to determine an amount of compensation for the loss of QOL associated on average with a given condition. The Committee recommended that VA develop such a tool, which it is well positioned to do, and then see if there are some conditions for which loss of QOL is much more severe than is reflected within the rating given by the existing Rating Schedule. It is possible that impairment ratings and degree of loss of QOL already tend to track together, in which case an analytical study would show those with greater loss of QOL are already being given the highest ratings. If those are not the findings from such a study, the committee recommended that VA develop a method of compensating for the loss of QOL.

In response to the query about instruments already available, we pointed to a very successful example in Canada that would prove useful. On page 125 of our re-

port, *A 21st Century System for Evaluating Veterans for Disability Benefits),* it says: "An example of quality-of-life research is the noneconomic loss survey of approximately 12,000 injured workers who received benefits from the Ontario, Canada, workers' compensation program, plus 300 individuals from the general population of Ontario who served as a control group. Seventy-eight medical conditions covering a wide range of impairments were selected as subjects for videos. Each video portrayed the limitations and adaptations to lifestyle required of the workers with a given condition. The workers discussed their condition with a therapist and demonstrated their capacity to perform various tasks of daily living. The procedure used to ascertain the quality-of-life ratings was described by Sinclair and Burton (1995):*

> Each survey respondent spent 30 minutes viewing 4 or 6 of the videos, randomly assigned, excluding videos depicting his or her condition. Respondents were asked to rate, on an "opinion meter" scale, the loss of enjoyment of life they believed they would suffer if they had the condition portrayed. These ratings were on a scale of 0 to 100, with 0 representing normal health and 100 representing death."

This approach or format could be employed in the VA population by studying three groups: a group of veterans with disabilities, a control group of veterans without disabilities, and still another control group taken from the general public of an age-matched group who have not served in the military. The average scores assigned by the general public would serve as a check that veterans are not given higher scores, and therefore more compensation, than the general public perceives as fair (and that they are not given a lot less, either).

Question 2: Currently, VA doctors are only involved in the exam process and give an opinion that is then interpreted by a Rater who assigned the percentage of disability. Should doctors be more involved in rendering a decision on a level of disability severity?

Response: I believe our Committee recognizes that physicians are well suited for determining the presence or absence of medical or psychological impairment (and its degree), but usually are not trained for interpreting the statutes and applicable government-derived levels of severity of disability (for which the Raters are trained and have expertise). Our Committee supports the concept that doctors should not be involved in rendering decisions on a level of disability severity, but strongly advocates changing the current process so that Raters have truly "ready access" to doctors for advice on medical and psychological issues that arise during the rating process, such as in interpreting evidence, and determining the possible need for additional exams or tests (this is Recommendation 5–5 in the report).

Question 3: Your Committee recommended that a Voc Rehab assessment be done before IU is awarded. Did it consider the complexity of that assessment and the resources that VCA would require?

Response: Recommendation 7–1 applies to those veterans already deemed to have a disability, and who then apply for IU. This is because Raters (who have no training in assessing functional limitations, which often is an essential factor in assessing employability) currently are usually attempting to make the determination of whether the veteran can engage in normal work activities on the basis of medical reports and the two-page application for IU. Those two pieces of information are often woefully inadequate in providing information about functional limitations, so necessary for a Rater to properly determine employability, and this at times results in a disservice to the veteran, the government, or both.

It is also our recommendation (6–1) that all individuals who apply for disability status at the time of separation from the service should be given a comprehensive medical, psycho-social, and vocational evaluation. This would establish a much-needed focus on how to achieve maximum success in the adjustment to civilian life for the veteran with a disability.

The Committee has indeed considered the complexity and the resources that would be required of VA, but believes that it is a legitimate part of the indebtedness that a Grateful Nation (a phrase repeated by Pres. George W. Bush in March 2008 while giving out a Medal of Honor) has to its surviving disabled veterans. It is simply modernizing an honorable legacy that began in the days of the Revolutionary War.

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*Sinclair, S., and J. F. Burton, Jr. 1995. Development of a schedule for compensation of noneconomic loss: Quality-of-life values vs. clinical impairment ratings. In: *Research in Canadian Workers' Compensation*, edited by T. Thomason and R. P. Chaykowski. Kingston, ON: IRC Press of Queen's University.

Question 4: Do private sector disability evaluating physicians already use automated systems in conducting their exams, such as electronic exam templates and decision support software that can match diagnosis and levels of impairment severity and loss of function or quality of life?

Response: The Committee did not research whether private sector disability programs use templates, and if they do, how they make use of this tool. VA has been using the template tool since 1997, and the IOM Committee believes its greatest utility lies in it being used to measure and assess the Consistency and the Technical Accuracy of the data collection during the C & P examinations. This is a very important part (but not sufficient unto itself) required for assessing the Quality of the Examination. Another part (yet to be developed) is assessing the quality of the Content within the data collected. Having both parts will then allow a determination of the true quality of the examination, and possibly be useful in training examiners to consistently provide the Raters with the information they need. Currently, its major usefulness is as a tool to evaluate the consistency and technical accuracy in the gathering of data by the C & P examination.

There is substantial difference between disability programs in the private sector and that of the VA. One illustration is that none of the private-sector employment opportunities carry with them the substantial risk to life and limb that military service carries—not even in our police and fire departments. Additionally, very often the types of injuries and diseases which servicemembers experience are not often encountered in the private sector. Accordingly, what may be perfectly appropriate in the assessment and compensation of a private-sector disability program may not be easily transferable to the setting involving our veterans of military service. For those reasons, it is my opinion that this process of decisionmaking about disability may, someday in the far distant future, eventually be helped by decision support software, but the current process of using a trained individual to make that judgment should not be supplanted any time soon.

Committee on Veterans' Affairs
Subcommittee on Disability Assistance and Memorial Affairs
Washington, DC.
February 29, 2008

Dean Kilpatrick, Ph.D.
Committee on Veterans' Compensation For
Post-traumatic Stress Disorder
Institute of Medicine
500 5th Street, NW
Washington, DC 20001

Dear Dr. Kilpatrick:

In reference to our Subcommittee hearing on The VA Schedule for Rating Disabilities on February 26, 2008, I would appreciate it if you could answer the enclosed hearing questions by the close of business on April 2, 2008.

In an effort to reduce printing costs, the Committee on Veterans' Affairs, in cooperation with the Joint Committee on Printing, is implementing some formatting changes for materials for all Full Committee and Subcommittee hearings. Therefore, it would be appreciated if you could provide your answers consecutively on letter size paper, single-spaced. In addition, please restate the question in its entirety before the answer.

Due to the delay in receiving mail, please provide your response to Ms. Orfa Torres by fax at (202) 225–2034. If you have any questions, please call (202) 225–3608.

Sincerely,

JOHN J. HALL
Chairman

Dr. Dean Kilpatrick's responses to questions posed by the Honorable John J. Hall, Chairman, Subcommittee on Disability Assistance and Memorial Affairs, pursuant to the Hearing on the VA Schedule on Rating Disabilities, February 26, 2008

Question 1: There has been discussion on PTSD and TBI having overlapping symptoms. How can the Rating Schedule capture that?

Response: The issue of potential overlap between PTSD and TBI symptoms was not discussed by the Institute of Medicine Committee on Veterans' Compensation for Posttraumatic Stress Disorder. Nor was the issue of how this could be addressed by the Rating Schedule specifically covered by our Committee. Therefore, my response to this question is based on my opinion and does not represent that of the Committee.

I believe it is useful to make four points.

First, the issue of potential overlap of some symptoms between PTSD and TBI is less important than understanding that both PTSD and TBI could result from the same type of combat incident. TBI can result from numerous types of events that happen in combat, including blast concussions from improvised explosive devices, penetrating head wounds from gunfire or shrapnel, and vehicle accidents. Our Committee report documented evidence that being wounded or injured is a substantial risk factor for developing PTSD (see Table 3–2 of the 2007 Institute of Medicine report *PTSD Compensation and Military Service,* "Risk Factors for PTSD in Military Populations", p. 76). Brain injury is no exception to the general principle that those injured or wounded in combat are more likely to develop PTSD. Therefore, the same incident that produces a TBI in the veteran might well produce a case of PTSD. In my opinion, it is important to consider whether veterans who have been injured sufficiently to produce TBI may also have PTSD and to conduct a careful examination to evaluate for PTSD in such cases.

Second, there is some overlap between TBI symptoms and PTSD symptoms, particularly with respect to memory problems surrounding the event that produced the TBI or PTSD. Specifically, some cases of TBI involve retrograde amnesia (that is, lack of ability to remember events that happened before the injury-producing event) or anterograde amnesia (the inability to remember the injury-producing event or things that occurred after it happened). One PTSD symptom is "inability to recall an important aspect of the trauma" (*DSM–IV-TR* PTSD diagnostic criterion C, symptom 3). If a veteran sustained a head injury sufficient to produce TBI and/or PTSD and they cannot remember what happened during the traumatic event that produced the injury, their inability to recall details may be the result of the brain injury, psychological trauma, or some combination of the two. In TBI cases where veterans have numerous PTSD symptoms but there is a question as to whether inability to recall details of the event stems from TBI or PTSD, I think it is counterproductive to spend a great deal of time and effort trying to establish the exact cause of this memory problem.

Third, common effects of TBI are post concussive symptoms which include concentration deficits, headaches, and fatigue. Obviously, more severe brain injuries are more likely to produce more severe deficits in functioning than less severe brain injuries, and the location of the brain injury also has an impact on the types of problems observed (for example, individuals with injuries to the frontal lobes may exhibit impairments in impulse control or increased anger). Some of these TBI consequences may overlap with PTSD symptoms of "difficulty concentrating" (diagnostic criterion D, symptom 3) or "irritability or outbursts of anger" (criterion D, symptom 2). Thus, it is possible for a veteran with TBI to have concentration problems as well as irritability, and outbursts of anger. Veterans with PTSD can also have these symptoms, as can veterans with TBI and PTSD.

Fourth, in my opinion, if a veteran has a war zone history that includes exposure to an event that is capable of producing TBI, that person should be evaluated clinically for both TBI and for PTSD. If they have both TBI and PTSD, you would expect to have some symptom overlap as described above. Trying to determine whether potentially overlapping symptom should be assigned to TBI, to PTSD, or to TBI/PTSD is difficult, although it is required in the current Department of Veterans Affairs disability compensation system. As our report noted,

> The Committee's review of the literature found no scientific guidance addressing the separation of symptoms of comorbid mental disorders for the purpose of identifying their relative contributions to a subject's condition. . . . The parsing is instead an artifact of a VA system built around the harsh realities of polytraumatic injuries encountered in warfare. Partitioning of symptoms among comorbid conditions is not useful from a clinical perspective, and research on it is has therefore not been given any priority. Clinicians are often able to offer an informed opinion on this question, but this is a professional judgment, not an empirically testable finding. (p.96)

In order to reduce the difficulties encountered in situations where multiple disorders co-exist, the report recommended that a national standardized training program be implemented for clinicians who conduct compensation and pension psychiatric evaluations. While this recommendation was focused on PTSD and other

mental disorders, I believe it applies equally to conditions like TBI where physical injuries may produce overlapping symptoms.

Question 2: The IOM discusses the Best Practices Manual for PTSD C&P Exams, but did not take a position on using it. Should VA mandate the manual?

Response: As you note, the Institute of Medicine Committee on Veterans' Compensation for Post Traumatic Stress Disorder did not take a position on this issue. I am happy to offer my personal opinion with the understanding that it should not be attributed to others on the Committee or to the Committee as a whole.

My Committee's review of compensation and pension (C&P) examinations for PTSD quotes the VA's *Best Practice Manual for Post Traumatic Stress Disorder (PTSD) Compensation and Pension Examinations*(http://www.avapl.org/pub/PTSD%20Manual%20final%206.pdf) at length. The *Manual* recommended using assessment tools that appear to tap virtually all of the information needed to conduct a thorough exam. In my opinion, the *Best Practice Manual* is an excellent starting point for the VA if it wishes to mandate best practices for PTSD C&P exams. However, our IOM Committee report as well as other recent efforts (the 2008 IOM report *A 21st Century System for Evaluating Veterans for Disability Benefits* and the reports issued by the Veterans' Disability Benefits Commission and President's Commission on Care for America's Returning Wounded Warriors) recommended changes in the process that have implications for the content of future C&P exams in areas such as the assessment of quality of life. Therefore, it is my opinion that the examination procedures described in the *Best Practice Manual* should not be mandated as is. Instead, I believe that the VA should request the National Center for PTSD to update the *Manual* to incorporate changes recommended in our Committee's and others reports as well as any other changes that are warranted by advances in the science regarding PTSD. After such revisions have been made and independently reviewed, I believe that it would be appropriate to mandate the *Manual's* use.

Question 3: Are VA Mental Health examiners and contractors adequately training in conducting C&P exams?

a. Should there be a required certification for physician examiners as well or just raters?
b. How should training and certification be developed?

Response: Our Committee did not explicitly address whether all mental health examiners and contractors were adequately trained in conducting C&P exams for PTSD. However, some of the data and testimony we reviewed suggests that this may not be the case. First, we heard testimony that some exams were being conducted in an hour or less. Given that the *Best Practice Manual* outlines an assessment that may take several hours to complete, this suggests that some C&P examiners may lack sufficient training to know what a comprehensive exam consists of and the skills to conduct it. Second, we reviewed evidence that there were substantial variations in PTSD disability ratings across VA regions. The basic data used by raters to establish disability ratings is that provided by the mental health professionals in their C&P exams. Therefore, it is reasonable to assume that some of the variability in PTSD disability ratings may be associated with variability in the mental health professional's training and skills in how to do a PTSD C&P exam. In my opinion, it is highly likely that not all examiners are sufficiently well trained in how to conduct these exams.

Question 3a: Should there be a required certification for physician examiners as well or just raters?

Response: Our Committee did not address this question. In my opinion, physicians and other mental health professionals who conduct PTSD C&P exams should be required to have appropriate training and experience in PTSD in military populations. It is unclear to me whether formal certification is required or whether the successful completion of coursework and clinical training—or the equivalent experience—would suffice to demonstrate the competency needed to carry out high-quality, thorough exams. Standardizing coursework and training requirements for examiners would foster consistent exams throughout the VA system, and should lead to more consistent ratings.

Question 3b: How should training and certification be developed?

Response: Our Committee did not address this question, but here are some of my thoughts. First, the VA needs to specify more carefully the types of information that should be gathered in C&P exams for PTSD as well as the assessment tools

that should be used to help gather the needed information. The *Best Practice Manual*, if revised as I suggested above, would be a good starting point for generating this material. Second, core content information about PTSD in general combat and military sexual trauma—related PTSD should be developed. This should include what is known about how PTSD impacts quality of life as well as ability to function in educational, work, and relationship settings.

Once this information is gathered, appropriate educational and clinical experience requirements should be set by a panel consisting of experienced VA clinicians (both physicians and other mental health professions) and outside experts. The agreed-upon requirements should be regularly reviewed and revised to insure that they reflect the best practice.

Committee on Veterans' Affairs
Subcommittee on Disability Assistance and Memorial Affairs
Washington, DC.
February 29, 2008

Jonathan Samet, M.D.
Chair, Committee on Evaluation of the
Presumptive Disability Decision-Making Process for Veterans
Institute of Medicine
500 5th Street, NW
Washington, DC 20001

Dear Dr. Samet:

In reference to our Subcommittee hearing on The VA Schedule for Rating Disabilities on February 26, 2008, I would appreciate it if you could answer the enclosed hearing questions by the close of business on April 2, 2008.

In an effort to reduce printing costs, the Committee on Veterans' Affairs, in cooperation with the Joint Committee on Printing, is implementing some formatting changes for materials for all Full Committee and Subcommittee hearings. Therefore, it would be appreciated if you could provide your answers consecutively on letter size paper, single-spaced. In addition, please restate the question in its entirety before the answer.

Due to the delay in receiving mail, please provide your response to Ms. Orfa Torres by fax at (202) 225–2034. If you have any questions, please call (202) 225–3608.

Sincerely,

JOHN J. HALL
Chairman

Institute of Medicine
Washington, DC.
March 18, 2008

Hon. John J. Hall
Chairman, Committee on Veteran's Affairs
U.S. House of Representatives
Washington, DC 20515

Dear Chairman Hall:

I am writing in response to your letter of February 29, 2008, that provided four questions in followup of my testimony before the Subcommittee on February 26, 2008. Attached, please find my responses.

I appreciated the opportunity to speak to the Subcommittee. Please do not hesitate to contact me if I can be of further assistance as you consider and use the report of the Committee on Evaluation of the Presumptive Disability Decision-Making Process for Veterans.

Sincerely,

Jonathan M. Samet, MD, MS
Professor and Chairman
Jacob I and Irene B. Fabrikant Professor in Health, Risk, and Society

JMS/dvw

Responses to Questions of the Honorable John J. Hall Chairman Subcommittee on Disability Assistance and Memorial Affairs

Question 1: The VDBC did not fully accept the standards for presumption the IOM proposed in its report. What is your reaction to the direction the VDBC chose to go with presumptions?

Response: This question refers to the uncertainty of the VDBC with regard to whether the "standard" for presumption should be association or causation. Both the report of the IOM PDDM Committee and of the VDBC noted the inconsistency in use of standards based on association and causation across presumptive decisions made under various laws. Most recently, the Institute of Medicine Agent Orange Committees have provided a judgment as to the strength of evidence for association, and that judgment has appeared to guide decisionmaking by the VA. The VDBC notes that this issue needs to be clarified.

In proposing that causation rather than association should be the standard, the IOM Committee recognized that some might view this approach as "raising the bar" for the strength of evidence needed. However, it should be noted that the Committee's classification of the strength of evidence does not call for full certainty as to causation, but simply that the balance point of the evidence be at a 50 percent level of certainty or above. Additionally, we propose a schema for evidence review that would give appropriate weight to evidence from non-epidemiological sources, such as the findings of new types of toxicologic assays that will likely become the mainstay of toxicity testing. The Committee thought that its framework could be used consistently across various types of exposures, even lacking epidemiological evidence on association.

The VDBC stated that it "... agrees with this scheme proposed by IOM, but cautions VA not to ignore evidence that shows an association between a condition and an environmental or occupational hazardous exposure." We also call for flexibility in the VA's response to findings. For example, even if evidence has not reached the bar of equipoise or above for causality, benefits might be offered, such as medical care coverage.

This matter of association of causation, which is embedded in different ways and with some vagueness in various laws, might be revisited by the Congress to insure that intent is clear.

Question 2: It seems that many of your Committee's recommendations were based on the need for additional surveillance, which DoD would need to do, and then for VA to study a broad spectrum of evidence of environmental and occupational hazards. Given that we have heard so much about the lack of information technology interoperability between DoD and VA with medical and service records, how transferable would that information be from DoD to VA?

Response: This question appropriately addresses the reality of trying to achieve a smooth transfer of information between DoD and VA. The IOM PDDM Committee carefully assessed the present status of information systems and planned changes. We recognize that a seamless flow of information from DoD to VA is a goal to be achieved. On the other hand, Veterans will be best served if their health can be tracked continually so that the consequences of exposures received during service can be assessed. We urge that this interoperability between DoD and VA be considered a goal. Our Committee did not make a technical assessment of how should be achieved.

Questions 3: The Committee report noted that, "Exposures to stressors and to the circumstances of combat have not yet been developed." You recommend more research. But with that lacking and based on the DSM guidance for PTSD and how it defines a stressor, what do you think of creating a stressor presumption for combat zone service?

The IOM Committee recognized that the stressors of combat are real, but that exposures to such stressors are not well documented. For those serving in a combat theater, there is inevitably the process of exposure to the many stressors associated with combat. We did not specifically take on the task of determining if a presumption should be made for stressors received in combat zone service.

Question 4: Developing the level of evidence as described in your report could take years. What should we do about getting veterans their benefits in the meantime?

Response: We recognize that achieving the full approach recommended by our Committee will take years. We offer a model that VA and DoD should always have in sight as they move toward a more firmly evidence-based system for determining

benefits for Veterans. We note that aspects of our approach could be implemented immediately.

With regard to understanding the health consequences of military service, evidence will always be accruing. For some diseases, there may be a lengthy period between exposure and the appearance of excess risk. We point out repeatedly, that decisions need to be made while evidence is accumulating, and that changes in benefits might be made as the evidence becomes more certain.

Committee on Veterans' Affairs
Subcommittee on Disability Assistance and Memorial Affairs
Washington, DC.
February 29, 2008

Joyce McMahon, Ph.D.
Managing Director, Center for Health Research and Policy
Center for Naval Analysis (CNA) Corporation
4825 Mark Center Drive
Alexandria, VA 22311

Dear Dr. McMahon:

In reference to our Subcommittee hearing on The VA Schedule for Rating Disabilities on February 26, 2008, I would appreciate it if you could answer the enclosed hearing questions by the close of business on April 2, 2008.

In an effort to reduce printing costs, the Committee on Veterans' Affairs, in cooperation with the Joint Committee on Printing, is implementing some formatting changes for materials for all Full Committee and Subcommittee hearings. Therefore, it would be appreciated if you could provide your answers consecutively on letter size paper, single-spaced. In addition, please restate the question in its entirety before the answer.

Due to the delay in receiving mail, please provide your response to Ms. Orfa Torres by fax at (202) 225–2034. If you have any questions, please call (202) 225–3608.

Sincerely,

JOHN J. HALL
Chairman

Questions of the Honorable John J. Hall
Chairman, Subcommittee on Disability Assistance and Memorial Affairs
Hearing on the VA Schedule for Rating Disabilities

Question 1: CNA reported that the level of life satisfaction or quality of life among disabled veterans is so low. Do you think the best way to address those issues would be to make this a more explicit part of the Rating Schedule from a strictly compensation point of view?

Response: In our opinion, it would be more appropriate to keep the quality of life scale as a separate element rather than combine it with the earning compensation rating process. If the quality of life were to be incorporated into the current rating criteria, this would add another complexity to the rating system of compensation that is already quite difficult for veterans to understand. The current system of compensation is to make up for lost earnings capacity. It would be best not to layer another different purpose on top of that until we understand more about which categories of disabled veterans will be entitled to a quality of life adjustment, and how that adjustment will be determined (e.g., based on average quality of life, based on combined disability rating, based on combined disability rating and primary type of disability, etc.).

In addition, in the Raters and VSOs surveys, we asked the respondents how they felt about the possibility of separately rating the impact of a disability on lost earning capacity and the quality of life of veterans during the claims process. In general, this suggestion was not supported by either raters or VSOs.

Question 2: At one point in your testimony you mentioned that your analyses pertained to earnings ratios of male veterans. How did female veterans fare? Are they being treated equitably by VBA?

Response: Note that none of our comparisons combine male and female veterans. This is necessary because the earned income profiles are substantially different by gender and the gender mix is not constant across age groups. For example, women account for 25 percent of service-disabled veterans under age 30 but only 2 percent for those 50 years and older. Hence, combining the genders would bias our results.

To facilitate an easy comparison between service-disabled veterans and their peers, we computed the ratio of earned income plus VA compensation of service-disabled veterans to the earned income of non-service-disabled veterans. Values less than 1 mean that VA compensation doesn't make up for earned income losses, and values greater than 1 mean that VA compensation more than makes up for losses. A value of 1 represents parity.

For male service-disabled veterans, the data yielded an earnings ratio of 0.99. For female service-disabled veterans, the earnings ratio was 1.01. Overall, female veterans fared as well as male veterans with regard to how well VA compensation makes up for earned income losses.

Question 3: It sounds like the surveys you did with the Raters and the VSO Representatives gave you great insight as to what is going on in the field among the people who are doing the actual claims processing. So, based on that feedback, what changes would facilitate making this a better system for compensating our Nations' disabled veterans?

Response: The raters and VSOs report that many veterans find the VA disability claims process to be confusing, time-consuming, and frustrating. Simplifying the process would be a good start, along with improving communication to the veterans who are applying for benefits. In addition, the surveys showed that the raters and VSOs agreed that the veterans had unrealistic expectations of how the claims process would work and the benefits they would receive. Another improvement might be to increase the clarity of the process so that veterans would have more realistic expectations with respect to the time it will take for a claim to be processed, the information that they will be required to provide, and the overall nature of the benefits that they are eligible to receive.

The respondents' answers to the Raters and VSO surveys yielded specific suggestions as to how the claims process could be improved. Both raters and VSOs felt that additional clinical input would be useful, and that clinical input from physicians of appropriate specialties and from mental health professionals would be especially useful. VSOs also identified input from rehabilitation specialists and medical records specialists as being a potentially useful source of information.

The raters and VSOs reported a wide range of variation in how they perceived the adequacy of their training and their proficiency in knowledge, skills and abilities. In addition, their years of experience also made a difference to the raters' perceptions about their abilities to implement the claims process and their ease at rating and deciding claims. Raters who reported feeling that they were not well-trained for their specific role, and those with fewer years of rating experience, found the rating process difficult. In addition, those feeling they were not well trained or lacking in experience felt that they had inadequate resources to help them decide claims—such as computer system support, information and evidence, time, and administrative, managerial and clerical support. Those who felt that they had good training were more likely to feel that they had adequate resource availability. In this sense, good training is a very important issue, but actual experience on the job also seems to yield a sense of confidence for the raters.

The raters and VSOs indicated that they felt that rating or deciding mental disorder claims was in general more problematic than rating or deciding physical condition claims. They perceived that claims with mental disorder issues, especially PTSD, required more judgment and subjectivity than claims with physical condition issues. In addition, they indicated that consistency was likely to be an issue for mental claims, in that mental disorder claims rated by different raters at the same VA Regional Office might not receive similar ratings. These factors might indicate that specialized resources and training should be provided for raters working on mental disorder claims. In addition, for the sake of consistency, it might be appropriate to have specially trained raters that would be assigned to deal with all claims relating to a mental disorder.

Among physical conditions, raters felt that neurological and convulsive disorders, musculoskeletal disorders (especially involving muscles), and disorders of special sense organs (especially eyes) were the most difficult and time consuming to rate. Specific training in how to gather information and rate these types of physical disorders might improve the raters' confidence in conducting the rating process.

A significant majority of raters indicated that the criteria currently used to determine IU status are too broad. They would like more specific decision criteria or more specific evidence guidelines.

Raters also reported that they are not given sufficient time to rate or decide a claim, and both raters and VSOs reported that there was too much emphasis on speed relative to accuracy. Raters especially feel that they are time-constrained when they are evaluating complex claims, and that the claims they see are getting more complex over time. This may provide support for increasing the size of the raters' work force, given that individual raters feel that they are being hurried to decide claims, and yet the overall time to decide claims is already considered to be unacceptably long.

Raters also reported challenges in obtaining evidence to decide claims—especially in obtaining needed evidence from medical examinations (particularly from private examiners). They indicated that the use of standardized assessment tools and more specific criteria or guidelines would also be helpful, especially for deciding claims regarding mental health issues—and in particular for PTSD claims.

To summarize, as indicated earlier, the VA claims process appears to be difficult for most veterans to understand and navigate. A majority of VSOs reported that they don't feel the process is satisfactory to most of their clients. Raters and VSOs are in agreement that veterans have unrealistic expectations with respect to the process and the benefits they expect to receive. However, in general most raters and VSOs believe that in the end, the claims rating process generally arrives at fair and correct decisions for veterans.

Committee on Veterans' Affairs
Subcommittee on Disability Assistance and Memorial Affairs
Washington, DC.
February 29, 2008

Dr. Mark Hyman, M.D.
American Academy of Disability Evaluating Physicians
223 W. Jackson Boulevard, Suite 1104
Chicago, IL 60606

Dear Dr. Hyman:

In reference to our Subcommittee hearing on The VA Schedule for Rating Disabilities on February 26, 2008, I would appreciate it if you could answer the enclosed hearing questions by the close of business on April 2, 2008.

In an effort to reduce printing costs, the Committee on Veterans' Affairs, in cooperation with the Joint Committee on Printing, is implementing some formatting changes for materials for all Full Committee and Subcommittee hearings. Therefore, it would be appreciated if you could provide your answers consecutively on letter size paper, single-spaced. In addition, please restate the question in its entirety before the answer.

Due to the delay in receiving mail, please provide your response to Ms. Orfa Torres by fax at (202) 225–2034. If you have any questions, please call (202) 225–3608.

Sincerely,

JOHN J. HALL
Chairman

Mark H. Human, M.D., Inc., F.A.C.P., F.A.A.D.E.P.
Los Angeles, CA

Hon John J. Hall
Chairman, Subcommittee on Disability Assistance and Memorial Affairs
c/o Orfa Torres
Via email and FAX

Response to Hearing Questions from February 26, 2008

Question 1: Can you describe in more detail how you, as a physician, conduct disability exams for other jurisdictions using the AMA Guides, CPT and ICD codes to create an evaluation? Tell me more about these Guides. What steps do you take in the process? How would you determine if an injury or illness was job related?

How would you diagnose and rate level of impairment? Is this an automated process?

Response: A patient is scheduled to be seen by administrative personnel who are overseeing the claim. At the time of scheduling the appointment, notice is given by my office requesting all available medical records. Records are received and reviewed prior to the claimant's arrival. Upon presenting to my office, the claimant fills out questionnaires pertinent to the evaluation including basic demographic data, HIPAA compliance information, job duty summaries, past medical history, family history, social history, review of systems, activities of daily living and pain questionnaires. The paperwork process takes from 20 minutes to an average of 45 minutes.

I then take a history from the patient which takes about 30 to 45 minutes. I examine the patient which takes about 10 to 15 minutes. The patient then undergoes any needed diagnostic testing which follows the CPT classification. The testing that is required reflects their presumed diagnoses, as well as what is recommended by the Guides to arrive at a proper impairment rating.

The diagnoses are based on the ICD classification system.

When I arrive at a diagnosis, I consult the appropriate chapter and section of the Guides for this condition. The instructions and Tables provide a structured format to follow.

Job relatedness determinations come from a careful history, and are usually determined 90 percent of the time based on the history and facts of the case.

Automated processes are available both from the AMA as well as private vendors. I can not underscore enough the necessity for the evaluating physician to receive proper training in use of the Guides from nationally recognized, AMA delegated society. I strongly endorse AADEP for this purpose.

Question 2: When you conduct an evaluation are you also ratings a degree of severity, such as the VA's 0–100 percent system?

Response: Yes, the Guides Tables take you step by step through a process that asks for a diagnosis and then modifies the rating based on the history, clinical examination and any associated laboratory testing.

Question 3: In your opinion, should VA be involving doctors more in the rating process rather than in only asking them for medical opinions that are then interpreted by a non-medical rating official? How should this information be conveyed between the examiner and the Rater?

Response: The ideal scenario is what I have outlined in question 1. The approach of using a physician evaluator is central to the process of arriving at a proper diagnosis. The physician then must have a thorough training and working knowledge of the Guides, in order to translate the findings into the appropriate impairment rating. The report has to have a final section where the diagnosis, impairment rating, and the table that was used in the determination are cited. A rater can then take this rating and convert whatever particular modifiers are required by the VA to arrive at the ultimate award. Examples of a VA modifier might be age, sex, prior occupations, years of service, etc.

Question 4: In your testimony, you mentioned that it took the State of California only 8 months to revise its workman's compensation system. Can you expand more on that processes and how they accomplished this so quickly?

Response: Governor Schwarzenegger made workers compensation reform a major item on his campaign. He held meetings just as you are doing. All stakeholders had input into the process. As with any change, there were groups that were resistant as well as claiming that the changes were not in the best interests of injured workers. However, those protests were much less about the Guides themselves and more about other claims handling changes specific to California. However, once passed into law, which was in April of 2004, the law took effect on January 1, 2008. While there were bumps, the process has proceeded well and continues to provide a common language for disability evaluation.

Please feel free to contact me with any further questions you may have. I would be willing to serve on the advisory Committee to assist in your transitions.

Committee on Veterans' Affairs
Subcommittee on Disability Assistance and Memorial Affairs
Washington, DC.
February 29, 2008

Sidney Wiessman, M.D.
Committee on Mental Healthcare for Veterans and Military Personnel
American Psychiatric Association
1000 Wilson Boulevard, Suite 1825
Arlington, VA 22209

Dear Dr. Weissman:

In reference to our Subcommittee hearing on The VA Schedule for Rating Disabilities on February 26, 2008, I would appreciate it if you could answer the enclosed hearing questions by the close of business on April 2, 2008.

In an effort to reduce printing costs, the Committee on Veterans' Affairs, in cooperation with the Joint Committee on Printing, is implementing some formatting changes for materials for all Full Committee and Subcommittee hearings. Therefore, it would be appreciated if you could provide your answers consecutively on letter size paper, single-spaced. In addition, please restate the question in its entirety before the answer.

Due to the delay in receiving mail, please provide your response to Ms. Orfa Torres by fax at (202) 225–2034. If you have any questions, please call (202) 225–3608.

Sincerely,

JOHN J. HALL
Chairman

American Psychiatric Association
Arlington, VA.
April 4, 2008

Chairman John J. Hall
House Committee on Veterans' Affairs
Subcommittee on Disability Assistance and Memorial Affairs
335 Cannon House Office Building
Washington, D.C. 20515

Ranking Member Doug Lamborn
House Committee on Veterans' Affairs
Subcommittee on Disability Assistance and Memorial Affairs
335 Cannon House Office Building
Washington, D.C. 20515

Dear Chairman Hall and Ranking Member Lamborn:

Thank you for the opportunity to speak before the House Subcommittee on Disability Assistance and Memorial Affairs on February 26, 2008 regarding the Department of Veterans Affairs Schedule for Rating Disabilities.

In reference to my testimony on Post-traumatic Stress Disorder in the Diagnostic and Statistical Manual of Mental Disorders, which is now in its fourth edition (DSM–IV), I was asked three followup questions by Members of the Subcommittee and I would like to submit my answers for the record.

The questions were as follows:

Question 1: Should VA have more than one code for rating all of mental health conditions that veterans may experience as disabling?

Response: I assume that this question means may a veteran have more than one diagnostic code for their condition when being rated for a disability. If one looks at the DSM it is already the case that one can have a diagnosis on axis one, axis two and axis three. Each of these conditions would or could relate to the veteran's functional capacity and they would have one score on axis five, the GAF. It would be equally possible that a veteran could meet the diagnostic criteria for two distinct diagnoses on axis one. The score on the GAF would be related to their functioning, not the Axis one diagnoses.

For example:
Axis One: PTSD, Major Depression
Axis Two: no diagnosis
Axis Three: Post Concussion

Axis Four: State of loss of consciousness following destruction of his HUMVE with broken arm
Axis Five: GAF 50

The critical issue is not the existence of one or more diagnoses but the evaluation of the veteran's functioning in determining the GAF. Only one GAF would exist.

Question 2: Should there be a presumption of a stressor if a veteran served in a combat zone?

Response: This question does not define what is meant by a combat zone. In Vietnam and Iraq it is safe to say wherever you were you were in danger. Thus if one defines being in Iraq as being in a combat zone, I would urge that all veterans be considered to be under the stress and threat of attack in that combat zone.

However if we were to look at the Korean war, there were sites late in the War if the country were considered a combat zone, where one would not have been under stress.

Briefly I would consider all soldiers in Iraq and Afghanistan as being under stress of potential attack, so my answer would be yes.

Question 3: During the hearing you differed greatly from the IOM's conclusions on the use of the GAF in assessing PTSD disability. Can you clarify your position in greater detail?

Response: Page 3 of the written testimony submitted by Dean G. Kilpatrick, Ph.D. at the hearing states "Currently, the same set of criteria are used for rating all mental health disorders." (I believe this refers to the GAF score). "They focus on symptoms from schizophrenia, mood, and anxiety disorders. The Committee found the criteria are at best a crude and overly general instrument for the assessment of PTSD disability."

The DSM instructions for the use of the GAF are explicit and would cover all of the areas of concern in assessing disability from PTSD not limiting it only to work impairment.

From the GAF:

"Consider psychological, social, and occupational functioning on a hypothetical continuum of mental health-illness. Do not include impairment of functioning due to physical (or environmental) limitation."

The GAF is then presented in a scale from 1 to 100. In the text itself explicit GAF text describing functioning is in bold print. After the bold print are "e.g."s. This is I believe where the misreading of the GAF comes on. "E.g." means according to Webster's exempli gratia (Latin for "for example"). Therefore, the "e.g."s are examples. A set of examples based on PTSD could be substituted for the examples included in the DSM. The integrity of the GAF would be maintained and the integrity of the various rating systems throughout the Federal Government based on the GAF would also be maintained.

I believe inadvertently the IOM readers read "e.g." as "i.e." which means id. es (Latin for "that is"). If the GAF had indeed used "i.e." then their criticism would have been correct. If the Committee is interested I could create a GAF scale using examples from the behaviors and functioning observed in patients with mild to severe PTSD.

In conclusion, the error in appreciating how the GAF was constructed and the use of examples not required behaviors in the GAF example accounts for the error in the IOM report.

I hope these responses adequately address the questions raised by the Committee. Thank you again for the opportunity to speak about this important issue and please let me know if I can be of any help in the future.

Sincerely,

Sidney Weissman, M.D.
Member, Committee on Mental Healthcare for Veterans and Military Personnel and their Families

Committee on Veterans' Affairs
Subcommittee on Disability Assistance and Memorial Affairs
Washington, DC.
February 29, 2008

Mr. Ronald Abrams
Joint Executive Director
National Veterans Legal Services Program
1600 K Street NW, Suite 500
Washington, DC 20006

Dear Mr. Abrams:

In reference to our Subcommittee hearing on The VA Schedule for Rating Disabilities on February 26, 2008, I would appreciate it if you could answer the enclosed hearing questions by the close of business on April 2, 2008.

In an effort to reduce printing costs, the Committee on Veterans' Affairs, in cooperation with the Joint Committee on Printing, is implementing some formatting changes for materials for all Full Committee and Subcommittee hearings. Therefore, it would be appreciated if you could provide your answers consecutively on letter size paper, single-spaced. In addition, please restate the question in its entirety before the answer.

Due to the delay in receiving mail, please provide your response to Ms. Orfa Torres by fax at (202) 225–2034. If you have any questions, please call (202) 225–3608.

Sincerely,

JOHN J. HALL
Chairman

National Veterans Legal Services Program
Washington, DC.
March 24, 2008

Honorable John J. Hall
Committee on Veterans' Affairs
335 Cannon House Office Building
Washington, DC 20515

Re: Subcommittee Hearing on VA Schedule for Rating Disabilities

Mr. Chairman:

Please find included in this submission answers to questions sent February 29, 2008 regarding the Subcommittee Hearing on VA Schedule for Rating Disabilities.

Sincerely,

Ronald B. Abrams
Joint Executive Director

NVLSP Response To The Questions Of Hon. John J. Hall, Chairman Subcommittee On Disability Assistance And Memorial Affairs

Question 1: You mentioned a very important point that I think highlights the stigma we are fighting against mental illness—the physically disabled can be 100 percent and still pursue employment, but those with mental disabilities cannot. Should this be a parity issue? Why not allow veterans with mental illnesses to work, if they can, and still be 100 percent service connected?

Response: NVLSP recommends that the VA's *General Rating Formula for Mental Disorders* be amended to accurately reflect a mental disorder's impact on the average veteran's quality of life and earning capacity. Congressman Hall's example aptly illustrates an underlying paradox: veterans suffering from a mental disorder cannot be rated 100 percent disabled if they are engaged in substantial gainful employment, despite the severity of their mental condition. In stark contrast, a gainfully employed veteran *with any other service-connected disability* (such as a severe heart or lung condition) is eligible to receive a 100 percent disability rating in addition to his or her full-time salary. This policy is obviously inequitable and penalizes the extraordinary individual who, although suffering from severe symptoms due to a mental disorder, is able to find a job that gives purpose and meaning to the veteran's life. NVLSP does not mean to suggest that there is no relationship between

the evaluation of mental illness and the average veteran's ability to hold steady employment. The connection, however, should not be absolute.

Moreover, this policy is inconsistent with current law and with multiple VA regulations. Chapter 38 U.S.C. § 1155 mandates that VA ratings "be based, as far as practicable, upon the *average impairments* of earning capacity resulting from such injuries in civil occupations" (emphasis added). Also see 38 C.F.R. § 3.321 which mimics the language of 38 U.S.C. § 1155. The standard is repeated in 38 C.F.R. § § 4.1 and 4.15 which state in part, "[t]he percentage ratings represent as far as can practicably be determined the *average impairment*. . . ." Finally, 38 C.F.R. § 3.340(a)(1) reinforces this average person standard in the context of a total disability rating, "[t]otal disability will be considered to exist when there is present any impairment of *mind or body* which is sufficient to render it impossible for the *average* person to follow a substantially gainful occupation" (emphasis added). Notice that in all five instances above, *no distinction is made between mental and physical impairments*, they are both to be assessed under an objective average person standard.

The VA's physical disability rating schedule is largely aligned with this standard. For all service connected disabilities but mental disorders, the severity of the veteran's symptomatology determines the percentage of disability the VA assigns. *See* 38 C.F.R. § 4.71a. However, the VA's *General Rating Formula for Mental Disorders* at 38 C.F.R. § 4.130 (2008) utilizes a contrary standard, one that is markedly unfavorable to veterans suffering with mental illness. For example, in order for a veteran to receive a 100 percent rating, that veteran, not the average veteran, must suffer from "*total occupational and social impairment.*" This abandons the "average person" standard mandated by law and espoused in VA regulations. Further it acts as a major disincentive for mentally ill veterans to try an overcome their disability.

By ignoring the average impairment standard, § 4.130 not only unfairly penalizes veterans suffering from service connected mental conditions, but the regulation also fails to adequately incorporate the impact of mental disabilities on a veteran's lifestyle. In the opinion of NVLSP, the inability of a veteran to maintain effective relationships with all or some family, friends, and co-workers should support a 50 percent or 70 percent evaluation without a tie-in to vocational difficulty.

NVLSP believes that a good first step would be to closely align the rating schedule with the Global Assessment of Functioning (GAF) scale. VA psychiatrists and other VA mental health examiners already employ the GAF scale when making mental health assessments and this alignment would streamline the rating process. For example, the rating schedule could be amended so that every individual assessed as a 45 on the 100-point GAF scale would receive the same percentage evaluation regardless of their individual ability to overcome their mental disorder.(Of course, VA adjudicators would not be required to accept GAF scores that are not consistent with the symptoms indentified by the examiner. In such instances, they could order a new VA mental health evaluation.) Thus, the rating schedule for mental disorders would be aligned with the average person standard mandated by 38 U.S.C. § 1155, 38 C.F.R. § 4.1, 38 C.F.R. § 3.340(a)(1) and 38 C.F.R. § 4.15.

Question 2: You stated that symptoms for TBI may wax and wane, therefore it is important to consider the history of the symptoms, isn't that true for mental disorders as well? Shouldn't every veteran have a well documented military history assessment?

Response: Symptoms noted during service are important in establishing service connection and in setting the initial evaluation. However, in the context of a current mental evaluation, the relevance of in-service noted symptoms diminishes the farther removed the individual is from service. It should be mentioned that in-service symptoms can be established through evidence not contained in service medical records. At times competent lay evidence is enough to establish that the veteran suffered certain symptoms while in service. 38 C.F.R. § 3.159(a)(2). *See also, Garlejo v. Derwinski*, 2 Vet. App. 619; 1992 and *Dizoglio v. Brown*, 9 Vet. App. 163; 1996.

Question 3: What do you think we should do about the level of evidence required to grant claims? Would you change that, and if so, how?

Response: NVLSP strongly suggests that the "benefit of the doubt" (38 U.S.C. § 5107, 38 C.F.R. § 3.102) standard remain intact.

Question 4: The causation standard was suggested by the IOM after a lengthy analysis. They found that the way VA sets presumptions has been "complex, perplex, varied, inconsistent, diverse, and opaque." This does not sound like the "benefit of the doubt" going to the veteran. It sounds more like it is based on the "luck

of the draw" and veterans' don't know what to expect. Wouldn't a scientific standard be better at establishing benefit of the doubt?

The answer is no. NVLSP strongly disagrees with the IOM suggestion that Congress or the VA utilize a causation standard to set service connection presumptions. As we discuss below, adoption of a causation standard for service connection presumptions would require the VA to deny benefits to literally tens of thousands of deserving disabled veterans who presently qualify for compensation under the statutory and regulatory presumptions established over the last four decades. In that 40 year span Congress and the VA have used a consistent, scientific standard to set presumptions of service connection and this standard wisely benefits veterans.

It should be clear at the outset that a causation standard is a very high standard that requires a great deal of definitive scientific evidence. A causation standard may be appropriate in the adversarial process when a trier of fact must weigh expert scientific opinions against one another in deciding a private civil lawsuit. But as a policy matter such a standard is completely inappropriate to decide whether veterans, who served our country in time of war, should receive disability compensation from the government. Too often these are situations where the scientific evidence is not developed enough to definitively answer whether an event experienced by thousands of veterans during military service caused a later developing disease from which thousands of these veterans suffer.

Over the last four decades the VA and Congressional response to the scientific shortcomings described above have been consistent and appropriate. The VA or Congress has established presumptions of service connection where the scientific epidemiologic evidence shows that there is a statistically significant association between a common event experienced by veterans in time of war and the subsequent development of a particular disease. They have refused to adopt a stricter standard. Several examples follow:

In the late 1970s, Congress mandated that the VA conduct a scientific epidemiologic study to gauge the relationship between veterans with leg or feet amputations and any subsequent increase in the rate of cardiovascular disease. The study concluded that this disabled group of veterans experienced a statistically significant increased risk of cardiovascular disease, but that a strict cause-and-effect relationship had not been established. Nevertheless based on the National Academy of Sciences report, the VA promulgated what is now 38 C.F.R. § 3.310(c) entitling veterans with "a service-connected amputation of one lower extremity at or above the knee or service-connected amputations of both lower extremities at or above the ankles" to service connected disability compensation for any subsequently developed cardiovascular disease. *See Nehmer v. VA*, 712 F. Supp. 1404, 1419 (N.D. Cal. 1989).

Another example involves exposure to Agent Orange. In 1984, Congress enacted Pub. L. No. 98–542, which required the VA to empanel an advisory group of scientists to advise it on the adverse health effects of Agent Orange exposure and to promulgate regulations establishing presumptions of service connection for those diseases that are scientifically related to such exposure. The VA instructed the scientists to use a strict cause and effect relationship between exposure and disease. Not surprisingly, the scientists found that Agent Orange caused only chloracne, a skin condition.

A class of Vietnam veterans challenged these rules, and in 1989, a Federal court invalidated the rules precisely because the VA had required a strict cause and effect relationship. The Court found that Congress and the VA had historically used a lower epidemiologic scientific standard focused on whether there was a statistically significant association between the event or exposure and the subsequent development of a particular disease. The Court found that Congress had intended the VA to use this more lenient standard when deciding what diseases should be presumptively service connected to Agent Orange exposure. *See Nehmer*, 712 F.Supp. at 1419–23 (N.D. Cal. 1989). When the VA procrastinated in adopting regulations to replace those invalidated by the Court in *Nehmer*, Congress enacted the Agent Orange Act 1991 requiring the VA to use a "positive association" standard similar to the one discussed in *Nehmer*. This was an explicit rejection of the causation standard and it remains the standard the VA uses today. Since the Agent Orange Act 1991, the VA has promulgated regulations providing presumptive service connection for many types of cancer due to Agent Orange exposure without requiring proof of causation. It would be tragically wrong to diverge from this longstanding tradition.

Question 5: Would you change the Rating Schedule to include a loss of quality of life scale or do you feel that it is already included in the compensation package or by awarding Special Monthly Compensation? Would you say that there already examples of quality of life loss, such as with procreative organs that are already included in the Rating Schedule?

Response: The current rating schedule is based primarily upon the average impairment in earning capacity. The extra benefits paid under the special monthly compensation codes (see 38 U.S.C. § 1114, and 38 C.F.R. § 3.350) do take into account some quality of life issues, but they are insufficient to compensate veterans for the diminished quality of life caused by many disabilities. NVLSP suggests that the VA study the rating schedule and adjust upward the evaluations for certain conditions such as amputations, the residuals of severe gunshot wounds, mental disabilities, and cognitive disorders, in order to take into account quality of life issues.

For example, if a veteran becomes impotent due to the impact of a service connected disability such as diabetes or hypertension and loses the ability to procreate—under current law he would generally receive a noncompensable evaluation (0&) plus $91 per month under special monthly compensation code "K". Loss of use of a creative organ secondary to impotence may be established in evaluating residuals of multiple sclerosis, diabetes mellitus, or other diseases where loss of erectile power is shown. A zero percent rating under DC 7522 will establish entitlement.

Thus, while the VA may award a compensable evaluation for penis deformity and testis atrophy under diagnostic codes 7522 and 7523, there is no provision in Part 4 that mandates a compensable evaluation for loss of erectile function sans deformity. In essence we are telling a veteran that his inability to have children or have a full relationship with his spouse is worth only $91 per month. That, frankly, is insulting.

Committee on Veterans' Affairs
Subcommittee on Disability Assistance and Memorial Affairs
Washington, DC.
February 29, 2008

Mr. Dean Stoline
Assistant Director
National Legislative Commission
The American Legion
1608 K Street, NW
Washington, DC 20006

Dear Mr. Stoline:

In reference to our Subcommittee hearing on The VA Schedule for Rating Disabilities on February 26, 2008, I would appreciate it if you could answer the enclosed hearing questions by the close of business on April 2, 2008.

In an effort to reduce printing costs, the Committee on Veterans' Affairs, in cooperation with the Joint Committee on Printing, is implementing some formatting changes for materials for all Full Committee and Subcommittee hearings. Therefore, it would be appreciated if you could provide your answers consecutively on letter size paper, single-spaced. In addition, please restate the question in its entirety before the answer.

Due to the delay in receiving mail, please provide your response to Ms. Orfa Torres by fax at (202) 225–2034. If you have any questions, please call (202) 225–3608.

Sincerely,

JOHN J. HALL
Chairman

American Legion
Washington, DC.
March 20, 2008

Hon. John J. Hall, Chairman
Subcommittee on Disability Assistance and Memorial Affairs
Committee on Veterans' Affairs
U. S. House of Representatives
335 Cannon House Office Building
Washington, DC 20515

Dear Chairman Hall:

In reference to your letter of request dated February 29, 2008, to answer a hearing question regarding our concern for reevaluations of service-connected veterans that arose from our testimony in your Subcommittee hearing on *The VA Schedule*

for Rating Disabilities on February 26, 2008, please find the attached answer in the format you requested.

If you have any further questions please contact me. My contact information is above. Thank you again for holding this important hearing for America's veterans.

Sincerely,

Dean Stoline, *Assistant Director*
National Legislative Commission

Attachment

Questions of the Honorable John J. Hall, Chairman

Question 1: In your statement you expressed concern over re-evaluation of service-connected veterans. I understand that it could be stressful, but isn't falling through the cracks more stressful and wouldn't it be better to make sure veterans are getting all that they deserve?

Response: The concern noted in our written statement pertains specifically to the recommendation of the Veterans' Disability Benefits Commission (VDBC) regarding the Department of Veterans Affairs establishing a holistic approach, with respect to post-traumatic stress disorder (PTSD), that, in part, calls for "reevaluation" every 2–3 years. (Recommendation 5–30; Chapter 5, Section III.3).

We are fully supportive of periodic reviews of the treatment process to gauge its effectiveness and to determine whether or not the veteran's PTSD medical condition has improved. It is, however, our opinion that this process should be separate and distinct from any re-evaluation done for the purpose of determining the severity of the condition for compensation rating purposes. Veterans should not perceive these periodic reevaluations of their condition and treatment process as an attempt to reduce their compensation benefits. Such a perception could cause undue stress and undermine the treatment process of the veteran.

Even the Institute of Medicine (IOM) PTSD compensation Committee concluded that across-the-board periodic reexaminations for veterans with service-connected PTSD are not appropriate. We also agree with the IOM's observation that symptomatology can improve (justifying reexaminations in such circumstances) and that a reexamination policy should be structured in a way that "limits disincentives for receiving treatment or rehabilitative services." We, therefore, encourage study and review of possible unintended consequences regarding the PTSD re-evaluation portion of the VDBC's recommendation.

Committee on Veterans' Affairs
Subcommittee on Disability Assistance and Memorial Affairs
Washington, DC.
February 29, 2008

Mr. Bradley Mayes
Director, Compensation and Pension Service
Veterans Benefits Administration
U.S. Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Dear Mr. Mayes:

In reference to our Subcommittee hearing on The VA Schedule for Rating Disabilities on February 26, 2008, I would appreciate it if you could answer the enclosed hearing questions by the close of business on April 2, 2008.

In an effort to reduce printing costs, the Committee on Veterans' Affairs, in cooperation with the Joint Committee on Printing, is implementing some formatting changes for materials for all Full Committee and Subcommittee hearings. Therefore, it would be appreciated if you could provide your answers consecutively on letter

size paper, single-spaced. In addition, please restate the question in its entirety before the answer.

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Sincerely,

JOHN J. HALL
Chairman

The Honorable John J. Hall, Chairman

Question 1: Doctors and other health providers are already trained in the tools, such as the AMA guides that Drs. Hyman and Weissman described in their testimony, so wouldn't it make more sense to use these tools rather than train people in an entirely new system?

Response: No, we do not believe so. The Department of Veterans Affairs (VA) is authorized, by statute, to compensate veterans for the average reductions in earnings capacity in civilian occupations due to injury or disease incurred in or aggravated by active military service. The Veterans' Disability Benefits Commission asked the Institute of Medicine (IOM) to look at disability compensation for veterans. In its report, *A 21st Century System for Evaluating Veterans for Disability Benefits,* the IOM looked at the American Medical Association (AMA) Guides, among other disability evaluation systems, and found that the Guides do not measure work-related disability, only degree of physical impairment, are designed for use by physicians, and do not determine percentage of impairment from mental disorders. The IOM instead recommended that VA update and improve its *Schedule for Rating Disabilities*, codified at 38 CFR Part IV, rather than adopt an impairment schedule developed for other purposes.

On Wednesday March 5, 2008, VA received a briefing on the AMA guides from Dr. Robert Rondinelli, Medical Editor of the 6th edition of the Guides. One of the issues that Dr. Rondinelli highlighted was the following AMA disclaimer: "The AMA Guides are not intended to be used for direct estimates of work disability; impairment percentages derived according to the Guides' criteria do not directly measure work disability, therefore, it is inappropriate to use the Guides' criteria or ratings to make direct estimates of work disability."

Based on Dr. Rondinelli's presentation, the application of the Guides appears significantly more complex than VA's existing system. The number of clinicians trained and competent in the application of the Guides is limited. We believe that adoption of the guides may significantly lengthen the time to obtain an examination. It is possible, using the Guides, to evaluate a condition in intervals of one percent. While this may be appropriate in workers compensation claims, we do not believe such fine distinctions reasonably reflect loss of earning capacity.

The CNA Corp., in a study for the Veterans' Disability Benefits Commission, found that the VA rating schedule with respect to lost earnings capacity of male service-disabled veterans at the average age of entry into the VA compensation system (50 to 55 years of age) appears to achieve congressional intent. CNA's analysis also found that the schedule is less effective in other respects, such as when dealing with earnings loss for veterans with mental disorders, under compensating at every level. Edition 6 of the AMA Guides does not allow for a disability evaluation for any mental disorder higher than 50 percent. It would appear that adoption of the Guides would aggravate CNA's findings regarding earnings-loss replacement for veterans with mental illnesses.

Question 2: During the hearing, you were not able to tell us if VHA already evaluates veterans for their quality of life. Isn't that what the SF–36 scale is designed to indicate?

Response: The Veterans Health Administration (VHA) doesn't use the standard form (SF)-36 on every veteran. VHA uses functional status tool like the SF–12v or the SF–36 as needed for the assessment of the patient. The SF–12v is a multipurpose short survey form. Survey questions are used to evaluate physical and mental functioning and overall health-related quality of life. Survey questions in the SF–12v form are selected from the SF–36. The SF–36 was developed outside of VA and is available to anyone for their population studies.

Question 3: Please explain why, according to the VDBC report, so many veterans with PTSD were rated with IU instead of 100 percent schedule rating.

Response: The rating schedule requires that a veteran must be experiencing "*total* occupational and social impairment" in order to receive a 100 percent schedular evaluation, such as evidence of gross impairment in thought processes or communication; persistent delusions or hallucinations; grossly inappropriate behavior; persistent danger of hurting self or others; intermittent ability to perform activities of daily living (including maintenance of minimal personal hygiene); disorientation to time or place; memory loss for names of close relatives, own occupation, or own name. In post traumatic stress disorder (PTSD) cases, a situation may arise where the evidence shows occupation and social impairment with deficiencies in most areas, such as work, school, family relations, judgment, thinking or mood. In these cases, a 70 percent schedular evaluation is awarded and VA regulations provide that, once the veteran has reached a 70 percent schedular evaluation and the available evidence shows unemployability, the veteran is eligible for compensation at the 100-percent rate based on the inability to obtain or maintain substantially gainful employment.

Question 4: What is VA's response to the recent IOM report on Presumptive Disability Decisionmaking?

Response: We appreciate the efforts of the IOM Committee that looked at the presumptive disability decisionmaking process. The IOM Committee recommended that Congress create two new boards: the Advisory Committee to recommend to the Secretary of Veterans Affairs exposures and illnesses needing further consideration and the Science Review Board, which would be independent from VA and evaluate evidence for causation. Its recommendation represents a departure from the process VA has used in the past to decide whether a presumption should be created. It is also a departure from the Agent Orange Act 1991, for example, which directs the Secretary to seek to enter into an agreement with the National Academy of Sciences to review and summarize the scientific evidence concerning the association between exposure to herbicides used in support of military operations in the Republic of Vietnam during the Vietnam era and each disease suspected to be associated with such exposure and to determine, to the extent possible: (1) Whether there is a statistical association between the suspect diseases and herbicide exposure, taking into account the strength of the scientific evidence and the appropriateness of the methods used to detect the association; (2) the increased risk of disease among individuals exposed to herbicides during service in the Republic of Vietnam during the Vietnam era; and (3) whether there is a plausible biological mechanism or other evidence of a causal relationship between herbicide exposure and the suspect disease. Our careful review of the report has not yet been completed. For this reason, VA has no formal response at this time.

Committee on Veterans' Affairs
Subcommittee on Disability Assistance and Memorial Affairs
Washington, DC.
February 29, 2008

Major General Joseph Kelley, M.D., USAF (Ret.)
Deputy Assistant Secretary of Defense
For Clinical and Program Policy
U.S. Department of Defense
1000 Defense Pentagon
Washington, DC 20301–1000

Dear Dr. Kelley:

In reference to our Subcommittee hearing on The VA Schedule for Rating Disabilities on February 26, 2008, I would appreciate it if you could answer the enclosed hearing questions by the close of business on April 2, 2008.

In an effort to reduce printing costs, the Committee on Veterans' Affairs, in cooperation with the Joint Committee on Printing, is implementing some formatting changes for materials for all Full Committee and Subcommittee hearings. Therefore, it would be appreciated if you could provide your answers consecutively on letter

size paper, single-spaced. In addition, please restate the question in its entirety before the answer.

Due to the delay in receiving mail, please provide your response to Ms. Orfa Torres by fax at (202) 225–2034. If you have any questions, please call (202) 225–3608.

Sincerely,

JOHN J. HALL
Chairman

Hearing Date: February 26, 2008
Committee: HVAC
Member: Congressman Hall
Witness: DASD (Clinical and Program Policy) Kelley

DoD Disability Advisory Committee

Question 1: You mentioned the DoD Disability Advisory Committee during your testimony. When did that group start interacting with VBA and do they ever discuss the Rating Schedule?

a. What would make the Rating Schedule a better tool from DoD's standpoint?

Response: Beginning in September 2007, Department of Veterans Affairs (VA) representatives were invited to the Disability Advisory Committee (DAC). In December 2007, VA Membership was officially written in the DAC charter. The rating schedule has been a topic of discussion and a formal briefing from the VBA on how changes are made to the VA Schedule for Rating Disabilities was given to the Members. A new process was developed for Members to bring up issues formally at the DAC. Continued close collaboration and establishment of joint working groups, such as with the Department of Defense/VA collaboration on traumatic brain injury, which lead to proposed updates to the Rating Schedule, prove to be the most beneficial use of both the tool and the expertise found in both Departments.

Question 2: During the hearing we discussed the Disability Evaluation System pilot that is ongoing between DoD and VA. Can you provide an update on the steps currently being taken to prepare for this transition to a single system for evaluating disabilities?

Response: The Disability Evaluation System (DES) Pilot was initiated to evaluate and significantly improve DES timeliness, effectiveness, simplicity, and resource utilization by integrating the Department of Defense (DoD) and the Department of Veterans Affairs (VA) processes by eliminating duplication, and improving case management practices. The DES Pilot includes a single, VA protocol-based medical exam, to include a general review of systems and other specialty medical examinations, for referred and claimed conditions. The Service medical authorities use the VA medical examination to aid in evaluation of members whose medical fitness for continued military service is questionable. The VA will use the medical examination to determine physical disability ratings. The exam will also serve as the separation physical should separation from the military service occur.

Military Department Physical Disability Evaluation Boards (PEBs) will determine servicemember fitness for continued military service. servicemembers who participate in the DES Pilot receive a single-sourced disability rating for use by the DoD and VA. The DES Pilot is testing enhanced case management methods for seamless transition of our wounded, ill, or injured to the care of the VA and prompt award of disability benefits by the VA after the member's separation from military service. The DES Pilot includes cases referred to the DES without regard to whether servicemember wounds, illnesses, or injuries were incurred in war. The DES Pilot does not include Reserve Component Non-duty related and Temporary Disability Retired List reevaluations.

Close collaboration between DoD and VA is occurring with weekly updates and special meetings for any issues. VA is providing Veterans Administration Schedule for Rating Disabilities training in April 2008 for DoD DES representatives, to ensure a thorough understanding of the VA rating process. Systems monitoring these members are being evaluated for upgrades and integration.

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