RATING THE RATING SCHEDULE— THE STATE OF VA DISABILITY RATINGS IN THE 21ST CENTURY

HEARING

BEFORE THE

SUBCOMMITTEE ON DISABILITY ASSISTANCE AND MEMORIAL AFFAIRS

OF THE

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U.S. HOUSE OF REPRESENTATIVES

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RATING THE RATING SCHEDULE— THE STATE OF VA DISABILITY RATINGS IN THE 21ST CENTURY

TUESDAY, JANUARY 24, 2012

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 10:08 a.m., in Room 334, Cannon House Office Building, Hon. Jon Runyan (Chairman of the Subcommittee) presiding.

Present: Representatives Runyan, Buerkle, McNerney, Barrow, Michaud, and Walz.

Also present: Representatives Harris and Miller.

OPENING STATEMENT OF CHAIRMAN JON RUNYAN

Mr. RUNYAN. Good morning and welcome. The Disability Assistance and Memorial Affairs Subcommittee will now come to order.

We are here today to examine the Department of Veterans Affairs current framework on rating for veterans injury, illness, and disabilities resulting from service in our Nation's military.

Along with my colleagues on this Subcommittee I take our focus on disability and veterans and to our wounded warriors very seriously, and on a personal note I am pleased to be able to participate in the House of Representatives Wounded Warrior Program by recently hiring Melissa Worthan, a Marine, disabled veteran as a caseworker in my district office. Ms. Buerkle and I were just having a conversation about this; she also hired a veteran who is a great liaison to have. These veteran-employees talk to veterans as they call in with their case issues in our district offices. I am truly honored to have Ms. Worthan as a member of my team.

My continued hope for DAMA is that this meeting of minds sets a precedent and tone for a broader promise that we have made our veterans population. That promise is to ensure that the entire claims process, the delivery of earned benefits and veterans medical services is transformed into a fully efficient and modernized system equipped with the best tools available to aid our veterans population in the 21st century.

Several years ago a commission was established to care for our veterans returning as wounded warriors; it was led by former Senator Dole and former Secretary of Health and Human Services,

Donna Shalala. The purpose of this commission was to examine the health care services provided to members of the military and returning veterans by the VA and the Department of Defense.

Around the same time, Congress created the Veterans Disability Benefits Commission, which was established in the National Defense Authorization Act of 2004. This commission was created by Congress out of serious concerns, many of which we still have today. Those concerns included the timeliness of processing disabled veterans claims for benefits.

This commission conducted a 2-year indepth analysis of benefits and services available to veterans and the processes and procedures used to determine eligibility.

Their conclusion was published in a comprehensive report entitled Honoring the Call to Duty, Veterans Disability Benefits in the 21st Century.

The end results of these reports were several recommendations, including the goal of updating and simplifying the disability determination and compensation system on a more frequent basis. Although select portions of the rating system have been updated throughout the past 20 years these reports refer to the rating schedule as outdated. The schedule as a whole has not been comprehensively revised since the conclusion of World War II.

They recommended the rating schedule be updated at recurrent and relative intervals to address advances in medical and rehabilitative care. Also recommended was a greater appreciation of understanding for certain disabilities such as PTSD. The more recent updates to the diagnostic criteria for new types of injuries such as TBI were a step in the right direction; however, I believe it is our duty to be vigilant and pressing for continued revision reflecting the continuing advances and understanding on all medical care and treatment.

In addition I am in agreement with their conclusion that a more candid emphasis on veteran quality of life should be taken into account in an updated rating schedule.

Therefore we are here today to honor our duty to our Nation's veterans. Just as we would not issue World War II era equipment and weapons to our current soldiers and Marines and expect them to be successful on the modern battlefield we should not be satisfied with the World War II era system for evaluating and rating their disabilities as a result of their service and sacrifice to this Nation.

I want to thank the VA, the DoD, and the present VSOs and General Scott for their valuable input as we work together to find important solutions.

I welcome today's witnesses to continue this ongoing discussion and offer their own specific recommendations to how to improve the current system of rating our veteran's disabilities.

I would now call on the Ranking Member for his opening statement.

OPENING STATEMENT OF HON. JERRY MCNERNEY, RANKING DEMOCRATIC MEMBER

Mr. MCNERNEY. Thank you, Mr. Chairman.

Today is an important hearing and it is a bipartisan hearing so I am really delighted that we are having this today.

As we have discussed over the course of many hearings in the 110th and 111th Congresses, the VA's claim processing system has many shortcomings which have left many disabled veterans without proper and timely compensation and other benefits to which they are rightfully entitled.

Today 66 percent of VA's 866,000 pending claims languish in backlog status.

At the heart of this system is the VA Schedule for Rating Disabilities or VASRD.

In this study the Veterans' Disability Benefits Commission 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 and psychological practices, and out of 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 agriculturally based and labor intensive. Today's economy is much different and the effects of disability may be greater than just the loss of earning capacity.

Many disability specialists believe that the loss of quality of life, functionality, and social adaptation may also be important factors.

Our Nation's disabled veterans deserve to have a system that is based on the most available and relevant medical knowledge. They do not deserve a system that is in many instances based on archaic criteria for medical and psychiatric evaluation instruments.

I know that Congress in the Veterans' Benefits Improvement Act of 2008, P.L. 110–389, directed the VA to update the VASRD and to delve into revising it based on modern medical concepts. I know that the VA in following this directive has undertaken a comprehensive review of the VASRD and I look forward to receiving a thorough update on its progress.

Congress also created the Disability Advisory Committee in P.L. 110–389, and I welcome General Scott here today who is the chair of the Committee and I also welcome his insight.

I look forward to the testimony today from all of the witnesses on the complex issues surrounding modernizing the VA rating schedule.

I know that 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 a comprehensive update.

There are over 2.2 million veterans of the wars in Afghanistan and Iraq with 624,000 who have already filed disability claims. There are also so many veterans whose claims were not properly decided in the past because of the analogous-based subjectivity that is inherent in the current VASRD.

Since the DoD relies on this system and as we transition to the one exam platform under the Integrated Disability Evaluation System bringing the VASRD into the 21st century is so critical. We must finish updating it without delay.

I look forward to working with you, Mr. Chairman, and the Members of this Subcommittee in providing stringent oversight of the VA Schedule for Rating Disabilities.

The VA needs to adopt the right tools to do the right thing so our Nation's disabled veterans get the right assistance they have earned and deserve.

I thank you, Mr. Chairman, and I yield back.

Mr. RUNYAN. Thank you, Mr. McNerney.

At this point I want to ask unanimous consent that Dr. Harris sit at the dais and participate in our hearing here today. Without objection so moved.

At this point the chairman now calls panel one to come to the witness table. We will be hearing first from Mr. Jeff Hall, the Assistant National Legislative Director for the Disabled American Veterans, then we will hear from Frank Logalbo, the National Service Director of Benefits and Service for the Wounded Warrior Project, and our final witness on this panel will be Mr. Theodore Jarvi, the Past President of the National Organization of Veterans' Advocates.

Your complete statement will be entered into the hearing record, and Mr. Hall, I know recognize you for 5 minutes.

STATEMENTS OF JEFFREY C. HALL, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS; FRANK LOGALBO, NATIONAL SERVICE DIRECTOR, BENEFITS SERVICE, WOUNDED WARRIOR PROJECT; THEODORE JARVI, PAST PRESIDENT OF NOVA, NATIONAL ORGANIZATION OF VETERANS' ADVOCATES, INC.

STATEMENT OF JEFFREY C. HALL

Mr. HALL. Thank you, Mr. Chairman. Good morning to you and Ranking Member McNerney and Members of the Subcommittee.

On behalf of the 1.2 million members of DAV it is an honor to be here to offer our views regarding the VA Schedule for Rating Disabilities and the revision process currently under way.

My written testimony, which has been submitted, focuses primarily on three key concerns. The current rating table revision process, which should be open but has effectively been closed to VSOs. The proposed revisions to the mental disorder section of the rating schedule which appear to be headed in a direction which may be harmful to veterans and could undermine the entire rating schedule. And compensating disabled veterans for the loss of quality of life, which the rating schedule should include.

Mr. Chairman, as I prepared my remarks for today I thought about what it really means to be a severely disabled veteran who wants to work, and I would ask you and the other Members of the Subcommittee to take a moment and think back about what you went through this morning as you prepared for and getting to work. Consider what you and millions of others go through each and every day just to make it to your job on time.

Now consider a veteran with serious service-related disabilities. Think about a paraplegic confined to a wheelchair as he heads to work, what must that veteran go through every single day? Perhaps enduring who knows how many additional hours daily just

getting to and from work because simple tasks that we take for granted such as practicing personal hygiene or negotiating a vehicle or using mass transit can be monumentally more complicated for him or her. Or a veteran with bilateral leg amputations. What does he or she have to go through when it snows and the driveway needs to be shoveled just in order to make it to the train station negotiating obstacles encountered along the way simply to get to work? Think of a severely disabled veteran and what they have already endured during the rehabilitation process and what they must withstand simply to compete for and in the same job as someone without disability.

Now imagine a system that measures his or her disability based on the ability of that veteran to hold full-time employment without any consideration about the obstacles that they must overcome or how that disability has forever altered their lives.

Mr. Chairman, that is the direction we fear that the VA is moving in with the ongoing mental health rating revision.

Based on two public briefings to the Advisory Committee for Disability Compensation, one in December 2010 and one in October 2011, the new mental health rating schedule would no longer look at the medical consequences of disability but instead focus solely on work, how often a veteran was unable to work or was impaired from working effectively.

For example, from what was discussed in October under this proposal a veteran unable to work 2 days per week would be rated 100 percent disabled, while a veteran with decreased work quality or productivity 2 days per week would be rated 70 percent disabled and so on using various combinations of work productivity and quality measures.

In such a system a disabled veteran suffering from PTSD or depression who has a job and is doing his or her best toward vocational fulfillment would be confronted with the dilemma of having to choose between working full-time or receiving disability compensation. Basically the less a veteran is able to work the more he or she is compensated.

Such an approach is not only directly contrary to the existing statute in legislative history and intent, it also raises a number of troubling questions about how such a system would work and what effects it would have on veterans and the disability compensation system.

How would VBA know when or how effectively a veteran was able to work? Will VBA simply rely on self-reporting by veterans to determine ratings or will they seek to verify the impact on work performance by contacting employers? How would this be done? Would VBA tell employers that they are verifying mental health disorders and ask employers to verify personnel records?

These are troubling questions indeed. What if a veteran has a law degree, but whose severe PTSD makes it so difficult to work around other people that the only job he can perform is as a night watchman or a custodian. Since he is able to work productively 40 hours per week does that mean he is not entitled to VA disability compensation?

What would that mean for other types of disabilities? Would a veterans whose legs were blown off by an IED in Iraq but who has

struggled mightily to overcome that disability and is working productively in a full-time job be subject to a lower disability compensation?

Mr. Chairman, we don't believe that this was the intent of Congress 75 years ago, and we certainly hope that it is not what Congress wants now.

We hope that this Subcommittee will seek answers to these and other questions about the ongoing VASRD update process to insure the integrity and intent of VA disability compensation system.

Finally DAV strongly believes that the time is long overdue that VA disability compensation implicitly and directly include compensation for the loss of quality of life. There is a well-established and understood concept in the field of disability that it has been recommended by numerous commissions, including the congressionally charted VDBC and other western countries which also offer comprehensive benefits such as Canada and Australia who do exactly that.

Mr. Chairman, DAV looks forward to working with you and other Members of the Subcommittee on this important matter.

This concludes my statement and I will be happy to answer any questions you may have.

[The prepared statement of Jeffrey Hall appears on p. 43.]

Mr. RUNYAN. Thank you, Mr. Hall.

As everybody noticed Chairman Miller has joined us at the dais. I would like to welcome him and his participation here. Do you have any comments you would like to make?

That being said, having missed the opportunity before we got started here, I know Dr. Harris would like to make a comment. Is there any other Members that are on the Subcommittee that would like to say anything before we get started? Dr. Harris.

Mr. HARRIS. Thank you, Mr. Chairman, I can just delay it until just before my questions.

Mr. RUNYAN. Okay, thank you.

Mr. HARRIS. Thank you for giving me the opportunity and thank you for allowing me to sit in.

Mr. RUNYAN. Thank you very much.

Mr. Logalbo, you are now recognized for 5 minutes.

STATEMENT OF FRANK LOGALBO

Mr. LOGALBO. Thank you.

Chairman Runyan, Ranking Member McNerney, and Members of the Subcommittee, thank you for holding this timely and important hearing on VA's rating schedule and for inviting the Wounded Warrior Project to provide testimony.

Wounded Warrior Project brings a special perspective to this subject reflecting its founding principal of warriors helping warriors. We pride ourselves on outstanding service programs that advance that ethic.

Among those program efforts Wounded Warrior Project across the country works daily to help warriors understand their entitlements and fully pursue VA benefits claims.

As Wounded Warrior Projects national service director, a position which I oversee A work of our service officers, I draw extensively from 17 years of claims adjudication experience and work with the

VA's rating schedule as a VSR, a senior service representative, rating specialist, assistant service center manager with the Veterans' Benefit Administration.

In our view VA's most important challenge as it works to update its rating schedule is to make compensation for mental health conditions as fair as possible.

Combat-related mental health conditions are not only highly prevalent and often severely disabling, but have profound consequences for warriors' overall health, well-being, and economic adjustment.

To illustrate the point, two-thirds of the Wounded Warrior Project or wounded warriors responding to a recent Wounded Warrior Project survey reported that emotional problems have substantially interfered with work or regular activities during the previous 4 weeks. And when asked to comment on the most challenging aspect of their transition some two out of five in the survey cited mental health issues.

Given the strong link between warriors' mental health and their achieving economic empowerment it is vital that compensation for service-incurred mental health conditions be equitable and make up for lost earning capacity, but deep flaws in both VA evaluation procedures and its rating criteria pose real problems for warriors bearing psychic combat wounds.

To its credit the Department of Veterans Affairs, the VA, has acknowledged that its rating criteria of mental health disorders needs thorough revision. Those criteria are deeply problematic.

To illustrate, one independent expert panel characterized the mental health rating criteria as crude and overly general, focused too narrowly on occupational and social impairment, and is failing to consider other factors like frequency of symptoms that are used in the rating physical disorders. Also given that VA disability ratings are to be based on average impairment of earning capacity, rating a mental health condition on the basis of that veteran's occupations impairment is simply inappropriate.

Eliminating occupational impairment as a defining rating factor in rating would be an important first step, but VA must also recognize that its rating criteria are unreasonably high.

An example would be the criteria for 100 percent rating more closely resembles a degree of impairment with a need for institutional care than simply functional impairment. In fact the criteria for 100 percent rating, which entitles a veteran to $2,679 in monthly entitlement, are most indistinguishable from the criteria, especially monthly compensation, which entitles the veteran to $3,100 monthly.

It is simple and reasonable for the disability bar to be seat that high.

VA most also insure that compensation for mental health conditions replaces average loss and earning capacity. Today it is not. The flaw was carefully documented in an analytic prepared for the Veterans' Disability Benefit Commission which showed that on average VA compensation for mental health condition fails to fully replace lost earnings unlike compensation for physical disabilities.

In short we believe VA must completely rewrite its rating criteria for mental health disorders, but let me stress, the best possible rat-

ting criteria alone with not result in fair and accurate compensation awards because VA's principal mechanism for evaluating the veteran's condition is fundamentally unreliable.

Currently the claims adjudication process relies heavily on examination conducted by a psychologist or psychiatrist who typically has never before met yet alone treated the veteran. Let us be clear, evaluating the extent of a psychiatric disability is far more complex than evaluating a physical condition which can be objectively measured. A one time 20- to 30-minute conversation in a hospital office simply will not tell the most knowledgeable, conscientious examiner how the veteran functions in the community, yet more than one in five wounded warriors who responded to Wounded Warrior Project survey last year reported their VA compensation examination for original PTSD claim was 30 minutes or less. Hurried or less incomprehensive C&P examinations heighten the risk of adverse outcomes, additional appeals, and long delays in veterans receiving benefits.

VA's mental health compensation determination should be based on the best evidence of a veteran's functional impairment associated with that service-connected condition.

We urge the Committee to press VA to revise current policy to give much greater weight to the findings of mental health professionals who are treating the veteran and are necessarily far more knowledgeable about his or her circumstances.

One last area of VA compensation policy we would like to address has the unfortunate effect of impeding many warriors with service-connected mental health conditions from overcoming disability and regarding productive life. It involves VA regulations that have long provided a mechanism to address a situation where a rating schedule would not warrant 100 percent rating, but the veterans are nevertheless unable to work because of a service-connected disability.

The regulations permit disability ratings in certain instances when the veteran is found unable to obtain substantially gainful employment. This individual employability rating results in a very substantial increase in the veteran's compensation. But while the veterans are rated based on individual employability the same compensation to those with 100 percent rating under the schedule the implication for employment differed drastically.

Veterans receiving IU who engage in a substantially gainful occupation for a period of 12 consecutive months can lose IU benefits and suffer steep reduction in compensation benefits. For some it can mean a sudden loss of approximately $1,700 monthly.

Expert panels have recognized that this cash cliff may deter some veterans from attempting to reenter the work force and have recommended a restructuring of the IU benefit.

The experience of the Social Security Administration which has successfully piloted a program step down approach to reducing benefits for beneficiaries who retain employment offers a helpful model.

Recognizing unemployment often acts as an powerful tool in recovery and is an important aspect of community reintegration for this younger generation of warriors. We believe that VA should revise the IU benefit to foster those goals.

In closing we emphasize that compensation for service-connected disability is not only an earned benefit, it is critically important to most veterans' reintegration and economic empowerment, and particularly for those who are struggling with psychiatric disabilities of war.

VA must work to make compensation for combat-related mental health conditions as fair as possible, and we look forward to working with the department and the Subcommittee to realize that goal.

Thank you.

[The prepared statement of Frank Logalbo appears on p. 47.]

Mr. RUNYAN. Thank you, Mr. Logalbo.

Mr. Jarvi, you are now recognized for 5 minutes.

STATEMENT OF THEODORE JARVI

Mr. JARVI. Thank you, Mr. Chairman for the opportunity to address you on behalf of NOVA and the many veterans they represent.

Our clients' cases are cases where the VA schedule of disabilities meets the road. We have recommendations for how to bring the schedule in sync with the purpose Congress has established for it in 38 U.S.C. 1155.

I agree with the prior speakers that that statute should be amended to include quality of life, but just as it stands the schedule for disabilities does not meet the requirements of the statute. That statute says VA shall adopt and apply the schedule of ratings based on impairment of earning capacity resulting from service-connected disabilities.

The VA schedule represents the VA's attempt to provide a narrative description of all the things that can go wrong with a person with a human body in mind, and then it assigns the VA the responsibility of assigning a disability rating or a combination of ratings for each veteran with service-connected disability; however, as we have heard, the schedule is out of date and not responsive to change. It contains obsolete medical terms and fails to incorporate modern medical knowledge.

Too often terms in a veteran's medical records can't be found in the schedule. What happens is that after VA rating officials read the veteran's medical records they must find a description in the schedule that sounds to them something like the veteran's condition. It is hard and results are uneven or wrong and that leads to appeals and lengthy delays.

NOVA asks why should the VA even be engaged in creating a schedule of disabilities when there is an accepted existing schedule of disabilities which is consistent with current medical terminology and usage?

NOVA recommends that VA use the International Code of Disabilities, the ICD. It is regularly updated, you won't have to be having this meeting again in 5 years, it is in its ninth edition and an updated tenth edition will be issued shortly. It is a great time for the VA to switch to the ICD.

There are good reasons for adopting the ICD. There is precedent for using professional schedules like this. The VA currently uses the American Psychiatric Association's standards for mental dis-

abilities, the DSH–4. General Scott's Disability Benefits Commission, which Congress established to review many aspects of VA recommended that VA use the ICD. And most importantly VA doctors already use the ICD in their daily work.

Doctors won't have to be retrained in how to apply the ICDs. They will have to be trained to use the VA's new schedules.

VA medical records will be consistent with the schedule.

We know VA is currently engaged in a regulation rewrite program, but it has gone on for too many years. This work could be greatly simplified if VA adopted the ICDs by reference.

NOVA's second recommendation is to reform the schedule so that ratings actually do compensate veterans based on loss of earning capacity and hopefully quality of life. There is no body of data which confirms or supports most of the percentages in the schedule. The percentages are rough estimates arrived at by doctors and VA rating officials who don't have training in evaluating lost earning capacity.

The schedule should be changed to connect medical conditions to accurate assessments of impairment for earning capacity.

VA should utilize experts who are trained in reviewing medical records and assessing the impact of disabilities on an earning capacity.

VA treats assessment of employability as a medical issue, but it is not.

VA asks the doctors to determine what in a veteran's condition renders him unemployable, but they don't have the training and experience for this task.

Many vets have more than one disability. Take a combat Marine who was shot through the leg in Afghanistan and has orthopedic, neurological, and psychological conditions. What VA doctor will assess the reduction in this veteran's earning capacity? The answer is none. None are competent to make an overall assessment of their earnings impairment. Vocational experts are suited for this job. We should include vocational experts into the rating system.

NOVA makes two recommendations for implementation of the ICDs and vocational experts. We need congressional guidance. VA needs congressional guidance on incorporating vocational experts into the VA disability system and incorporating the ICD.

Second, VA must be required to move more quickly. VA must be forced to pick up their operational tempo. Military people know what that means. Veterans are dying while waiting for the VA to do its job.

In my small private practice in Tempe, Arizona I have had more than 60 veterans die waiting for their benefits to be finally adjudicated. That is a well-staffed platoon. That is a platoon of regret and we need to make them move faster.

Thank you.

[The prepared statement of Theodore Jarvi appears on p. 52.]

Mr. RUNYAN. Thank you, Mr. Jarvi.

With that we are going to begin the questions, alternating either side in the order that they arrived. And I will start. My first question is directed to Mr. Hall in talking about quality of life compensation.

Can you elaborate on the DVA's views on how we can accurately rate disabilities and compensate for them? Because I know there is a lot of gray area out there and we have talked about the ability to work and I know Mr. Logalbo touched on that a little bit as well. How do you nail it down to where we are eliminating the guesswork from it?

Mr. HALL. Thank you, Mr. Chairman.

Quality of life, it does entail a great deal of questions. We know that other countries do utilize or include a quality of life component in their rating criteria. How that would be utilized in the current VA schedule for rating disabilities here is something that we are still exploring.

I would be happy to provide further detail after we continue to research that particular aspect of it, but essentially, you know, an average impairment in work capacity versus average loss of earnings, they are two completely different things. Loss of earnings meaning the actual loss of wages because an individual was not paid for services rendered or time lost on the job. Average impairment in earning capacity as the law is intended we do believe also included a component for functional limitations in the daily activities and also a quality of life component; however, that has not been instituted or actually pushed to the point that it needs to be.

But quality of life in itself versus functional limitations of daily activity, meaning non-work-related type activities, i.e. hobbies, things like that, that an individual would not be able to do or would be limited because—or by reason of their disability, quality of life is the enrichment, to enjoy life to its fullest extent would be severely impacted.

Again, the rating schedule simply does not take that into consideration as Mr. Logalbo had stated from his years of experience working with it. My same years of experience working with it, the rating schedule just simply does not take that into account and must.

We also know that it should not be limited to simply work-related limitations.

Mr. RUNYAN. I hear that all the time and I think the biggest thing as we move forward and you try to set criteria we have to work together to figure out how best to formulate that and put a piece of legislation out there, because obviously it is too broad, too vague as we stand and we had problems.

And it leads right into my question with Mr. Logalbo. I know we get it and I just want to get it for the record so everybody can hear it, do most veterans understand and feel comfortable with the ratings they receive from both the VA and the DoD?

Mr. LOGALBO. We deal with that on a daily basis reaching out to the warriors and the veterans, even the family care givers in the community, and throughout that a lot of them do not understand a lot of the complex rating decisions or the information that is in there and they do continue to contact us continuously to make sure that one, they understand the disability percentage with the references and their entitlement to benefits.

Mr. RUNYAN. And also tying into that, we deal with that a lot specifically on this Subcommittee with obviously being the Disability Assistance Subcommittee, but the inconsistency and dif-

ference in the ratings between the DoD and the VA, what is the common misnomers about all of that stuff?

Obviously as we move forward the records don't transfer and these ratings aren't the same. How can we systematically step forward and try to smooth that road bump out?

Mr. LOGALBO. I think as a transition through the warrior—like if you look at the MEBPB process and working with the VA and us working it and along with the DoD and the Committee we can look at those issues, you know, together, and see, you know, from our standpoint as a warrior, as 1 Wounded Warrior Project and warriors moving forward what would be the best solution to make that transition as smooth as possible.

Mr. RUNYAN. Thank you.

With that I recognize Mr. McNerney.

Mr. MCNERNEY. Thank you, Mr. Chairman.

This issue so to complicated I almost don't know where to start here.

Mr. Jarvi, you have a pretty strong recommendation that we move forward with adopting the ICD–9, and that sounds like a pretty good idea, except I know that there are some concerns about that.

One of the things that I think would be driving us in that direction is this sort of lack of uniformity or repeatability of the current analogous-based system and I am hearing it from some of the other veterans organizations that they think the current system has virtues that we ought to be aware of, and so I would like to have Mr. Logalbo address that.

What do you think would be the advantage or disadvantage of moving forward with the ICD system?

Mr. LOGALBO. Again, with the ICD–9 I don't have enough—my overall opinion would be with the rewrite of the disability rating schedule is to work with the VA and the Subcommittee to look at, you know, some of the research and see if it would be, you know, a cause of the factor.

I think the disability rating schedule rewrite from years of experience is moving in the right direction based on, you know, the committee reports, but I would be willing to work, you know, along side to see if it would be a viable option moving forward.

Mr. MCNERNEY. Mr. Jarvi, does the ICD–9 have pretty strong provisions for mental disabilities and impairments that would be adoptable by the VA?

Mr. JARVI. The ICD is primarily for physical disabilities. General Scott in his Disability Benefits Commission report recommended the use of the ICDs with a proviso that peculiarly military-related disabilities could be accepted from the ICD provision. In other words the VA doesn't have to operate them in toto, doesn't have to include them in toto, it can make special provisions for—or it should make special provisions for military disabilities that are unlike anything you find in civilian life.

Mr. MCNERNEY. But I mean that is sort of wavering, sort of undoes the reliability, and certainly we would like to see that with a system that we would adopt. I mean I would like to see a system that is reliable from State to State. If an individual got a rating and then went to another office and got a different rating I would

like to see that lack of uniformity go away, and that would have to apply to mental disabilities as well, and I think that is kind of what we are trying to get at here.

Mr. Hall, would you like to comment on how we could get there?

Mr. HALL. Personally I am not that familiar with the ICD process.

I would just simply say that while we might be able to adopt certain aspects of the ICD–9, it is still really to DAV, it still comes back to the fact that any revision or whatever the end product may be cannot be based solely on functional limitations as it is related to work.

Mr. MCNERNEY. Okay. The ICD–9, does it have provisions for quality of life or is it strictly disabilities?

Mr. JARVI. No, it is more mechanical, it doesn't include quality of life. We heartily approve of the inclusion quality of life, but the difficulty of measuring that is a problem.

The courts made an important step in that direction when they passed the—or when they rendered the DeLuca case which required the VA to include considerations of pain in its evaluations. Up until the DeLuca case the VA was strictly measuring for instance restrictions in range of motion without any consideration of pain. Certainly pain is one of those quality of life issues that is critical in a VA disability case.

Mr. MCNERNEY. Okay, thank you.

Mr. Chairman, I yield back at this point.

Mr. RUNYAN. Thank you, Mr. McNerney.

Mr. Harris.

Mr. HARRIS. Thank you very much, Mr. Chairman, and thank the Members of the Subcommittee for allowing me to join you here today.

You know, as a physician and Navy veteran I am familiar with many of the issues facing our veterans, but really until I got to Congress didn't understand firsthand how difficult some of the interactions with the veterans with the system are and certainly delays in processing in benefits and pension claims and having access to quality medical care, two of those that we do have to deal with.

Let me ask you though, Mr. Jarvi, the ICD–9 is a diagnosis code, I mean it is just a medical diagnosis code. Clearly, you know, pain, there are pain diagnostic codes, so what you would end up with is a veteran who has—probably the disabled veteran, so probably end up having multiple ICD–9 codes that would have to be integrated together, but is it your testimony that you think that would be better than the prevailing system because of the uniformity between providers?

I mean all providers know what an ICD–9 code book looks like and they know how to work it, is that what you are proposing, that that would simplify the process of classifying veterans?

Mr. JARVI. Right. The schedule of rating disabilities really does three things. It makes general classifications of disabilities, then it attempts to describe their disability, and then it assigns percentages.

The ICD–9 is primarily valuable for those first two functions, not necessarily for the third. The third is where we think that the vocational experts can play an important part.

Mr. HARRIS. Sure, that makes sense.

Now for all three of you, you know, one of the reasons why I wanted to join the Subcommittee today is because of the increasing number of complaints we are getting from our veterans about a backlog of claims processing. In fact as I look through the study, and I will ask a consent panel of performance and accountability report, you know, it says there were 1.3 million claims last year and one million were handled. Well that means 300,000 weren't handled.

And Mr. Jarvi, like your experience, I mean we have had people who in the short time that we have been dealing with veteran's claims who have passed away waiting for their claims to be adjudicated.

And I will ask all three witnesses, is this something that you observe as a—because the report if the department suggests that, you know, don't worry things are getting better, but our impression is that no, they are not, they may in fact be getting worse because we are involved in some recent wars and actions overseas that increase the number of our disabled veterans.

What is your impression from out in the field, is it getting better or worse? And Mr. Hall and Mr. Logalbo if you would—why don't you just give me your impression.

Mr. JARVI. Mr. Harris, it slowed down dramatically as the VA focused on Agent Orange issues for the last year. It is beginning to pick up again now. We have noticed a slight increase in tempo, but nothing dramatic at all, it is pretty much the same. And the unfortunate part about that is that when we have to decide what to devote our resources to in terms of advocacy we actually have to look at the veteran's age. It is a problem.

Mr. HARRIS. Mr. Logalbo.

Mr. LOGALBO. I agree with Mr. Jarvi. The claims, the actual you know herbicide claims that were out there did slow down the process which did increase the backlog. A number of warriors are continuing to wait, you know, an extensive amount of time for the disability claims to be processed.

Mr. HARRIS. And Mr. Hall.

Mr. HALL. It is been a while since I have been in the field, but in touch with those of us, you know, our office is in the field and testifying before this Subcommittee and others, I don't know if it is accurate to say that it has slowed down or it has gained more. Certainly we all understand the principal of one million claims processed, but 1.3 million were actually received.

With DAV being have involved with the many other aspects with VBA we appreciate their outreach to include us in a lot of the process to include the complicated process of the veteran's benefits management system, which is driving forward. I believe it is Providence, Rhode Island and Salt Lake and getting ready to spread out to other regional offices, which may in fact improve the claims process or the timeliness of the claims process, but between that and a lot of the other pilot projects that they have going on, you know, at various stations the Indianapolis Integration Lab, dif-

ferent things like that, we simply can't see where whether or not it is actually getting better but we have written some papers ourselves on it and I would be happy to forward those to you if you would like to read them.

Mr. HARRIS. I would appreciate that, thank you very much.

Thank you very much, Mr. Chairman.

Mr. RUNYAN. Thank you, Mr. Harris.

Mr. Michaud.

Mr. MICHAUD. Thank you very much, Mr. Chairman, Mr. Ranking Member for having this very important hearing today.

I also just want to comment, Mr. Chairman, your opening statements about the Wounded Warrior Program and hiring a staffer in your congressional office. We have had one and that is an excellent program, it has definitely added a lot of value to our congressional office having a wounded warrior soldier there on staff. So I commend you and Ms. Buerkle for hiring one.

So my question actually relates around the ICD. I guess I don't believe I heard Mr. Hall say whether DAV agrees with the ICD recommendation that Mr. Jarvi had recommended. Is that something that you think—what I really like about it is the fact that it is updating all the time and the VA won't have to wait another 40 years or so to reevaluate it.

So what is the DAV's comment on Mr. Jarvi's recommendation?

Mr. HALL. Well, as I had stated, sir, I personally am not that familiar with the ICD process. DAV and others, my boss, we can probably get you something in more detail, but again, in short I don't think any system going to something that focuses solely on functional limitations related to work is something that is acceptable to anybody.

As Mr. Jarvi had said, it is more of a mechanical process and does not include the quality of life component, which we have heard not only from myself but others here today, must be included in the rating schedule.

So if the ICDs do not include that in there I can't see how DAV would be supporting including that. Maybe aspects of it, but not the overall.

Mr. MICHAUD. Okay. And speaking this for all three, speaking about the quality of life criteria, which I can understand having part of that in there, but how do you deal with that issue because it is very subjective? And a good example is when they closed the air force base in Limestone, Maine, the ultimate decision why they closed it was the quality of life; however, if you ask the people that live in Russup County they love the quality of life, so it is very subjective.

So how do you build that into a system and have it be considered fair on that—as to all three of you—that question?

Mr. HALL. Well again, we don't have the exact how to. We know that other countries do it. Whether it is a rating formulated, something that is added to a baseline of disability, it is added to it, I know that we have special monthly compensation above and beyond a base rating, but that is reserved for those individuals with things such as amputations or loss of use of an extremity or blindness or something of that nature.

Including it in there, we know that it must be included in there because again it can't simply be related to how it affects a person's ability to work because it is going to disincentivize individuals from actually going to work.

Okay, when an individual has to contemplate and negotiate these steps over here just to simply get up here where you or I wouldn't normally have to do that that is a quality of life issue. They have to take into account every single step that we again common or routine activities we wouldn't think of.

So again, while we might not have the exact answer for it, we know that it must be included in there, and we are happy to work with the Subcommittee and move that particular issue forward.

Mr. LOGALBO. Thank you, Mr. Chairman.

On the quality of life issue itself if you look at the foundation of Wounded Warrior Project as economic empowerment, our organization has 16 different programs. One of the components is our service program that allows warriors to actually solidify that single part, that compensation part, and then we have other programs to make sure and insure that the warrior and our organization is the most well-adjusted and successful generation of veterans that we have. And basically with the Wounded Warrior Project is, it is, you know, our point is to do a holistic approach with our 16 programs and make sure that each portion of the warrior is taken care of from transition from military to civilian life to insure that they are most successful.

Mr. JARVI. I wasn't necessarily suggesting that quality of life should not be included, we would like to see it included. We don't know necessarily how it will be measured, but what the purpose of our recommendation regarding the ICDs is, is that it enhances a smooth transition from the medical records to a VA rating. It is a starting point, it is an initial way for raters to understand what is going on in the veteran's medical case.

Mr. RUNYAN. Thank you, Mr. Michaud.

Mr. Walz.

Mr. WALZ. Thank you, Mr. Chairman and Ranking Member for holding this. Thank you for being informative as our panel, this is a challenging subject.

I would just like to state again thank you to the Members for their hiring of veterans.

I would also like to make note the chairman has left, but Chairman Miller, myself, and Congresswoman Fudge kind of led a little initiative, tonight you will see a lot of Members bringing guests to the State of the Union tonight that are Iraq veterans to say a very public thank you. I have Mike McLaughlin from Mankato, Minnesota here whose father is a combat-wounded Vietnam veteran. Mike did two tours in Iraq of being there, so for all of us to say thank you for that and thank you for continuing to put the emphasis on this.

You are exactly right, this is a very, very subjective situation, but it is one that is paramount to us is, is getting this right.

The claims backlog troubled all of us for a long time. I think that all of us understand though the ultimate goal here is an accurate claim. Just getting it done we have seen is not good enough, just getting it done on time if it is not accurate.

And I would also mention one thing that is very challenging about this, I think the chairman is exactly right when he asked you, Mr. Logalbo, you know, if you hear people complaining about the process, I would be interested, has anybody ever complained to you that they have too high of a rating?

Mr. LOGALBO. With the warriors that we serve they are really motivated and to be successful, so their own premise, a lot of the warriors that we are serving is to make sure that they get back into society.

Mr. WALZ. That is exactly the point. I am trying to figure this out. And I think this goes back, you also mentioned, and I am interested about this, the restructuring of the IU. How would we do that? Do you have some ideas on that?

Mr. LOGALBO. That is a process we were—basically is we use Social Security as a guide, but we would be more than willing to work with the Subcommittee and the Committee and also the Department of Affairs looking at the best way to restructure it so it is the best suitable for the warrior to get back into—adjust into the economy.

Mr. WALZ. Is it safe to say this is similar to our health care cost where we have 15 percent of the population accounting for 80 percent of the cost in the last, you know, 36 months of life or whatever, is this a case of the IU is eating up a bigger and bigger share of the disabilities?

Mr. LOGALBO. That I couldn't answer.

Mr. WALZ. Okay.

Mr. LOGALBO. I don't know.

Mr. WALZ. I just see it start to happen. Because I think you are right, I think we have to get structured at this in trying to figure it out. We want them to be accurate, we want to get people back working again, we want to be fair in how we do it, and I do believe this quality of life issue, this is one I really struggle with of how do we get to that.

I have to be very honest, and I am looking forward to our next panel helping me out with this, I tend to think I am leaning the way all of you are, a structure like the ICD or something, the AMA is going on, it is very difficult.

I guess I would throw this out there to you. I know we are always balancing this issue of doing right by veterans, doing it in an efficient manner, and the costs.

I will not apologize for the added claimed by Agent Orange. That was something we advocated for, that cluster of folks in southeast Minnesota who brought the issue of Parkinson's forward, I am very proud of the work we did for them. If I have my way we are going to make VA busier with blue water, but that will be for another time.

With that being said, is it time to think about allowing individual physician assessment, that treating physician rule, or are we going end up with a situation—I know this is also hard—how do you keep up then with the pace? It is not as if VA denies claims to save money, they are trying to get them accurate. I trust physicians to do this right, but are we going to then be criticized for look at all these claims that you have approved and the cost it has been and we have no control over that physician who did it? Is there a

lucrative business approving claims then out there by treating physicians?

I just ask all of you to if you could give me your candid assessment the way you see that.

Mr. HALL. Well, let me ask you do you think with everything surrounding the backlog of claims, which I have been here before you before, it is an important subject, but with the backlog of claims do you think that it is possible that going to a system that is based solely on how it affects an individual's work is going to speed the process up? Do you think that might be an underlining factor?

Mr. WALZ. No. Yeah.

Mr. HALL. I mean it is something that we certainly think about because to us it is illogical. It is illogical to omit to as they had stated in the—I believe it was the ACDC back in October to—or the Veterans' Disability Commission, to reject the mental rating disorders criteria and to eliminate social impairment from the rating schedule itself, that is not feasible. Again, we are——

Mr. WALZ. This is where I struggle, because I think we could speed the system, I think we could become more efficient, but as I said, again the goal is, is the fairness to the veteran, and there is the quality of life issues, there is in each and every one of these cases is unique depending on where the ability of the skills and the ability to get back are for each of these folks, so I really struggle with this.

Mr. HALL. Yeah, I mean one good point with that would be Congress has worked diligently with the employment bills, the legislation that has been enacted, we want to put veterans to work, we want to encourage them and incentivize employers to hire veterans, that is on the front end.

On the back end this could head down a path that would actually be contrary to that to say we are pushing you to go back to work, but if you go back to work you are not going to receive disability compensation.

Now that may be a very raw way to look at it, but again, if you look at the reports coming out of those commissions, which we as we understand it, because we have not been fully included into the open and transparent process, VSOs, it has been closed off to us, we want to be engaged more indepth with that, but I agree with you.

Mr. WALZ. My time is just about it.

Individual physician assessment?

Mr. JARVI. If I may address your questions about the treating physician rule.

Mr. WALZ. Yeah.

Mr. JARVI. It is a bad rule because veterans who want to challenge their ratings when they think they have been improperly rated generally the only person they have to go to is their treating physician. Their option is to go to a forensic physician whose report may cost thousands of dollars.

The veteran really needs to be able to introduce the evidence from their own treating physicians. It is an important change and I hope the Committee addresses it.

Mr. WALZ. Thank you Mr. Chairman, I appreciate it.

Mr. RUNYAN. Thank you, Mr. Walz. I was just talking to the Ranking Member about how we move forward and how we improve this process. The comments we heard from Mr. Hall, and his comments about Mr. Jarvi with the ICD things, I think the biggest thing is we have to find a framework that works for most of our stuff and everyone make these pieces fit together.

Dr. Harris commented that the medical world has their own language they are used to, the VA has their own world and a lot of the things they put on the medical staff, so we have to find this common ground so we are not always trying to merge two different volumes of a book that says a lot of similar things. I think that the quality of life issue is going to be a challenge, because every single one of those determinations is different. Everybody has a different—and I know this from my personal experience—everybody has a different pain threshold, a different way they deal with those injuries and such.

So we are not going to solve it in this hearing, I just wanted to raise the issue so we can take an honest look at it and attempt to make this fair for everybody. I think at the end of the day it will happen.

So with that being said I want to thank you gentlemen on behalf of the Subcommittee for your testimony and look forward to working with you on these matters, because obviously we have a long way to go and it is the mission of this Committee to take care of the ones who sacrificed everything for everything we have.

So thank you and you are excused now.

At this time I would like to call the next panel up to the table.

At this time I welcome Mr. Tom Murphy, Director of the Compensation Service for the Veterans Benefits Administration, U.S. Department of Veterans Affairs. Next we will hear from Mr. John Campbell, the Deputy Assistant Secretary of Defense for the Wounded Warrior Care & Transition Policy, U.S. Department of Defense. He is accompanied by Dr. Jack Smith, Acting Deputy Assistant Secretary for Clinical and Program Policy in the Office of the Assistant Secretary of Defense for Health Affairs.

We appreciate your attendance today and your complete written statements will be entered into the hearing record.

With that being said, Mr. Murphy, you are now recognized for 5 minutes.

STATEMENTS OF THOMAS J. MURPHY, DIRECTOR OF COMPENSATION SERVICE, VETERANS BENEFITS ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; JOHN R. CAMPBELL, DEPUTY ASSISTANT SECRETARY OF DEFENSE, WOUNDED WARRIOR CARE & TRANSITION POLICY, U.S. DEPARTMENT OF DEFENSE; ACCOMPANIED BY DR. JACK SMITH, ACTING DEPUTY ASSISTANT SECRETARY FOR CLINICAL AND PROGRAM POLICY FOR HEALTH AFFAIRS, U.S. DEPARTMENT OF DEFENSE; COLONEL DANIEL CASSIDY, DEPUTY COMMANDER OF THE U.S. ARMY PHYSICAL DISABILITY AGENCY; ROBERT POWERS, SECRETARY OF THE NAVY COUNCIL OF REVIEW BOARDS, U.S. DEPARTMENT OF DEFENSE; CAPTAIN FRANK CARLSON, MC, PHYSICAL EVALUATION BOARD, U.S. DEPARTMENT OF DEFENSE

STATEMENT OF THOMAS J. MURPHY

Mr. MURPHY. Thank you, Mr. Chairman.

Chairman Runyan, Ranking Member McNerney, and Members of the Subcommittee, thank you for the opportunity to testify on the state of the VA Disability Rating Schedule.

The VASRD is the engine which VA is able to provide veterans with compensation for diseases and injuries they incur while serving our Nation.

Section 1155 of Title 38 U.S.C., and the statute's implementing regulation 38 CFR 4.1, require VA to assign veterans who are service-connected with percentage ratings that represent the average impairment in earning capacity resulting from diseases and injuries that were incurred or aggravated during active military service.

Section 1155 also provides that the schedule be constructed to provide ten grades of disability for payments of compensation with increments of 10 to the total 100 percent. Congress sets the associated dollar amount under 38 U.S.C. 1144.

The current rating schedule has three basic concepts introduced in the 1945 schedule. First, compensation based on average loss earnings capacity. Second, use of disability evaluations and associated compensation ranges. And third, disabilities organized into discrete body systems.

The current rating schedule differs from the 1945 rating schedule due to periodic updates to individual body systems throughout the years and now contains diagnostic codes for 15 body systems.

Various studies and commissions since 2007 have made many recommendations relating to VA's Disability Compensation Program.

For example, the Institute of Medicine in its 2007 report to the VDBC recommended that VA immediately update the current rating schedule, devise a system for keeping the schedule up-to-date, and conduct research on the ability of the rating schedule to predict actual loss in earnings.

In 2007 the VDBC recommended that priority be given to the mental disorders section of the rating schedule to include PTSD, TBI, and other mental disorders. It further recommended that VA address the other body systems until the rating schedule is comprehensively revised.

The President's Commission on Care for America's Returning Wounded Warriors in its 2007 report recommended that the rating schedule focus on veterans ability to function directly instead of inferring it from physical impairments.

A Center for Naval Analyses study determined that VA compensation, on average, is generally appropriate relative to earned income losses. The study found that veterans with physical disabilities are properly compensated while those with mental disabilities may be under-compensated.

In 2009 VA began a comprehensive revision and update of all 15 body systems contained in the rating schedule.

VBA implemented a detailed project management plan that will result in a complete modernization of the rating schedule by 2016. The plan calls for the application of current medical science and econometric earnings loss data consistent with our charge in 38 U.S.C. 1155.

Each body system starts with an initial public forum intended to solicit updated medical information from governmental and private sector subject-matter experts, as well as input on needed improvements in the rating schedule from the public and interested stakeholders, such as veteran service organizations. This is accomplished in the most transparent manner possible.

As VA convened work groups of subject matter experts for each body system a common theme emerged, there is a need for a shift in focus in the rating criteria from a symptomatology-based system to one which focuses on functional impairment.

Subject-matter experts have concluded that while symptoms determine diagnosis, the translation of symptoms into functional impairments and overall disability is the indicator of impairment in earning capacity.

Another important aspect of the review process for each system is the execution of an econometric earnings loss study. Each study will provide the data necessary to determine whether current compensation rating levels accurately reflect the average impairment in earnings capacity for specific conditions in the current rating schedule.

VA is partnering with the George Washington University in connection with five body systems to analyze the income and benefits data. VA may solicit proposals from other entities to carry out the studies for the remaining body systems.

Currently proposed rules to revise three body systems are undergoing final review within VA. Drafts of proposed rules for ten more body systems are underway, and all will incorporate the results of the earning loss studies.

This week, public forums will be completed for the four remaining body systems.

We at VA recognize the importance of insuring that the VASRD meets the needs of veterans in the 21st century. Through a successful modernization and revision of the rating schedule VA is anticipating and proactively preparing for the needs of Veterans and their families.

[The prepared statement of Thomas Murphy appears on p. 57.]

Mr. RUNYAN. Thank you, Mr. Murphy.

Mr. Campbell, you are now recognized for your statement.

STATEMENT OF JOHN R. CAMPBELL

Mr. CAMPBELL. Thank you, Mr. Chairman.

Good morning Ranking Member McNerney and Members of the Subcommittee, thank you for the opportunity to be here this morning to discuss the Department of Veterans Affairs Schedule for Rating Disabilities known as VASRD as it applies to the Department of Defense.

I am pleased to be on a panel with my colleague from VA's Veterans Benefits Administration, Mr. Thomas Murphy. I am also joined this morning by Dr. Jack Smith from DoD's Health Affairs, Colonel Daniel Cassidy from the Army, Captain Frank Carlson, and Robert Powers from the Navy.

DoD uses the disability evaluation system to determine if a servicemember is fit for continued military service, and if found unfit servicemembers are retired or separated with disability benefits for service-connected injuries, illness, or diseases.

As you know, in order to achieve more consistent disability ratings assigned by the military departments and the Department of Veterans Affairs the national defense authorization Act of 2008 required the military departments to utilize the VASRD for making determinations of disability ratings without deviating from that schedule.

VA disability ratings are based primarily on the degree of impairment by injuries incurred or aggravated while on active duty while the VASRD percentage ratings represent the average impairment and earning capacity in civil occupations.

Military departments use the VASRD disability rating to determine whether an unfit servicemember will be retired or separated with disability benefits.

As you can see the two departments use the VASRD for different purposes and there are some instances where VASRD ratings are not relevant to DoD's requirements.

Sleep apnea, for example, discussed in detail in my written statement is a perfect one where exceptions to the strict application of the VASRD should be allowed in certain circumstances.

In May 2011 VA Secretary Shinseki proposed draft legislation to the Congress entitled the Veterans Benefits Programs Improvement Act 2011 in which he requested that period for reevaluating former servicemembers with traumatic mental health conditions be extended from 6 months to 18 months following their release from active service.

Reevaluating servicemembers within 6 months following the separation has a significant impact on limited behavioral health resources and may be of mental benefit in determining a change in those mental health conditions.

We support the proposed legislation as an initial step toward standardizing the requirement for the military departments to reevaluate former servicemembers with traumatic mental health conditions, specifically post-traumatic stress disorder who are placed on temporary disability retirement as the same timeframe established for reevaluating other medical conditions.

Ultimately the DoD would prefer to eliminate mandatory reevaluation for all traumatic mental health conditions.

Our recommendation is to treat these conditions like all others, that is to set reexamination requirements only when necessary and to rate the condition at its observed level of severity rather than at a 50 percent minimum.

While the department recognizes that the VA's secretary ultimate responsibility and decision of authority for the content of the VASRD, the department believes it should have more developmental input given the direct connection between the VASRD ratings and the decision to place servicemembers on medical retirement lists with annuities, benefits, and health care.

Moreover we appreciate VA's outreach to include DoD in the body system rating update review that began last year and the service's participation through their subject matter experts.

DoD plans to continue to participate in VA's public meetings as DoD and VA leadership continue discussing how to strengthen DoD's role in the VASRD rewrite process.

We look forward to finalizing a memorandum of understanding with the VA which will formalize DoD's active voice in the future development and modernization of the VASRD.

Mr. Chairman, this concludes my opening statement, I appreciate the opportunity to be with you today and look forward to any questions that you or other Members of the Subcommittee have.

Thank you.

[The prepared statement of John Campbell appears on p. 60.]

Mr. RUNYAN. Thank you, Mr. Campbell.

My first question is, Mr. Murphy, I know you witnessed what Mr. Hall had to say on the last panel, and quality of life is a huge part of what he deals with in his organization, whether we are talking about PTSD and social anxiety and people's inability and through that whether, they are driven to give back through charity work However, through PTSD they are having social anxiety or are not able to kind of unwind a little bit because of something that was created.

Would the VA agree that there is a need to take a look at that type of thing?

Mr. MURPHY. The VA has to function within its statutory limitation, which is we are limited to providing compensation for average impairment of earnings.

So along those lines any compensation for quality of life would be beyond the authority that we have to compensate veterans.

Mr. RUNYAN. Okay. There has been recommendations that the entire ratings schedule be revised. Is the VA considering that at all?

Mr. MURPHY. The VA is in the middle of a program of an entire look top to bottom of the rating schedule. In fact as of this week the last of the 15 body systems is currently under revision.

Mr. RUNYAN. And I know our timeline has been dragging quite behind on a lot of that stuff. Is there any finality in the near future on any of that?

Mr. MURPHY. Yes. Three of the regulations are in the final draft mode, one of those is sitting with our Office of General Counsel, ten of them are in draft rule making phase, and the additional four are just entering that phase as of this week with the VASRD form going on in New York City.

Mr. RUNYAN. Okay.

Mr. MURPHY. We realize that this is a very important process that has a significant impact on the veterans of this Nation, but on the other hand this is a process that needs to be done right, and a little extra time now can save us a significant amount of time in making sure we do it right for veterans the first time.

Mr. RUNYAN. In talking, other conversations we have had in dealing with—and it came up in the last panel too—the veterans lack of understanding of the process. Is there any attempt at the VA to address the lack of education and how the veteran understands the rating system?

Because I think that is one of the big disconnects, when people have the information they understand the process they are a lot more comfortable with it. I think that the education aspect of it and how to move forward is important.

Now are we doing that early on or are we doing it after there is a problem and everybody is frustrated and at that the point a lot of times it is hard to break that barrier down?

Mr. MURPHY. VA is doing some significant work to fix that very issue. It is in VA's best interest and the best interest of the veteran for everybody to understand exactly what is going on in this process.

So there is a couple of things that are happening right now. We have introduced what is called a DBQ, disability benefits questionnaire. Standardized evaluation, medical evaluation, 81 of them currently in use by all VHA practitioners. We are in the process of releasing those to the general public.

We talked earlier, the earlier panel discussed some comments about a veteran not being able to understand and have input into the system. The DBQ evaluation is the exact same evaluation that you would receive, the exact same form that you would receive inside provided by a VHA practitioner, and a veteran will very shortly be able to take that to his private treating physician and submit that to VA for evidence to rate their claim.

On top of that we have one of the initiatives in place that Mr. Hall was talking about on the previous panel, is the simplified notification process. We realize that our notification process has a lot of legal explanation in there and we are in a pilot phase right now simplifying that, taking that into some plain English and explaining it to the veteran in a way that you don't need to have a legal degree to interpret.

Mr. RUNYAN. And then Mr. Campbell, and I would like Mr. Murphy to respond also, but starting with Mr. Campbell.

In talking about the different ratings that we get from the DoD and the VA on the same thing, do you find any common areas that we can work on there to—like I said, I think in the previous one, to kind of eliminate that bump in the system?

Mr. CAMPBELL. We use the VA Disability Rating Schedule to ascertain whether a servicemember is fit or unfit for duty and their condition whether they stay in the service or don't say in the service, and then in the disability evaluation system we utilize that to help servicemembers move forward in the system.

Mr. RUNYAN. But it almost seems like you are using the same set of rules, and obviously we know how this works, there are two

different results out of them. Do we need to have a better integration maybe and talking from the DoD to the VA to kind of smooth that out so this process isn't reinvented as we transition?

Mr. CAMPBELL. I don't believe that the ratings themselves are that different. There are some inconsistencies, there are some peculiarities where our understanding of a rating is different.

Like sleep apnea, as I mentioned in my oral statement, there is a difference there, but I think in most cases they are pretty consistent.

Mr. RUNYAN. Would you agree with that statement, Mr. Murphy?

Mr. MURPHY. Yes, I would. Completely agree with it. Sleep apnea being a prime example, we rate it based on the symptoms displayed by the veteran and then the Department of Defense applies that inside their world to constitute the rating that they use for continued service.

Mr. RUNYAN. Well, I bring that up because that question arises all the time. It is something that I think we should probably dig in a little deeper around in this Subcommittee because I think it is a little more frequent than you guys are aware of and I think that is part of the issue, we go back to the education aspect, going both ways down that street.

So I thank you and recognize Mr. McNerney.

Mr. MCNERNEY. Thank you, Mr. Chairman.

Mr. Murphy, thank you for appearing before the committee today again.

Does the VA intend to publish the proposed VASRD provisions, and if so when will that happen?

Mr. MURPHY. Yes, sir, we will publish each of the body systems as they are completed through their draft process inside of VA, then we will follow under the Administrative Procedures Act, we will publish them in the *Federal Register* as a draft, receive comments from the public, rewrite, if the comments are extensive and any rewriting is extensive then those drafts will be republished before a final is published and put into effect.

So there is a significant comment period to come on anybody's system before anything is put into a final form.

Mr. MCNERNEY. One of my questions is the significance of the standards like the VASRD versus the training, and it seems to me that they are both pretty relevant and pretty important.

I am sure that your specialists are very well trained, but the variance between outcomes is a big problem. Do you think it is due to the training or do you think it is due to the sort of subjective nature of the standards?

Mr. MURPHY. I think that is a much more complex question than we give it credit for, and training is absolutely a part of it. You have approximately 3,700 raters spread across 50 plus offices across the country and our challenge in the training world is how to get each one of them to read a single piece of evidence and come to the identical conclusion every single time. And the way we are attacking that is through as you heard earlier, the introduction of Veterans Benefits Management System by introduction through the disability benefits questionnaire. And the answer is we attack that by standardizing the process as best we can and putting it

into a uniform format which leaves the individual to come to the same conclusion given the same set of evidence.

We think that the disability benefits questionnaire is going to give us significantly strides forward in obtaining the quality goals that we have in front of us.

Mr. MCNERNEY. I hate to jump around but I only have 5 minutes.

One of the issues that seems to be coming up today is the disparity between physical disabilities and mental disabilities and the difference in compensation between those two sort of categories, and I understand that they are different in terms of how to evaluation and the difficulty and so on.

What do you think the barriers are to adopting standards for mental disabilities compensation?

Mr. MURPHY. Mr. McNerney, that is the very reason we are doing the revision of the VASRD, to eliminate the recommendations that were coming from three or four different Committees in here, and we are going through it to eliminate the variances that we are talking about and to identify a process that is a better representative of the disabilities that veterans are suffering.

Mr. MCNERNEY. What are the barriers?

Mr. MURPHY. I don't think that we have barriers sitting in front of us. We have gathered the best medical professionals we can both inside and outside the VA, so private sector and inside the government, and we are significantly down the road on the draft rule making process of that.

So the identification of what are those barriers will come with the publishing of the draft regulation in the near future.

Mr. MCNERNEY. But you yourself stated that physical disabilities are considered to be compensated appropriately where a mental disabilities are not. So we still have a long ways to go then in terms of developing standards as I would understand it.

Mr. MURPHY. I quoted one of the reports from the Center for Naval Analysis that they considered. Center for Naval Analysis considered physical disabilities to be adequately compensated and that mental disabilities to be undercompensated, and with that piece of information when we go into the draft rule making process it guides us where we want to go with the medical advisors and practitioners that we have to insure that we are adequately compensating for the disabilities that are suffered by veterans.

Mr. MCNERNEY. Mr. Campbell, the Veterans' Disability Benefits Commission study found that there were variances in the way that DoD rates disabilities in comparison to the way the VA rates disabilities. As you probably know the VA also had its own issues with variances between raters and regional offices.

What steps would you recommend to gain more consistency in rating between the VA and the DoD?

Mr. CAMPBELL. Mr. McNerney, I wanted to correct a statement I made earlier, I didn't really understand the question.

In terms of the integrated disability evaluation system the DoD uses the VA disability ratings to insure greater consistency in the outcomes for servicemen and women. That process that we have in place does insure a greater consistency that the ratings were the same.

Mr. MCNERNEY. Within the DoD.

Mr. CAMPBELL. Within the DoD.

Mr. MCNERNEY. What about the variances between DoD and VA?

Mr. CAMPBELL. Well, within this particular system there should not be any, you know, any differences.

Mr. MURPHY. Are we referring to the differences between, for example, a veteran may come to VA and get a rating of 70 percent, but through the IDEA process would get a percentage that would be lower than that based on the fact that the DoD rates on unfitting conditions as opposed to VA looking at assessment of the total veteran? Is that the differences in rating that you are referring to?

Mr. MCNERNEY. Yes.

Mr. CAMPBELL. Oh. Well we just rate the condition found unfitting for the servicemember, the VA rates for all conditions, unfitting and anything else that the VA doctors determine as a condition to be rated.

Mr. MCNERNEY. How do you both feel about the ICD, International Classification of Diseases and VA adopting something, again at least for the physical side?

Mr. MURPHY. I would recommend that we not limit our self to just the ICD–9 codes. It is an option as opposed to the option.

And the reason I say that is, is it is something that is being considered under the revision for the VASRD, we are also looking at the AMA guides and we are looking at the World Health Organizations International Classifications on Functioning, and the point being that we are so early in the draft process here that there are no options that are off the table and ICD–9 codes being adopted as the standard is certainly in the discussion.

Mr. MCNERNEY. Thank you, I am going to yield back here.

Mr. RUNYAN. Thank you, Mr. McNerney.

Mr. Walz.

I dropped the ball on the first round, he is a visiting Member, so.

Mr. WALZ. Thank you very much.

Well again, and I have to congratulate you, Mr. Chairman, you did what I have been asking for for a long time, we have VA and DoD at the same table and that is something. As a seamless transition guy I can't tell you, but I do in all seriousness thank both of you. I can see the effort that is going here, this is a step in the right direction, it is a very complex issue as, you know, the Chairman and the Ranking Member have pointed out, but I appreciate you helping us try and get there.

I just have a couple of things on this. And I still keep coming back to it, and I am glad that Dr. Harris is here, because this issue of the science and the art of medicine as it plays into this is a really difficult one to navigate.

The difficulty I know in DoD is you are determining fitness for war fighting duty, VA is taking care of our veterans, and so I mean many times I preach that gospel of seamless transition, I do understand that your core missions are different, even though that that main focus is on that veteran, so thank you for being so candid with us, thanks for trying to help us understand a way we can do that.

I guess maybe to you, Mr. Campbell, just asking this, during that PEB, and I follow up a little bit on Mr. McNerney's point on, who advocates for the veterans during a PEB or for that warrior? Who is there to advocate for them if you will?

Because that is a pretty important time, right, when they are in an evaluation board there are medical things.

I am just asking from a standpoint of I think of this, and maybe I am approaching this wrong, I had in my own personal time I had 20 years of service right after September 11th, wanted to re-up, had to do a medical review board, deemed I couldn't hear, imagine that 20 years of artillery so I couldn't hear and that was deemed up fit. So I went back, got a civilian doctor, did some work, got that done, came back and was allowed to re-up.

I was advocating for myself to stay in to do service and all of that, who is advocating for these guys on when they are hurt?

Mr. CAMPBELL. I brought some subject-matter experts with me who actually were on the ground.

Mr. WALZ. That will be helpful.

Mr. CAMPBELL. And I ask Colonel Cassidy if he would like to respond to the question.

Colonel CASSIDY. Thank you, sir.

As far as advocates during the medical evaluation board and physical evaluation board process we have a number of advocates. One that you are most familiar with is the physical evaluation board liaison officer are kind of counselors and that kind of shepard the soldier or servicemember through the process.

I think your direct question is who assists as far as when there are issues with the fitness determination or ratings.

We have an Office of Soldier Counsel that is subordinate to our medical department that are lawyers for the most part that are trained in both—they have gone to the VA school for ratings, and attend our training courses so they are absolutely familiar with the VA schedule for rating and our fitness standards so they would be direct advocates that would go before the physical evaluation board to argue for a soldier.

And then recently within the last 2 years we have put a medical evaluation board counsel down at each of the MTFs to assist the soldiers with understanding their medical evaluation boards and helping them through that appeal process.

Mr. WALZ. This kind of goes to the heart of what the chairman has been saying about understanding the process, especially important here when people are looking at careers and things that can go forward about those wanting to serve as we heard from the previous panel talking about trying to get it there, so these are advocates while they are part of DoD, but they are advocates for those veterans, that is their specific purpose to make sure you are that all their rights and responsibilities and things that that soldier needs and has are being advocated for.

Colonel CASSIDY. Sir, with the office of soldier counsel that is absolutely correct. They similar to a defense lawyer.

Mr. WALZ. Yeah, I was going say, they are a public defender or whatever. Is that adequate, is there a need no outside counsel with those or does that really make it hard?

Colonel CASSIDY. The soldiers are not just limited to the office of soldier counsel, they can bring in private attorneys, we have a number of pro bono attorneys that represent soldiers or they can bring in any representative they choose. We have had disabled American vets, American Legion have come to represent soldiers. So it is not limited to just those.

Mr. WALZ. Okay, I appreciate that. I am running out of time I want to throw a quick one at you, Mr. Murphy.

I know we are in a transition stage here, the paperless system at Winston Salem, the only problem I am having and I am totally cognizant and empathetic to you on this, once you go paperless there is no transition between the papered world and the paperless world, so when claims end up down there we can't get them back if there is problems; is that correct?

Your people down there have been fabulous on helping us with some problems as we have called in, the problem for the veteran is, is that I know you are moving in the right direction, I know moving to that paperless system is going to take a little while, but the lack of communication—are we addressing that or is this a growing pain that we are going live with?

Mr. MURPHY. You are talking about the BDD——

Mr. WALZ. Yes.

Mr. MURPHY [continuing]. Claims that are being processed in Winston Salem in the individual environment?

Okay. The electronic record is the system of record, that is the official I want to see it, that is it, that is the electronic record. The documents that are retained after that are literally stored in big boxes in a gigantic room.

Mr. WALZ. Yeah.

Mr. MURPHY. In terms of from a legal standpoint the source document just became the electronic world that you are seeing as a result of the BDD.

Mr. WALZ. Okay. And this growing pain of moving back and forth, it left St. Paul, went down there, that is—I mean they are going a great job of troubleshooting these, but I am just afraid again that burden of backlog of claims of troubleshooting for congressional inquires is a very inefficient way to go about business, but——

Mr. MURPHY. It is, but it also is an avenue for veterans that are not taken care of adequately through the system to address their concerns and to make things right for them. So it is a necessary process.

Mr. WALZ. I appreciate it. Thank you, Mr. Chairman.

Mr. RUNYAN. Thank you, Mr. Walz.

Mr. Harris.

Mr. HARRIS. Thank you, Mr. Chairman, and again thanks to the Committee for letting me sit in, because I do want to scratch the surface of this a little bit.

Mr. Murphy, in the 2011 Performance and Accountability report, you know, there is a lot of talk about performance result, but let me ask you, with regards to these claims are you surveying continuously the claimants for satisfaction specifically with the process?

Mr. MURPHY. We are talking about the veteran's satisfaction with that process as opposed to the quality of the process?

Mr. HARRIS. Yeah, quality. I just want, you know, if you're people-centric you have to have the perception that you are doing a good job.

And again, you know, for instance there are these figures that I know the survey says well, 64 percent of veterans are satisfied with their in-patient care, 55 out-patient care, 97 percent with the appearance of veteran cemeteries.

Mr. MURPHY. Yeah.

Mr. HARRIS. I got to tell you, you know, by that time it is a little too late. You have to have done everything right up until that time.

Mr. MURPHY. Absolutely.

Mr. HARRIS. So do you continuously survey for satisfaction on the veteran's side with regards to claims processing?

Mr. MURPHY. We are, yes.

Mr. HARRIS. And what is the results?

Mr. MURPHY. And we are expanding that process now.

Mr. HARRIS. What is the result and what——

Mr. MURPHY. I am not able to talk to the results of that, but let me give you a little bit of background ream quick on what we are doing.

We hired J.D. Powers & Associates because of their reputation for quality and we want a straight answer, solid feedback to us on where we are doing wrong.

We are expanding it to look into multiple areas. We started in the benefits assistance service specifically around phone centers, public contact centers, and interaction points with the veterans.

So we recognize that it is there, we are expanding where we are using their services to tell us about veteran satisfaction, and I am sorry, sir, but I am unable to give you the numbers on that today.

Mr. HARRIS. Okay. And if they come available if you would share them I would appreciate that.

Hopefully again we are going take some active measures. Because again, I am here because we are getting so many complaints that things are taking long.

With regards to the 1.3 million figure for claims, are those new claims filed or that is just existing claims——

Mr. MURPHY. You mean like in original claims?

Mr. HARRIS. Yes. Where is the 1.3 million, that figure that comes in the report?

Mr. MURPHY. Depending on the time of year that you are looking 20 to 30 percent are new original never been seen before claims. The remainder are claims for increase and other types of changes to existing claims.

Mr. HARRIS. Okay. So when the figure is that 1.3 million claims are filed, 1 million processed, what happens to those other 300,000? I mean do they just—we haven't gotten around to them or is that where the backlog is occurring?

Mr. MURPHY. No, the backlog is all across is board, and the backlog is actually a measure of any case, with the date clock being the date that it becomes a formal claim, and it is measured from any claim that is longer than 125 days since the date it was filed it becomes a part of the backlog.

So no, it doesn't matter where you are in that 1.3 million.

Mr. HARRIS. And what has been happening to the number of backlog claims in the past year? What has been happening?

Mr. MURPHY. We struggle internally a lot with what we call working the right next claim, and the process of developing a claim there is a series of gathering evidence steps that you go through from service treatment records to private medical records to examinations, et cetera, and the secret to our success is going to be that we work the claim that is ready to be rated and moved to the rating board next.

When all of the evidence is presented, it is in the right format, it is in the right way and it is ready to be made—a decision to be made.

So to look at it and say, well, this one was a simple one issue claim or this one was a new claim or a claim for increase, it doesn't matter. The next claim that has all the evidence that is ready to proceed to the rating board goes to the rating board and that is the one the rater works on.

Mr. HARRIS. So what are the specific ways you are going to deal with those 300,000 cases that were—you know, the difference between the new claims and the claims that were processed?

I mean I know the digital claim system is one, but I am a little skeptical that that will acutely affect it, except in a negative way, because for instance whenever you take a health system, and you know the VA system has the finest electronic record in the world, I will bet you it took a while of in that transition things actually slowed down a little bit.

How are you doing to deal with that as you go toward digital claims? I am afraid we are just going to—you know, that backlog is going to grow, not shrink.

Mr. MURPHY. Absolutely. We have a 5-year forecast knowing what the number of claims is going to be, looking at 2, 3, 4, 5 years down the road, and the answer is how do we take care of those veterans in less than 125 days like the secretary has stated as our goal and do it with the resources that we have currently on board? And the answer to that is, the only way we are going to be able to do that is we need to get out of the paper world and into the digital world.

Very shortly you are going to see the introduction of something called the Vonac Direct Connect, VDC, it is a 526 claim for disability done in electronic format.

Think something along the lines of your Turbo Tax interview process completed electronically. At the same time the veteran has the opportunity to submit any private evidence that they want considered in the case, and what just that little bit that I just described to you takes months out of our process.

Mr. HARRIS. Just as a benchmark what are the percent of claims that are handled in less than 125 days?

Mr. MURPHY. Forty-four percent, quoting Mr. McNerney's numbers earlier talking about 66 percent being in the backlog, so the inverse of that would be true, the other 44 percent would not be.

Mr. HARRIS. Thank you so very much and thanks to all the Members sitting at the witness table for taking care of our men and women in uniform and who have been in uniform.

Thank you.

Mr. RUNYAN. Thank you, Mr. Harris, and I know the Ranking Member and I have a couple more questions so we will get another round in quickly.

Mr. Campbell, what purpose does the DoD have in actually giving a percentage of disability? For example, why is it that you have to make a rating just say fit or unfit?

Mr. CAMPBELL. I am sorry, would you repeat the question? I am sorry.

Mr. RUNYAN. The purpose of the DoD making a disability rating instead of just an up or down on whether they are fit for service or unfit for service, what is the purpose there in the DoD?

Mr. CAMPBELL. That is what we are required to do under current legislation.

Mr. RUNYAN. Are there thresholds in there that have to be met for certain pathways that they have to fit into as they are found—what is the threshold for fit, unfit in your service? To say you are not fit to continue.

Mr. CAMPBELL. There are a number of conditions that need to be met that you can actually do your job, whatever your MOS is, specifically able to perform the duties in a proper and efficient way.

There are more specifics, I mean I can get you the actual——

Mr. RUNYAN. No, my question is more of it is either able or not able.

Mr. CAMPBELL. Right.

Mr. RUNYAN. That is not part of the process, correct?

Mr. CAMPBELL. That is the determination that DoD makes.

Mr. RUNYAN. And it is just yes or no, up or down?

Mr. CAMPBELL. Right.

Mr. RUNYAN. There is no percentage involved in this of capability, disabled, there is none of that involved in that process? You are 10 percent disabled, 20, 30 percent disabled?

Mr. CAMPBELL. Can I ask Colonel Cassidy?

Mr. RUNYAN. Certainly.

Colonel CASSIDY. Sir, the standard for fitness is as Mr. Campbell indicated whether or not a soldier in the case of the Army can perform their duties in their MOS, whether or not there is an impact, the medical condition impacts their performance of duties in their MOS, whether or not it poses a risk to themselves or others, and the third criteria is maintaining that individual on active duty would impose a burden on the military to maintain that individual.

I think the percentage you are talking about is the threshold, the 30 percent disability rating that is required to receive a military retirement. That is a second order type decision. The first decision that all physical evaluation boards make is whether or not the servicemember is fit or unfit for each condition, for all conditions that are identified, then under the integrated service we turn the case over to the VA to actually determine the ratings for each condition and then the VA provides those ratings back to the military and we accept the rating for the military unfitting conditions, which are a subset of all service connected conditions.

Mr. RUNYAN. Thank you very much.

Mr. McNerney.

Mr. MCNERNEY. Thank you, Mr. Chairman.

I have a couple things on my mind regarding questionnaires. Mr. Murphy, you mentioned the DBQ, and also I was concerned about the WLQ, the work limitation questionnaire. How extensive are these questionnaires, how long does it take to go through them?

I mean one of the things that was mentioned in the prior panels was a 30-minute interview by a mental specialist is not sufficient to give a proper disability rating. So how reliable are these kind of questionnaires and what is involved in it?

Mr. MURPHY. They are extremely reliable. And the reason I say that with confidence is they were written by my staff in conjunction with the VHA doctors, with the Board of Veterans Appeal, Office of General Counsel, we had some VSO involvement, all the players, all the stakeholders that are involved in this process sitting down and over the course of months for each one of these DBQs going through and lining up exactly the questions that need to be answered in order to rate that veteran.

So what happened in the process is we lined up the disability benefits questionnaire with the condition in the VASRD. So when you are completing the DBQ you are taking the rater to the right parts, to the right decision points in the VASRD, which is one of the concerns raised by the earlier panel was the consistency in rating decision, and my answer to that was the DBQ will significantly improve that quality and consistency and that is how it is going to happen.

Mr. MCNERNEY. And you mentioned, it would be in the future similar to a Turbo Tax interview. And when you do Turbo Tax you also have to have your paperwork behind you. How would you enforce or verify the veteran's answers?

Mr. MURPHY. With secure access through eBenefits level two similar to the way you would access your bank account. We can positively identify who the individual is. The form then becomes prepopulated with the information that we know about that veteran, and as we talked just a few moments ago, 60 to 70 percent or 70 to 80 percent of the veterans are claimed for increase, we already have a history of that veteran.

So when the veteran comes in to file that claim form I prepopulate it with the information from that individual veteran and then they explain to us what the additional conditions or increased impacts are and then we assess it from there.

For a new veteran coming in it would be as simple as we prepopulate the information from our DE214 service records and other service treatment records that we may already be in possession of for that individual.

Mr. MCNERNEY. Okay, sounds reasonable.

How long would it take for a veteran to finish one of these questionnaires?

Mr. MURPHY. Going through what we call the wiring diagram, electronic version of it that I sat through last week, 30, 45 minutes on a relatively simple case.

It obviously has to be tied back to the complexity and the number of contentions that the individual is doing and the individual circumstances for that veteran.

Mr. MCNERNEY. Well, one of the inconsistencies that I am aware of is veterans with mental disabilities are generally speaking not

able to work and continue to receive disability benefits. Is that something that we can address here?

Mr. MURPHY. Are we talking back to tying that back to the completing the electronic claim?

Mr. MURPHY. Yes. That is absolutely one of the issues being addressed in the revision of the VASRD.

What we don't want to do is we don't want to put a negative incentive saying that if——

Mr. MCNERNEY. Right.

Mr. MURPHY [continuing]. I receive treatment, I become better and I go back to work, I put a negative disincentive to stay home because if I go to work it is just going to offset what I am already making by sitting at home. So that is being addressed in the draft regulations.

Mr. MCNERNEY. Okay, Mr. Chairman, I yield back.

Mr. RUNYAN. All right, Mr. Walz, nothing further?

I thank you gentlemen on behalf of the Subcommittee for your testimony and we again welcome working closely with all of you as we tackle these impacts that we are having on our veterans, and you all are excused.

I now invite General James Terry Scott to the witness table. General Scott is the Chairman of the Advisory Committee on Disability Compensation.

I welcome you, General, and your complete statement will now be entered into the hearing record and you are recognized for five minutes.

Sir, is your mic on?

General SCOTT. I think it is on now.

Mr. RUNYAN. There we go. Thank you.

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

General SCOTT. Okay. I am glad to be here with you today representing the Advisory Committee on Disability Compensation.

This Committee is chartered by the Secretary of Veterans Affairs under the provisions of the U.S. Code and in compliance with Public Law 110–389 to advise the secretary with respect to the maintenance and periodic readjustment of the VA Schedule for Rating Disabilities.

Your letter asked me to testify on the Advisory Committee's work to date and my views on the work being done by the VA to update the disability rating system.

Our focus has been in three areas of disability compensation. Requirements and methodology for reviewing and updating the VASRD; the adequacy and sequencing of transition compensation and procedures for servicemembers transitioning to veteran status; and disability compensation for non-economic loss, often called quality of life.

I am prepared to answer questions about these areas of focus. These are now for the record.

After coordination with the secretary's office and the senior VA staff we have added review of individual unemployment, review of the methodology for determining presumptions, and review of the

appeals process as it pertains to the timely and accurate award of disability compensation. These issues will be addressed in our next report to the secretary and the Congress.

Regarding the current project to update the disability rating system I believe the project management plan that the VA has laid out will achieve the goals sought by all.

The revised VASRD will be a guide for veterans, medical examiners, and claims adjudicators that is simpler, fairer, and more consistent than the current process.

The secretary and the VBA should be commended for undertaking this long overdue revision, which has been repeatedly called for by the Congress as well as numerous boards, studies, and reports.

Some of you may recall former Senator Dole's observation at the congressional out brief of the Dole-Shalala Commission where he said that the VASRD at that time was 600 pages of band-aids. While perhaps an overstatement, his views reflect those of many of the participants in commissions and studies.

The revision of the VASRD is not a stand alone operation, it is part of a larger effort that includes electronics claims filing, use of disability questionnaires, and improved claims visibility at all stages.

In my judgment, many of the current VBA initiatives depend on a successful and accepted revision of the rating schedule.

Some stakeholders have expressed concern that the revision effort may adversely affect current and future veterans. My own view is that if properly done the revision will simplify and expedite claims preparation, medical examinations, and claims adjudication. These will in turn help the VBA reduce processing time and increase accuracy.

Consistency among raters and regional offices, another recurring area of concern, should be improved.

There is an inherent resistance to change that must be overcome through involving all the stakeholders in the process and insuring that the purpose and results of the revisions are understood.

A concern, which I share, is that the process is not scheduled for completion until 2016; however, the scope and complexity of revising and updating all 15 body systems is daunting.

The first major step, gathering and assembling the medical data for all body systems, is well along. The forums at which each body system has been discussed by leading medical experts have resulted in broad agreement on how to update medical terminology and medical advances.

The work groups of subject-matter experts for each body systems are now analyzing the results of the forums in order to develop specific proposed changes to the schedule.

The econometric data sought in conjunction with George Washington University will assist in determining the relationship between specific conditions and average impairment of earnings loss.

The process, to include publishing draft changes in the *Federal Register* offers all stakeholders an opportunity to request clarifications and make comments. I believe that this step will protect current and future veterans from unintended consequences as revisions move toward implementation.

The Advisory Committee is involved in all steps in this rating schedule revision process. As an outside advisory committee we are able to offer advice and suggestions directly to the secretary and VA management. We listen closely to the subject-matter experts from outside sources who meet with us as well as to the VA professionals who are leading the effort. The members have an opportunity to ask questions, offer suggestions, and track the progress of the revision. We are a sounding board for options and proposals.

The committee includes experience and expertise from DoD, VA, the congressional staff, disability law, family programs, and the VSO community. Our meetings are open to the public.

Some of the presenters who come from the outside have somewhat radical or out of the box ideas. We listen to them carefully and move on.

And one of the problems we occasionally run into is that an outside presenter with a very you might call an innovative solution to our problems may propose a solution that causes people's hair to get on fire, but we have that under control. That is just one person's presentation.

In conclusion, Mr. Chairman, the Advisory Committee on Disability Compensation is deeply involved in the VA project to revise the VASRD.

We appreciate the openness of the VA leadership and staff to our questions and recommendations. We recognize that even the best revisions will not solve all the complex issues of disability compensation, but the members believe that the updated schedule will address many of the noted shortcomings of the current version, such as outdated medical terminology, outdated diagnosis and treatment regiments for illnesses and injuries, changes in today's social and work environment, and the apparent earnings loss disparities between mental and physical disabilities. It will also offer an institutional process for future updates.

Thank you for your attention and the opportunity to testify. I look forward to any questions you may have.

[The prepared statement of James Terry Scott appears on p. 61.]

Mr. RUNYAN. I will start the questions. Addressing this committee last year put forth a recommendation to develop and implement new criteria specific to PTSD in the VA Schedule for Ratings Disabilities. Can you identify those deficiencies veterans with PTSD could suffer with the current schedule?

Obviously the problems that we have and obviously dealing with mental disorders right now I think and talking to people it is still kind of a gray area and there is a lot to learn scientifically on how we move forward, but what are they specifically in the ratings?

General SCOTT. Well, the Center for Naval Analysis on behalf of the VDBC, which I chaired some years ago, their analysis showed that veterans suffering from mental disabilities were undercompensated across the board based on their average earnings loss, and they also showed that those with physical disabilities were compensated quote about right.

So one of the things that we are looking at is how do we think about changing the rating schedule to accommodate that?

You know, 100 percent is 100 percent, So that is about all, you know, you can't really go above that, but what I think you are

going to see at the end of the day is that PTSD, the degree of disability associated with PTSD is going to be recognized in terms of a higher percentage of disability rating that is assigned. In other words, I think you will see more people who are suffering from the more severe PTSD rated at 100 percent or at 70 percent as opposed to the lower percentage that the current criteria seems to place them at.

Does that answer your question, sir?

Mr. RUNYAN. Well, I think it is being done inside the revision of the mental disability body system. That is in my judgment probably the very toughest one of the body systems to revise. None of them are easy, but this one is certainly the toughest because there is a certain amount of subjectivity involved in this as we all recognize.

So you have to get a good diagnosis, and I think that the medical community that has been working with the revision is well on the way to that.

The second thing is you have to say well, how bad is this? What is the average earnings loss going to be for this individual?

And I keep coming back to that because that is the basis of which as you well know, sir, that disability is compensated, that is what—there is a lot of discussion about well, what about quality of life and all that, and it is very important, and I have some strong views on that, but the statutory or the legislative ability to deal with the disabilities is pretty much centered on average earnings loss.

And I believe that that will get us pretty far down the road of saying, okay, well, this individual is suffering so greatly from either PTSD or a combination of problems that he will be rated at 100 percent as opposed to something less than that for people who aren't.

And I realize that is a major concern of all the stakeholders, is how can you fairly do that? And I believe we are going to come up with it. I know there is some concern about that.

I believe that the VA is going to come up with it.

General SCOTT. Right.

Mr. RUNYAN [continuing]. And you know, I have had the discussion with many people, do we actually have the manpower or the structure in the VA to establish a lot of that? And I think that is another question that arises with that.

So thank you for that.

Mr. McNerney.

Mr. MCNERNEY. Thank you, Mr. Chairman.

Thank you, Lieutenant General Scott for your hard work, for your service to our country, and for your free and thoughtful answers here this morning.

There has been a lot of discussion about the quality of life and including a component in the scale of rating. Do you have any idea how the VA can go about—I mean you said earlier that you have strong ideas on this issue—on what tools they have that might be available in the short term?

General SCOTT. Well quickly I think there are two ways that you can look at quality of life. You can look at it as it exists today in saying, okay, there are some imputed quality of life compensations

imbedded in the system as it exists now, and I would include to some extend the special monthly compensation, some part of that, and in some cases where there appears to be an overcompensation based on degree of disability, and you can also say that many of the other things that the VA does address quality of life.

One could start with medical care if you wanted to. You could talk about many of the things that the VA and the DoD are doing together regarding making transition easier, you can talk about the family care legislation that was passed by the Congress recently.

So you can take a position that there is currently some compensation for loss of quality of life or you can take the position that there should be a separate compensation program for quality of life.

My personal view on that is that if that is the direction that the Congress and the VA want to go that it needs to in many ways model the special monthly compensation program so that the criteria are clear and definite and that the quality of life additional payment, if you will, goes to people who obviously, clearly, and without question have lost some quality of life.

The studies that were done for the VDBC would indicate that at some of the lower levels of disability there is not significant loss in quality of life, but that at the higher levels, particularly when you start talking about paralysis, amputations, blindness, and on and on, the very serious disabilities that an argument can be made that there is so much quality of life that is not compensated by the current system that it should be addressed.

What the VDBC said was that we should consider and up to a 25-percent increase in the compensation for serious loss of quality of life. Now up to, that is how we get to the very seriously disabled where it is obvious cases that quality of life is tremendously impacted, and it also addresses the issue that at some of the lower levels it is—the data would show that there is not a significant impairment to quality of life, and that would be my position on it, and that is my position only, not reflecting the Committee's or the VA's.

Mr. MCNERNEY. So do you identify any tools that could be used in helping to quantify quality of life impairment?

General SCOTT. I think it would start with what is the degree of degradation of quality of life based on the physical or mental disability?

In other words, I think if you could start by looking at people who are in the 100 percent category or somewhere near that and that is where you would start looking to see how much degradation of quality of life might be associated with their particular disability.

But again, I think the parameters have to be clear as to what we are talking about, what disabilities we are talking about, what impacts, it would have to be some pretty complex legislation or rule making, because what you don't want to do is organize a parallel system that more or less encourages people to seek a higher level of disability compensation in order to break into the area where quality of life might be added on.

In other words, you can't just base it on percentages, it has to be based on something besides that.

Mr. MCNERNEY. Okay, thank you, Lieutenant General.

Mr. RUNYAN. Thank you, Mr. McNerney.

Mr. Walz.

Mr. WALZ. Thank you, Chairman.

Thank you, General. I think your last statement was very true, I think about it for most of us quality of life on the lowest of the disability ratings is hearing is certainly impacted if you can't hear your children in the morning or whatever it might be.

General SCOTT. Right.

Mr. WALZ. So this is a complex issue.

I will ask you, General. You sat here and you got to hear, and I would argue that both the panels are advocates for veterans, but we heard our VSOs and some folks on the first panel, experts in VA and DoD, how do you respond to some of the things that you heard during that, some of the suggestions, maybe the individual physician assessments and some of those types of things?

I know it is a very generalized question, but it worked out well that you got to hear both sides and your job is unique that you are a VA under law entity, but you are advocating for all those veterans.

General SCOTT. Well, I will be glad to make a couple comments about ICD if you would like.

Mr. WALZ. Yeah, that would be great.

General SCOTT. What the Veterans Disability Commission recommended regarding ICD is that it be considered as an appendix to the regulation. So it is there, it can be used, it should be used, but the problem with incorporating it in with the regulation then it really gets tough to change, but if you made it an appendix to the regulation then when they go to ICD–10, which I think is in the mill somewhere right now, then you just change an appendix and we don't have to try to get a regulation change done.

So to me that gives the opportunity for the medical professional who is doing the examination to use the standardized codes that are well understood by all without getting into, well, you know, now we have chipped it into cement by putting it into the regulation as ICD–9, and then as we all know sooner or later it is ICD–10 and then it is 11, and so what do you do, but you could change an appendix without having to go back and change the regulation, if I understand it right.

So that would be the approach that I would take to integrate the ICD, kind of the commonly accepted medical terminology into the system.

Also understanding as was pointed out by some others that there are unique situations and medical conditions that are not going to be found in the ICD, and they will still have to be worked into the VA system through the regulation.

In other words, there are some things are aren't going to be covered by ICD–9 or 10 or 11 or whatever and they are going have to be accounted for.

And one of the things that I believe that this revision will do, I think it will make it less of a requirement to use individual unemployment as a catchall for people that you don't know what to do with.

In other words, if we get this revision right it should be clear enough that the disabilities of the veteran fall into categories and

we should get the percentages right so that we don't have a huge number of people that can't work, but their disability is not recognized inside the system at say the 100 percent level or whatever.

And so I think we can over time in the long run reduce the number of instances of individual unemployment by getting the revisions right.

One of the other things that was mentioned was outreach. Somebody mentioned what is the outreach program? I would give Secretary Shinseki very high marks for attempting to outreach to the veterans' community and to the DoD for outreach to the servicemembers before they leave the service.

Some years ago it was all pretty perfunctory when people left the service. You would say, well, there is nothing wrong with you so we are not going give you a physical and you don't really need to see anybody, good-bye, here is your DD214. And what occurred then is that you had people who later on developed problems and sometimes it took a long time to get them as you mentioned, sir, get in the system and get them working.

So the DoD is doing I think a very good job in increasing the outreach to people departing, and I think that Secretary Shinseki has done a very good job of getting outreach to veterans about how to apply and how to get into the system and all of that.

One of the things that the VDBC recommended was that all departing servicemembers from all services have an exit physical. We all got an entry physical when we went into the military, but it is still not really standard across the board in all the services for everyone that there is an exit service. If you do that then you have bookends. You have a you went in here and this was your condition, you came out here and this was your condition. It makes it lot easier for the VA.

Mr. WALZ. I couldn't agree more, and especially on the mental health screening, then we have a benchmark, we know where to go.

But overall if I could, I know my time just ran out, some of the—I wouldn't call them criticisms—but some of the critiques is, is the process open enough, is everybody getting their word in, and you on this committee are comfortable we are moving in the right direction, General?

General SCOTT. Again, speaking for myself. I am comfortable that the process is open. I mentioned our committee meetings are open to the public, so when someone comes in they—anyone can come in and listen and at the end of them we always say does anybody got anything to say, and it can be from the back benches someone can say, well, what about this or what about that.

I think that the process of developing the regulation that the VA is going through I think it is open in the sense that we start out the medical forums are open, people come to them and all of that, once the draft is put together—you know, somebody has to sit down with a blank piece of paper and a typewriter and make a draft, and once the draft is done, and then the draft needs to be passed around for comment, observation, and all of that, and the safety valve is a *Federal Register* where that draft reg has to be published for a certain amount of time, anybody that wants to can comment, and then it is up to VA to take all those comments and suggestions and integrate them as necessary into it.

And so that is a long answer to say yes, I think the system is as open as you can make it and keep it moving.

Mr. WALZ. I appreciate that.

Thank you, Mr. Chairman.

Mr. RUNYAN. Thank you, Mr. Walz.

General Scott, on behalf of the Subcommittee I thank you for your testimony and appreciate your hard work on behalf of our Nation's veterans and your attendance here today, and with that you are excused. Thank you.

I want to repeat my desire from the Subcommittee's first hearing last year, and that is to work with Members on both side of the aisle to insure that America's veterans receive the benefits they have earned in a timely and accurate manner, and I believe assessing and where necessary updating the present state of the disability rating schedule is another crucial step in the endeavor.

I ask unanimous consent that all Members have five legislative days to revise and extend their remarks and include extraneous material.

Hearing no objection so ordered.

I thank the Members for their attendance today and this hearing is now adjourned.

[Whereupon, at 12:18 p.m., the Subcommittee was adjourned.]

A P P E N D I X

Prepared Statement of Honorable Jon Runyan, Chairman, Subcommittee on Disability Assistance and Memorial Affairs

Good morning and welcome everyone. This oversight hearing of the Subcommittee on Disability Assistance and Memorial Affairs will now come to order.

We are here today to examine the Department of Veterans Affairs' current framework for rating veterans' injuries, illnesses, and disabilities resulting from service in our military.

As I mentioned during my opening remarks of our first hearing last year, my hope is that this meeting of minds sets a precedent and tone for a broader promise we have made to our veteran population for the remainder of this 112th session.

And that is to ensure the entire claims process, the delivery of earned benefits, and veterans medical services, is transformed into a fully efficient and modernized system equipped with the best tools available to aid our veteran population in the 21st century.

Several years ago, a Commission was established on Care for America's Returning Wounded Warriors led by former Senator Bob Dole and former Secretary of Health and Human Services Donna Shalala. The purpose of this commission was to examine the health care services provided by the VA and the Department of Defense to members of the military and returning veterans.

Around the same time, Congress created the Veterans' Disability Benefits Commission, established under the National Defense Authorization Act of 2004. The commission was created by Congress out of many of the same concerns we still hold today, including the timeliness of processing disabled veterans' claims for benefits.

This commission conducted a 2-year, indepth analysis of benefits and services available to veterans, and the processes and procedures used to determine eligibility. Their conclusions were published in a comprehensive report titled "Honoring the Call to Duty: Veterans' Disability Benefits in the 21st Century."

The end result of these reports were several recommendations, including the goal of updating and simplifying the disability determination and compensation system on a more frequent basis.

Although select portions of the ratings system have been updated throughout the last 20 years, these reports refer to the rating schedule as "outdated," noting that it has not been comprehensively revised since the conclusion of World War II.

They recommend the Rating Schedule be updated at recurrent and relative intervals, due to advances in medical and rehabilitative care, and a greater appreciation and understanding of certain disabilities, such as PTSD. The more recent updates to diagnostic criteria for newer types of injuries, such as TBI, were a step in the right direction.

However, I believe it is our duty to be vigilant in pressing for continued revision reflecting the continued advances and understanding in medical care and treatment. In addition, I am in agreement with their conclusion that a more candid emphasis on veteran quality of life should be taken into account in an updated ratings schedule.

Therefore, we are here today to honor our duty to the Nation's veterans. Just as we would not issue World War II era equipment and weapons to our current soldiers and Marines and expect them to be successful of the modern battlefield; we should not be satisfied with a World War II era system for evaluating and rating their disabilities as a result of their service and sacrifice to this Nation.

I want to thank the VA, the DoD, the present VSOs, and General Scott for their valuable input as we work together to find important solutions.

I welcome today's witnesses to continue this ongoing discussion and offer their own specific recommendations on how to improve the current system of rating our veterans' disabilities.

I would now call on the Ranking Member for his opening statement.

Prepared Statement of Honorable Jerry McNerney,
Ranking Democratic Member

Thank you, Mr. Chairman.

I would like to thank you for holding today's hearing.

As we have discussed over the course of many hearings in the 110th and 111th Congresses,the VA's claims processing system has many shortcomings which have left many disabled veterans without proper and timely compensation and other benefits to which they are rightfully entitled. Today, 66 percent of VA's 886,000 pending claims languish in backlog status (meaning longer than 125 days).

At the heart of this system is the VA Schedule for Rating Disabilities (or VASRD). 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 and psychological practices—and out of 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 prewar occupations. At the time, the American economy was primarily agricultural based and labor intensive.

Today's economy is different and the effects of disability may be greater than just the loss of earning capacity. Many disability specialists believe that loss of quality of life, functionality, and social adaptation may also be important factors.

Our Nation's disabled veterans deserve to have a system that is based on the most available and relevant medical knowledge. They do not deserve a system that in many instances is based on archaic criteria for medical and psychiatric evaluation instruments.

I know that Congress, in the Veterans' Benefits Improvement Act of 2008, P.L. 110–389, directed VA to update the VASRD and to delve into revising it based on modern medical concepts. I know that VA, in following this directive, has undertaken a comprehensive review of the VASRD, and I look forward to receiving a thorough update on its progress.

Congress also created the Disability Advisory Committee in P.L. 110–389. I welcome General Scott here today who is the Chair of that Committee and also welcome his insight. I look forward to the testimony today from all of the witnesses on the complex issues surrounding modernizing the VA Rating Schedule.

I know that 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 a comprehensive update. There are over 2.2 million veterans of the wars in Afghanistan and Iraq with 624,000 who have already filed disability claims. There are also so many veterans whose claims were not properly decided in the past because of the analogous-based subjectivity that is inherent in the current VASRD.

Since the DoD also relies on this system, and as we transition to the one exam platform under the Integrated Disability Examination System (IDES), bringing the VASRD into the 21st century is so critical. We must finish updating it without delay.

I look forward to working with you, Mr. Chairman, and the Members of this Subcommittee in providing stringent oversight of the VA Schedule for Rating Disabilities. VA needs to adopt the right tools to do the right thing, so that our Nation's disabled veterans get the right assistance they have earned and deserve.

Thank you, and I yield back.

Prepared Statement of Jeffrey C. Hall,
Assistant National Legislative Director of the Disabled American Veterans

Chairman Runyan, Ranking Member McNerney and Members of the Committee:

On behalf of the Disabled American Veterans and our 1.2 million members, all of whom are wartime disabled veterans, I am pleased to be here today to offer our views regarding the VA Schedule for Rating Disabilities.

Mr. Chairman, as you know VA disability compensation is a monthly benefit paid to veterans for disabilities resulting from active military service. The VA Schedule for Rating Disabilities (VASRD) is the determining mechanism to provide ratings for disability compensation. Divided into 15 body systems containing more than 700 diagnostic codes, the VASRD establishes disabilities by assigning percentages in 10 percent increments on a scale from 0 percent to 100 percent. As defined in title 38, United States Code, section 1155, ratings must be based on the "average impair-

ments of earning capacity," a term that has remained unchanged in the law for more than 50 years. Congress did not choose to use "actual earnings loss" or "average earnings loss," both of which would have very different results and implications. Under this system, a veteran who is able to overcome the impairments in bodily function caused by their disabilities and productively work is not punished by a reduction in disability compensation.

Since its last major revision to the VASRD in 1945, VA continued to make changes to account for new injuries and illnesses with the developments in medical sciences, however there has been no comprehensive review or update to ensure that disability categories, rating percentages and compensation levels were accurate, consistent and equitable for more than 60 years. In 2007, both the Congressionally mandated Veterans Disability Benefits Commission (VDBC), as well as the Institute of Medicine (IOM) Committee on Medical Evaluation of Veterans for Disability Compensation in its report "A 21st Century System for Evaluating Veterans for Disability Benefits," recommended that VA regularly update the VASRD to reflect the most up-to-date understanding of disabilities and how disabilities affect veterans' earnings capacity. In line with these recommendations, in 2010, the Veterans Benefits Administration (VBA) began a 5-year process to update each section of the VASRD, beginning with mental disorders and the musculoskeletal system. It is VBA's stated intention to continue regularly updating the entire VASRD every five years.

Additionally, pursuant to Public Law 110–389, Congress established the Advisory Committee on Disability Compensation (ACDC) to help implement the recommendations of the VDBC, specifically the effectiveness of the VASRD. One recommendation from the ACDC was that veterans service organization (VSO) stakeholders be consulted at several critical moments throughout the VASRD review and revision process, to ensure the expertise and perspectives of VSOs were incorporated to produce a better result. Unfortunately, over the past two years, there has been little opportunity for VSO input during the update and revision process. While VBA has held a number of public forums and made some efforts to include greater VSO participation, the process itself does not allow input during the crucial decisionmaking period. Because these public forums were conducted at the very beginning of the rating schedule review process, veterans service organizations were not able to provide informed comment, since VBA had not yet undertaken any review or research activities.

For example, a joint VBA–VHA mental health forum was held in January 2010 with VSOs invited to make presentations. Since that time, there has been no opportunity for further VSO review of or input to the revision process. Moreover, the VBA Revision Subcommittee tasked with doing the actual work on the VASRD update was not even formed at that time. Consequently, VSO and other stakeholder involvement really took place before the actual revision process had begun. While the public forum may be part of the official record, it is unclear whether any of the Subcommittee Members actually know of that input. Over the course of the next 2 years, there has been no transparency of the work of this Subcommittee and no opportunity to provide any input on the mental disorders VASRD update.

In August 2010, the VBA and VHA held a Musculoskeletal Forum, which also included a VSO panel. Additional public forums on other body systems have been held over the past year, each ostensibly offering an opportunity for VSO and public input. Some of these, however, were held in remote locations, such as Scottsdale, Arizona, which resulted in less of an opportunity for most VSOs to observe, much less offer any input. We do want to note that VBA has made an effort to increase the level of VSO participation at some of the public forums, however from that point forward the process has essentially been closed.

While we are appreciative of any outreach efforts, we are concerned that but for these initial public forums, VBA is not making any substantial efforts to include VSO input during the actual development of draft regulations for the updated rating schedule. Since the initial public meetings, VBA has not indicated it has any plans to involve VSOs at any other stage of the rating schedule update process other than what is required once a draft rule is published, at which time they are required by law to open the proposed rule to all public comment. We strongly believe VBA would benefit greatly from the collective and individual experience and expertise of VSOs and our service officers throughout the process of revising the VASRD. As the ACDC noted, it would have been helpful to include the experience and expertise of VSOs during its deliberations on revising the VASRD. Moreover, since VBA is committed to continual review and revision of the VASRD, we believe it would be advantageous to conduct reviews of the revision process itself so future body system rating schedule updates can benefit from "lessons learned" during prior body system updates.

Mr. Chairman, there is no question that the current VASRD for Mental Disorders (VASRD–MD) has some significant problems that must be addressed. As the nature of mental health disorders has become better understood, and increasing numbers of returning servicemembers have been diagnosed with such disorders, particularly PTSD, the flaws of the VASRD–MD have become increasingly apparent. Unlike most physical conditions, the majority of mental health disorders do not have visible symptoms that can be measured with precision. Since the rating schedule relies primarily on objective measures of symptomology, VBA has struggled to establish uniform and standard ratings for mental disorders. DAV and others who have studied the rating schedule have agreed that there is a need to revise and update the VASRD–MD in order to achieve consistency and parity for mental health disorders.

Unfortunately, however, it appears that VBA's efforts to revise and update the VASRD–MD are heading in a direction that could harm veterans suffering with mental health disorders and potentially threaten the integrity of the entire veterans disability compensation system.

Following the January 2010 VBA–VHA public forum on mental health disorders, VBA established a Revision Subcommittee to review and update the VASRD for mental disorders. Since that Subcommittee was established sometime in early 2010, DAV and other VSOs have had no opportunity to engage with or provide any input to that Subcommittee. However, based upon two public briefings made by the Subcommittee over the past year, it appears that they have gone beyond updating or revising the schedule, and instead are intending to completely throw out the current system and substitute a dramatically different process for rating and compensating veterans for service-connected mental health disorders.

At a December 2010 meeting of the Advisory Committee on Disability Compensation (ACDC), members of the Revision Subcommittee provided a Power Point briefing about their progress on updating the VASRD–MD. In that briefing, they stated clearly that they had "rejected" the entire rationale of the VASRD for mental disorders, and instead decided to create a brand new one that focused only on functional impairment, completely eliminating any consideration of social impairment or other non-work-related losses or quality of life issues. Rather than relying on medical judgments of the severity of mental health disorders to determine ratings, they were proposing to rely instead on the veteran's work performance. This would be a clear departure from almost a decade of consistent legislative history about the purpose of veterans disability compensation.

Mr. Chairman, over the past year, we have made repeated requests for VBA to explain the new rating system they have been developing, to answer questions about how and why they are moving in this direction, and to allow VSO stakeholders to share our input as they finalize this brand new mental health rating schedule. Since VBA has yet to respond to any of our requests, we are left with a number of troubling questions.

According to what was presented at the ACDC meeting, and confirmed again at the ACDC meeting in October 2011, the new mental health rating schedule would rely on how often a veteran was unable to work or was impaired in working effectively. For example, based upon their current draft proposal, a veteran who was unable to work 2 days per week would be rated at 100 percent, a veteran who had decreased work productivity or quality 2 days per week would be rated at 70 percent, a veteran who missed appointments or deadlines 1 day per week would be rated at 50 percent, and so on using various other combinations of work productivity and quality measures. Basically, the less a veteran worked, the more he or she would be compensated. In effect, rather than compensate for "average impairments of earning capacity," under this approach a veteran would be more closely compensated for his or her personal loss of earnings.

Such an approach is not only directly contrary to existing statute and legislative history and intent, it also raises a number of troubling questions about how such a system would work and what effects it would have on veterans and the disability compensation system.

For example, how would VBA measure a veteran's reduced work productivity? At the December 2010 ACDC briefing, the Subcommittee indicated that their proposal was based on a business and industry tool known as the Work Limitations Questionnaire (WLQ), which was developed to measure productivity losses for the business due to employees' health problems, and the impact that medical care and other intervention programs might have to mitigate such losses. The WLQ relied upon confidential responses from employees about how their health conditions were affecting their productivity and performance. Aggregating this data, the business or industry could then determine the economic cost of health problems, and the economic benefit of various treatment and intervention programs.

What is yet to be answered is how such a tool would work for the VA disability compensation program. Does VBA intend to use this same tool to determine how much compensation to pay a veteran? Will VBA simply rely on self-reporting to determine ratings or will they seek to verify the impact on work performance by contacting employers? How would they confirm or refute a veteran's contention that his mental health disorder is decreasing his work quality? Would VBA have to obtain and analyze employees' personnel records and performance reviews?

Such a system that looks only at the individual veteran's ability to work raises other troubling scenarios. What of a veteran who has a law degree, but whose severe PTSD makes it so difficult to work around other people that the only job he can perform is as a night watchman or janitor? Since he is able to work productively 40 hours per week, does that mean he is not entitled to any VA disability compensation?

Moreover, we are concerned about a statement made by VBA's Revision Subcommittee that this "... model based on the Work Limitations Questionnaire can be applied to service-connected disability in all body systems." What would that mean for other types of disorders? Would a veteran whose legs were blown off by an IED in Iraq, but who has struggled mightily to overcome that disability and is working productively in a full-time job, lose his disability compensation? Would a veteran who suffered severe burns and is in constant pain, but works through that pain, be denied full compensation?

We believe that disability percentages should be based on a medical determination with emphasis being placed upon limitations involving routine activities and not simply a prediction of how employment may be affected. In fact, title 38 of the Code of Federal Regulations, section 4.10, it states, in part, "[T]he basis of disability evaluations is the ability to function ... under ordinary conditions of daily life including employment ... a person may be too disabled to engage in employment even though he or she is up and about and fairly comfortable at home or upon limited activity." Conversely, even though an individual is able to engage in employment does not necessarily mean he or she is less disabled.

Mr. Chairman, we hope that this Subcommittee will seek answers to these and other questions about the ongoing VASRD update process to ensure the integrity and intent of the VA disability compensation system.

Finally, as VBA completes its ongoing update and revision of the rating schedule, we strongly believe that it is time for VA to develop and implement a system to compensate service-connected disabled veterans for loss of quality of life and other non-economic losses. Under the current VA disability compensation system, the purpose of the compensation is to make up for "average impairments of earning capacity," whereas the operational basis of the compensation is usually based on medical impairment. Neither of these models fully incorporate non-economic loss or quality of life into the final disability ratings, though special monthly compensation (SMC) does in some limited cases. SMC affords compensation beyond baseline ratings to individuals who suffer the loss or loss of use of one or more extremities, organs of special sense, as well as other similar disabilities. SMC is also provided to individuals whose service-connected disabilities leave them housebound or in need of the regular aid and attendance by another person. Similarly, when an individual's service-connected conditions are rated less than 100 percent, but they are unable to obtain or maintain substantially gainful employment, Individual Unemployability (IU) may be granted, which would allow compensation at the 100-percent rate, although he or she may be rated less than total.

However, none of these programs addresses the non-work losses that may be suffered by veterans as a result of their disabilities. While SMC may help pay for the additional costs a double amputee may incur through their daily activities, it does not compensate for the extra time, effort, or pain he or she goes through just to get up in the morning and move forward with the day. It certainly does not compensate for the loss of enjoyment in life activities that can result from severe disabilities.

In 2007, the Institute of Medicine looked at this issue and recommended that the current VA disability compensation system be expanded to include compensation for non-work disability (also referred to as "non-economic loss") and loss of quality of life. Non-work disability refers to limitations on the ability to engage in usual life activities other than work. This includes ability to engage in activities of daily living, such as bending, kneeling, or stooping, resulting from the impairment, and to participate in usual life activities, such as reading, learning, socializing, engaging in recreation, and maintaining family relationships. Loss of quality of life refers to the loss of physical, psychological, social, and economic well-being in one's life.

The IOM report stated, "[C]ongress and VA have implicitly recognized consequences in addition to work disability of impairments suffered by veterans in the

Rating Schedule and other ways. Modern concepts of disability include work disability, non-work disability, and quality of life (QOL). . . .''

After more than 2 years examining how the rating schedule might be modernized and updated, the VDBC agreed with the recommendations of the IOM study, and recommended that the, ''[v]eterans 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 of quality of life.''

The IOM report, the VDBC (and an associated Center for Naval Analysis study) and the President's Commission on Care for America's Returning Wounded Warriors (chaired by former Senator Bob Dole and former Secretary Donna Shalala) all agreed that the current benefits system should be reformed to include non-economic loss and quality of life as a factor in compensation.

In fact, other countries do just that. Both Australia and Canada provide a full range of benefits to disabled veterans similar to VA benefits, including health care, vocational rehabilitation, disability compensation and SMC-like payments. However, both Canada and Australia also provide a quality-of-life (QOL) payment.

Canada, under their Pension Act, includes a QOL component in its disability pensions. Much like VA's current system, the Canadian disability compensation system first determines functional or anatomical loss. After a rating has been assigned for a condition under the medical impairment table, a QOL rating is determined and the ratings added. In order to determine the QOL rating, the Canadian system looks at three components: the ability to participate in activities of independent living, the ability to take part in recreational and community activities, and the ability to initiate and take part in individual relationships.

The Australian Department of Veterans' Affairs also utilizes a system that combines medical impairment and functional loss with QOL interference. Unlike the Canadian system, which provides an individual QOL rating for each condition, the Australian model assigns an overall QOL rating based on total medical impairment. In order to determine the level of QOL impairment, the Australian system considers four categories: personal relationships, mobility, recreational and community activities and employment and domestic activities.

In closing, DAV believes that in addition to providing compensation to service-connected disabled veterans for their average loss of earnings capacity, VA must also include compensation for their non-economic loss and for loss of their quality of life. We strongly recommend that Congress and VA determine the most practical and equitable manner in which to provide compensation for non-economic loss and loss of quality of life and move expeditiously to implement this updated disability compensation program.

Mr. Chairman, DAV looks forward to working with you, as well as all of the Members of the Subcommittee, to protect and strengthen the benefits programs that serve our Nation's veterans, especially disabled veterans, their families and survivors. This concludes my statement and I would be happy to answer any questions.

Prepared Statement of Frank Logalbo, National Service Director, Benefits Service, Wounded Warrior Project

Chairman Runyan, Ranking Member McNerney, and Members of the Subcommittee:

Thank you for holding this hearing on VA's rating schedule and for inviting Wounded Warrior Project (WWP) to provide testimony.

This hearing is both timely and important given the responsibility of the Secretary of Veterans Affairs to ''adopt and apply a schedule of ratings of reductions in earning capacity from specific injuries or combinations of injuries . . . based as far as practicable, upon the average impairment of earning capacity resulting from such injuries in civil occupations . . . [and] from time to readjust this schedule of ratings in accordance with experience.'' [1]

As you know, VA's disability rating schedule has not been comprehensively revised or updated since 1945. Congress recognized the troubling implications of that gap in creating the Veterans' Disability Benefits Commission.[2] Importantly, among the Commission's recommendations in its 2007 report were that VA ''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, ad-

[1] 38 U.S.C. sec. 1155.

[2] National Defense Authorization Act of 2004, Public Law 108–136.

vances in medical knowledge and technology, and the evolving nature of warfare and military service.[3] Building on the Commission's findings and recommendations, Congress wisely directed VA to establish an Advisory Committee on Disability Compensation to advise the Secretary on the maintenance and periodic readjustment of the schedule of rating disabilities.[4] That Committee is playing a vital role in monitoring, questioning, and advising VA as it is working to update the disability rating schedule.

WWP brings a special perspective to this subject, reflecting its founding principle of warriors helping warriors. We pride ourselves on outstanding service programs that advance that ethic. Among those program efforts, WWP staff across the country work daily to help Wounded Warriors understand their entitlements and fully pursue VA benefits' claims. But our goal is broader: To ensure that this is the most successful, well-adjusted generation of veterans in our Nation's history.

Unique Impact of Mental Health Disability

From that perspective, we believe that perhaps no aspect of VA's work on modernizing its rating schedule may be more important than to bring the evaluation and rating of mental health conditions into the 21st century. It is very clear to us at WWP that combat-related mental health conditions are not only highly prevalent among OEF/OIF veterans and often severely disabling, but they have profound consequences for warriors' overall health, well-being, and economic adjustment. We see this in our day-to-day work with Wounded Warriors. Moreover, the annual surveys that WWP has conducted in partnership with RAND have confirmed those impressions, and provided us important data.

WWP's most recently completed survey of more than 5,800 servicemembers and veterans wounded after 9/11 found that one in three of the more than 2,300 respondents reported that mental health issues made it difficult to obtain employment or hold jobs.[5] Almost two-thirds of those surveyed reported that emotional problems had substantially interfered with work or regular activities during the previous 4 weeks.[6] And more than 62 percent indicated they were experiencing current depression (compared to a rate of 8.6 percent in the general population, and an earlier RAND projection of nearly 14 percent among OEF/OIF veterans generally).[7] Only 8 percent of respondents did not experience mental health concerns since deployment.[8] Of those surveyed, post-traumatic stress disorder was their most commonly identified health problem.[9] Questioned about their experience in theater, 83 percent had a friend who was seriously wounded or killed; 78 percent witnessed an accident that resulted in serious injury or death; 77 percent saw dead or seriously injured non-combatants; and 63 percent experienced six or more of these types of traumatic incidents.[10]

Asked to comment on the most challenging aspect of their transition, some two in five of those surveyed cited mental health issues. Their words are telling:

"I've been dealing with PTSD/Depression for many years now and it just seems to never go away. It affects my day to day activities. I seem to have lost my self purpose and interest."

"My main problems are being emotionally numb, isolation, freezing up in social environments, drugs and not having the desire or energy to put toward changing my situation any more. It has been over 5 years, and I am still just as bad as and even worse than when I came back."

"My greatest challenge is the feeling of uselessness and helplessness of coping with a mental illness."[11]

Some acknowledged finding help from VA therapists and clinics. Others had less positive experiences—commenting, for example, "the VA is overwhelmed at this point and discouraging for young troopers seeking care. . . . Too much medicine gets thrown at you. Each provider thinks they can solve the complex issue of PTSD/Com-

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[3] Veterans' Disability Benefits Commission Report, Honoring the Call to Duty: Veterans' Disability Benefits in the 21st Century, p. 4 (2007).
[4] Public Law 110–389 (October 10, 2008).
[5] WWP Survey, p. 67. In contrast to the one in three so responding, only about one in five identified "not physically capable" and "not qualified/lack of education" as creating greatest difficulty.
[6] Id., p. 34.
[7] Id., p. 41.
[8] Id., p. 53.
[9] Id., p. ii.
[10] Id., p. 16.
[11] Id., pp. 83–4.

bat Stress with meds." [12] Overall, our Wounded Warriors' battles with mental health issues underscore the importance not only of addressing substantial gaps in VA health care but significant challenges for the Veterans Benefits Administration.

Given the strong link between veterans' mental health and their achieving economic empowerment, it is vital that compensation for service-incurred mental health conditions be equitable and make up for lost earning power. But deep flaws in both VA evaluation procedures and its rating criteria pose real problems for warriors bearing psychic combat wounds.

Veterans seeking compensation for a mental health condition typically undergo a compensation and pension (C&P) examination, which is intended to develop documentation for disability-evaluation purposes, to include determining the severity of the condition. Where the examination and other pertinent evidence establishes a basis for a grant of service-connection for a mental health condition, adjudicators determine the level of compensation to be awarded by evaluating examination findings by reference to criteria for rating mental health disorders that have been codified in Federal regulation at 38 CFR sec. 4.130.

Flawed Mental Health Rating Criteria

To its credit, VA has acknowledged that its criteria for rating mental health disorders for compensation purposes need thoroughgoing revision,[13] and officials have stated that major studies agree that mental health issues have a greater impact on earnings than VA for which is currently compensating.[14]

Major changes are needed. An expert panel convened by the Institute of Medicine (focused specifically on PTSD) characterized VA's schedule of ratings for mental disorders (which is a single set of criteria for rating all mental disorders except eating disorders) as a crude, overly general instrument for assessing PTSD disability.[15] The IOM panel cited two major limitations in the rating criteria: First that it lumps everything into a single scheme, allowing for very little differentiation across specific conditions; second that occupational and social impairment is the driving factor for each level of disability, omitting consideration of secondary factors (such as frequency of symptoms or treatment intensity) used in rating physical disorders.[16]

The criteria's reliance on occupational and social impairment departs in a very fundamental way from the core principle that disability ratings are to be based on *average* impairments of earning capacity.[17] No other disability is rated by reference to "occupational impairment," and in any other instance under the rating criteria the actual impact of a veteran's occupational functioning would be irrelevant. The emphasis on occupational impairment throughout the criteria for rating mental disorders places the focus inappropriately on the individual veteran's capacity for employment, rather than on average impairment of earning capacity. We concur with the IOM panel's view that eliminating occupational impairment as the defining factor in rating mental health conditions would result in greater parity between the rating of mental and physical disorders.[18] It could also remove the disincentive to seeking gainful employment.

The mental health rating criteria are also unreasonably high. By way of example, the criteria for a 100 percent schedular rating require:

> "Total occupational and social impairment, due to such symptoms as: Gross impairment in thought processes or communication; persistent delusions or hallucinations; grossly inappropriate behavior; persistent danger of hurting self or others; intermittent inability to perform activities of daily living (including maintenance of minimal personal hygiene); disorientation to time or

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[12] Id., p. 90. Recent studies document the widespread off-label VA use of antipsychotic drugs to treat symptoms of PTSD, despite the recent finding that one such medication is no more effective than a placebo in reducing PTSD symptoms. Leslie, D., Mohamed, S., & Rosenheck, R., "Off-Label Use of Antipsychotic Medications in the Department of Veterans Affairs Health Care System" *Psychiatric Services, 60* (9), (2009) 1175–1181; Krystal, John H.; et al. (2011) "Adjunctive Risperidone Treatment for Antidepressant-Resistant Symptoms of Chronic Military Service-Related PTSD: A Randomized Trial," *JAMA*; 306(5), (August 3, 2011) 493–502.

[13] The Veterans Benefits Administration and Veterans Health Administration sponsored a "Mental Health Forum" on January 28–29, 2010 to begin a dialogue and process aimed at rulemaking to revise the rating criteria for mental disorders.

[14] Id.

[15] Committee on Veterans' Compensation for Post-Traumatic Stress Disorder, "PTSD Compensation and Military Service," National Academies Press (2007), p. 6.

[16] Id., at 156.

[17] 38 U.S.C. sec. 1155.

[18] Committee on Veterans' Compensation for Post-Traumatic Stress Disorder, "PTSD Compensation and Military Service," p. 157.

place; memory loss for names of close relatives, own occupation, or own name."

With such elements as "persistent danger of hurting self or others," the criteria more closely resemble the degree of impairment associated with psychiatric hospitalization or other institutional care than simply severe functional impairment. In other respects, the criteria describe such profound impairment as to render the individual unable to perform self-care. As such, they closely reflect the very high degree of impairment associated with eligibility for special monthly compensation based on a need for aid and attendance of another person.[19] Surely an individual who manifests "gross impairment in thought processes or communication," "persistent delusions or hallucinations," "grossly inappropriate behavior," "persistent danger of hurting self or others," or "disorientation to time or place," is in need of ongoing protective care. To set so high a bar for a 100 percent rating for a mental health disorder is not simply to blur the line between the 100 percent rating and the criteria for aid and attendance, but virtually to erase it.[20] The criteria for a 100 percent rating (and lesser percentage ratings) must be relaxed. But regulatory changes should also be made to ensure that veterans whose mental health status is as severely impaired as now reflected in the criteria for a 100 percent rating can receive special monthly compensation.

If mental disorders are to be rated under a single set of criteria, VA must enable adjudicators to take account of the many ways in which mental illness may manifest itself. For example, while the criteria for a 100 percent rating are intended to be applied to rate a very wide range of illnesses, they focus narrowly on profound schizophrenia.[21] As such, they provide virtually no basis for assigning a 100 percent rating for such widely prevalent and often profoundly disabling conditions as major depression, PTSD, and anxiety.

Finally, VA must ensure that compensation for mental health conditions replaces average loss in earnings capacity. Today it does not! As carefully documented in a detailed 2007 report to the Veterans Disability Benefits Commission ("the CNA Report"), it is important in assessing whether compensation replaces average lost earnings to distinguish between physical and mental disabilities. The CNA Report shows that average VA compensation for physical disabilities approximated lost earnings based on non-service-connected peer group earnings. In contrast, however, for veterans whose primary disability was a mental condition VA compensation fell below lost earnings, and for those who were severely disabled at a young age VA compensation fell substantially below lost earnings.[22] Similarly, CNA found substantial employment rate differentials between veterans with a primary physical disability and those with a mental one, with the average employment rate of service-disabled veterans with a mental health condition markedly lower than for veterans with a physical condition.[23]

In our view, VA must completely rewrite its rating criteria for mental disorders with the goal of fairness, reliability, and accuracy. In doing so, it must abandon principal reliance on occupational impairment, which has the effect of discouraging veterans from pursuing gainful employment and from achieving overall wellness. Criteria that evaluate disability on the basis of the applicable domain or domains that most affect an individual (as reflected in the rating criteria for traumatic brain injury, for example) offer a possible model for achieving greater reliability. Any such criteria must also reflect how disabling mental disorders actually are.

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[19] "... need for regular aid and attendance [due to] ... incapacity, physical or mental, which requires care or assistance on a regular basis to protect the claimant from the hazards or dangers incident to his or her daily environment." 38 CFR sec. 3.352(a).

[20] Given that the rating schedule sets so unreasonably high a level of impairment for a 100% rating, it is not surprising that the 70%, 50% and other rating levels also set the bar at unreasonably high points. To illustrate, an individual who experiences "near continuous panic or depression," "inability to establish or maintain effective relationships," "difficulty in adapting to stressful circumstances," and "neglect of personal appearance and hygiene,"—symptoms now entitling one to a 70% rating—cannot realistically be considered able to hold a job. It is hardly surprising, therefore, that a high percentage of veterans with a schedular 70% rating for a mental disorder receive a total disability rating based on individual unemployability. Likewise, the criteria for a 50% rating—impaired memory, judgment and thinking; difficulty in understanding complex demands, mood disturbance, weekly panic attacks, and difficulty in establishing and maintaining effective relationships—seem hardly consistent with the notion that such individuals, on average, have lost only half of their earning capacity. In short, these are not equitable criteria; they dramatically under-rate the extent of disability and earning capacity.

[21] See *http://www.schizophrenia.com/diag.php#common*.

[22] CNA Corp., "Final Report for the Veterans' Disability Benefits Commission: Compensation, Survey Results, and Selected Topics (August 2007), 3–4. Accessed at *http://www.cna.org/documents/D0016570.A2.pdf*.

[23] Id., 48.

Risk of Error in C&P Examinations

But even the most thoroughgoing revision of VA's criteria for rating PTSD, or mental disorders generally, will not by itself result in fair, accurate compensation awards. Currently, the claims-adjudication process relies heavily on an examination conducted by a psychologist or psychiatrist who typically has never met (let alone treated) the veteran before. In addition, VA C&P examinations of mental health conditions have long been criticized as superficial, and routinely fall far short of a VA best-practice manual, which suggests such an examination can take three or more hours to complete.[24] Years-old problems of too-hurried VA compensation examinations have not abated.

In response to a survey WWP conducted last year, more than one in five Wounded Warriors reported that VA C&P examination associated with the adjudication of their original PTSD claim was 30 minutes or less in duration. A recent VHA-conducted survey of its mental health clinicians found that over 26 percent of responding mental health providers said the need to perform compensation and pension examinations pulled them away from patient care.[25] Hurried, or less than comprehensive, C&P examinations heighten the risk of adverse outcomes, additional appeals, and long delays in veterans receiving benefits. It bears noting that meaningful evaluation of a mental health condition requires a painstaking inquiry that often depends on developing a trusted relationship with a client, on probing inquiry, and on sustained dialogue.[26] A brief, one-time office visit with a stranger is hardly conducive to such an encounter, and—disconnected from the claimant's community, home, and workplace or school, as applicable—provides only the most distant impression of the extent of disability.

VA mental-health compensation determinations should be based on the best evidence of a veteran's functional impairment associated with that service-connected condition. As such, we believe it is important to recognize the inherent limitations of C&P mental health examinations. An adjudication system aimed at accurately assessing functional impairment of a disabling mental health condition should seek a more reliable basis for assessment.

We urge this Committee to press VA to revise current policy and give much greater weight to the findings of mental health professionals who are treating the veteran, and are necessarily far more knowledgeable about his or her circumstances. To the extent that VA must still rely on C&P exams, strict measures should be instituted to ensure much more thorough, reliable exams.

Individual Unemployability

We believe there is yet another area in which VA compensation policy should be modernized. In this instance one of VA's compensation regulations has the effect of impeding many wounded veterans—particularly those with service-incurred mental health conditions—from overcoming disability and regaining productive life. By way of background, VA regulations have long provided a mechanism to address the situation where the rating schedule would assign a less than a 100 percent rating, but the veteran is nevertheless unable to work because of that service-connected condition. In instances where a veteran has a disability rating of 60 percent of or more, or at least one disability ratable at 40 percent or more and sufficient additional disability to bring the combined rating to 70 percent or more, VA may grant a 100 percent disability rating when it determines the veteran is "unable to follow a substantially gainful occupation as a result of service connected disabilities." This Individual Unemployability (IU) rating results in a very substantial increase in the veteran's compensation.

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[24] An Institute of Medicine (IOM) study on PTSD compensation reflected concern that VA mental health professionals often fail to adhere to recommended examination protocols. As an IOM panel member described it at a congressional hearing, "Testimony presented to our committee indicated that clinicians often feel pressured to severely constrain the time that they devote to conducting a PTSD Compensation and Pension ("C&P") examination—sometimes 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 three hours or more to properly complete." (Dean G. Kilpatrick, Ph.D., Committee on Veterans' Compensation for Post-Traumatic Stress Disorder, Institute of Medicine, Testimony before House Veterans' Affairs Committee Hearing on "The U.S. Department of Veterans Affairs Schedule for Rating Disabilities" Feb. 6, 2008, accessed at: http://veterans.house.gov/hearings/Testimony.aspx?TID = 638&Newsid=2075&Name=%20Dean%20G.%20Kilpatrick,%20Ph.D.

[25] Chairman Patty Murray, Letter to Robert A. Petzel, Under Secretary for Health, Department of Veterans Affairs (October 3, 2011).

[26] See Gold, et al. "AAPL Practice Guidelines for the Forensic Evaluation of Psychiatric Disability," *Journal of the American Academy of Psychiatry and the Law, (2008)* 36: S3–S49.

While veterans receiving IU are compensated at the same monetary level as those who receive a 100 percent rating, the implications for employment drastically differ. A veteran who receives a schedular rating of 100 percent for a disability other than a mental health condition is not precluded from gainful employment. But for veterans receiving IU, engaging in a substantially gainful occupation for a period of 12 consecutive months can result in a loss of IU benefits and a subsequent reduction in compensation benefits.[27] For some veterans, this can spell a sudden loss of as much as $1,700 in monthly income. Both the Institute of Medicine (IOM) and Veterans' Disability Benefits Commission have recognized this decrease as a "cash-cliff" that may deter some veterans from attempting to re-enter the work force.[28]

We concur with the recommendations of the IOM and Veterans' Disability Benefits Commission that the IU benefit should be restructured to encourage veterans to reenter the work force. The experience of the Social Security Administration (SSA)—which has had success piloting a gradual, step-down approach to reducing benefits for beneficiaries who return to employment—offers a helpful model. SSA's experience has shown that, for those reentering the workplace, a gradual rather than sudden reduction in disability benefits not only allowed participants to minimize the financial risk of returning to work, but over time participants actually increased their earning levels above what they would have received in disability payments.[29] Inherent in this approach is the underlying assumption that individuals with disabilities can and will re-enter the work force if benefits are structured to encourage that opportunity.

Recognizing that employment often acts as a powerful tool in recovery and is an important aspect of community reintegration for this young generation of warriors, we believe VA should revise the IU benefit to foster those goals.

Compensation for service-connected disability is not only an earned benefit, it is critically important to most veterans' reintegration and economic empowerment, and particularly so for those struggling with the psychic wounds of war. VA has much work to do to make compensation for combat-related mental health conditions as fair as it should be. We look forward to working with the Department and this Subcommittee to realize that goal.

Prepared Statement of Theodore Jarvi, Past President, National Organization of Veterans' Advocates

The National Organization of Veterans' Advocates (NOVA) thanks Chairman Jon Runyan and Ranking Member Jerry McNerney for the opportunity to testify about the functional utility of the Disability Rating Schedule used by the Department of Veterans Affairs (VA).

NOVA is a not-for-profit 501(c)(6) educational membership organization incorporated in the District of Columbia in 1993. NOVA represents more than 500 attorneys and agents assisting tens of thousands of our Nation's military veterans, their widows, and their families obtain VA benefits. Our primary purpose is providing quality training to attorneys and non-attorney practitioners who represent veterans, surviving spouses, and dependents before VA, the U.S. Court of Appeals for Veterans Claims (Veterans Court), and the U.S. Court of Appeals for the Federal Circuit (Federal Circuit).

NOVA operates a full-time office in Washington, DC. Accompanying me is Paul Sullivan, our new NOVA Executive Director, who will assist this Subcommittee and staff with any followup questions regarding VA's disability claim adjudication process with the over-arching goal of assisting VA with providing timely and accurate disability compensation claim decisions.

One of NOVA's regular functions is monitoring and commenting on VA rulemaking. In this regard, NOVA submits comments on changes in the VA Schedule of Rating Disabilities (VASRD). This is an area of close scrutiny. NOVA also files challenges to VA rule making at the Federal Circuit when we believe VA rule changes may harm veterans or veterans' access to legal representation. Most recently, NOVA is challenging VA's unilateral and unannounced determination that

[27] 38 CFR sec. 3.343(c).

[28] Institute of Medicine, *A 21st Century System for Evaluating Veterans for Disability Benefits.* Committee on Medical Evaluation of Veterans for Disability Compensation, National Academies Press, 2007, 250, and Veterans' Disability Benefits Commission, *Honoring the Call to Duty: Veterans Disability Benefits in the 21st Century*, October 2007, 243.

[29] Social Security Administration, "Benefit Offset Pilot Demonstration—Connecticut Final Report." September 2009, accessed at: http://www.ssa.gov/disabilityresearch/offsetpilot.htm.

the Board of Veterans Appeals (BVA) would no longer be subject to a VA regulation it had followed for years.

NOVA files amicus briefs on behalf of claimants before the CAVC, the Federal Circuit and the Supreme Court of the United States. The CAVC recognized NOVA's work on behalf of veterans when the CAVC awarded the Hart T. Mankin Distinguished Service Award to NOVA in 2000. The positions stated in this testimony are approved by NOVA's Board of Directors and represent the shared experiences of NOVA's members as well as my own 20-year experience representing our veterans and their families before VA, the Veterans Court, and Federal Circuit.

NOVA's goals today are to work with Congress and VA to implement the following:

- Establish a VASRD based on impairment of earning capacity; focusing on the congressional requirement that VA compensate veterans for reductions in such *capacity* from service connected injuries, rather than totally on medically based criteria.
- Provide VA guidance concerning how vocational experts are to measure impairment of earning capacity.
- Establish a uniform system for evaluating medical disabilities using the 2007 recommendations of the Veterans' Disability Benefits Commission (VDBC), which featured disability standards used by VA's Veterans Health Administration (VHA), such as the International Classification of Diseases (ICD) and American Medical Association (AMA) guides, while retaining some of the unique conditions relevant for disabilities incurred during or aggravated by military service.
- Require VA to publish proposed VASRD revisions at the earliest possible date so an open dialogue on the issue can commence among interested stakeholders, especially NOVA.

PROBLEMS WITH THE VA DISABILITY RATING SCHEDULE ARE WELL KNOWN

VA regulations in the Code of Federal Regulations are divided into 75 different parts. Only one of those parts, Part IV, deals with the VASRD. There are 88 pages of narrative descriptions which attempt to cover nearly all of the many medical conditions that affect the human body and mind. VA's attempt falls short. For instance, the VASRD is not consistent with diagnostic classifications used by all other health care providers, including VHA.

The VASRD is a unique set of disability rating criteria first implemented in 1933. The list of qualifying disabilities was greatly expanded in 1945. There were changes again in 1988 and 1996. The existing VASRD is not totally static, but the construct has been fundamentally the same for nearly 80 years. Since 2001 VA pursued an extensive regulation rewrite program [1] in an effort to correct shortfalls in its regulations. As recently as last year, VA staff concluded the VASRD is ambiguous, poorly organized, stated in outdated or overly technical terms, and uses obsolete language.[2]

What happens when the VASRD fails to accurately identify a veteran's condition and/or disability? In those situations, the individual VA rating specialists compare a veteran's medical records to all the descriptions in the VASRD, and find one that comes *closest* (is analogous) to the veteran's condition. Predictably, this results in great variances in the official condition listed in VA records as well as the veteran's disability percentage. Common conditions such as Gastroesophageal Reflux Disease (GERD) and Irritable Bowel Syndrome (IBS) do not appear in the VASRD, so VA rating specialists must find something analogous to the veteran's symptoms. In another example of the incomplete VASRD, VA rating specialists have to know that veterans presenting with an unstable shoulder or elbow should be evaluated under one of the Codes for "flail joint" because it is an obsolete term unlikely to appear in the veteran's medical treatment records.

Selecting analogous codes is a difficult task for VA rating specialists who do not have medical training. VASRD remains incomplete and flawed as proven by the wide variation in disability payments found in VA ratings in different States and regions for veterans with similar ailments. Errors in VA adjudications arise not only from the employment of new and inexperienced claims adjudicators, but also from the difficulty in applying the VASRD.

Dispositions of veterans' appeals by the Veterans' Court provide an indication of the scope of VA's significant problem harming our veterans. In 2010 the Veterans' Court disposed of 4,959 VA appeals. Of those, only 741, or 15 percent, of BVA ap-

[1] http://www.va.gov/ORPM/Summary__of__Regulation__Rewrite__Project.asp.
[2] VA Regulation Rewrite Project: Update January 2011, McKevitt, Pine, Russo.

peal decisions were affirmed. Only 854, or 17 percent, of BVA decisions were dismissed for technical reasons. The Veterans Court found an astounding 3,062 VA decisions to be in error, in whole or in part, a staggering 62 percent. Not all of these VA errors were due to problems with the VASRD. However, many VA errors were traced back to VA's inadequate rating schedule. Because only about 10 percent of all BVA decisions are appealed, the likelihood exists that the problems are much wider spread than this measure suggests.

HOW ARE VETERANS AFFECTED?

If it is difficult for VA rating officials and VA appeals experts to apply the VASRD, then NOVA asks Congress to consider the serious difficulties faced by *unrepresented* veterans with complex disability compensation benefits claims. Veterans are still barred by law from obtaining legal assistance until they have been denied by VA for at least one condition at the Regional Office level. Unrepresented veterans must contend with finding, reading, and understanding VA's complex regulations on how to pursue their claims. Then veterans must somehow find and decode the VASRD as it applies to their specific disability claim decision. Because VA's rating schedule is so complex, our veterans might as well be handed the keys to the Starship Enterprise and told to explore the universe.

If a veteran is dissatisfied with a VA rating and seeks a private medical evaluation of his or her condition, the veteran's physician must be literally educated anew on the VASRD's obsolete and incomplete requirements. Private physicians rarely have time for such complicated tasks, even if they are willing to address the questions raised by faulty VA adjudication.

When the veteran's claim is adjudicated, VA's rating decision occasionally contains the VASRD code number which VA applies to the disability, but no more. The veteran is not provided with a copy of the VA examination used to rate the claim. The veteran is not alerted to the possibility that other VASRD codes may be equally applicable, or to the fact the rating was arrived at through the process of an analogous rating, or the range of severity of the condition within the VASRD code used.

Lack of information about how the VASRD codes are used significantly impacts the veteran's disability rating, often with a low rating as well as isolating the veteran from meaningful participation in adjudication of the claim. If the veteran later obtains legal representation, the representative starts out with a messy denial, or a minimal grant of benefits, flowing from an adjudication in which the veteran submitted little or no evidence because he could not understand VA's complex and adversarial VASRD-based system.

ARE CURRENT EFFORTS ENOUGH?

NOVA remains concerned VA's Regulation Rewrite Project is unfinished. NOVA remains pessimistic about the final product that may eventually emerge from VA's Regulation Rewrite Project. Our concern is well founded, based on prior VASRD revisions.

For instance, a final rule amending 38 CFR 4.75 through 4.84a was published in the *Federal Register* on November 10, 2008, at 73 FR 66543. This rule revised portions of the rating schedule addressing eye disabilities. Blind veterans are some of our most disabled, but VA's cumbersome revisions rendered obtaining accurate and timely decisions very difficult. This is doubly true because VA frequently elects to use non-medical doctor examiners to evaluate medically complex conditions. For example, VA often uses non-medical doctor optometrists to opine on complex medical questions such as the etiology of retinitis pigmentosa, or Leibers Optic Atrophy.

Another instance in which VA amendments of the VASRD worked to veterans' disadvantage is in the evaluation of spinal disabilities. In August 2003, the VA amended the VASRD by revising the portion dealing with spine disabilities. No one disputes the spine is a central element of the body, carrying an elaborate nerve network which operates the arms, neck, and legs. Back conditions are one of the most common kinds of all veterans' claims, and these conditions are often the most painfully disabling.

Despite the centrality of the spine in the body system, and the frequency with which back claims occur, the highest rating available in the VA's 2003 amendments for either the cervical or lumbar spine was 40 percent, absent ankylosis, a rare condition.[3] A higher rating was available, but only if the veteran is prescribed a certain amount of "bed rest" for his back condition.[4] A 40 percent rating means a veteran

[3] Ankylosis means fusion, which is 0 degrees of Range of Motion.

[4] 38 CFR §4.71a, DC 5243, Note 1 [For purposes of evaluations under diagnostic code 5243, an incapacitating episode is a period of acute signs and symptoms due to intervertebral disc syndrome that requires bed rest *prescribed by a physician and treatment by a physician*.]

with a profoundly painful back condition cannot even qualify as being unemployable under 38 CFR § 4.16 [5] unless the veteran finds a doctor willing to prescribe bed rest. The lack of a "bed rest" prescription often means compensation rated at 40 percent, or $541 per month, compared with a more accurate rating of 100 percent, or $2,673 per month. This represents a potential loss of more than $25,000 in disability benefits per year for the remainder of the veteran's life.

The hitch here is doctors often do not and will not prescribe "bed rest" for a bad back. It is contraindicated and possibly medical malpractice to do so.[6]

Another area of concern relates to dental disorders. The VASRD (VA Diagnostic Code 9913) provides for compensation for tooth loss only when there is bone loss due to in-service trauma or disease. While service connection for treatment purposes only may be granted for loss of teeth in service where there is no bone loss, such tooth loss without bone loss can also be very painful and disabling. We must ask why there is no provision for compensation in such circumstances.

There are many other examples. The VASRD is unresponsive to new diseases, developments, or advances in medical knowledge. Currently, when a VA rating specialist adjudicates a claim for GERD or IBS, the VA employee will find no Disability Code for those common conditions. Similarly, other more exotic conditions are absent.

What is the rating specialist to do in such circumstances? VA must go to 38 CFR § 4.20, which states, "When an unlisted condition is encountered it will be permissible to rate under a closely related disease or injury in which not only the functions affected, but the anatomical localization and symptomatology are closely analogous." VA rating specialists rarely ask medical experts what is *most* "analogous" to the veteran's condition. Instead, VA staff engage in a hit-or-miss estimate, often to the veteran's detriment.

VA's Diagnostic Codes (DC) should be regularly updated to provide new DCs and evaluative criteria for new conditions, and VA rating specialists should be directed to seek medical expertise before selecting analogous DCs.

WHAT SHOULD BE DONE?

To determine what should be done to provide the greatest benefits for our veterans, we can look to the past for guidance to avoid repeating preventable and harmful mistakes.

In May 2005, the Veterans' Disability Benefits Commission (DRBC), established by Congress to review benefits going to disabled veterans and the survivors of deceased veterans, held meetings in Washington, D.C. Congress instructed it to examine three specific issues:

- the "appropriateness" of compensation and other benefits for disabled veterans and for the survivors of veterans who died from causes related to military service;
- "the appropriateness of the level of such benefits"; and
- "the appropriate standard . . . for determining whether a disability or death of a veteran should be compensated."

The 13-member DRBC, chaired by retired Army Lieutenant General James Terry Scott, then asked a distinguished panel of experts [7] (the "Committee") about (1) the advantages and disadvantages of adopting other universal medical diagnostic codes rather than the unique VA system, and (2) the advantages and disadvantages of using established guides for evaluation of permanent impairment (Guides) instead of the VASRD.

The resulting report of the Committee was far more comprehensive than any study or collection of anecdotal complaints compiled on the subject before or since. The Committee considered alternative diagnostic classification codes such as the International Classification of Diseases (ICD) maintained by the World Health Organization, the Social Security Administration system for its disability benefits program based loosely on the ICD–9–CM, and the American Medical Association Guides to the Evaluation of Permanent Impairment.

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[5] Sixty percent is the schedular requirement for unemployability consideration.

[6] "Bed Rest for Acute Low-Back Pain and Sciatica (Review)" Hagen, Hilde, Jamtvedt, Winnem; The Cochrane Library, 2009, Issue 4; "Treatment of Acute Low Back Pain—Literature Review" Knight, Deyo, Staiger, Wipf; Uptodate.com, March 10, 2011. UpToDate is a clinical decision support system that helps clinicians provide patient care using current evidence to answer clinical questions quickly at point of care.

[7] The Committee on Medical Evaluation of Veterans for Disability Compensation. See Chap 8 [Other Diagnostic Classification Systems and Rating Schedules], *A 21st Century System for Evaluating Veterans for Disability Benefits*. National Academies Press, 2007.

The Committee compared the relative strengths and weaknesses of each system. They noted how VASRD contains numerous instances of outdated terms and names, especially in the orthopedic section of the musculoskeletal and neurological systems, which have not changed since 1945. For instance it noted that VA raters must know that Parkinson's disease should be rated as *paralysis agitans*.

The Committee commented that traumatic brain injury (TBI) is the signature injury of the war in Iraq, but the VASRD's diagnostic code for brain disease due to trauma (DC 8045) had not been revised since 1961. They found that VA raters are directed to evaluate TBI according to its numerous neurological consequences, "such as hemiplegia, epileptiform seizures, facial nerve paralysis, etc.," and there is no other guidance in the VASRD for the rater to consider. This is a heavy burden to place on VA raters, and an impossible task for veterans who are trying to advocate on their own.

The Committee recognized switching to an entirely new system of disability codes would have significant consequences, but it pointed out that if VA must update its own VASRD, the same difficulties will arise. They found the cost of switching to a different set of codes would also be offset by the benefits veterans would gain by having a system aligned with modern medical practice and recordkeeping.

Based on its analysis, the Committee made two recommendations which sought to incorporate favorable features of both the ICD and the AMA Guides. They were:

> **Recommendation 8–1.** VA should adopt a new classification system using the International Classification of Diseases (ICD) and the Diagnostic and Statistical Manual of Mental Disorders (DSM) codes. This system should apply to all applications claims?, (apply to all applications?) including those that are denied. During the transition to ICD and DSM codes, VA can continue to use its own diagnostic codes, and subsequently track and analyze them comparatively for trends affecting veterans and for program planning purposes. Knowledge of an applicant's ICD or DSM codes should help raters, especially with the task of properly categorizing conditions.

> **Recommendation 8–2.** Considering *some of the unique conditions relevant for disability following military activities*, it would be preferable for VA to update and improve the Rating Schedule on a regular basis rather than adopt an impairment schedule developed for other purposes.

NOVA's RECOMMENDATIONS

1. Establish a VASRD based on impairment to earning capacity.

There are several steps which can be taken and should be required by Congress for VA to modernize its current rating schedule. NOVA believes vocational experts are better suited than doctors for meeting the intent of Congress in 38 U.S.C. § 1155 (the congressional requirement that VA compensate veterans for *reductions in earning capacity* from service-connected injuries).

Congress must decide whether the measurement or assessment of the degree of impairment of a veteran's earning capacity is a medical question or a vocational one. VA's VASRD treats the question exclusively as a medical issue. For instance, endocrinologists, cardiologists, or oncologists are routinely asked to determine if a veteran's medical condition renders him or her unemployable. This is totally outside the training and expertise of such specialists. In order to bring the VASRD into accord with the intent of the system, Congress should require VA to modify this medical model in favor of a medical/vocational model to assess a veteran's disability.

After doctors have identified and assessed a veteran's service-connected medical condition(s), VA should use that information to evaluate the impact on the veteran's earning capacity arising from the disability. This would be based on expert testimony of vocational experts who are in a better position to provide consistent impairment assessment of earning capacity. The use of medical personnel to assess earning capacity impairment defeats the goals expressed in U.S.C. § 1155 and CFR § 4.2.

Congress should provide VA guidance concerning how vocational experts are to measure impairment of earning capacity to prepare VA for the type of vocational assessment described above. Using this baseline, VA should ask vocational experts to compare the degree of a veteran's service-connected disability, using the 10 percent increments, as in 38 U.S.C. § 1114(a) through (j) to assess percentage reduction of the veteran's earning capacity.

The provisions of § 1114(a) through (j) provide a progressive set of standards which can be used to carry out VA's goal of compensating veterans for lost earnings.[8]

2. Establish a uniform system of evaluating medical disabilities using the informed recommendations of the Veterans' Disability Benefits Commission.

Despite NOVA's reservations about VA regulation making in general, we know the VASRD needs serious attention and revision. Additionally, VA's use of the VASRD must become more transparent to veterans.

Adoption of disability standards that are recognized outside VA, such as the ICD and AMA guides, ensures changes will not be made solely to save VA money at the expense of our wounded, injured, ill, and disabled veterans.

NOVA urges Congress to revisit the work of the Committee and the Veterans' Disability Benefits Commission which Congress commissioned.

VA rulemaking is inherently slow and, in almost every aspect of veterans' claims adjudication, VA makes delay its hallmark. NOVA fervently requests VA be pushed to publish its proposed VASRD revisions at the earliest possible date so an open dialogue on the issue can commence.

In conclusion, NOVA thanks the Subcommittee for its interest in VA's rating schedule, an issue we follow with significant interest. NOVA's leaders and staff are prepared to provide additional examples and assistance to Congress and VA in our continuing cooperative effort to improve the delivery of accurate and timely VA disability compensation claim benefits to our veterans.

Prepared Statement of Thomas J. Murphy, Director, Compensation Service, Veterans Benefits Administration (VBA)

Mr. Chairman and Members of the Subcommittee:

Thank you for the opportunity to testify on the state of the VA disability ratings schedule. The Department of Veterans Affairs (VA) Schedule for Rating Disabilities (rating schedule) is the engine through which VA is able to provide veterans with compensation for diseases and injuries they incur while serving our Nation. It is this rating schedule that guides the disability rating personnel of the Veterans Benefits Administration (VBA) and Department of Defense (DoD) in making the correct determination of the compensation benefit level applicable for a veteran's service-connected condition(s). The manner of rating veterans for their service-connected conditions has evolved since the 1917 War Risk Insurance Act created the first rating schedule that was used to calculate replacement of lost earnings for our veterans. This evolution continues as we update the rating schedule to include the signature injuries of our current wars.

Today, I will describe the history of the rating schedule and the statutory basis for our current schedule, 38 United States Code (U.S.C.) § 1155, and I will explain how VBA is actively and comprehensively ensuring that this legislative mandate is implemented effectively. To focus on the Subcommittee's concerns regarding the contemporary state of disability ratings, I will also describe VBA's current plan to ensure the rating schedule is as accurate and modernized as possible, to meet the needs of veterans in the 21st century.

I. *Rating Schedule's Authority and Brief History*

Section 1155 of Title 38, U.S.C., and the statute's implementing regulation, at 38 Code of Federal Regulations (CFR) § 4.1, require VA to assign veterans who are service-connected with percentage ratings that represent as far as practicable the average impairment in earning capacity resulting from diseases and injuries that were incurred or aggravated during active military service. This statutory and regulatory mandate is the current manifestation of a history of the rating schedule that has included various measures of disability. Section 1155 also provides that "[t]he schedule shall be constructed so as to provide ten grades of disability, and no more,

[8] (a) While a disability is rated 10 percent monthly compensation shall be $127; (b) while a disability is rated 20 percent monthly compensation shall be $251; (c) while a disability is rated 30 percent monthly compensation shall be $389; (d) while a disability is rated 40 percent monthly compensation shall be $560; (e) while a disability is rated 50 percent monthly compensation shall be $797; (f) while a disability is rated 60 percent monthly compensation shall be $1,009; (g) while a disability is rated 70 percent monthly compensation shall be $1,272; (h) while a disability is rated 80 percent monthly compensation shall be $1,478; (i) while a disability is rated 90 percent monthly compensation shall be $1,661; (j) while a disability is rated as total monthly compensation shall be $2,769.

upon which payments of compensation shall be based," with increments of 10 to the total 100 percent. Congress sets the associated dollar amount rates of compensation under 38 U.S.C. § 1114.

With the outset of the first rating schedule in 1917, the law focused on average loss of earning capacity as the measure for replacement of lost income for veterans. In 1925, lawmakers switched to an individual occupation-based evaluation of compensation before returning to the original concept of average impairments of earning capacity without regard to occupation under a new schedule in 1933. The schedule would undergo future revisions, notably in 1945, the year in which a system was developed that forms the baseline from which VA has developed the current rating schedule. Particularly, the 1945 rating schedule introduced three basic concepts that are still evident in today's scheme for rating veterans: (1) compensation that is based, to the extent possible, on average lost earnings capacity; (2) use of disability evaluations, and associated compensation ranges, from 10 percent through 100 percent disability, including a potential non-compensable zero percent evaluation for each disability; and (3) disabilities organized into 14 discrete body systems—for instance, musculoskeletal, digestive, organs of special sense, or mental disorders—with unique descriptive diagnostic codes for diseases and injuries within each system. The current rating schedule differs from the 1945 rating schedule due to periodic updates to individual body systems throughout the years and now contains diagnostic codes for 15 body systems. Revisions in 1961 updated the mental disorder diagnostic codes, which had been largely unchanged since 1933.

Starting in 1989, VA has incrementally revised the rating schedule many times with consideration given to the views of Veterans Health Administration (VHA) clinicians, VBA disability rating personnel, groups of non-VA medical specialists, and comments received from Veterans Service Organizations (VSOs), veterans, and other public and private interested stakeholders in response to various Notices of Proposed Rule Making.

II. *Increasing Focus on Rating Veterans' Disabilities: Recent Studies and a New VA Rating Schedule Initiative*

With increased interest turning to veterans' benefits and care, deservedly so due to the return of servicemembers from recent conflicts, various studies and commissions since 2007 have made many recommendations relating to VA's disability compensation program. Some studies and commission reports have proposed wholly new concepts for rating disabilities. Some of these recommendations for improvement have been outside the bounds of VA's current statutory authority based on average impairments of earning capacity; however, some recommendations have been within the scope of VA's mandate from Congress.

For example, the National Academy of Sciences' Institute of Medicine (IOM), in its 2007 report to the Veterans Disability Benefits Commission (VDBC), *A 21st Century System for Evaluating Veterans for Disability Benefits*, recommended, in part, that VA immediately update the current rating schedule, beginning with body systems that have been in place for a long time without a comprehensive update. The IOM report also recommended that VA devise a system for keeping the schedule up-to-date, and that VA regularly conduct research on the ability of the rating schedule to predict actual loss in earnings. The report additionally recommended that VA regularly use the results from research on the ability of the rating schedule to predict actual losses in earnings to revise the rating system, either by changing the rating criteria in the schedule or by adjusting the amount of compensation associated with each rating.

The 2007 VDBC report, *Honoring the Call to Duty: Veteran's Disability Benefits in the 21st Century*, recommended that priority be given to the mental disorders section of the rating schedule, urging that VA begin by updating those body systems that addressed the rating of post-traumatic stress disorder, other mental disorders, and traumatic brain injury. The report further recommended that VA address the other body systems until the rating schedule is comprehensively revised. Another recommendation, made by the President's Commission on Care for America's Returning Wounded Warriors in its 2007 report, *Serve, Support, Simplify*, is that the rating schedule focus on a veteran's ability to function directly instead of inferring it from physical impairments.

One major aspect of the previously mentioned VDBC report was the results of a survey study by the Center for Naval Analyses (CNA) on disability compensation as a replacement for the average impairment in earning capacity. It was determined that VA compensation, on average, is generally appropriate relative to earned income losses. However, the study found, particularly, that veterans with physical disabilities are properly compensated, while those with mental disabilities may be under-compensated. 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. While the study provided VA with an empirical basis for developing ways to correct any rating inconsistencies, it also confirmed that the current rating schedule generally provides fair compensation for lost earnings.

VA is moving forward with a complete revision of the rating schedule while understanding that the current rating schedule is in many aspects sufficient as an adequate proxy for earnings loss. The efforts VA is taking toward modernization will ensure it continues to effectively serve veterans.

In October 2009, following these studies and reports, VA began a comprehensive revision and update of all 15 body systems contained in the rating schedule. VBA has implemented a project management plan detailing the organizational, developmental, and supporting processes that will result in a complete modernization of the rating schedule by 2016. The plan calls for the application of current medical science and econometric earnings loss data, consistent with our charge in 38 U.S.C. § 1155. VBA's project management plan incorporates a comprehensive, systematic review process for each body system, to include an initial public forum intended to solicit updated medical information from governmental and private-sector subject matter experts, as well as input on needed improvements in the rating schedule from the public and interested stakeholders, such as Veterans Service Organizations. These forums have gathered medical science experts and interested stakeholders in a single meeting to engage in challenging dialogue and capture current medical information, all in the most transparent manner possible. In 2009, VA held mini-forums for the endocrine and hematologic/lymphatic systems. Public forums for the mental disorder and musculoskeletal systems were held in 2010. In the interest of expediting the rating schedule revision process, in 2011, VA held public forums regarding eight body systems: dental and oral conditions, the genitourinary system, the digestive system, rheumatologic diseases and immune disorders, infectious diseases, the cardiovascular system, the respiratory system, and the system addressing the impairment of auditory acuity.

As the next step in the plan, VA convened work groups of subject matter experts for each body system to assist in development of specific changes. A common theme emerging from the work groups analyzing the schedule is the need for a shift in focus in the rating criteria from a symptomatology-based system of rating to one which focuses on functional impairment. Subject matter experts involved with the revision process have concluded that while symptoms determine diagnosis, the translation of symptoms into functional impairments and overall disability is the indicator of impairment in earning capacity.

Another important aspect of the review process for each system is the execution of an econometric earnings loss study. Each study will provide the data necessary to determine whether current compensation rating levels accurately reflect the average impairment in earning capacity for specific conditions in the current rating schedule. They will help identify any discrepancies between earnings loss and VA disability compensation by analyzing if conditions are adequately compensated based on current associated evaluation levels. VA is partnering with The George Washington University in connection with five body systems to analyze income and benefits data to carry out these studies. VA may solicit proposals from other entities to carry out the studies for the remaining body systems.

To provide a more concrete example of our process, I would like to describe the steps VA has undertaken for one body system—the musculoskeletal system. In August 2010, clinical musculoskeletal experts, stakeholders, including Veterans Service Organizations and DoD officials, gathered in Washington D.C. for a public forum addressing musculoskeletal diseases and injuries. Following the public forum, the subject matter experts gathered to kick off the workgroup phase, using information obtained in the public forum to discuss areas of the current schedule potentially in need of revision. Over the next 10 months, the workgroup held periodic in-person meetings and teleconferences to craft revisions to the schedule. Simultaneously, The George Washington University began an earnings loss study for the musculoskeletal system. Drafting of a proposed rule revising the system has begun, and VA looks forward to publishing it in the *Federal Register* for public comment. When comments are received, we will consider each comment to determine whether changes to the proposed regulations for the body system are needed and will respond to each comment in a published final rule. Changes to the rating schedule for the body system will then become effective.

As noted earlier, VBA is committed to modernizing the rating schedule by 2016. Currently, proposed rules to revise three body systems are undergoing final review within VA, and drafts of proposed rules for ten more systems are underway, and all will incorporate the results of earnings loss studies. This week, public forums

to obtain the input of medical experts and interested stakeholders will be completed for the four remaining body systems.

While VA is nearing the completion of its modernization of the rating schedule, this effort does not signify the end of the initiative. VA intends to establish a process that requires continual review and more frequent updating of body systems. This will ensure America's veterans are compensated for their disabilities based on both cutting-edge medical science and the economic impacts of their disabilities resulting from military service.

III. *Conclusion*

VA recognizes the importance of ensuring that its Schedule for Rating Disabilities meets the needs of veterans in the 21st century. Through a successful modernization and revision of the rating schedule, VA is anticipating and proactively preparing for the needs of veterans and their families. VA is currently implementing a comprehensive initiative to modernize the rating schedule, with input from, DoD, VSOs, private-sector experts, members of the public, and Congress. VA continues to look for ways to improve the rating schedule and will consider changes and improvements that appropriately compensate our Nation's veterans while meeting the rating schedule's statutory mandate. VA looks forward to continued input from this Subcommittee, Congress, and other stakeholders in working together to ensure the best possible rating schedule for our Nation's veterans and their families.

Prepared Statement of John R. Campbell,
Deputy Assistant Secretary of Defense

Mr. Chairman and Members of the Subcommittee:

Thank you for the opportunity to be here today to discuss the use of the Department of Veterans Affairs Schedule for Rating Disabilities (VASRD) by the Department of Defense (DoD) in the Disability Evaluation System (DES). Codified in Title 38, the VASRD governs how the Department of Veterans Affairs (VA) compensates veterans for injuries and diseases acquired or aggravated during military service.

As you know, the Integrated Disability Evaluation System (IDES) integrates the DoD and VA DES processes in which servicemembers receive a single set of physical disability examinations conducted according to VA examination protocols, disability ratings prepared by VA, and simultaneous processing by both Departments to ensure the timely and quality delivery of disability benefits. Both Departments use the VA protocols for disability examination and the VA disability rating to make their respective determinations. DoD determines fitness for duty and compensates for unfitting conditions incurred in the line of duty (Title 10), while VA compensates for all disabilities incurred or aggravated during military service for which a disability rating is awarded and thus establishes eligibility for other VA benefits and services (Title 38).

To ensure more consistent disability ratings, the National Defense Authorization Act for Fiscal Year 2008 (P.L. 110–181) mandated the DoD to use the VASRD for disability ratings by the Physical Evaluation Board (PEB), including any applicable interpretation by the United States Court of Appeals for Veterans Claims, without exception. As a result, decisions on servicemember's medical retirement and disability compensation are tied to the VASRD. After a servicemember is declared unfit, VA uses the VASRD to determine the degree of disability resulting from the unfitting condition(s) and DoD then applies the VA rating to ascertain whether retirement or separation applies. A DoD disability rating of 30 percent or above qualifies for military retirement, while a disability rating below 30 percent qualifies for separation and severance pay.

The VASRD compensates for the average impairment in earning capacity resulting from such diseases and injuries and their residual conditions in civil occupations, and VA compensation ratings are based on the degree of impairment. As a result, there are some instances where VASRD ratings are not always relevant to DoD's requirements. Sleep apnea is an example of how VASRD ratings may not accurately reflect the degree of disability or even unfitting conditions. Under the VASRD, sleep apnea requiring continuous positive airway pressure (CPAP) treatment, would receive a rating of 50 percent. Although this condition might be unfitting for some military occupational specialties, many other military personnel would be able to continue on active duty and function very well with CPAP treatment.

VA is in the midst of a total rewrite of the VASRD and has solicited DoD expert participation in upcoming public workshops. We appreciate VA's outreach to include

DoD in the body system rating update review, and DoD plans to continue to participate in VA's public meetings. DoD and VA leadership are discussing how to strengthen DoD's role in the VASRD rewrite process. DoD very much looks forward to having an active voice in future development and modernization of the VASRD.

Mr. Chairman, the Department looks forward to continued collaboration with the VA in achieving the goal of ensuring both servicemembers and veterans are evaluated using the latest medical evaluation and diagnostic criteria. Once again, I appreciate the opportunity to discuss DoD's views on the modernization of the VASRD, and this concludes my statement.

Prepared Statement of James Terry Scott, Lieutenant General USA (Ret.), Chairman, Advisory Committee on Disability Compensation

Mr. Chairman and Members of the Subcommittee: It is my pleasure to appear before you today representing the Advisory Committee on Disability Compensation. The Committee is chartered by the Secretary of Veterans Affairs under the provisions of 38 U.S.C. in compliance with P.L. 110–389 to advise the Secretary with respect to the maintenance and periodic readjustment of the VA Schedule for Rating Disabilities. Our charter is to "(A)ssemble and review relevant information relating to the needs of veterans with disabilities; provide information relating to the character of disabilities arising from service in the Armed Forces; provide an ongoing assessment of the effectiveness of the VA's Schedule for Rating Disabilities; and provide ongoing advice on the most appropriate means of responding to the needs of veterans relating to disability compensation in the future."

Your letter asked me to testify on the Advisory Committee's work to date and my views on the work being done by the VA to update the disability rating system.

The Committee has met 35 times and has forwarded two reports to the Secretary that addressed our efforts as of September 30, 2010 and fulfilled the statutory requirement to submit a report by October 31, 2010. (Copies of these reports were furnished to majority and minority staff in both Houses of Congress.) The Secretary of Veterans Affairs responded to both reports.

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

After coordination with the Secretary's office and senior VA staff, we have added review of individual unemployment, review of the methodology for determining presumptions, and review of the appeals process as it pertains to the timely and accurate award of disability compensation. These issues will be addressed in our next report to the Secretary and the Congress.

Regarding the current project to update the disability rating system, I believe the project management plan that the VA has laid out will achieve the goals sought by all stakeholders, including the Congress. The revised VASRD will be a guide for veterans, medical examiners and claims adjudicators that is simpler, fairer, and more consistent.

The Secretary and the VBA should be commended for undertaking this long overdue revision which has been repeatedly called for by the Congress as well as numerous boards, studies, and reports. Some of you may recall former Senator Dole's observation at the congressional outbrief of the Dole-Shalala Commission where he said that the VASRD is 600 pages of band-aids. While perhaps an overstatement, his views reflect those of many participants in commissions and studies.

It is easy to understand why the can has been kicked down the road for a long time. The revision requires significant resources. The VA is working on many high priority projects that compete for resources and management effort.

The revision of the VASRD is not a stand alone operation. It is part of a larger effort that includes electronic claims filing, use of disability questionnaires, and improved claims visibility at all stages. In my judgment, many of the current VBA initiatives depend on a successful and accepted revision of the rating schedule.

Some stakeholders have expressed concern that the revision effort may adversely affect current and future veterans. My own view is quite the contrary. If properly done, the revision will simplify and expedite claims preparation, medical examinations, and claims adjudication. These will, in turn help the VBA reduce processing time and increase accuracy. Consistency among raters and regional offices, another recurring area of concern, should be improved.

There is an inherent resistance to change that must be overcome through involving all stakeholders in the process and insuring that the purpose and results of the revision are understood.

A concern, which I share, is that the process is not scheduled for completion until 2016. However, the scope and complexity of revising and updating all 15 body systems is daunting. The first major step, gathering and assembling the medical data for all body systems is well along. The forums at which each body system is discussed by leading medical experts have resulted in broad agreement on how to update medical terminology and medical advances.

The work groups of subject matter experts for each body system are now analyzing the results of the forums in order to develop specific proposed changes to the schedule.

The econometric data sought in conjunction with GWU will assist in determining the relationship between specific conditions and average impairment of earnings loss.

The process, to include the publishing of draft changes in the *Federal Register* offers all stakeholders an opportunity to request clarifications and make comments. I believe this step will protect current and future veterans from unintended consequences as revisions move toward implementation.

The Advisory Committee on Disability Compensation is involved in all steps in the rating schedule revision process. As an outside advisory committee, we are able to offer advice and suggestions directly to the Secretary and senior VA management. We listen closely to the subject matter experts from outside sources who meet with us as well as to the VA professionals who are leading the effort. The members have an opportunity to ask questions, offer suggestions, and track the progress of the revision. We are a sounding board for options and proposals. The Committee includes experience and expertise from DoD, VA, congressional staff, disability law, family programs, and the VSO community.

In conclusion, the Advisory Committee on Disability Compensation is deeply involved in the VA project to revise the VASRD. We appreciate the openness of the VA leadership and staff to our questions and recommendations. We realize that even the best revision will not solve all the complex issues of disability compensation, but the members believe the updated schedule will address many of the noted shortcomings of the current version such as outdated medical terminology, outdated diagnosis and treatment regimens for illnesses and injuries, changes in the social and work environment, and apparent earnings loss disparities between mental and physical disabilities. It will also offer an institutional process for future updates.

Thank you for your attention and the opportunity to testify today. I look forward to your questions.

MATERIAL SUBMITTED FOR THE RECORD

Statement of Verna Jones, Director, National Veterans Affairs and Rehabilitation Commission, The American Legion

Mr. Chairman and Members of the Committee:

As the Nation's largest wartime veterans' service organization, The American Legion has been deeply involved in ensuring proper care and compensation for service disabled veterans since our founding in 1919. Every day, over 2,000 American Legion accredited service officers are hard at work providing advocacy free of charge to veterans in their often arduous quest for disability compensation for injuries and conditions incurred as a result of their service. These service officers are frontline soldiers in the fight for justice for these disabled veterans. Their insights, coupled with insights gleaned from interviews with VA staff in over fifty Regional Office Action Review visits over the last decade, have provided The American Legion with critical insight into the problems inherent in the VA Rating Schedule.

Any attempt to reform or revise the rating schedule must begin by considering the overall mission and purpose of the Department of Veterans Affairs (VA.) To paraphrase the words of President Abraham Lincoln, VA exists to care for those who have borne the battle and for their families and their orphans. The American Legion believes therefore any rating schedule must be built upon the guiding principle of serving the disabled veteran.

Understanding this principle, concerns of VA must be examined and understood in the proper context. Those with experience in the VA disability rating system will agree the current regulations are difficult for veterans and employees of VA to utilize effectively. However, care must be taken in revision to ensure regulations are not simply changed for administrative expediency that comes at the expense of veterans. We cannot afford to simplify for bureaucratic convenience if those simplifications result in an overall negative impact on disabled veterans.

The adjudication of claims in a timely and accurate manner is perhaps the greatest challenge facing VA's service to disabled veterans. As of January 3, 2012 over 65 percent of pending compensation claims were still pending over 125 days. Accuracy figures are difficult to determine as VA still does not publish accuracy ratings with the same prominence as those for timeliness despite repeated requests from The American Legion and other service organizations. If VA is to achieve their stated goal of 98 percent accuracy and zero claims pending over 125 days by 2015 they will clearly need help, and some of that help will most likely come from a more efficiently designed rating schedule.

Clarity of language and ease of use will be essential in making the tools adjudicators must use to fairly process veterans' claims. Simply rewriting the regulations will not replace the need to properly train those who must interpret the regulations on a daily basis to ensure veterans receive their fair due. Currently over half of VA's employees have less than 3 years experience on the job. This is a transformational time and that must be used to VA's benefit, shedding institutional biases of the past for a more agile and efficient work force. Of course, service to the disabled veterans must assume its place at the proper position of prominence. These VA employees must be trained on the new regulations, and that training time cannot be sacrificed in the service of raw output. An improperly trained staff would only waste the good efforts invested in the creation of the regulation rewrite.

Any rewrite must also be directed toward better consistency, and The American Legion believes this must be considered not solely with regard to variations across regional offices, but also across the various branches of active duty service and the medical and physical evaluation boards. One only has to consider lawsuits such as *Sabo, et al. v. United States* to realize there are still widespread issues with proper application of the existing laws at the critical bridge point of transition between active duty and veteran status. American Legion personnel also are deeply involved tracking the status of disabled active duty servicemembers experiencing the Medical Evaluation Boards (MEBs) and Physical Evaluation Boards (PEBs) and have noticed inconsistencies across branches of service.

Just as veterans with identical knee injuries should receive the same rating whether they are evaluated in Newark, NJ or Oakland, CA active duty servicemembers with identical injuries should be evaluated equally regardless of whether they serve in the Air Force, Coast Guard, Navy, Army or Marine Corps. Furthermore, it is only common sense that ratings on both sides of the green line dividing active duty and veteran status should be consistent. Sadly, this is not the current state of affairs.

The American Legion would like to thank VA for the progress being made toward better inclusion of service organizations and concerned stakeholders in the revision

process. This very week I am attending a review of proposed changes to the VA Schedule for Rating Disabilities (VASRD) and we have had regular meetings and briefings from VA as a part of this process. This is important. Any change to the rating schedule will require thought and analysis, and a proper period of informed consideration of changes cannot be underestimated. We hope this continues throughout the process, and that there is deep consideration of the input from organizations such as The American Legion and others. Our service officers are right there with VA's adjudicators in the frontline trenches. The input from these sources is incalculable and deserves heavy consideration and recognition of its value. Furthermore, The American Legion encourages field testing of any changes before any final decisions are made. Often unintended consequences are not immediately apparent when a regulation is rolled out, and the old military advice that no plan survives first contact is an important guiding principle.

The rating system as a whole is indeed full of challenges. The mental health section is desperately in need of revision, and VA is in the process of addressing this. In American Legion Regional Office visits, this section is consistently mentioned by VA employees as the most difficult to interpret. Care should be exercised however. In the past, the diagnostic schedule for Traumatic Brain Injury was justly recognized as being inadequate to address the impact of the sometimes terrible injury. However, the system ultimately rolled out, while medically addressing all the proper information, was unwieldy and even incomprehensible to many who are required to use the new schedule on a daily basis.

The American Legion is sympathetic to the line VA must walk in designing the rating schedule. The ratings must be complete enough to adequately address complex injuries, but must be clear enough to be interpreted by non-medical employees during the claims process. It is difficult, but we believe possible, to achieve this with the input of veterans' law experts and medical professionals as well as those adjudicators and service officers who utilize the system on a daily basis.

This is not a new task. Daniel Cooper, Chairman of the VA Claims Processing Task Force noted the need to "rewrite and organize the C&P Regulations in a logical and coherent manner . . ." over a decade ago in October of 2001. This is an ongoing task and will require continued input of all interested stakeholders be they from Congress, VA, the service organizations or even the lawyers and medical professionals who also use the system.

If there is one underlying point to remember throughout this process however, it is this: the disability system exists to serve those veterans who have suffered ongoing and often devastating effects in the service of this country. Every act must be considered in light of how well it will serve those veterans.

Statement of Paralyzed Veterans of America

Chairman Runyan, Ranking Member McNerney, and Members of the Subcommittee, Paralyzed Veterans of America (PVA) would like to thank you for the opportunity to provide our views on the current state of the Department of Veterans Affairs (VA) ratings schedule and the steps that are being taken to transform the ratings schedule and claims process into a more modern system. As you know, the VA is currently in the process of revising the Schedule for Rating Disabilities. Meanwhile, it is also in the process of transforming the entire claims process into a more modern system that should ensure that veterans will receive an accurate ratings decision the first time.

VA Schedule for Rating Disabilities

The amount of disability compensation paid to a service-connected disabled veteran is determined according to the VA Schedule for Rating Disabilities (VASRD), which is divided into 15 body systems with more than 700 diagnostic codes. In 2007, the congressionally mandated Veterans Disability Benefits Commission (VDBC), established by Public Law 108–136, the "National Defense Authorization Act of 2004," recommended in its final report that the VA regularly update the Schedule for Rating Disabilities. Likewise, the Institute of Medicine (IOM) Committee on Medical Evaluation of Veterans for Disability Compensation, supported this idea in its report "A 21st Century System for Evaluating Veterans for Disability Benefits" recommending that the VASRD be regularly revised to reflect the most up-to-date understanding of disabilities and how disabilities affect veterans' earnings capacity.

In line with these recommendations, the Veterans Benefits Administration (VBA) is currently engaged in the process of updating all 15 of the body systems. Additionally, it has committed to regularly updating the entire VASRD every 5 years. As

VBA indicated in its statement before the Subcommittee at the hearing on January 24, 2012, the review process for all 15 body systems is in various stages of completion, ranging from interim final rules being written to already having been posted for public review in the *Federal Register*.

Meanwhile, in order to help implement the recommendations of the VDBC, Congress established the Advisory Committee on Disability Compensation (ACDC) in Public Law 110–389 to advise the Secretary on "... the effectiveness of the schedule for rating disabilities ... and ... provide ongoing advice on the most appropriate means of responding to the needs of veterans relating to disability compensation in the future." In its 2009 "Interim Report" and its first "Biennial Report" dated July 27, 2010, the Advisory Committee recommended that the VBA follow a coordinated and inclusive process while reviewing and updating the Schedule for Rating Disabilities. Specifically, the ACDC recommended that veterans service organization (VSO) stakeholders be consulted several times throughout the review and revision process, both before and after any proposed rule is published for public comment.

While VBA has held a number of public forums and made some other good faith efforts to include greater VSO participation, the process itself does not allow input during the crucial decisionmaking period. Because these public forums were conducted at the very beginning of the rating schedule review process, veterans service organizations were not able to provide informed comment, as the VBA had not yet undertaken review or research activities.

VSOs and other stakeholders were invited to offer comments and suggestions before the VBA working groups were even created. As a result, while the discussions from the public forums may be part of the official record, the insight and information provided during these forums was likely never considered by the working groups once they were established. As the ACDC noted, it would have been helpful to include the experience and expertise of VSOs during their deliberations on revising the VASRD. With this in mind, the soon-to-be-released FY 2013 *Independent Budget* will recommend that the VBA should involve veterans service organizations throughout the process of reviewing and revising each body system in the rating schedule, not only at the beginning and end of its deliberative process. Moreover, the VBA should conduct regular after-action reviews of the rating schedule update process, with veterans service organization participation so that it may apply "lessons learned" to future body system updates. Additionally, we highly encourage the Subcommittee and full Committee to carefully review any proposed rules that would change the VASRD, particularly if such rules would change the basic nature of veterans' disability compensation.

Quality of Life

One of the most important aspects of a revision to the ratings schedule for PVA and its members is the consideration of quality of life as a component of a new ratings schedule. PVA's opinion has always been that the schedule for rating disabilities is meant to reflect more than just the average economic impairment that a veteran faces. VA disability compensation also takes into consideration the impact of a lifetime of living with a disability and the everyday challenges associated with that disability. This approach reflects the fact that even if a veteran holds a job, when he or she goes home at the end of the day, that person is still disabled.

While seriously disabled veterans have the benefit of many adaptive technologies to assist with employment, these technologies do not help them overcome the many challenges presented by other events and activities that unimpaired individuals can participate in. Most spinal cord injured veterans no longer have the ability to conceive children. Most of them cannot perform normal bowel and bladder functions or easily bathe themselves. Many cannot play ball with their children or carry them on their shoulders. Many severely disabled veterans suffer from potential negative stereotypes due to disability in all aspects of their lives.

This matter was researched a great deal by the IOM Committee on Medical Evaluation of Veterans for Disability Compensation in its report, "A 21st Century System for Evaluating Veterans for Disability Benefits," released in 2007. IOM recommended that the current VA disability compensation system be expanded to include compensation for non-work disability (also referred to as "non-economic loss") and loss of quality of life.

Under the current VA disability compensation system, the purpose of the compensation is to make up for average loss of earning capacity, whereas the operational basis of compensation is usually based on medical impairment. Neither of these models generally appears to incorporate non-economic loss or quality of life into the final disability ratings, though special monthly compensation (SMC) does in some limited cases. The IOM report stated:

> In practice, Congress and VA have implicitly recognized consequences in addition to work disability of impairments suffered by veterans in the Rating Schedule and other ways. Modern concepts of disability include work disability, non-work disability, and quality of life (QOL). . . .''

The Veterans Disability Benefits Commission (VDBC), which was mandated by Congress, spent more than 2 years examining how the rating schedule might be modernized and updated. Reflecting the recommendations of the comprehensive study of the disability rating system by the IOM, the VDBC in its final report issued in 2007 recommended:

> 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 of quality of life.

Ultimately, the IOM Report, the VDBC, and the President's Commission on Care for America's Returning Wounded Warriors (the Dole-Shalala Commission) all agreed that the current benefits system should be reformed to include non-economic loss and quality of life as a factor in compensation.

With regards to the question of how to quantify quality of life for certain service-disabled veterans for compensatory purposes, PVA believes an important benchmark to examine would be how ''regular need for aid and attendance (A&A)'' is assessed. The need for regular A&A is measured against enumerated criteria that have to do with meeting basic human needs (answering the call of nature, protection from hazards of daily living, etc.) insofar as a catastrophic disability has impeded the ability to address those needs. As with the demonstrated ''need'' for something, quality of life is an abstraction that, while subjective, can be predicated on differentiating objective indicators of a veterans potential for success (notwithstanding his or her disability) based on education level, rank, employment, and similar factors.

Mental Disorders Ratings Schedule

PVA also has serious concerns about potential changes to the mental disorders rating table that have been discussed and may be proposed to create an entirely new methodology for rating mental health disorders, such as PTSD. Since this proposal was developed entirely after the public forum conducted by the Veterans Health Administration and VBA in January 2010, it has essentially been done without any VSO input. The VSO community has only been afforded two additional opportunities to be updated on the activities of VBA with regards to revising the mental health disorders component of the VASRD.

Despite very little information being provided, we have concluded that VBA has decided to go beyond updating or revising the schedule, and instead are intending to completely discard the current system entirely and develop a dramatically different process for rating and compensating veterans for service-connected mental health disorders. Based on briefings we received in 2011, it seems that the VBA intends to implement a mental health disorders rating schedule that looks only at how often a veteran was unable to work effectively. If this is in fact the approach that VBA has chosen, then it has apparently developed a ratings schedule completely contradictory to the long stated purpose of veterans' disability compensation.

PVA is particularly appalled by the mere suggestion that this is an acceptable method to rate a veteran's service connected disability. It blatantly ignores the far greater impact that a disability has on that veteran's quality of life and ability to accomplish activities of daily living. If VBA does in fact present a revised ratings schedule that presumes to rate veterans according to inability to perform work, this Subcommittee, and in fact all of Congress, should vigorously oppose this plan. While VBA has the regulatory authority to update and revise the VASRD, considering the limited transparency to the process, it will be important for Congress to look closely at any changes being proposed. Most importantly, Congress must ensure that such revisions adhere strictly to the law which requires that the levels of disability compensation are based on the principle of the ''average loss of earnings capacity'' as required by statute.

To ensure that the revisions accurately reflect the intent of the law and substantially address the disparities found by the studies cited in this article, the IB veterans service organizations strongly recommend that VA conduct extensive testing of the revised criteria against cases rated under the existing criteria prior to publication of a proposed revision. The test should include both the new rating criteria and revised disability examination protocols. It is only through such testing, the results of which can be used to support the proposed revisions that veterans can be assured that the new criteria corrects past inequities.

Variability in the IDES/MEB Process

Currently, the process for evaluating servicemembers through the integrated disability evaluation system (IDES) and the Medical Evaluation Board (MEB) contains too much variability across military departments and between the VA and the Department of Defense (DoD). While VA rates a disability based on diminished earning capacity, DoD evaluates based simply on the fitness to serve, two altogether differing lenses of assessment in the philosophical and practical sense. It is important to remember, however, that the VA's disability evaluation examines the veteran as a whole with the combination of all possible disabilities being rated. Meanwhile, the DoD only evaluates to the limit of determining fitness to serve, and no more. This can produce a result where a Marine who has incurred a spinal cord injury that has left him as a quadriplegic might receive a 60 percent evaluation for spinal cord injury from DoD then a 100 percent rating from VA for the same injury. PVA believes this disparity in valuation can be resolved by adopting one standard across all military departments and VA, perhaps by adding a "readiness" evaluation for servicemembers to the Disability Benefits Questionnaires (DBQ) used to rate veterans.

The "Treating Physician Rule"

In the past, VA referred to *VHA Directive 2000–029, Provision of Medical Opinions by VA Health Care Practitioners*, to provided veterans with an efficient means of obtaining a medical opinion from their VA treating clinicians when being considered for a rating from VBA. However, VA revised this directive, presumably once the higher courts began rejecting the treating-physician rule, to impede a veteran's ability to obtain a medical opinion from his VA treating physicians to support a VA disability claim. The VA typically cites the case of Guerrieri v. Brown considered by the United States Court of Appeals for Veterans Claims (CAVC) to support its rejection of the "treating physician" rule. In that case, the Court rejected the rule because it "might raise a conflict with the VA's evaluative process outlined in 38 CFR § 3.303." Guerrieri, 4 Vet. App. at 472. Thus, the Court's rejection of the "treating physician" rule was based on its interpretation of 38 CFR § 3.303.

The reasons VA proffered for adopting the directive made the case for why it was necessary. In fact, the Directive specifically states that "restrictions on the ability of VA health care providers to provide statements and opinions for VA patients are inconsistent with the goal of VHA to provide comprehensive care and place a serious burden on veterans who depend on VHA for their care." The VHA did reiterate the point that this policy must be implemented in a way that avoids inappropriate VHA participation in the claims adjudication process that determines eligibility for VA disability benefits. The definition of "inappropriate" in this case may require further discussion. However, to altogether close off this means of accurately assessing the nature and severity of a veteran's condition only adds to the inefficiency that typifies the VA claims adjudicative process.

Once this avenue to substantiating a claim had been cut off, veterans were forced to heavily rely on the findings of C&P examiners who neither had first-hand knowledge of a claimant's medical condition and prognosis nor provided the hands-on medical care necessary to fully appreciate the medical history beyond what could be gleaned from a VA claims file. PVA believes that the original provisions of VHA Directive 2000–029 should be reinstated in order to allow a veteran to substantiate his or her claim for disability based on medical treatment he or she received within the VA. While opinions have called into question the objectivity of a medical care provider's opinion when substantiating his or her patient's condition, we see no reason why the "treating physician's" opinion should be marginalized, as is currently the case in the claims process.

PVA appreciates the opportunity to express our views on the ongoing revision of the VASRD. We cannot emphasize enough that the final outcome of any revisions should place the interests of the veteran first and foremost. We look forward to working with the Subcommittee to ensure that veterans receive the best possible determination for benefits in the most efficient manner possible. Thank you.

Statement of Jim Vale, Director, Veterans Benefits Program, Vietnam Veterans of America

Chairman Runyan, Ranking Member McNerney and Members of the Committee, Vietnam Veterans of America (VVA) thanks you for the opportunity to present our statement for the record on "Rating the Rating Schedule—The State of VA Disability Ratings in the 21st Century." We would also like to thank you for your over-

all concern about the VA Rating System that is impacting our troops and veterans, especially the current generation of war fighters returning home today who are suffering from Post-Traumatic Stress Disorder (PTSD).

We are deeply concerned with the state of our VA Disability Rating System, and share many of the same concerns as our fellow Veteran Service Organizations regarding the need to compensate disabled veterans for their loss of "Quality of Life" and other economic losses in addition to compensating for "average impairments of earning capacity." Rather than repeating what has already been said, we would like to focus our comments on the problems with the VA Disability Rating System when the VA rates claims for Post-Traumatic Stress Disorder (PTSD).

The Current VASRD is Grossly Inadequate for Rating PTSD Because It Ignores Fundamental Differences Among Various Psychiatric Disorders

VA regulations have historically adopted the nomenclature and diagnostic criteria of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM).[1] The DSM recognizes the differences among the various psychiatric disorders (e.g., psychoses, like schizophrenia, and neurosis, like PTSD). Some psychiatric disorders are organic in nature, some are acquired and some are congenital. Some are chronic, some are intermittent and acute. Yet the rating schedule completely ignores such differences. Instead, it lumps all psychiatric disorders together and evaluates them under the exact same list of symptoms.[2] This is both inherently inconsistent and illogical. The DSM diagnostic criteria are expressly adopted, but fundamental differences among various psychiatric disorders are virtually ignored.

The VA Should Initially Undertake a Comprehensive Review of the Rating Schedule In Concert With Medical, Psychiatric and Vocational Experts

New rating criteria should be developed that take into account not only impairment in industrial capacity, but also the psychiatric effects of physical disability and the effect of physical and psychiatric disability on the veteran's quality of life. VVA often advocates for a "Veterans' Health Care System," rather than a health care system that happens to be for veterans, based on the unique nature of veterans' disabilities. Such disabilities are incurred in unique ways and have unique consequences. It is the very nature of a veteran's disability that demands a system of evaluating disabilities that keeps pace with technology, current medical standards and practices, socioeconomic factors and individual self-esteem.

VA Does Not Follow Their Own Procedures

As mentioned by previous VVA Veterans Benefits Program Directors in prior VVA testimony, local Veterans Health Administration (VHA) officials routinely do not provide adequate training, materials, or time to examining clinicians to let them do their job correctly in performing C&P exams. An excellent example is the "Best Practices Manual for Adjudication of PTSD Claims." VA examiners should be trained in these "Best Practices" and given sufficient time by their clinic directors to successfully complete their job. We frequently hear complaints from veterans that their C&P exam lasted only 20 minutes. This is inadequate per IOM standards:

> "It is critical that adequate time be allocated for this assessment. Depending on the mental and physical health of the veteran, the veteran's willingness and capacity to work with the health professional, and the presence of comorbid disorders, the process of diagnosis and assessment will likely take at least an hour or could take many hours to complete. . . . Unfortunately, many health professionals do not have the time or experience to assess psychiatric disorders adequately or are reluctant to attribute symptoms to a psychiatric disorder."[3]

Examiners are required by law to review a claimant's entire claims file and medical record.[4] Unfortunately, it is common for veterans to appear for a C&P exam and discover their examiner has not reviewed or even been provided their claims folder.

If VA properly used their own manual, policy, procedures, rules, trained their employees properly, gave them proper tests, and let their professionals do their job correctly; almost all VA staff would get it right the first time. This would obviate the

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[1] 38 CFR § 4.125(a).
[2] 38 CFR § 4.130.
[3] National Research Council. "2 Diagnosis and Assessment." *Post-Traumatic Stress Disorder: Diagnosis and Assessment*. Washington, DC: The National Academies Press, 2006. Available: *http://www.nap.edu/openbook.php?record__id=11674&page=17*. (last visited January 30, 2012).
[4] 38 CFR § 4.2.

need to "churn" claims back and forth in the system. Add to this effective supervision and VA would greatly increase their accuracy and output.

VA Should Use the Best Medical Science To Accurately Diagnose and Assess PTSD

The Institute of Medicine (IOM) report of June 16, 2006 presented the best medical science as to how to accurately diagnose and assess PTSD. Unfortunately, VA does not follow these recommendations, even though VA commissioned and paid for this study. If VA were to use the PTSD assessment protocols and guidelines as strongly suggested by the Institutes of Medicine back in 2006,[5] our veteran warriors would receive the accurate mental health diagnoses needed to assess their PTSD.

International Classification of Diseases (ICD) 9/10

VVA at this time does not support the adoption of ICD 9/10 to replace the VASRD and DSM codes for mental health disabilities. There are too many differences that would increase the confusion and complexity for VA raters trying to rate PTSD claims. For example, ICD 9/10 lacks DSM–IV criterion A2 for PTSD.[6]

Diagnostic and Statistical Manual of Mental Disorders (DSM)–IV

We are waiting for the revision of the DSM–IV (scheduled to be revised by 2013). Preliminary evidence suggests there will be further separation of some mental health classifications. We feel the VASRD should reflect these latest medical advancements in classification of mental health conditions and follow the revised DSM standards.

Disability Benefit Questionnaires (DBQ)

VA describes DBQs as "... streamlined medical examination forms designed to capture essential medical information for purposes of evaluating VA disability compensation and/or pension claims from veterans or servicemembers."[7] DBQs are designed to closely follow the VASRD, and increase consistency and accuracy of VA rating decisions by replacing traditional C&P medical opinions with "Turbotax-like" questionnaire for doctors to quickly point and click when evaluating veterans. This potentially reduces the amount of reading a VA rater must do when rating a claim. VVA supports the use of DBQs, but cautions DBQs are only as good as the VASRD they are based on.

In closing, on behalf of VVA National President John Rowan and our National Officers and Board, I thank you for your leadership in holding this important hearing on this topic that is literally of vital interest to so many veterans, and should be of keen interest to all who care about our Nation's veterans. I also thank you for the opportunity to speak to this issue on behalf of America's veterans.

Vietnam Veterans of America Funding Statement

January 30, 2011

The national organization Vietnam Veterans of America (VVA) is a non-profit veterans' membership organization registered as a 501(c)(19) with the Internal Revenue Service. VVA is also appropriately registered with the Secretary of the Senate and the Clerk of the House of Representatives in compliance with the Lobbying Disclosure Act of 1995.

VVA is not currently in receipt of any Federal grant or contract, other than the routine allocation of office space and associated resources in VA Regional Offices for outreach and direct services through its Veterans Benefits Program (Service Representatives). This is also true of the previous two fiscal years.

For Further Information, Contact:

Executive Director for Policy and Government Affairs
Vietnam Veterans of America
(301) 585–4000, extension 127

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[5] National Research Council. "2 Diagnosis and Assessment." *Post-Traumatic Stress Disorder: Diagnosis and Assessment*. Washington, DC: The National Academies Press, 2006. Available: *http://www.nap.edu/openbook.php?record__id=11674&page=1.* (last visited January 30, 2012).

[6] Id. p. 14.

[7] U.S. Dept. of Veterans Affairs, *Fact Sheet: Disability Benefit Questionnaires*. *http://benefits.va.gov/TRANSFORMATION/disabilityexams/docs/DBQ__Fact__Sheet.doc*.