

**EXECUTIVE SUMMARY OF
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ASSISTANT NATIONAL LEGISLATIVE DIRECTOR
OF THE
DISABLED AMERICAN VETERANS
FOR THE
SUBCOMMITTEE ON DISABILITY ASSISTANCE AND MEMORIAL AFFAIRS
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
JANUARY 24, 2012**

- 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.
- The basis of disability evaluations is the ability to function under ordinary conditions of daily life, including employment; however, 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, although an individual is able to engage in employment does not necessarily mean he or she is less disabled.
- Disability ratings, according to title 38, United States Code, section 1155, should be based on “average impairments of earning capacity,” not “earnings loss” or “average earnings loss.”
- In 2007 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 recommended VA regularly update the VASRD to reflect the most up-to-date understanding of disabilities and how disabilities affect veterans’ earning capacity.
- The Advisory Committee on Disability Compensation (ACDC) was that veterans service organizations (VSO) stakeholders were to be consulted throughout the review and revision process, to include prior to and following any proposed rule being published for public comment, however such consultation has not occurred.
- In early 2010, VA began revising the VASRD section dealing with mental disorders; however, the proposed solution discussed at two ACDC briefings appears problematic because it undercuts the purpose of the disability compensation program and would adversely impact veterans. Also, applying this proposed standard to other body systems, such as the musculoskeletal system, could be equally problematic.
- In addition to determining the level of disability compensation provided as a result of average loss of earnings capacity, the VASRD should include compensation for the loss of quality of life suffered by veterans.

**STATEMENT OF
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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 impairments 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 five-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 decision making 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 two 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 service

members 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 nonwork-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 two days per week would be rated at 100 percent, a veteran who had decreased work productivity or quality two days per week would be rated at 70 percent, a veteran who missed appointments or deadlines one 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 noneconomic 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 noneconomic 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 nonwork 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 “noneconomic 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 two 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 noneconomic 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 noneconomic 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.