FINDINGS OF THE VETERANS' DISABILITY BENEFITS COMMISSION

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS

U.S. HOUSE OF REPRESENTATIVES

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CONTENTS

October 10, 2007

FINDINGS OF THE VETERANS' DISABILITY BENEFITS COMMISSION

WEDNESDAY, OCTOBER 10, 2007

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 10:02 a.m., in Room 334, Cannon House Office Building, Hon. Bob Filner [Chairman of the Committee] presiding.

Present: Representatives Filner, Brown of Florida, Snyder, Michaud, Herseth Sandlin, Hall, Hare, Berkley, Salazar, Rodriguez, Donnelly, McNerney, Space, Walz, Buyer, Moran, Brown of South Carolina, Boozman, Brown-Waite, Bilbray, and Bilirakis.

OPENING STATEMENT OF CHAIRMAN FILNER

The CHAIRMAN. Good morning. I call to order this meeting of the House Committee on Veterans' Affairs. We have an especially important, helpful, and I hope productive hearing with the members of the Veterans' Disability Benefits Commission chaired by Lieutenant General James Terry Scott.

We thank all of you for joining us today, and we want to thank the Commission for its work for over 2 years. Chairman Scott was telling me that you would meet for several days each month and more frequently in recent months. So it has been a big commitment and we thank all of you for that and trying to draw together a mass of information to help us improve this system.

We thank you for the report that you have produced and are glad that you felt this call to duty. You met many, many times with all of the stakeholders and I think that you have tried to fashion a report that honors the sacrifices that our men and women in uniform have made.

The Veterans' Disability Benefits Commission was established by the National Defense Authorization Act of 2004 out of recognition of the impact that the current conflicts of Operating Enduring Freedom (OEF) and Operating Iraqi Freedom (OIF) would have on our resources in both the U.S. Department of Veterans Affairs (VA) and the Department of Defense (DoD).

It was our hope, and I think you have met that hope, that you would provide recommendations to increase the efficiency and effectiveness of providing benefits and services to our veterans, their dependents, and survivors in a manner that reflects the dignity of their service.

Your report became even more relevant once the conditions at Walter Reed were reported and people became very knowledgeable of some of the defects of our system, especially the growing backlog of the claims at the VA. And you address this in a very timely manner as it turns out because the Nation is focused on these issues.

Just as we did in the 1990s when Congress, the Administration, Veterans Service Organizations (VSOs), and stakeholders partnered to place greater emphasis on turning the Veterans Health Administration (VHA) into a world-class, technologically adept entity, I think your report tells us that we must devote the same resources and brain power to turning around the Veterans Benefits Administration (VBA) to become a world-class, technologically adept, 21st century organization.

So I look forward to working with you and your Commission and the VA to make that a reality because we have to do this.

As you point out, as we continue to give full resources to the war, let us not forget the warrior and the warrior's family. Our men and women should not only get first-class weapons to fight and receive third-class benefits after fighting, we must make them all first class.

We all know about the claims backlog, whether from the regional offices or the Board of Veterans' Appeals or the U.S. Court of Appeals for Veterans Claims, have become intolerable, leading to long waiting times, and unmanageable, frankly, given the funding shortfalls that have been apparent over the last decade.

But I think we have a system that could be improved as you point out, and the employees and dedicated people who work for the VA will be able to achieve what you want with additional resources and the changes.

The Veterans Benefits Administration, on their Web site and in their training, I assume, talk about a covenant that they make, a covenant that says we are the leaders in one of our Nation's most vital and idealistic service organizations. Because we serve veterans and their dependents, our mission is sacred.

And it quotes both President Lincoln and General Omar Bradley, words that many of us have come to know. Of course, Lincoln's famous phrase, "To care for him who shall have borne the battle and for his widow and his orphan." General Bradley in 1947 said, "We are dealing with veterans, not procedures, with their problems, not ours."

And that covenant further states as we carry out this mission, we willfully enter into a covenant with one another to always be guided by the fundamental principles of accountability, integrity, and professionalism. These principles form the foundation of leadership and service to America's veterans. That is what the VBA says is its covenant.

So we want to extend that covenant, devote all our resources, brain power, and willpower, man and woman power to improve the current system of delivery of benefits so we optimize the outcomes for everyone.

We have the privilege to be able to serve our veterans and their families. You have honored them with your long study, and I think you have given us a lot of work to do to follow-up. We will give you

all the time you need to explain what you have done and if you would like to introduce and call on any of the Commission Members.

Mr. Buyer, I would recognize you for an opening statement.

[The prepared statement of Chairman Filner appears on p. 33.]

OPENING STATEMENT OF HON. STEVE BUYER, RANKING REPUBLICAN MEMBER

Mr. BUYER. Thank you very much.

General Scott, thank you for being here and congratulations to you and to your Commissioners who are also here with you. I consider you and your Commissioners patriots and nobles. You have taken on a great cause on behalf of Congress to look at these issues that best affect America's most sacred asset, those men and women who put on the uniform and are somehow hurt, harmed or injured in some way, whether it be in the workplace, during peace, or in combat operations.

Let us also never forget the families, the ones who kept the watch fires burning, and their children. And that is why we have looked to you on what upgrades, if necessary, must be done.

So I commend all of you for your dedication and your work over the past 2½ years. Your efforts required many long hours discussing these issues in meetings and pouring over an array of complex materials to arrive at the recommendations you have presented to us.

I heartily agree with the eight guiding principles that you identified. These principles provide a sound basis for considering any recommendations for improvement to veterans' benefits. Clearly you and your fellow Commissioners share my sentiments that veterans, the men and women of the Armed Forces, are among our Nation's most finest citizens.

We are in a long war against global terrorism. The enemy we encounter has its sights set on objectives it hopes to accomplish for many years from now. It is our grandchildren they also plan to oppress. We have no choice but to engage those who despise free will and wish to destroy us and the freedom we cherish.

It is imperative that we maintain a military that is capable of swift response and world-wide theater operations. To do so, we must continue to attract the caliber of people our military has now, and those who must serve should be confident that they and their families will be cared for should harm come their way.

Early during the initial review of your report, I could see the Commission understood this fact very well. The Commission wisely focused on the veterans' long-term issues such as the need to revamp the disability, retirement, and compensation systems.

It has been my longstanding view that we must modernize the VA and establish a transition process that is seamless in its efficiencies between DoD and VA. The Commission's report, along with the recommendations of the Dole-Shalala Task Force, is a big step toward attaining this goal.

So I look forward to hearing your testimony. We will carefully consider all the Commission's recommendations and hopefully use those we determine are most beneficial as a guide to meaningful

and long-term policies to improve the lives of veterans and their families.

Mr. Chairman, I suggest this Committee consider the Commission's priority recommendations first and those that are determined to be meritorious should receive prompt legislative action.

Also, Mr. Chairman, along with the recommendations from the Dole-Shalala Task Force, there appear to be potential PAYGO issues as we consider the Commission's recommendations. While we may not have to grapple with these questions today, we must be mindful of them. As Congress and the Administration move forward, we must deal with the funding issues that pertain to these recommendations.

I also have one last bit of housework and a friendly recommendation to the Chairman. You have had some very good hearings here over the summer and we have been holding these hearings on Wednesday at ten o'clock. This is a Committee and many of us have a lot of issues going on in a lot of different committees. My recommendation to the Chairman is to hold a hearing like this at ten a.m. on Thursday so that these hearings could be better attended by the Members. And that is my friendly recommendation to you.

And I thank you and I yield back the time.

The CHAIRMAN. Thank you, Mr. Buyer. I always welcome friendly recommendations. I would just amend one part of your statement. We are an A+ Committee, not a C Committee.

I understand what you meant in terms of scheduling, but most of us are here because we think, excluding yourself, it is such an important Committee. But we will look at the scheduling issues that you have raised.

General Scott, thank you again for being with us and you have the floor. And if you would maybe introduce some of your Commission Members who are with us today so we can thank them also.

STATEMENT OF LIEUTENANT GENERAL JAMES TERRY SCOTT, USA (RET.), CHAIRMAN, VETERANS' DISABILITY BENEFITS COMMISSION; ACCOMPANIED BY RAY WILBURN, EXECUTIVE DIRECTOR, VETERANS' DISABILITY BENEFITS COMMISSION

General SCOTT. Chairman Filner, Ranking Member Buyer——

The CHAIRMAN. Make sure that microphone is on, please.

General SCOTT [continuing]. It is my pleasure to be with you today. And I will introduce the seven Commissioners that were able to be here, seven of the other twelve: Commissioner Brown; Commissioner Joeckel; Commissioner Jordan; Commissioner Livingston; Commissioner Matz; Commissioner McGinn; and Commissioner Wynn.

As you stated, sir——

The CHAIRMAN. We want to thank all of them, you know. If you would just stand up so we can thank you, all of you.

[Applause.]

The CHAIRMAN. By the way, I do not know if you were going to say it, but on your Web site, amongst your members are 2 Congressional Medal of Honor recipients, 2 Distinguished Service Crosses, 9 Silver Stars, 6 Distinguished Flying Crosses, 5 Bronze Stars for

Valor, 13 Purple Hearts, and 8 Combat Infantry Badges or Combat Action Ribbons, so——

[Applause.]

The CHAIRMAN [continuing]. It is obviously a very distinguished group.

General SCOTT. Well, sir, as you mentioned, the Commission was established to study the benefits and services that are provided to compensate and assist veterans and their survivors for disabilities and deaths attributable to military service.

Specifically we were tasked to examine and make recommendations concerning the appropriateness of such benefits, 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.

We conducted an extensive and comprehensive examination of the issues relating to veterans' disability benefits. This is the first time that we know of that the subject has been studied in depth by an outside entity since the Bradley Commission in 1956.

We identified 31 issues for study. We made every effort to ensure that our analysis was evidenced based and data driven. And we engaged two well-known organizations to provide medical expertise and analysis, the Institute of Medicine (IOM) of the National Academies of Science and the Center for Naval Analyses (CNI) Corp. Both offered tremendous assistance to us, particularly the IOM in the fields of medicine for which the Commission Members probably were less prepared than we could have been.

So we are offering 113 recommendations covering wide spectrums of veterans' disability benefits issues to ensure that the benefits fairly and uniformly compensate all service-disabled veterans and their families.

Some recommendations are inexpensive, some are not. Some can be adopted by the VA and/or DoD. Others will require involvement of the Department of Labor and the Social Security Administration. Others will require legislation.

The Commission understands that not all recommendations can be adopted immediately. We have identified 14 recommendations that in our judgment are higher priority. We hope the Congress and the departments will carefully consider all recommendations, however.

Brief summary of our findings. VA compensation currently paid to disabled veterans is generally adequate to offset average impairment of earnings. A comparison with the earnings of veterans who are not service disabled demonstrated that disability causes lower earnings and employment levels at all levels of severity and all types of disabilities.

The amount of compensation is generally sufficient to offset loss of earnings except for three groups of veterans, those whose primary disability is PTSD or Post Traumatic Stress Disorder and other mental disorders, those who are severely disabled at a young age, and those who are granted maximum benefits because their disabilities make them unemployable.

The Commission particularly focused on the issues concerning the care for the severely injured such as amputees and those with a Traumatic Brain Injury or TBI. We have not demonstrated that

we are prepared to provide adequate care and support for these veterans.

The families of the severely injured are assisting in the care and rehabilitation of these wounded warriors. Some are sacrificing jobs, careers, homes, health insurance, and facing tremendous impact on their own health in order to support their injured family members. We recommended that Congress should provide some healthcare and caregiver allowances for these families.

Quality of Life. We believe that the level of compensation should be based on the severity of the disability and should make up for the average impairments of earnings capacity and the impact of the disability on functionality and quality of life. It should not be based on whether it occurred during combat or combat training or on the geographic location of an injury or whether the disability occurred during wartime or a time of peace.

Current compensation payments do not provide a payment above that required to offset earnings loss. Therefore, there is no current compensation for the impact of disability on the quality of life for most veterans.

While permanent quality of life measures are developed, studied, and implemented, we recommend that compensation payments be increased up to 25 percent with priority to the more seriously disabled.

The VA Rating Schedule. The Commission concluded that the current VA schedule for rating disabilities which is used to evaluate veterans' severity of disability has not been adequately revised since 1945. We recommend that the rating schedule be updated as soon as possible but certainly within the next 5 years.

As a matter of priority, this update must include specific criteria for the evaluation and rating of Traumatic Brain Injury and all mental disorders. The schedule should also be revised to account for new diagnostic classifications, new medical criteria, and medical advances.

In addition, VA should create a process for keeping the rating schedule up to date including publishing a time table and creating an Advisory Committee for revising the medical criteria for each body system.

Post Traumatic Stress Disorder. The Commission believes that a holistic approach to PTSD should be established that couples compensation, treatment, and vocational assessment. We also believe that reevaluation should occur every 2–3 years to gauge treatment effectiveness and to encourage wellness.

Individual Unemployability (IU). Veterans with service-connected disabilities rated 60 percent or more but less than 100 percent and who are unable to work due to their disabilities can be granted what is known as individual unemployability and be paid at the 100 percent rate.

The number of such veterans has increased by 90 percent over the past few years causing considerable attention. Our analysis found that the increase is largely explained by the aging of the cohort of Vietnam veterans and the worsening of their service-connected disabilities. As the rating schedule is revised, specific focus should be given to the criteria for PTSD and other mental disorders so that IU, individual unemployability, does not need to be award-

ed so frequently. And I might add that the same goes for other disabilities. We would hope that a revision of the rating schedule would dramatically decrease the requirement for individual unemployability.

Presumptions. When there is evidence that a condition is experienced by a sufficient cohort of veterans, a presumption can be established so that it is presumed to be the result of military service. This has been done for radiation exposure, Agent Orange defoliant in Vietnam, and other conditions.

The Commission asked IOM to review the existing process for making these decisions and IOM recommended a detailed, comprehensive, and transparent framework based on scientific principles. Our Commission believes that this framework will improve the process. We have some concern over the use of the term causal effect as the standard as opposed to the existing standard for association of effect.

I might add parenthetically that this was one of the finest reports that the IOM did for the Commission. And if you have the opportunity to read just one of these other reports that were furnished by the CNAC or the IOM, I would recommend this report on presumptions. Dr. Samet from Johns Hopkins chaired it and I think you will find it clear, lucid, and it helps get the medicine back into presumptions and the politics out of it.

Moving along, sir, *Transition.* The Commission recommends a realignment of the DoD disability evaluation process used to separate retired servicemembers who are not fit for military duty. The military services, Army, Navy, and Air Force, should determine whether a servicemember is fit for duty and VA should determine the level of disability of servicemembers who are found unfit for duty. This will ensure equitable and consistent ratings.

We believe that DoD should also mandate that separation examinations be performed on all servicemembers to ensure that known conditions at the time of discharge are documented.

I might add, sir, that the Navy already does this. And we strongly recommend that the other services do it because it gives you a book end. There is an entry physical when a person comes on active duty and there should be an exit physical when they go off. And it would make it tremendously easier to work the claims in the VA system if this data were available to the people that have to make the decisions.

Regarding concurrent receipt of military retirement and VA disability compensation, the Commission's study found these to be two different programs with entirely different missions. DoD retirement recognizes years of service and VA disability payments compensate for impairment in earnings and should compensate for impact on quality of life.

Over time, Congress should eliminate the ban on concurrent receipt for all military retirees and for all servicemembers who are separated from the military due to service-connected disabilities. Priorities should be given to veterans who separate or retire with less than 20 years of service and with a service-connected disability rating of 50 percent or greater or with a disability as a result of combat.

Payment offsets should also be eliminated for survivors of those who die in service or retirees who die of service-related causes so that these survivors can receive both VA dependency and indemnity compensation and DoD's survivor's benefit plan.

Compatible Electronic Information Systems. VA and DoD should expedite their efforts to implement compatible electronic information systems. We believe that this is one of the most important actions that can be taken. Not only will this improve claims processing, but it will enhance the ability to share medical records and avoid some of the unfortunate cases that slip through the cracks during transition from DoD to VA.

Claims Processing. We have devoted a significant amount of the report to claims processing. I will just say here that we studied the existing processing system for disabled veterans and we are very disappointed by the burdensome bureaucracy and the delays that our veterans face.

Therefore, we recommend that VA establish a simplified and expedited process using best practices and maximum use of information technology to improve the claims cycle.

Again, sir, we talked in great deal about that in the body of the report.

So we generally agree with the advice recently presented by the Dole-Shalala Commission. We differ on some small points. We believe that all disabilities and injuries should be compensated based on the severity of the disability and naval to combat or combat-related injuries.

In conclusion, sir, the Commission believes that if our recommendations are implemented, a system for future generations of disabled veterans and their families will be established that will ensure seamless transition and improve their quality of life. It is our hope that the President, the Congress, the VA, and the DoD take this opportunity to create a veterans disability benefits system that will adapt as the needs of future veterans change and grow.

Speaking on behalf of all the Commissioners, it has been an honor and a privilege to serve our current and future veterans through this effort. And I would like to personally thank each member of the Commission and the Commission staff for their hard work and professionalism.

And, sir, I would be happy to take some questions. I would ask that our Executive Summary be accepted into the record. And I would also ask that the Executive Director of the study be allowed to join me at the table for the question session.

[The prepared statement of General Scott appears on p. 37. The Veterans' Disability Benefits Commission Report will be retained in the Committee files. A copy of the report can be obtained from the Commission's website at:
www.vetscommission.org/pdf/FinalReport10-11-07-compressed.pdf.]

The CHAIRMAN. Without objection, so ordered. And if the Executive Director would come forward.

Again, thank you so much, General. That was a very concise but important summary.

We will start comments with Ms. Brown from Florida.

Ms. BROWN OF FLORIDA. Thank you, Mr. Chairman, and thank you for holding this hearing.

And thank you, General Scott, for your service to the country and your service on this Commission.

As you know, Congress established this Commission in 2004 when the war was still beginning and we did not know much about what would become the signature injury of the war in Iraq and Afghanistan—Traumatic Brain Injury.

I appreciate the hard work you, your Commissioners and staff did to fulfill the requirement and mandates we gave you.

The very first of your priority recommendations states that the VA should immediately begin to update the current rating schedule. Your investigation into the rating schedule seemed to indicate that it works generally well, except for the lack of responsiveness regarding PTSD and mental health.

While I am disappointed in this, I am not surprised, considering the lack of enthusiasm in the private healthcare insurance industry to fund mental health.

Reading over your recommendations, it seems as though the major need for Congress is to be involved in more funding. You have my 100 percent support of it and I think most Members on this Committee would do the same. Thank you for your work.

And I guess my question is, many of your recommendations have been addressed by this Committee in one way or another over the past few years. The President's Commission on Care for American Returning Wounded Warriors known as the Dole-Shalala Commission recommended many of the same things you have, only more concisely.

Do you have any thoughts, more detail that you want to go into, comparison of the reports and, you know, your recommendations in comparison to their recommendations?

General SCOTT. Yes, ma'am. And thank you for the question.

We reviewed three other Commissions that met essentially during this long time frame that our Commission was meeting. We also provided raw data that our analysis was turning up as we went along to each of these Commissions that were meeting.

The Independent Review Group on Rehabilitative Care and Administration at Walter Reed and the National Naval Medical Center directed by the Secretary of Defense, the Task Force on Returning Global War on Terror Heroes chaired by Secretary Nicholson, the Returning Wounded Warriors, the PCCWW also known as the Dole-Shalala Commission, and our own, and we did a side-by-side comparison of findings and recommendations. And we found that in most areas, there was pretty much agreement on what should be done. And as you mentioned, ma'am, some of these things have been around for a while.

Where I think we probably put a little more time into some of these areas, let me talk briefly. Quality of life. One of the things that we did, we had a survey done of disabled veterans to try to get some insight as to what the impact of their disabilities at different levels was on the quality of life.

And because of the time that we had to do this, we were able to do these surveys and do some analysis that the other commissions were not, although the Bradley Commission and Dole-Shalala Commission both recommended that some accommodation be made for quality of life of the veterans.

We spent a good bit of time, and it is certainly in the big book, it is not in the summary, on vocational rehabilitation and employment (VR&E). We think that is an under-emphasized area. It is quite obvious to all of us that the goal is to return the veteran to as near whole as can be done and reintegrate them into the society to the maximum extent it can be done. And we think some emphasis on vocational rehabilitation and employment is probably needed in that regard.

I will not go into the line by line, but let me just say that in most areas, there was a concurrence among these reports. We did not look at Walter Reed. It was not in our charter. We did not look at the specifics of medical care for individual cases. We looked at medical care as a very important veterans' disability benefit, but we did not get into it.

As the Chairman mentioned, you worked that pretty hard in years past, so we did not really get into it except to say that where the Post Traumatic Stress Disorder and other mental problems are concerned, we believe there should be more engagement by the medical profession and we believe that the clinicians who make these diagnoses, we need to be sure that they are trained and experienced in making these diagnoses. And we are a little uneasy about the level of that expertise and experience among the clinicians that are making diagnoses.

Now, we also recommended that the adjudicators, the people that look at a claim and try to determine what is the level of disability, have access to medical expertise so that without having to send the whole paper file about that thick all the way back to the veterans' health side of it to get it reevaluated. In other words, they should have some quick way of getting some medical advice to assist them in the adjudication.

And, again, that impacts in a very large way on this claims backlog and trying to make the system smoother and work more quickly to the advantage of the veteran.

Did I answer your question, ma'am?

Ms. BROWN OF FLORIDA. Yes, sir. And my time is up. But can you say a word about the caregiver because I think it is such an important point that so many of the injured, when they go home, if it was not for the caregiver, they just cannot make it. And we do not have a system in place to assist the caregiver in any way.

General SCOTT. That is right, ma'am. And we recommended that VA be authorized to provide family services and to extend healthcare and allowances to caregivers.

Another way of addressing that would be to eliminate the Survivor Benefit Plan/Dependency and Indemnity Compensation (SBP/DIC) offset and to allow pending claims and to eliminate the TRICARE co-pays and deductibles for the families of severely injured people.

So we have addressed that in several different places throughout the body of the report. And I am hopeful that your staff can pull that together and make it into something that you find useful in trying to offer some relief to these families.

Ms. BROWN OF FLORIDA. Thank you so much, General Scott.

I yield back the balance of my time.

The CHAIRMAN. Is that side-by-side comparison included in the report or is that an additional thing that you can provide us?

General SCOTT. It was hastily put together when it became apparent that I was not well enough versed on all the detail from the other commissions.

The CHAIRMAN. If you can provide that to us, that would be wonderful.

General SCOTT. We would be happy to provide it for the record.

[The Commission side-by-side comparison appears in Enclosure 1 in the post-hearing questions for the record, which appear on p. 48.]

The CHAIRMAN. Thank you.

Mr. Brown, you have the floor.

Mr. BROWN OF SOUTH CAROLINA. Thank you, Mr. Chairman.

And I, too, would like to thank the members of this Commission and particularly, General Scott, for your involvement.

And if I could have the liberty, Mr. Chairman, to say a few words about one of my constituents that is on the Commission, General James Livingston, who is one of the Medal of Honor recipients and also a great friend to the veterans.

And also in the audience is Mr. John Vogel. John, would you stand up. He is former Under Secretary and former Director of the VA Hospital in Charleston. He is also a constituent of mine now.

But I really do appreciate the report and particularly one item I would like to expand upon is the H.R. 5089, General, which I have cosponsored for, I guess, about the last 4 years now trying to basically eliminate the survivor benefit offset. And I appreciate you bringing that as part of your recommendation and we certainly will consider the other 112 recommendations you brought forward. And thank you for your service and to all the other members of the Commission.

The CHAIRMAN. Thank you, Mr. Brown.

Mr. Snyder.

Mr. SNYDER. Thank you, Mr. Chairman.

Mr. Chairman and General Scott, I wanted to acknowledge Nick Bacon, who is not with us today from Arkansas, is one of the Medal of Honor recipients that was on the Commission. And he is another example of a veteran who for the rest of his professional life has been working on issues involving veterans.

I also appreciate what you all have said about you think the benefits need to be based on the disability and not necessarily the geography or how they were caused. Senator Dole and I had that discussion when he was here a week or two ago. And I gave him an example of, you know, somebody, a painter at the Little Rock Air Force Base who falls off a ladder and suffers Traumatic Brain Injury. We would hate to have side-by-side two households of one family getting a whole different benefit because of how they were injured. So I appreciate the position that you all have taken.

I want to ask two or three specific questions. It has been several years, I do not remember, Mr. Buyer, if it was under your chairmanship, but we had a group of Iraqi veterans with fairly severe disabilities and one or two of them testified that they made the decision not to stay in the service even though they think that they—at least one of them thought he could have even though he had an

artificial limb because of apprehension about subsequent loss of disability income if he stayed in the service.

Did you all address that issue or how did you address that issue?

General SCOTT. My recollection is that we never really talked about the impact, the financial impact of someone who elected to stay in the service and, therefore, decided to forego VA compensation at that time.

But as you point out, sir, the advances in medicine and I would say advances in how the services view disabilities has led us to a position where we have a number of people who are staying in.

I am aware of two officers from Vietnam who lost a foot or a leg and who were allowed to stay on active duty and now it is a routine thing to evaluate what the person can do for us in the future and, if possible, retain him on active duty.

Mr. SNYDER. I think your report deals with this issue of incentives or disincentives for getting better.

General SCOTT. Right.

Mr. SNYDER. And we would not want our incentive to be that you better get out of the service rather than try to stay in and finish your career even though you may have lost one or two or even three limbs or had severe injuries in other faculties. If there is a way they can be accommodated to complete their military career, that may be an issue that we need to follow along as we make changes.

General SCOTT. Sir, I think the issue in the servicemember's mind might be how will this affect my opportunity for promotion and future tenure. If a person believes that he or she would be allowed to progress, then the financial incentive would be on the side of staying in the service, I would think.

Mr. SNYDER. I wanted to ask a specific question. I have not read the full report. You have a very obviously thoughtful report. You put a lot of time into it. It is a very, very complex issue which is why this was set up. I am on the House Armed Services Committee, why this Commission was set up.

Did you all come to any kind of ballpark annualized cost estimate if everything that you all recommended was implemented and you have recommended doing this over several years' time, let us suppose 5 years from now, or what the annualized, your rough estimate of what the cost would be in new dollars?

General SCOTT. Well, for starts, we did, in fact, cost out the major recommendations——

Mr. SNYDER. Right.

General SCOTT [continuing]. Using data from the Congressional Budget Office or from wherever it was available. And I would be the first to say that they were ballpark figures. In other words, I could not attest——

Mr. SNYDER. No, no. I understand.

General SCOTT [continuing]. To the precise accuracy of them. But in terms of the quality of life recommendations we made, we did a hypothetical that said that at the 100 percent disability level, if you increase that person's compensation by 25 percent and then scaled it back and down to the 10 percent disability level where it was 2½ percent, that we came up with a total amount of annual compensation additive of about $3 billion.

But, again, our hypothetical was if you gave the full 25 percent quality of life kicker to the 100 percent disabled and you scaled that back down as the level of disability was reduced down to 10 percent and you gave them essentially what amounts to quality of life addition of $3.00 a month——

Mr. SNYDER. Now, that is for that one provision. What if everything is in, all your major recommendations, what would be the total? You have concurrent receipt recommendations and SBP recommendations and——

General SCOTT. Well, you know, I am going to have to provide that for the record. We can do a quick try to add them up here, but I have it broken down by recommendation, but I have not aggregated it. But we will provide it for you.

[The Commission cost estimates for major recommendations appears in Enclosure 1 in the post-hearing questions for the record, which appear on p. 48.]

Mr. SNYDER. Thank you for your service. This is a very complex issue and your report obviously deals with this in a very comprehensive way. And the Congress is going to need to digest this and move forward on this. But your report is a great, great start to this. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

Mr. Bilirakis, you have the floor.

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

General Scott, as you may know, my father, Congressman Mike Bilirakis, played a role in establishing the Veterans' Disability Benefits Commission during negotiations on the concurrent receipt.

I have continued my father's work in this matter and introduced legislation to provide for full concurrent receipt of military retired pay and VA disability compensation.

Therefore, I was pleased to read the Commission's recommendations pertaining to the concurrent receipt issue. I am sure that the Commission's positive recommendations on this issue will greatly help in the fight to eliminate the unfair offset between the military retired and VA disability compensation.

Along the way to enacting the concurrent receipt and disability payment which was established in Public Law, Congress enacted several other measures including the Combat Related Special Compensation Program. I have heard from some retirees that they find the myriad of different benefits confusing.

In the Commission's deliberations on the concurrent receipt issue, did you consider whether or not concurrent receipt benefits should be simplified?

General SCOTT. The quick answer is, yes, sir, we did. And I think you will find in the report a very detailed discussion of the overlaps that are in the present system now and the gaps that exist in it.

Mr. BILIRAKIS. Okay. Thank you very much.

I would like to talk to you maybe privately a little more detailed.

General SCOTT. Yes, sir.

Mr. BILIRAKIS. Thank you.

General SCOTT. Glad to.

The CHAIRMAN. Thank you.

Mr. Michaud, who chairs our Health Subcommittee.

Mr. MICHAUD. Thank you very much, Mr. Chairman, for having this hearing.

And I, too, want to thank the Commissioners for all your hard work.

In the report, and I would like to quote a part of it, and that quote says, "Little interaction between the Veterans Health Administration which examines veterans for evaluation of severity of symptoms and treats veterans with PTSD and the Veterans Benefit Administration which assign disability ratings and may or may not require periodic reexamination."

This report talks about a new holistic approach to PTSD that would couple treatment, compensation, and vocational assessment.

Could you, Mr. Chairman, go into greater detail of how this approach would be implemented, what benefits it would bring, and how we could minimize the potential unintended negative incentives in the treatment of PTSD or other mental health disabilities.

General SCOTT. Sir, we discussed the rationale behind our conclusions and recommendations in some detail in the big book there. But the perception of a disincentive would be addressed by coupling treatment, compensation, and vocational rehabilitation and assessment and with periodic reevaluation. I believe that would address that perception.

The perception, as you know, to be sort of short and blunt about it is that people who get themselves diagnosed with PTSD and then go off and collect a benefit for the rest of their life and we did not really find that to be an accurate perception, but it is there and has to be dealt with.

But we really believe that if we come up with this holistic approach that really combines treatment, compensation, and vocational assessments and training and periodic reevaluation that will take care of the perception and it will also perhaps give us an opportunity to get some more insights on the disease of PTSD.

As an aside, sir, I was not particularly satisfied that the body of literature on PTSD and the methodology that the VHA uses to diagnose it and the VBA uses to adjudicate the level of disability was necessarily sound. I believe that, speaking for myself now, I believe a whole lot more education and training is needed by the people that do it.

I think you need to be sure that you have the right sort of clinician doing the diagnosis and you have the right sort of training in the adjudicator who tries to make a determination of, well, is this PTSD and, if so, how bad is it, and are there other co-morbidity factors like depression or maybe bipolar or something like that affects this, and then what should the treatment regimen be.

The medical literature that we had access to differentiated between curing PTSD and making it better. In other words, there seems to be a general concurrence that it is treatable and that there will be relapses and remittances throughout a period of time, but it is treatable. And so that is where we were headed with our recommendations, sir.

Mr. MICHAUD. Thank you very much.

I yield back, Mr. Chairman.

The CHAIRMAN. Thank you, Mr. Michaud.

Mr. Boozman, you are recognized.

Mr. BOOZMAN. Thank you.

First of all, General, I want to thank you and the rest of your Commissioners for the outstanding job and all of the hard work. And I know that this was a lot of hard work and we really appreciate you all stepping forward and answering the call as you have so many times in all of your all's careers. So thank you very much.

I have a statement that I would like to put in the record, Mr. Chairman, if that is okay.

[The prepared statement of Congressman Boozman appears on p. 36.]

The CHAIRMAN. Thank you.

And all Members may have any statements put in the record.

[The prepared statements of Congresswoman Herseth Sandlin, Congresswoman Brown-Waite, and Congressman Salazar appear on p. 35.]

Mr. BOOZMAN. Thank you.

Let me just ask, do you agree with the VR&E's Task Force recommendation that the program should, and I quote, "Place priority on disabled veterans who have the most serious disabilities that impact quality of life and employment?" And if so, and I think you do, how do we implement that priority?

General SCOTT. Well, we spent a fair amount of space in the report talking about vocational rehabilitation. And what we found is that the number of counselors is inadequate to ensure that the targeted 125 cases per counselor can be met.

We found that the number of applicants and participants has increased, but the number of veterans who are successfully rehabilitated by VA standards has remained constant over the years and we are kind of puzzled about that.

The conclusion that we made was that vocational rehabilitation is not accomplishing its goal, again, if you agree with us that the goal is to return the disabled veteran to as near a normal life as they can have both in the economy and as an individual.

We made several recommendations to enhance the service to disabled veterans. In the report, they are on page 76, 77 and 195. Some of the thoughts would be additional employment counseling and screening IU applicants for vocational rehabilitative possibilities.

We recommended access to vocational rehabilitation for medically separated servicemembers, not just the tremendously disabled, but for all. We think that there should be some incentives to vocational rehabilitation and we spell them out in some more detail.

And also, we were not convinced that there had been very much real research on employment among disabled veterans. A lot of it seemed to be just hypotheticals as to what the employment among disabled veterans is.

Some of the data we turned up in our analysis and our surveys got at the different levels of employment in certain groups. For instance, as should probably come as no surprise, the disabled veterans with mental disabilities had a very low employment rate, whereas those with physical disabilities had a higher rate. And it varied based on the level of disability.

So basically, the implementation of our recommendation is going to require some additional staffing and funding for the VR&E, but

we really think that is a good place to spend some money in terms of getting people back into the society to the extent that it can be done.

And also it may require some legislation because we think employment counseling should be expanded from what our understanding of the requirement for that is.

Does that answer your question, sir?

Mr. BOOZMAN. Yes, sir, very much.

The Commission noted that the VA does not collect long-term data on VR&E participants. Would you recommend that VA conduct a longitudinal study of voc rehab participants with regular reports to Congress on the outcomes of, you know, the cohort being followed? Is that something that you could support?

General SCOTT. Well, we think it is something that the data should be gathered on. In other words, at the moment, it is too easy to declare this veteran is rehabilitated and then move on. And nobody ever goes back to see what transpired, how long did this rehabilitation last, was this converted into a long-term employment opportunity or was it just at the moment that the person was employed so they declared it a success and moved on.

So that is why we think a longitudinal study would be quite helpful in determining what is the long-term effect of a vocational rehabilitation program.

Mr. BOOZMAN. Good. Thank you. And, again, thank you to all of your Commissioners.

Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Walz.

Mr. WALZ. Thank you, Mr. Chairman.

And, General Scott, thank you so much and to all the Commissioners. I cannot tell you as a Member of this Committee, as a veteran, and as an American citizen who is concerned about this how pleased I am with the work you have done and how optimistic I am on this issue.

The research that you did and the analysis is truly complex, but you did it in such a way that I am hoping, and I think everyone up here would agree, that we actually move forward on these critical issues because this is a very emotional issue.

And I spent yesterday at a field hearing up in Mr. Hall's district, with Representative Lamborn, and it was on this disability claims problem. And the stories there are heartbreaking.

A Marine Sergeant who was unable to get his benefit claim processed and during the time that he waited, approximately 3 years, his life degenerated into substance abuse and bankruptcy and family problems.

Once the claim process kicked in, once he started getting the help, once he started moving forward, this young Marine is moving his life forward and we know how critical that is.

With that being said, and, as I say, I am optimistic on this and looking at this claims processing and backlog, your recommendation 9.1, I am looking at this and the report of the Veterans Claims Adjudication Commission talks about it is perceived as inefficient, untimely, inaccurate, and so on.

I turn the page and I look at a task force here, a Processing Task Force for 2001 needs to be revised. I look at the Institute of Medi-

cine. Says it is not efficient and fair. They deserve that. The Center for Naval Analysis and what the American public and what the veterans are seeing is the same old story again.

You have done a fantastic job of pointing out things that need to be addressed, things that I think we all intuitively thought but needed the analysis to back it up in a comprehensive manual. It is here in front of us.

I am looking at figure 9.1 on page 306 in here that shows me how we can reduce that claims backlog.

General, can you tell me if it is you and you are telling Congress, and I know your recommendations are in here, but sum it up, can we get this done? Can we reduce this claim backlog? How specifically are we going to do that?

And I can tell you that I can feel it from yesterday from Sergeant Lassos the impact of doing that is going to be immeasurable. So if you could walk me through that for just a second and talk to this Committee about how that is going to happen and the charge that you are giving to us and put that onus of responsibility on us to make this happen.

General SCOTT. Well, first, the good news, sir. The VBA has been authorized to hire, I believe it is 3,000 additional adjudicators over the next year and a half. That is a start.

Now, the question is, how quickly can they be trained to do the work? One of the real problems with the claims backlog is initial inaccuracies in the claims processing which results in appeal after appeal after appeal and it goes up to the Board of Veterans Appeals or the Court of Appeals for Veterans Claims. And it gets kicked all the way back down and it starts over and the file is either mailed or Fed-Ex'd from one of these entities to another. It cannot be done electronically at the moment.

So it is more people in the right place. You know, as the cliché says where the rubber meets the road. Training and education and standardization of the claims processing process and the processors with the goal of reducing the errors that occur initially which just compound as it goes on and in many cases, that makes up what the problems are.

The atrocious figure of the 800 plus days is for appeals claims. And for new claims that are in pretty good shape, it is still nothing to brag about, but it is somewhere in the 177 or something like that. But at any rate, we have to reduce the error rate that results in all these appeals.

There are some possibilities for, and we mentioned in the report, best practices of business and some information technology. But it has been pointed out by the Dole-Shalala Commission IT is not the silver bullet. It would be a great assistance for the movement of these claims around, but it is a matter of best practices.

And why can't an adjudicator open a claim on a computer, send that forward? Obviously there is some subjectivity involved because every person is different. But there is a lot of it that is not really subjective. So, you know, if they just get into best business practice, train people, keep them on the job, keep them doing the adjudication, I think that is probably as key as anything else is.

Then, as you well know, sir, the judicial requirements as well as regulatory requirements get pretty complicated. The "Veterans

Claims Assistance Act" has, according to the Under Secretary for Benefits, in some ways slowed the process down because it caused them to do certain things that slow the process down.

So let me give you an example. A veteran gets a letter and the first four or five pages is indecipherable legalese. Finally, on the last page, it tells the veteran what he or she has got to do. Surely we can come up with a letter that meets the legal parameters that tells the veteran in the first or second paragraph, hey, bud, here is what you have to do to get this thing moving and, you know, just things like that.

Again, we made a lot of recommendations. But on the other hand, you know, what we think should happen is that the VBA's feet should be held to the fire since you have given them more assets of 3,000 more people and set up some goals for reducing it and then help them legislatively as they come forward with legitimate requirements or legitimate things that would help the process.

But, a lot of it is inside the VBA and I have had this conversation with VA and with the Under Secretary for Benefits. And they agree. So it is really multifaceted. It is people. It is training. It is standardizations. It is best business practice. It is finding those documents and processes that can be simplified and still stay within the law or change the law in some cases to make it a little bit easier to do.

But right now it is so complicated that it is a wonder to me that anyone is ever able to get a claim processed.

Mr. WALZ. I agree. Well, thank you, General. And you can be sure that those recommendations are going to sink in up here and we want to see it too. So thank you.

I yield back, Mr. Chairman.

The CHAIRMAN. Thank you.

Ms. Brown-Waite.

Ms. BROWN-WAITE. Thank you very much.

And thank you, General, and all the Members of your Commission for putting together a very good report.

Your comment on the initial inaccuracy reminded me of a case that I was involved in my district where I swear those raters once it was stamped as rejected that all the way down the line, nobody opened up that folder where that initial error was made.

And when I read through it, and I saw the man and know him, I said this is absolutely wrong. I think that happens far too many times. It is almost like maybe we should mandate that they sign their initials at the bottom that they actually read what is in the folder. You know, maybe it is the college professor in me coming out, but that happens, I am afraid, far too often. And I appreciate your addressing that.

On page six of the summary, you indicated that you did a survey of disabled veterans and survivors. What was the number of people who were actually surveyed and what was the error rate?

General SCOTT. Okay. We surveyed 21,000 people.

Ms. BROWN-WAITE. Wow.

General SCOTT. Twenty-one thousand veterans. And 1,800 survivors.

Ms. BROWN-WAITE. What was the return rate because I am sure if it was a mailed survey——

General SCOTT. It was a telephone survey. Let me tell you how we did this. The Center for Naval Analyses contracted with a company that does telephone surveys and we provided or they were provided a list of veterans in certain categories so that we were not skewed by either age or geography or particular ailment or anything like that. It was across, and I think the report explains pretty much, all the different——

Ms. BROWN-WAITE. So it was a good survey?

General SCOTT [continuing]. Categories that were surveyed.

Ms. BROWN-WAITE. Right.

General SCOTT. And so that was what was done. And we wanted a 95 percent confidence level in the results of the survey and so that is why we had to go to such a large number of people.

Ms. BROWN-WAITE. The finding that physical disabilities did not lead to decreased mental health, was the question asked, you know, are you on obviously pain medication because, you know, anyone on pain medication usually is pretty happy? Was that follow-up question asked?

General SCOTT. Well, you know, I will have to furnish that for the record. I reviewed the survey. The Commission reviewed the survey before it went out and we made sure that we all agreed that it was asking the questions that we thought were important.

[The Commission survey results appears in Enclosure 1 in the post-hearing questions for the record, which appear on p. 48.]

I cannot remember exactly where we were on that, but I will say this, that broadly speaking, we determined that the people that had mental disabilities had poor physical health.

Ms. BROWN-WAITE. Right.

General SCOTT. Another reason for why we need to do a better job of analyzing and treating these people so we can improve their physical health as well.

However, the reverse was not true, that the people with physical disabilities did not have more than expected mental problems.

Ms. BROWN-WAITE. Right. So I think the natural follow-up question would be, are they on medication because anyone who has suffered, say, back pain without medication, you are pretty darned depressed.

My next question is, one of the recommendations that you make in your testimony and in the summary that we have involves increasing disability compensation payments by 25 percent until a systematic compensation methodology is developed. How long do you think that this methodology will take to develop? Why has it not ever been developed before? And do you know how much this 25 percent increase would actually cost?

General SCOTT. Let me see if I can start with, again, there has been since the Bradley Commission study comments and general statements that quality of life should be a consideration in compensation.

The best example is a wheelchair-bound veteran who is able to work in the economy, but none of us would willingly trade places with that individual because we all know intuitively that he has a different quality of life based on the disability.

So there has been a lot of discussion about how do you look at that, how do you consider disability or how do you consider the

quality of life as disability. The Dole-Shalala Commission studied the same thing and they made the recommendation that a study be put together with Congressional oversight to determine how best to address the issue of compensation for quality of life.

It is hard for me to estimate how long it would take to do that. Certainly if the legislation that gets through has that as a requirement for a study, I would hope there would be some sort of a time parameter placed on it. And that is a better way of determining how to compensate for quality of life than an across-the-board increase. We would agree with that.

But these things have a way of going on and on and on. And so particularly and I mentioned that it is up to 25 percent. It was not the intent of the Commissioners to say that everyone with a 10 percent disability should have a 25 percent increase in compensation based on quality of life because clearly the degree of disability would have a lot to do with the impact on quality of life.

So we put together a hypothetical as to how that might be and let me see if I can get back to them here.

Ms. BROWN-WAITE. And did you cross those out?

General SCOTT. Pardon me?

Ms. BROWN-WAITE. Did you cross those out?

General SCOTT. I did or we did. The hypothetical that we put together said that a 100 percent disabled person who is now receiving $2,393 in individual compensation per month, with a quality of life increase of 25 percent, that would be about $598 and that would raise them to $2,991.

Going to the other end of the scale, a 10 percent disabled person who is receiving $112 a month, we suggested that the quality of life for that person might be 2½ percent, which would be an additional $3 a month.

So, again, we scaled this out on this hypothetical based on the degree of disability, percentage of disability. And the particular hypothetical that we ran here showed that the annual quality of life compensation additive to the $19 billion compensation as it exists now would be $3 billion in rough terms.

And we will be happy to furnish you a copy of this hypothetical. We will certainly furnish it for the record.

[The Hypothetical Example appears in Enclosure 2 of the post-hearing questions for the record, which appears on p. 56.]

Now, obviously if you decided that you wanted to give everybody a 25 percent quality of life kicker, it would be a significantly greater sum. But we said it should be based, we thought, on the degree of disability. And we said up to, so, it might be that after your deliberations, you came out with instead of 25, it was 15 percent.

But what we said was up to 25 percent on a temporary basis until a study could be put together to try to better determine how to compensate for quality of life which has been an issue that has been talked about and talked about and talked about over the years.

And so we came up with a methodology, you could say a sort of rule of thumb methodology to use until this is done. And arguably, if the study were done well and quickly, it might come up with results that would obviate the necessity for this particular kicker.

Ms. BROWN-WAITE. Thank you, General.

I yield back.

The CHAIRMAN. Thank you.

Mr. Hall. And we thank you for the hearing you held yesterday, I guess——

Mr. HALL. That is right, Mr. Chairman.

The CHAIRMAN [continuing]. In your district on these issues. And I understand Mr. Walz was there and Mr. Lamborn, and they said it was a very moving hearing in addition to the helpful information that came out. So if you can inform us about that.

Mr. HALL. Thank you, Mr. Chairman. Yes.

And thank you, General, and to all your Commissioners also for the work you have done.

We have a lot of reading to do and I was wondering is this entire report available on the Web site?

General SCOTT. It is. It is on the Veterans' Commission Web site and it will be moved to the VA Web site at some point. So the entire report is indeed on a web site.

Mr. HALL. That is really good news.

I have only a couple of questions——

General SCOTT. Yes, sir.

Mr. HALL [continuing]. Having not read the report yet. But under your eight principles, the second one, the goal of disability benefits should be rehabilitation and reintegration into civilian life to the maximum extent possible and the preservation of the veteran's dignity.

We had a veteran at the hearing that Congressman Walz, and Congressman Lamborn attended with me yesterday who was suffering from a Traumatic Brain Injury, a Marine sniper who was in a coma for a while and they wondered whether he would survive.

And he has not only survived, but he has recovered the use of his left arm and is speaking and, you know, what is going on inside really seems like it is all there, although the reconnection to his physical body is a process that takes rehabilitation and therapy, speech therapy and physical therapy and so on.

And he is a year and a half past the injury now. His neurosurgeon says this is the most critical time, that, you know, the progress that can be made in this case as in the case of stroke, for instance, is descending with time and you want to get as much therapy and as much stimulation of the right kind as soon as possible.

And there has been sort of a battle going back and forth between his parents and the VSOs have been working with him and the VA office that they are working with. His neurosurgeon suggests and neuropsychologist suggest 5 days a week, 4 hours a day of therapy. And the VA is saying 2 days a week, 40 minutes a day of therapy.

So they have that back and forth thing. The parents say that every time he is reduced, his therapy is reduced, they can see him backsliding.

I know he was wheeled up to the witness table in front of us and I saluted him. And he said do not salute me, I am not an officer. And I said I am saluting your courage and your sacrifice, sir. And he said, okay. He winked at me.

So, you know, there is a lot going on in here and he can grab you with his left hand really hard. And they said he would not be able to do that.

So in the spirit of the goal being rehabilitation, reintegration into civilian life to the maximum extent possible, I am wondering how many cases like this there are and, you know, whether your Commission talked about in the context of TBI cases whether there was a plateau for treatment at which you would say there is no point going beyond such and such a time.

General SCOTT. I do not have a current figure for the number of diagnosed TBI cases, but we will get it supplied for the record.

[Commission follow-up information regarding the number of TBI disabilities appears in Enclosure 1 in the post-hearing questions for the record, which appear on p. 49.]

The Commission also had the great privilege of hearing from disabled veterans who were suffering from TBI and hearing the trials and tribulations they went through regarding both medical treatment and therapy that followed. And it had quite an impact on us and on our recommendations.

And that is one of the reasons that we went after Vocational Rehabilitation and Employment Service pretty hard. We think that by spending a few more dollars and taking a hard look at eligibility, as one of the other gentlemen mentioned a while ago on VR&E, that we can do more for these people. And as you point out, sir, that every one of those cases is a little bit different. And so we certainly do not agree that a cookie cutter approach of so many days or so many minutes is fitting for all the cases and it would be the Commission's view that VA is going to have to individually tailor the treatment for these individuals.

And in some cases, where they are nowhere near a VA or DoD facility, they are going to have to do it through the fee-based or the outsourced medical system. There has got to be a provision so that VA can pay for civilian care for people who cannot get it because of where they live or whatever. And so we took somewhat of a look at the fee-based system and we had some recommendations in that regard as well.

But truly, every one of these cases are individual and has to be treated individually. And so I believe we have brought to VA's attention that needs to be done and we hope to bring to your attention that in some cases, it may be necessary to either target funding for these sorts of programs or in some way ensure that these vocational and these other rehabilitative efforts are properly managed and funded by VA.

Mr. HALL. Thank you, sir.

Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Bilbray.

Mr. BILBRAY. Yes, Mr. Chairman.

Let me just say frankly, General, congratulations. I have seen a lot of reports and as far as we have been able to review this, it is one of those unique times where we get a report that is frank, tough, but fair. And I want to just congratulate your entire team and the Commission addressing this issue.

And hopefully we will be able to take this information and turn it into something positive and actually rather than sitting around

talking about it like so many of us here in D.C. do so often, we will be able to put together something that actually will help to implement the strategy that you have highlighted in this report. So thank you very much. I appreciate it.

And I yield back, Mr. Chairman.

The CHAIRMAN. Thank you, Mr. Bilbray.

Mr. Hare.

Mr. HARE. Thank you, Mr. Chairman.

And thank you so much for all the work that you and the Commission did, General. I know it took a lot of time and a lot of thought went into it.

I wanted to get your thoughts on an idea here. We were talking about the backlogs and you talked about the 3,000 new people being hired over an 18-month period and, you know, to simplify the letter so that people do not get caught in this thing.

There has been some discussion about when the veteran files a disability claim, why err on the side of the VA. Why not process the claim and then if we want to take a look at it, similar to what we do with an Internal Revenue Service (IRS) return, why do we not just go ahead and audit the claim because the vast majority of veterans, I would say 99.999 percent, are not going to try to take advantage of the system?

And it seemed to me that is a real effective way. My fear is, and this is one question, I have two for you, my fear is that by the time we get these 3,000 people up and trained and moving in an 18-month period, this backlog is going to get worse before it gets better and we are going to be losing some people through retirement, so really that number of 3,000 may be significantly less.

I just wanted to see what you thought about the possibility of being able to say, look, if the veteran files this claim, why do we not process the claim because ultimately the way I understand it, if the claim is accepted, we have to pay retroactive anyway. So it is not going to cost us any additional funds.

Secondly, if the veteran passes away in the middle of this process, I believe we had some people testify that person's spouse has to start all over again at square one which to me seems to be very disingenuous because they have gone through all this process, they could be here for 5 to 6 years, and now they have to start all over again. So that would be one question.

Then my second question to you is, using the single rating formula, I know you talked about this and you may have in your opening statement, I apologize for being late, to rate mental conditions with conditions like TBI and Post Traumatic Stress Disorder coming back with significant frequency, do you have a problem or do you see where we could have a problem with this one-size-fits-all approach in terms of being able to handle mental conditions and is that a disservice that you think we are giving to our returning soldiers because if we are only going to use the one rating system and you have two very distinct types of problems here? So I just wanted to kind of get your thoughts maybe on both.

General SCOTT. Well, let me try to answer your second question. What we hope to achieve with our recommendations regarding mental issues, as they relate to the rating schedule was we determined, and I believe that the VA essentially agrees with us, that

the present rating schedule lumps together virtually all mental issues to include TBI, post traumatic stress syndrome, and other mental disorders.

And we suggested as a matter of priority in fixing the VA rating schedule that the schedule address those separately in such a way to make it easier for the clinicians to properly diagnose what is wrong with the person because they basically now are required to follow the VA rating schedule. And the same with the adjudicators who have to determine what is the level of disability.

So we think it is very important to separate the post traumatic stress, Traumatic Brain Injury from other mental problems and to have a set of standards and the schedule that enables them to properly sort that out so that you know what it is you are talking about. And part of that is the clinician has got to be able to determine what the problem is, which is a training and experience problem. And then the adjudicator has to be able to evaluate what level of disability is there.

Does that get at your second question, sir?

Mr. HARE. Yes, it does. Thank you.

General SCOTT. Okay. And I am sorry, sir. Do you mind telling me again what your first question was?

Mr. HARE. Well, I am new on this Committee. I understand that. But I was sitting with Congressman Joe Donnelly and we were having coffee one time. We were just talking about wait a minute, it seems to me we should be erring on the side of the veteran on these disability claims. If we are really going to fix the backlog, we can throw more people into the process on adjudicating the claim.

General SCOTT. Right.

Mr. HARE. But ultimately if we are going to pay the claim out and we trust our veterans, and I certainly do, to submit these, why do we not start the claim process and then if we want to audit the claim, we treat it like we would when somebody files their taxes? So I guess my point is erring on the side of the veteran and not the VA.

General SCOTT. Uh-huh. Well, we discussed not in great detail the work that a Harvard professor, and I cannot recall her name right now——

The CHAIRMAN. Bilmes. Professor Bilmes.

General SCOTT. Bilmes did and she recommended exactly that, that if a veteran comes in and claims a disability, that it be stamped approved and the payments start immediately. And then at some point later down the line, it would be looked at again.

And, you know, I think I am speaking for the VA position on this as they are very concerned that they would have a very difficult time going back and dealing with the claims that were either unjustified or that were tremendously overrated during that initial process and all of that.

So I think it is a matter of a view that it might not be the best stewardship of the taxpayers' money to just pay claims whenever somebody came in and made one rather than try to make at least some sort of an attempt to adjudicate what sort of a level it would be.

Now, we did not study that in great detail, but, you know, it might be that is something that you would want to commission VA to take a look at and see.

But, again, sir, I think part of the answer is simplifying the claims process, the paperwork, getting more trained people on the job, cutting the error rate which one of the Members mentioned earlier that was a significant problem on individual cases and has contributed to the backlog.

But, you know, I am speaking now for myself and not the Commission. You know, there is certainly nothing wrong with studying the idea of paying claims when submitted.

The VA's concern about it is could they ever go back and audit it. And VA has had significant difficulties, they tell me, in ever going back and recouping money or adjusting ratings downward.

Now, my understanding is that there are some either legal or regulatory rules in place that after a certain period of time that the level of disability cannot be reduced.

Mr. HARE. I know my time is up, but I just wanted to say one thing with regard to that.

We have had the VA here and they have said the average now is 177 days.

General SCOTT. Right.

Mr. HARE. And what they hope to do is get that down to 145 days. For that veteran and his or her family that is really dependent upon that disability, you know, if that is the goal, I think they better shoot a lot lower than 145. And, you know, I just think that we need to do better.

But I want to just say again I thank you for everything you have done and your Commission. It is a wonderful report and I hope we can get to the day where we can err, again, as I say, on the side of our veterans and not the bureaucracy that goes along with it.

So thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Mr. Hare.

Mr. Donnelly.

Mr. DONNELLY. Thank you, Mr. Chairman.

And, General, thank you so much for all your hard work on this.

As Mr. Hare was saying, we have had some discussions about this disability claim process and here is my concern is when you come back and you still have a mortgage to pay, you still have car payments to make, your children do not stop needing to be fed, and 177 days later, they are starting to crack open the claim and see what we can do. Well, for that 6-month period, the mortgage people do not go away and the car payment people do not go away.

And so there is a need to get this right from day one. And as Mr. Hare was saying, you know, they tell us, well, we can move this from 177 days to 144 days. Well, it puts a number of veterans in an almost impossible situation as you can imagine.

I had a chance again last night to talk to then Secretary Nicholson and even he supported for a pilot program for Iraqi veterans, Afghanistan veterans, that we take a look at this payment from day one, audit the claims. And, you know, I think our feeling here is that auditing the claims and if they are wrong to adjust them that is the right thing to do. We do not think we will be in a position where we say, well, that is not fair. The claim is the claim.

And I know one of the things Mr. Nicholson had or what was being discussed was when that claim is put forward, make a set payment of a 30 percent disability from the start so it does not get out of hand.

What would you think about that kind of idea?

General SCOTT. As a Commission, we really did not study the notion of paying up front. But from a personal point of view, I could not object to doing it as long as it was some sort of a pilot program and as long as it was some sort of a set percent that the Congress felt comfortable with in terms of doing that.

Now, we did make a recommendation that transition payments should be made to tide people over through these periods of time. And I believe the Dole-Shalala Commission made basically the same recommendation that we should offer a transition payment that was based on the soldier's or the servicemember's monthly payment for a period, and in some cases, it was 3 months, in some, it was 6 months, to get away from this period of absolute destitution for somebody.

And then also there is the Benefits Delivery at Discharge (BDD) Program that if properly advanced at more locations would also get the ball rolling a good bit quicker on it.

A number of the cases that we did examine, and I will be perfectly honest with you, we did not study a lot of individual cases, we had people that were representative of different issues and problems come before the Commission where we talked to them. But a number of the problems that we did talk about were people who had not filed a claim until well after they got out either because they did not know how or they could not or something like that. And that has exacerbated the problem by making the process longer.

I would be the first to agree with you that reducing the time from 177 to 145 days is not the answer and it should be more like 60 to 90 days it would seem to me at the very most to get it done.

Again, I do not know, speaking for myself and not the Commission, I do not know that I would have any personal problem with some sort of a trial program.

You know, I think that the VA as an institution has been beat about the head and shoulders from so many different directions and so many different people that the notion of trying something new is met with a fair amount of skepticism because they are afraid that at the end of the day that they will be left holding the bag on it.

And so, you know, I am hopeful that a new Secretary will come in with some ideas on how to look at some of these problems and I hope that new Secretary's relationship with the Committees and with the Congress is such that he will be able to get some support for some things he wants to do.

But the notion of paying some people at a relatively low rate, 30 percent, just to get the ball rolling is certainly something that I have no personal objection to. And I guess if we were doing this Commission again, we would probably try to do something about it.

But I think it can be studied in a relatively quick way by the VA and maybe a couple of outside agencies to determine what are the

parameters of something that could make it work so that it would not be a headline grabber around town here that, you know, VA gives away money without proving claim or something like that. I think if it were done properly, it could probably be done.

Does that answer your question, sir?

Mr. DONNELLY. Yes, it does, General. And thank you very, very much for your service to our country. We are deeply in debt to you.

The CHAIRMAN. Thank you, Mr. Donnelly.

Ms. Herseth Sandlin.

Ms. HERSETH SANDLIN. Thank you, Mr. Chairman.

Thank you, General Scott, for your hard work and that of your fellow Commission members.

And as the Chairwoman of the Economic Opportunities Subcommittee, I wanted to explore a couple of areas with you specific to the jurisdiction of that Subcommittee, one that I believe the Ranking Member, Mr. Boozman, did talk with you as it relates to VR&E benefits. And I may get to that at the end of my questioning.

But if we could talk about specially-adaptive housing for a moment, I was particularly interested to review the recommendations for the Specially-Adaptive Housing Program. I agree that the program has failed to account for the rising construction costs that we have seen across the board and we have introduced legislation to try to correct that as it relates to adjustments for inflation and the overall amount that a veteran can receive for the housing modifications.

You did explain in the report that severe burn victims are not eligible for the program. And at one point, a constituent of mine was told or his wife was told as she was filling out all of the paperwork necessary to receive the grant, kind of informed on an informal basis that, well, you know, if he uses a wheelchair at all, you should simply note that he is wheelchair bound because that essentially enhances the likelihood that he will be eligible for the grant.

Now, you know, as he is undertaking his physical therapy, you know, there is the hope that at some point, he will not need any type of mobility device.

But did you uncover any other area where you feel that there are deserving disabled veterans who are not qualified, who are not eligible for the specially-adaptive housing grants?

General SCOTT. Well, I think we did address that specifically with the burn victims. And to the best of my recollection, we did not encounter any other Catch-22s, you could say, where a severely disabled individual for whatever reason did not meet the qualifications. But that is not to say that there are not some others out there.

But the burn victim thing became readily apparent to us as we worked through it as did the fact that we recommended that you take a look at the adaptive housing allowance based on the update.

Now, we looked at, as you may have noted, all these different allowances with all the special compensations and some of them interestingly are connected to a cost of living adjustment (COLA), an annual COLA, and some are not. And it did not appear to us that there was a lot of rhyme nor reason to which ones were and which

ones were not, which ones were only updated by legislation and that would tend to be on a less than periodic basis.

So, you know, we had some questions in our own mind as to why some of them were treated in one way and some another. And so we tried to point that out. We pointed out the anomalies in the report and that was certainly one of them, ma'am.

Ms. HERSETH SANDLIN. Well, thank you. And thank you again specifically for addressing the issue of severe burn victims and the current status of ineligibility for the Specially Adaptive Housing Program.

And we have uncovered in a Subcommittee hearing that even the building specification document has not even been updated for this program since, I believe, the mid 1970s. So I think we have a lot of work to do to make it a program that can be better utilized by many of our returning servicemembers.

On Traumatic Servicemembers' Group Life Insurance (TSGLI), you outlined in your report that most instances, TSGLI has become the intended financial bridge from the time of injury until the soldier is eligible for VA benefits. And you explained that the April 2007 Independent Review Group report recommended that the Secretary of Defense should review TSGLI to include TBI, Traumatic Brain Injury, and Post Traumatic Stress Disorder.

Now, while many TBI-related injuries are covered, PTSD is not. I believe you may have stated it in the report, but do you support providing the TSGLI to those suffering from PTSD and would you make the benefits retroactive?

General SCOTT. I do not think we addressed that. And, you know, my understanding of that particular legislation is that it was not intended that it include something like PTSD, that it was for the more traumatic type injuries that were readily discernible and all that.

And as you well know, the problem with PTSD is it can be an immediate onset or it can be delayed for a long period of time and it can remit and relapse and on and on. So I did not really, again speaking for myself and not the Commission, I really did not categorize PTSD in the same way that I did the TBIs and the traumatic amputations and the other disabilities that fall under TSGLI.

Ms. HERSETH SANDLIN. Thank you.

And with the indulgence of the Chairman, I would just note that on page 352 of the report, the Commission did suggest that Congress mandate Transition Assistance Programs (TAP). And I agree with you. I agree with the Commission's recommendation.

And at the very least, as we transition to try to provide adequate funding for all of TAP, we should at the very least in light of the importance of all the programs, but VR&E in particular for service-connected disabled veterans, mandate the Disabled Transition Assistance Program (DTAP) for disabled veterans who are separating from service.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Ms. Herseth Sandlin.

Mr. McNerney.

Mr. MCNERNEY. Thank you, Mr. Chairman.

General Scott, I certainly want to thank you and the Commission for developing this comprehensive report and for leadership in this endeavor. It is a big need.

And I certainly hear a lot from the veterans in my district. One of things you have discussed here this morning is the claims delay, so I look forward to trying to implement these recommendations.

One of the things that concerns me, of course, was just mentioned, is the Post Traumatic Stress Disorder and Traumatic Brain Injury. Do you think as a part of a holistic approach that we need more inpatient PTSD treatments or do you think that the current approach is more effective and is there a need for more research in terms of effective PTSD treatments?

General SCOTT. Well, let me start off by saying that I certainly think there is a need for more research. One of the reports that we were not able to take any benefit of because it did not get completed, an IOM report, regarding PTSD treatment.

And I would commend that report to you when it is completed. It is actually being done on behalf of VA, but we hope to be able to utilize it in our deliberations as well. So I would recommend taking a look at it.

But the Commission's view was that VA really did not know as much as it needed to know about PTSD and part of that again is we do not have a lot of confidence that the clinicians who are making diagnosis were qualified and experienced to do that. We do not have a lot of confidence that the adjudicators that were establishing levels of disability for PTSD were qualified, trained, and experienced to do that.

So the answer is, yes, there needs to be a fair amount more of research done so that VA can state with some authority and some research to back it up a little bit more definitively what should be done about PTSD as it appears in veterans.

Did I miss part of your question here, sir?

Mr. MCNERNEY. Yes. Do you think there is more need for inpatient treatments?

General SCOTT. We really did not study the need for inpatient versus outpatient. A lot of what we did look at was the role of the Vet Centers and other what you might call outpatient treatment activities. And basically what our concern was that there was not a lot of treatment going on.

Now, I think there are 340,000 people that have been diagnosed with PTSD and about 240,000 of them are receiving some sort of compensation. But it is not for sure how many of those are receiving any treatment at all and, if so, how much and is it the right sort of treatment.

So I do not think I can say definitively there should be more or less inpatient vis-à-vis outpatient, but I think there probably needs to be, as I said earlier, this connectivity between compensation, treatment, vocational rehabilitation, and reexamination if we are to achieve our goal of reintegrating the veteran into society to the maximum extent possible.

So I guess I punted your question. I do not think I have an answer should there be more inpatient treatment facilities. I will ask and try to get you a response to that question, sir, but I do not think it came up in our research.

[The information regarding inpatient PTSD treatment appears in Enclosure 1 in the post-hearing questions for the record, which appear on p. 49.]

Mr. MCNERNEY. Thank you, General.

Another question of concern is complementary alternative medicine. I have not really studied the report yet, but do you think that we should provide veterans with a mechanism to have access to complementary medicine if they feel that is a need or if their physician thinks that is a significant need?

General SCOTT. Sir, we did not address that. We looked largely again at healthcare sort of in the whole as a very important disability benefit. And then because of the concern and interest of all of the Members and VA and everybody else, we took a harder look at PTSD.

But I do not think I am qualified to comment on the complementary care as an issue. I will try to find out what the current policy is and get that over to you at the VA because, quite frankly, I do not know what it is right now.

Mr. MCNERNEY. Okay. Thank you, General.

I will yield back.

The CHAIRMAN. General Scott, thank you so much for being here. Your command of the issues is impressive and also your humbleness when you do not know something. And I appreciate that separation.

Now, Mr. Wilburn, I am sure your efforts were enormous and we thank you also.

I personally found your discussion both of mental health and employability very, very important. These are major areas. It is sort of a cultural change. It is hard to legislate. But the focus of a system on that is very, very important. We thank you for adding your voice.

Two areas where I thought you might have gone I will say more radical or more comprehensive. Number one, on the so-called presumptive issues.

General SCOTT. Right.

The CHAIRMAN. And I do not know if I heard you right or if it is explained in the body of the report, but you said that, say, for Agent Orange, that has been done, we accept it. And I do not think that is true. In fact, a major problem that Vietnam vets still have is fighting the system for ailments which they are convinced are related to their service in Vietnam. And by law, there is a limit on the presumptiveness of a whole range of things.

And, on the issue that Mr. Hare and Mr. Donnelly raised of accepting things, maybe the pilot ought to be with Vietnam vets. We want to honor the returning vets, but I will tell you that the older veterans are so frustrated and so, I do not know, just very—they feel victimized by the system for years.

For example, I was in Illinois. It was Mr. Hare's district, I guess. No. It is Mr. Walz's district, I think, where the couple that had Parkinson's, is it, and I was handed a list of, I do not know, 500 veterans, Vietnam veterans who had Parkinson's in their early fifties which is, I do not know, a decade or more where, you know, you should get that.

And it was clear that this had to be related to Vietnam. And, yet, by law, which we have introduced a bill to change, you could not be compensated for either—it was specifically for Parkinson's or Lou Gehrig's disease. And I say, hey, if you served. I mean, the presumptive tests are you have to put your boots down in a certain place and have a certain, you know, prove that the chemical was there at this time.

It is so burdensome that I think we should just accept the presumption. If you were in Vietnam, we treat you. You served us, we serve you.

So I do not know if I misheard you or I took it too far, but I do not think that presumptive issue has been solved at all.

General SCOTT. Well, I may have in an effort to be brief overstated the Vietnam reference. But what I had hoped to say was that the current law or current way of determining presumption does not have as much science or medicine in it as it probably ought to and that in some cases, for some ailments including radiation ailments and some of the Vietnam-related Agent Orange issues, presumptions have been made.

The CHAIRMAN. I understand. It has not gone far enough.

General SCOTT. So I did not mean to imply that it covered all valid or worthwhile presumptions, just certain ones. And I think type two diabetes is one of them and there are some others that the presumption does cover.

The CHAIRMAN. Right. I understand. There is a whole range that it does. And I hope that before this Congress is over, we address that.

The other issue that I again had wished for a more radical approach that Mr. Hare and Mr. Donnelly brought up, and I am so glad our new Members are taking this, they have not been beaten down yet by the bureaucracy and telling us we cannot do this. I mean, to have more people and more time, obviously you are going to bring down the backlog, but it is not fast enough and it is not complete enough. And as was pointed out, we could probably fall behind while we are trying to improve it.

I think we have to cut through the bureaucracy very quickly and do it soon. And whether it was Professor Bilmes' approach similar to the IRS, of accepting claims subject to audits—by the way, I would add, I think a suggestion to deal with your sense of accountability is that if a claim was submitted with the help of a properly trained officer either from one of the VSOs, they have, you know, service officers, the counties, States, and I do not know that they are all equally trained, but we could set that up and certify them and if the claim has been helped by one of those certified officers, then we can do what was suggested except it is subject to audit in addition.

[Follow-up information from the Commission regarding immediate processing of claims subject to post award audits appears in Enclosure 1 in the post-hearing questions for the record, which appear on p. 49.]

So I think you can put some accountability in there to really get this claims thing down quickly because none of us can go to a town meeting without hearing such a sense of frustration and fighting the bureaucracy sometimes does more harm to the physical health,

let alone the mental health of the veteran, more than the original ailment probably did. That is, we have to stop this adversarial approach where they have to prove every little detail and every little place, you know, if your boots were not on that ground at that time.

So if we have to do a pilot program, I do not know if we have to, but I might start with those Vietnam vets because we owe them so much and we did not treat them with the respect or honor they might have had or recognize the mental health issues or, of course, for years, they denied that the Agent Orange was even a possibility, you know, the causation.

So I think we would like to take those two areas dealing with breaking through this 600,000 backlog. And I understand there has been more than 300,000 new claims filed by our Iraqi vets.

So you have given us a real good start. It is really important that your prestige and the incredible work that you all have done on the Commission for a couple years is going to give us the sense, and will prove to our colleagues, that what we are doing is the right way to go.

And I accept the charge that you have made, but, you know, I am sure you feel from all of us on both sides of the aisle in this Committee that we will pursue these recommendations. We will try to get enacted as quickly as possible those that can be accomplished by legislation and then try to deal with the cultural issues with any new leadership that comes to the VA.

So, General and all of your Commission Members, Mr. Wilburn, thank you so much for everything.

This Committee will be adjourned. Thank you.

[Whereupon, at 11:51 a.m., the Committee adjourned.]

A P P E N D I X

Prepared Statement of Hon. Bob Filner, Chairman, Full Committee on Veterans' Affairs

The Committee on Veterans' Affairs will come to order. I would like to thank the Members of the Committee, Chairman Scott, and all those in the audience for being here today.

Chairman Scott, let me begin by saying that you, your staff and the experts on whom you have relied have done a yeoman's job in producing this report and you have honored the call to duty.

After convening over 50 public business sessions with interested stakeholders, the final report is a culmination of 2 years of assessing of our Nation's system of compensation and assistance for veterans and their survivors and dependents.

Your mission was an arduous and daunting one—to examine the way our benefits systems operate and to provide recommendations on how to make the delivery of these benefits and services work better—in a way that represents the tremendous sacrifices that our men and women in uniform have made.

As most in this room know, the Commission is a construct of Congress, conceived in the Defense Reauthorization Act of 2004. Borne primarily out of recognition of the impact that the current conflicts of Operation Enduring Freedom and Operation Iraqi Freedom would have on VA/DoD resources, it was our hope that you would provide recommendations to increase the efficiency and effectiveness of providing benefits and services to our veterans and their dependents and survivors in a manner that truly reflects the dignity of their service to our country.

To do this, you had the wisdom to know that not only would you need to commission studies by the IOM and the Center for Naval Analysis Corp., but that you would need to be multi-prospective—looking to the past, present and future—to try to fix a system that has suffered from serious internal flaws for decades. So you took a look at the collection of good ideas that have accumulated over the years, from those contained in the Bradley report, to Dole-Shalala and the President's Commission Reports, and numerous IOM and Center for Naval Analysis reports, to inform your 114 recommendations.

After the discovery of the conditions at Walter Reed and the many reports on the growing backlog at the VA, there are now many resources and ideas for the VA to tap about how to best administer its benefits and healthcare programs. But this report is unique, because it synthesizes these great ideas to provide a roadmap for moving forward.

I believe that just as we did in the 90's when Congress, the Administration, VSOs, veteran advocate organizations and other stakeholders, partnered to place greater emphasis on turning the VHA into a world-class, technologically adept entity, we must devote the same resources and brain power to turning around the VBA. It must become a world-class, technologically adept, 21st Century organization.

I look forward to working with the leadership of the VA to making this a reality. Needless to say, we must also apply this same brain power and energy to perfecting seamless transition.

As we continue to give full resources to the war, let us not forget the warrior and the warrior's family. Our men and women should not get first class weapons to fight only to receive third-class benefits after fighting. We must continue on a path to making the benefits provided to our veterans first-rate and uncompromised.

I will not belabor this point, but the current waiting periods at all levels in the VA disability benefits system, from 177 days at the regional office to 751 days at the VBA or 240 days at the CAVC, are all unacceptable. These waiting times became exacerbated to the point of unmanageability due to the funding shortfalls over the past 10 years. But I firmly believe that they belie a system that is girded by dedicated and professional employees committed to our veterans.

I was looking at the VA's website recently, and I came across the Veterans Benefits Administration's (VBA's) covenant. I do not need to tell any of you the signifi-

cance and impact of entering into a covenant, so I wanted to share the VBA's with this audience.

It states that, "We are the leaders in one of our Nation's most vital and idealistic service organizations. Because we serve veterans and their dependents, our mission is sacred." It then goes on to quote both President Lincoln and General Omar Bradley; quotes which are posted in all VA offices:

> ". . . to care for him who shall have borne the battle, and for his widow and his orphan . . ." President Lincoln; March 4, 1865.
>
> "We are dealing with veterans, not procedures—with their problems, not ours." General Omar Bradley; 1947.

It further states, that, "As we carry out this mission, we willfully enter into a covenant with one another to always be guided by the fundamental principles of Accountability, Integrity, and Professionalism. These principles form the foundation of Leadership and Service to America's veterans."

Today, I want all of us (all relevant stakeholders) to enter into a covenant to devote our collective resources, brainpower, willpower and manpower to improve the current system of delivery of VA benefits, one which will optimize outcomes for all of our Nation's veterans.

I want us all to remain cognizant of the privilege we have in being able to devise the policies and administer the benefits for these brave and deserving men and women and their families.

There is real sanctity in this privilege—we should always be mindful of whom we are serving. I think this report is an important step on that journey and I look forward to hearing the Chairman's testimony today.

Prepared Statement of Hon. Steve Buyer,
Ranking Republican Member

Thank you Mr. Chairman,

General Scott, thank you for visiting with us today to testify on the recommendations of the Veterans' Disability Benefits Commission.

This prestigious commission was established by Public Law 108–136, the National Defense Authorization Act of 2004, to carry out a study of the benefits that are provided to compensate and assist veterans and their survivors for disabilities and deaths attributable to military service.

General Scott, you and your fellow members of this commission are to be commended for your dedicated work over the past 2½ years.

Your efforts required many long hours discussing issues in meetings, and poring over an array of complex materials to arrive at the recommendations you have presented.

I heartily agree with the eight guiding principles [included in the Executive Summary] you identified.

These principles provide a sound basis for considering any recommendations for improvement to veterans' benefits.

Clearly, you and your fellow commissioners share my sentiments that veterans and the men and women of the armed forces are among our Nation's finest citizens.

We are in a long war against global terrorism.

The enemy we encounter has its sights set on objectives it hopes to accomplish 100 years from now.

. . . it is our great grandchildren whom they plan to oppress.

We have no choice but to engage those who despise free will, and wish to destroy us, and the freedom we cherish.

It is imperative that we maintain a military that is capable of swift response in a world-wide theatre of operations.

To do so, we must continue to attract the caliber of people our military now has, and those who serve must be confident that they and their families will be well cared for should harm come their way.

Early on during my initial review of your report, I could see the Commission understood this fact well.

The Commission wisely focused on veterans' long-term issues, such as the need to revamp the disability retirement and compensation systems.

It has been my longstanding view that we must modernize VA and establish a transition process that is seamless in its efficiency.

The Commission's report, along with the recommendations of the Dole/Shalala commission, is a big step toward attaining this goal.

So I look forward to hearing your testimony, General Scott.

We will carefully consider all of the commission's recommendations, and hopefully use those we determine are most beneficial as a guide to meaningful and long-term policies to improve the lives of veterans and their families.

Mr. Chairman, I suggest that this Committee consider the Commission's priority recommendations first, and that those that are determined to be meritorious should receive prompt legislative action.

Also, Mr. Chairman, there appears to be potential for PAYGO issues, as we consider the Commission's recommendations.

While we may not have to grapple with these questions today, we must be mindful that as Congress and the Administration move forward, we must deal with the funding issues that pertain to the recommendations.

Thank you, and I yield back my time.

Prepared Statement of Hon. Stephanie Herseth Sandlin, a Representative in Congress from the State of South Dakota

Thank you Mr. Chairman for holding this hearing today to examine the final report of the Veterans' Disability Benefits Committee.

As the Chairwoman of the Economic Opportunity Subcommittee, which maintains jurisdiction over veterans' employment, re-employment, and housing matters, among other topics, I am very interested in exploring the recommendations of the Commission regarding Vocational Rehabilitation and Employment (VR&E) and specially adaptive housing.

The men and women in uniform who defend this country and make our economic and political systems possible, indeed, have earned our best efforts to provide them with adequate benefits to help them transition from life in the military to the civilian world.

We can and must do better. Congress must work harder to ensure that our Nation's servicemembers, who each day endure the cost of freedom, receive the care they have earned and deserve.

I look forward to hearing from Mr. Scott and to closely examining the Commission's findings and recommendations.

Thank you again Mr. Chairman.

Prepared Statement of Hon. Ginny Brown-Waite, a Representative in Congress from the State of Florida

Thank you Mr. Chairman.

I want to thank you for testifying before this Committee today.

The Veterans' Disability Benefits Commission was established by the National Defense Authorization Act of 2004, to consider the appropriateness of benefits and services administered by the Department of Veterans Affairs and the Department of Defense. Through its hard work, the Commission has compiled 113 recommendations to improve care for veterans across the Nation.

This is the second Commission report that this Committee has received on ways to improve the benefits and services provided to veterans. I eagerly await your testimony on the Commission's findings and look forward to working with you to improve the lives of veterans across the country.

Once again, I welcome you to the hearing and look forward to hearing your thoughts on the issue before us today.

Prepared Statement of Hon. John T. Salazar, a Representative in Congress from the State of Colorado

Thank you Mr. Chairman and thank you Mr. Scott for both your military service and for your service as Chairman of this commission.

As the Members of this Committee are aware, legislation relating to veterans or veterans benefits have been introduced more often in this Congress than any other.

While preparing for this hearing I searched the L–I–S website just to get an idea of just how many that might be.

I found five hundred and fifty five bills that made some sort of reference to veterans.

What this says to me is this Congress, and those before it are committed to finding ways to properly care for those who served and the families that support them.

Yet we have all seen the problems that are facing our veterans, old and young—in the case work that our congressional office undertake.

The issue that I would like to bring up, in part deals with back logs, but on a larger scale with just how much can truly be accomplished by vets when they try to navigate the process alone.

I hear stories every week from vets that have disability claims open for months, or even years that seem to go nowhere.

Then when they call my office, often as a last ditch effort, and we intercede, miraculously a lost file is found, or things start to move.

Did the commission examine the success rates of those cases handled by the veteran themselves vs. those assisted by a Congressional office?

And if so what recommendations specifically can be made to both *simplify and expedite* the claims process?

Prepared Statement of Hon. John Boozman,
a Representative in Congress from the State of Arkansas

Good morning General Scott, Members, and staff of the Disability Commission. I greatly appreciate the work each of you has put into the report. To those of you who are veterans, I thank you for your military service and your dedication to improve the lives of those who have followed in your footsteps.

You have produced a significant contribution to our continuing quest to care for the 1 percent of America who man the ramparts to protect the 99 percent. I hope, at over 550 pages, you were getting paid by the word.

It is going to take some time to absorb and understand your thoughts and recommendations. As the Ranking Member on the Economic Opportunity Subcommittee, I am especially interested in your work regarding the vocational rehabilitation and employment program which should be the crown jewel of all VA benefit programs.

While not specifically in your charter, I do wish you had taken a more in-depth look at the complexity of the claims processing system because it is impossible to separate the benefits from the processes involved. Paygo rules will make it very difficult to make the significant increases in benefits you have proposed, but we can do something to meet what I believe are the most common complaints from veterans and those center on timeliness, consistency and quality.

This Committee is faced with a balancing act that pits due process against efficient and accurate rating. It will be up to what is often called the Iron Triangle of the Congress, VSOs and VA to find a way to provide sufficient due process without constricting the flow of claims through the disability rating system.

I note that in your recommendations, the commission mentions increasing use of information technology to improve and speed processing. In my opinion, the closest thing to a silver bullet to fix the processing mess is to implement an automated claims processing system that actually takes data from multiple sources and produces a recommended disability rating. It is being done in the private sector and it can be done at VA if they have the will.

Once again, thanks to you and your fellow commissioners and staff members for the work you have done.

Prepared Statement of Lieutenant General James Terry Scott, USA (Ret.)
Chairman, Veterans' Disability Benefits Commission

Veterans' Disability Benefits Commission
Established Pursuant to Public Law 108–136
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October 10, 2007

The Veterans' Disability Benefits Commission is pleased to submit its report, *Honoring the Call to Duty: Veterans' Disability Benefits in the 21st Century,* as the formal written statement to accompany testimony before the House Committee on Veterans' Affairs.

The full 562-page report is available online at www.vetscommission.org/reports.asp. Attached is the Executive Summary.

Sincerely,

James Terry Scott, LTG, USA (Ret.)
Chairman

Executive Summary

The Veterans' Disability Benefits Commission was established by Public Law 108–136, the National Defense Authorization Act of 2004. Between May 2005 and October 2007, the Commission conducted an in-depth analysis of the benefits and services available to veterans, servicemembers, their survivors, and their families to compensate and provide assistance for the effects of disabilities and deaths attributable to military service. The Department of Veterans Affairs (VA) expended $40.5 billion on the wide array of these benefits and services in fiscal year 2006. The Commission addressed the appropriateness and purpose of benefits, benefit levels and payment rates, and the processes and procedures used to determine eligibility. The Commission reviewed past studies on these subjects, the legislative history of the benefit programs, and related issues that have been debated repeatedly over many decades.

Congress created the Commission out of concern for a variety of issues pertinent to disabled veterans, disabled servicemembers, their survivors, and their families. Those matters included care for severely injured servicemembers, treatment and compensation for Post Traumatic Stress Disorder (PTSD), the concurrent receipt of military retired pay and disability compensation, the timeliness of processing disabled veterans' claims for benefits, and the size of the backlog of those claims. Another area of concern was the program known as Individual Unemployability, which allows veterans with severe service-connected disabilities to receive benefits at the highest possible rate if their disabilities prevent them from working. The Commission gave these issues special attention.

The Commission received extensive analytical support from the CNA Corp. (CNAC), a well-known research and consulting organization. CNAC performed an in-depth economic analysis of the average impairment of earning capacity resulting from service-connected disabilities. In addition, to assess the impact of disabilities and deaths on quality of life, CNAC conducted surveys of disabled veterans and survivors. To gain insight into claims processing issues, CNAC surveyed raters from VA and representatives of veterans' service organizations who assist veterans in filing claims. CNAC also completed a literature review and a comparative analysis of disability programs similar to those provided by VA.

The Commission received expert medical advice from the Institute of Medicine (IOM) of the National Academies. Required by statute to consult with IOM, the Commission asked the institute to conduct a thorough analysis of the VA Schedule for Rating Disabilities (hereafter the Rating Schedule) and a study of the processes used to decide whether one may presume that a disability is connected to military service. In addition, the Commission examined two studies that IOM conducted for VA about the diagnosis of PTSD and compensation to veterans for that disorder. Unfortunately, a third IOM study—of the treatment of PTSD—was not completed in time to be considered by the Commission. Additionally, the Commission conducted eight field visits and held numerous public sessions.

Guiding Principles

The Commission wrestled with philosophical and moral questions about how a Nation cares for disabled veterans and their survivors and how it expresses its gratitude for their sacrifices. The Commission agreed that the United States has a solemn obligation, expressed so eloquently by President Lincoln, ". . . to care for him who shall have borne the battle, and for his widow, and his orphan . . ."[1]

In going about its work, the Commission has been mindful of the 1956 Bradley Commission principles, which have provided a valuable and historic baseline. This Commission's report addresses what has changed and what has endured over those five decades and throughout our Nation's wars and conflicts since the Bradley report. Many of the changes—social, technological, cultural, medical, and economic—that have taken place during that time span are significant and must be carefully considered as our Nation renews its compact with our disabled veterans and their families. This long-term context, a history of both significant change and key elements of constancy from the 1950s to the 21st century, provides the solid basis for this Commission's principles, conclusions, and recommendations.

This Commission identified eight principles that it believes should guide the development and delivery of future benefits for veterans and their families:

1. *Benefits should recognize the often enormous sacrifices of military service as a continuing cost of war, and commend military service as the highest obligation of citizenship.*
2. *The goal of disability benefits should be rehabilitation and reintegration into civilian life to the maximum extent possible and preservation of the veterans' dignity.*
3. *Benefits should be uniformly based on severity of service-connected disability without regard to the circumstances of the disability (wartime v. peacetime, combat v. training, or geographical location.)*
4. *Benefits and services should be provided that collectively compensate for the consequence of service-connected disability on the average impairment of earnings capacity, the ability to engage in usual life activities, and quality of life.*
5. *Benefits and standards for determining benefits should be updated or adapted frequently based on changes in the economic and social impact of disability and impairment, advances in medical knowledge and technology, and the evolving nature of warfare and military service.*
6. *Benefits should include access to a full range of healthcare provided at no cost to service-disabled veterans. Priority for care must be based on service connection and degree of disability.*
7. *Funding and resources to adequately meet the needs of service-disabled veterans and their families must be fully provided while being aware of the burden on current and future generations.*
8. *Benefits to our Nation's service-disabled veterans must be delivered in a consistent, fair, equitable, and timely manner.*

With these principles clearly in mind, the Nation must set the firm foundation upon which to shape and evolve a system of appropriate—and generous—benefits for the disabled veterans of tomorrow.

The Commission believes that just as citizens have a duty to serve in the military, the Federal Government has a duty to preserve the well-being and dignity of disabled veterans by facilitating their rehabilitation and reintegration into civilian life. The Commission believes that compensation should be based on the nature and severity of disability, not whether the disability occurred during wartime, combat, training, or overseas. It is virtually impossible to accurately determine a disease's origin or to differentiate the value of sacrifice among veterans whose disabilities are

[1] Lincoln, Abraham, *Second Inaugural Address,* March 4, 1865, www.ourdocuments.gov/doc.php?flash=true&doc=38.

of similar type and severity. Setting different rates of compensation for the same degree of severity would be both impractical and inequitable.

Disabled veterans require a range of services and benefits, including compensation, healthcare, specially adapted housing and vehicles, insurance, and other services tailored to their special needs. Compensation must help service-disabled veterans achieve parity in earnings with nonservice-disabled veterans. Compensation must also address the impact of disability on quality of life. Money alone is a poor substitute for the consequences of the injuries and disabilities faced by veterans, but it is essential to ease the burdens they experience.

It is the duty of Congress and VA to ensure that the benefits and services for disabled veterans and survivors are adequate and meet their intended outcomes. IOM concluded that the VA Rating Schedule has not been adequately revised since 1945. This situation should not be allowed to continue. Systematic updates to the Rating Schedule and assessments of the appropriateness of the level of benefits should be made on a frequent basis.

Excellent healthcare should be provided in a timely manner at no cost to veterans with service-connected disabilities (i.e., service-disabled veterans) and, in the case of severely injured veterans, to their families and caregivers.

The funding and resources necessary to fully support programs for service-disabled veterans must be sufficient while ensuring that the burden on the Nation is reasonable. Care and benefits for service-disabled veterans are a cost of maintaining a military force during peacetime and of fighting wars. Benefits and services must be provided promptly and equitably.

Results of the Commission's Analysis

The analyses conducted by the Commission with the assistance of IOM and CNAC provide a consistent and complementary picture of many aspects of veterans' disability compensation.

Ensure Horizontal and Vertical Equity

For veterans to receive proper compensation for their service-connected disabilities, the VA Rating Schedule must be designed so that ratings result in horizontal and vertical equity in terms of compensation for average impairments of earning capacity. Horizontal equity means that persons with the same ratings percentage should have experienced the same loss of earning capacity. Vertical equity means that loss of earning capacity should increase in proportion to an increase in the degree of disability. A comparison of the earnings of disabled veterans with those of veterans who lacked service-connected disabilities revealed that the average amount of earnings lost by disabled veterans generally increased as disability ratings increased. In addition, mortality rates rose with degree of disability. Thus, vertical equity is achieved. The average earnings loss was similar across different types of disabilities except for PTSD and other mental disorders, indicating that horizontal equity also is generally being achieved at the level of body systems.

Ensure Parity with Nondisabled Veterans

Overall, disabled veterans who first apply to VA for compensation at age 55 (the average age) receive amounts of money that are nearly equal to their average loss of earnings as a consequence of their disabilities among the broad spectrum of physical disabilities.

The earnings of a representative sample of nondisabled veterans were compared with the sum of earnings plus compensation of disabled veterans to determine the extent to which disability compensation helps disabled veterans achieve parity with their nondisabled counterparts. Among veterans whose primary disabilities are physical, those who are granted Individual Unemployability are substantially below parity; those who are rated 100 percent disabled and who enter the system at a younger age (45 years or less) are slightly below parity; and those who enter at age 65 or older are above parity. For those whose primary disabilities are mental, the sum of earnings plus VA compensation is generally below parity at average age of entry, substantially below parity for severely disabled individuals who enter the system at a younger age, and above parity for those who enter at age 65 or older. Also, among veterans whose primary disabilities are mental, those rated 10 percent disabled are slightly below parity. Thus, parity is generally present with respect to earnings loss except among individuals whose primary disabilities are mental, among the younger severely disabled, and among those granted Individual Unemployability.

Compensate for Loss of Quality of Life

Parity in average loss of earnings means that disability compensation does not compensate veterans for the adverse impact of their disabilities on quality of life.

Current law requires only that the VA Rating Schedule compensate service-disabled veterans for average impairment of earning capacity. However, the Commission concluded early in its deliberations that VA disability compensation should recompense veterans not only for average impairments of earning capacity, but also for their inability to participate in usual life activities and for the impact of their disabilities on quality of life. IOM reached the same conclusion; moreover, it made extensive recommendations on steps to develop and implement a methodology to evaluate the impact of disabilities on veterans' quality of life and to provide appropriate compensation.

The Commission concluded that the VA Rating Schedule should be revised to include compensation for the impact of service-connected disabilities on quality of life. For some veterans, quality of life is addressed in a limited fashion by special monthly compensation for loss of limbs or loss of use of limbs. Some ancillary benefits attempt to ameliorate the impact of disability. However, the Commission urges Congress to consider increases in some special monthly compensation awards to address the profound impact of certain disabilities on quality of life and to assess whether other ancillary benefits might be appropriate. While a recommended systematic methodology is developed for evaluating and compensating for the impact of disability on quality of life, the Commission believes that an immediate interim increase of up to 25 percent of compensation should be enacted.

A survey of a representative sample of disabled veterans and survivors was conducted to assess their quality of life and other issues. The survey found that among veterans whose primary disability is physical, their physical health is inferior to that of the general population for all levels of disability, and their physical health generally worsens as their level of disability increases. Physical disabilities did not lead to decreased mental health. For veterans whose primary disability is mental, not only were their mental health scores much lower than those of the general population, but their physical health scores were well below population norms for all levels of mental disability. Those veterans with PTSD had the lowest physical health scores.

The survey also sought to address two specific issues through indirect questions. There are concerns that service-disabled veterans tend not to follow medical treatments because they fear it might impact their disability benefits. This premise was not substantiated. Likewise, when questioned whether VA benefits created a disincentive to work, only 12 percent of respondents indicated they might work or work more if not for compensation benefits; thus, this is not a major issue.

Update the Rating Schedule

The Rating Schedule consists of slightly more than 700 diagnostic codes organized under 14 body systems, such as the musculoskeletal system, organs of special sense, and mental disorders. For each code, the schedule provides criteria for assigning a percentage rating. The criteria are primarily based on loss or loss of function of a body part or system, as verified by medical evidence; however, the criteria for mental disorders are based on the individual's "social and industrial inadaptability," meaning the overall ability to function in the workplace and everyday life.

IOM concluded that it has been 62 years since the VA Rating Schedule was adequately revised and made a series of recommendations for immediately updating the Rating Schedule and requiring that it be revised on a systematic and frequent basis. The Commission generally agrees with these recommendations; however, the Commission does not agree that the revision should begin with those body systems that have not been revised for the longest time period. Rather, the Commission recommends that first priority be given to revising the mental health and neurological body systems to expeditiously address PTSD, other mental disorders, and Traumatic Brain Injury. A quick review by VA of the Rating Schedule could be completed to determine the sequence in which the other body systems should be addressed, and a timeline should be developed for completing the revision.

To emphasize the importance and urgency of revising the Rating Schedule, the Commission urges Congress to require that the entire schedule be reviewed and updated as needed over the next 5 years. Congress should monitor progress carefully. Thereafter, the Rating Schedule should be reviewed and updated on a frequent basis.

Individual Unemployability

The Individual Unemployability (IU) program enables a veteran rated 60 percent or more but less than 100 percent to receive benefits at the 100 percent rate if he or she is unable to work because of service-connected disabilities. IU has received considerable attention recently because the number of veterans granted IU in-

creased by 90 percent. The Commission found this increase to be explained by the aging of the cohort of Vietnam veterans.

Develop PTSD–Specific Rating Criteria and Improve PTSD Treatment

Concerning PTSD and other mental disorders, it is very clear that having one set of criteria for rating all mental disorders has been ineffective. IOM recommended separate criteria for PTSD. Similarly, the CNAC survey of VA raters found that raters believe separate criteria for PTSD would enable them to rate PTSD claims more effectively. In addition, the earnings analysis described above demonstrates that there is a disparity in earnings of those with PTSD and other mental disorders and that the current scheme for rating all mental disorders in five categories of severity—10, 30, 50, 70, and 100 percent—does not result in adequate compensation. It is also unclear why 31 percent of those with PTSD as their primary diagnosis are granted IU, especially since incapacity to work is part of the current criteria for granting 100 percent for PTSD and other mental disorders. It would seem that many of these veterans should be awarded 100 percent ratings without IU. The Commission agrees with the IOM recommendation that new Rating Schedule criteria specific to PTSD should be developed and implemented based on criteria from the *Diagnostic and Statistical Manual of Mental Disorders*.

The Commission believes that a new, holistic approach to PTSD should be considered. This approach should couple PTSD treatment, compensation, and vocational assessment. The Commission believes that PTSD is treatable, that it frequently recurs and remits, and that veterans with PTSD would be better served by a new approach to their care. There is little interaction between the Veterans Health Administration, which examines veterans for evaluation of severity of symptoms and treats veterans with PTSD, and the Veterans Benefits Administration, which assigns disability ratings and may or may not require periodic reexamination. It is evident that PTSD reexaminations have been scheduled with less frequency in recent years due to the backlog of disability claims. It is also evident that case management of PTSD patients could be improved through greater interaction between the therapy received in Vet Centers and treatment in VA medical centers. IOM concluded that the use of standardized testing and the frequency of reexaminations should be recommended by clinicians on a case-by-case basis, but did not suggest how that would be achieved. The Commission suggests that treatment should be required and its effectiveness assessed to promote wellness of the veteran. Reexaminations should be scheduled and conducted every 2 to 3 years.

Improve Performance of Vocational Rehabilitation and Employment

The Commission believes that the goal of disability benefits, as expressed in guiding principle 2, is not being met. In spite of the studies done and recommendations made in recent years, the Vocational Rehabilitation and Employment (VR&E) program is not accomplishing its primary goal. The Commission believes that recent studies have provided the necessary analyses and that VA possesses the necessary expertise to remedy this failure. Simply put, VA must develop specific plans and Congress must provide the resources to quickly elevate the performance of VR&E.

Allow Concurrent Receipt

The Commission carefully reviewed whether disabled veterans should be permitted to receive both military retirement benefits and VA disability compensation. The Commission also reviewed whether the survivors of veterans who die either on active duty or as a result of a service-connected disability should be allowed to receive both Department of Defense (DoD) Survivor Benefit Plan (SBP) and VA Dependency and Indemnity Compensation (DIC). Currently, military retirees with service-connected disabilities rated 50 percent or higher are authorized to receive both benefits, which are being phased in over the next few years. Survivors are not authorized to receive both benefits. The Commission is persuaded that these programs have unique intents and purposes: military retirement benefits and SBP are intended to compensate for years of service, while VA disability compensation and DIC are intended to compensate for disability or death attributable to military service. It should be permissible to receive both sets of benefits concurrently.

In addition, the Commission believes that those separated as medically unfit with less than 20 years of service should also be able to receive military retirement and VA compensation without offset. Currently, those receiving ratings of less than 30 percent from DoD receive separation pay, which must be paid back through deductions from VA compensation for the unfitting conditions before VA compensation is received. Those receiving DoD ratings of 30 percent or higher and a continuing disability retirement have their DoD payments offset by any VA compensation. Priority among medical discharges should be given to those separated or retired with less

than 20 years of service and disability rating greater than 50 percent or disability as a result of combat.

Allow Young, Severely Injured Veterans to Receive Social Security Disability Insurance

Among the benefits available for disabled veterans, those not able to work may be eligible for Social Security Disability Insurance (SSDI). To be eligible for SSDI, an individual must have worked a minimum number of quarters, be unable to work because of medical conditions, not have income above a minimum level, and be less than 65 years of age. At 65, SSDI converts to normal Social Security at the same amount. Some very young servicemembers who are severely injured may not have sufficient quarters to qualify for SSDI. The Commission recommends eliminating the minimum quarters requirement for the severely injured. Only 61 percent of those granted IU by VA and 54 percent of those rated 100 percent by VA are receiving SSDI. Considering the very low earnings by those rated 100 percent and the exceptionally low earnings of those granted IU, it is apparent that either these veterans do not know to apply for SSDI or are being denied the insurance. Increased outreach should be made and better coordination between VA and Social Security should result in increased mutual acceptance of decisions.

Realign the VA–DoD Process for Rating Disabilities

The Commission also assessed the consistency of ratings by DoD and VA on individuals found unfit for military service by DoD under 10 U.S.C. chapter 61. Some 83,000 servicemembers were found unfit between 2000 and 2006. DoD rated 81 percent of those individuals as less than 30 percent and discharged them with severance pay, including over 13,000 who were found unfit by the Army and given zero percent ratings. Seventy-nine percent of these servicemembers later filed claims with VA and received substantially higher ratings. The reasons for the higher ratings are that VA rates about three more conditions than DoD, and at the individual diagnosis level VA assigns higher ratings than DoD.

The Commission finds that the policies and procedures used by VA and DoD are not consistent and the resulting dual systems are not in the best interest of the injured servicemembers nor the Nation. Existing practices that allow servicemembers to be found unfit for preexisting conditions after up to 8 years of active duty and that allow DoD to rate only the conditions that DoD finds unfitting should be reexamined. Servicemembers being considered unfit should be given a single, comprehensive examination and all identified conditions should be rated and compensated.

The Commission agrees with the President's Commission on the Care of Returning Wounded Warriors that the DoD and VA disability evaluation process should be realigned so that the military determines if the servicemember is unfit for service and awards continuing payment for years of service and healthcare coverage for the family while VA pays disability compensation. However, in accordance with one of our key guiding principles, the Commission believes that benefits should not be limited to combat and combat-related injuries. Nor does the Commission believe that VA disability compensation should end and be replaced with Social Security at retirement age.

Link Benefits to Cost-of-Living Increases

In its review, the Commission found that the ancillary and special-purpose benefits payments and award limits are not automatically indexed to cost of living. A few of these benefits have not been increased in many years, and as a result, some no longer meet the original intent of Congress. The Commission recommends that Congress raise ancillary and special-purpose benefits to the levels originally intended and provide for automatic annual adjustments to keep pace with the cost of living.

Simplify and Expedite the Processing of Disability Claims and Appeals

VA disability benefits and services are not currently provided in a timely manner. Court decisions, statutory changes, and resource limitations have all contributed to this unacceptable situation. Numerous studies over the years have assessed the processing of both claims and appeals and have made numerous recommendations for change. Still, veterans seeking disability compensation face a complex process. The population of veterans is steadily decreasing with the passing of veterans of World War II and the Korean war. Yet, the aging of the Vietnam Era veterans means that they are filing original and reopened claims in large numbers. Technology offers opportunities for improvement, but it is unlikely to solve all problems. The Commission believes that increased reliance on best business practices and maximum use of information technology should be coupled with a simplified and ex-

pedited process for well-documented claims to improve timeliness and reduce the backlog. The Commission is aware that a significant increase in claims processing staff has been recently approved but is also aware that the time required for training and the slow development of job experience will limit the speed with which results can realistically occur.

The Commission believes that claimants should be allowed to state that claim information submitted is complete and waive the normal 60 day timeframe permitted for further development.

Improve Transition Assistance

A smooth transition from military to civilian status is crucial for veterans and their families to quickly adjust to civilian life. This goal, often expressed as "seamless transition," has yet to be fully realized, although VA and DoD have made significant improvements during the past few years. The two departments' medical and other systems are not truly compatible, and both departments will have to rely on paper records for many years. Perhaps the single most important step that can be taken to assist veterans, particularly those who are disabled and their families, and to reduce the lengthy delays plaguing claims processing would be to achieve electronic compatibility. In addition, the Commission believes that making VA benefit payments effective the day after discharge will help ease the financial aspect of transition.

Improve Support for Severely Disabled Veterans and their Caregivers

Severely disabled servicemembers who are about to transition into civilian life need far more support and assistance than is currently provided. An effective case management program should be established with a clearly identified lead agent who has authority and responsibility to intercede on behalf of disabled individuals. The lead agent should be an advocate for servicemembers and their families. In addition, VA should be authorized to provide family assistance similar to that provided by DoD up until discharge. TRICARE deductibles and copays are costs incurred by the severely disabled; the Commission believes that these costs should be waived. In addition, consideration should be given to expanding healthcare and providing an allowance for caregivers of the severely disabled. Currently, healthcare is only provided for the dependents of severely disabled veterans but not for parents and other family members who are caregivers.

Implement a New Process for Determining Presumption

Various processes have been used to create presumptions when there are uncertainties as to whether a disabling condition is caused by military service. Presumptions are established when there is evidence that a condition is experienced by a sufficient cohort of veterans and it is reasonable to presume that all veterans in that cohort who experience the condition acquired the condition due to military service. The Commission asked IOM to review the processes used in the past to establish presumptions and to recommend a framework that would rely on more scientific principles. IOM conducted an extensive analysis and recommended a detailed and comprehensive approach that includes the creation of an advisory committee and a scientific review board, formalizing the process and making it transparent, improving research, and tracking military troop locations and environmental exposures. Perhaps most importantly, the approach includes using a causal effect standard for decisionmaking rather than a less-precise statistical association. The Commission endorses the recommendations of the IOM but expresses concern about the causal effect standard. Consideration should also be given to combining the advisory committee on presumptions with the recommended advisory committee on the Rating Schedule.

Conclusion

The Commission made 114 recommendations. All are important and should receive attention from Congress, DoD, and VA. The Commission suggests that the following recommendations receive immediate consideration. Congress should establish an executive oversight group to ensure timely and effective implementation of the Commission recommendations.

Priority Recommendations

Recommendation 4.23 **Chapter 4, Section I.5**

VA should immediately begin to update the current Rating Schedule, beginning with those body systems addressing the evaluation and rating of Post Traumatic Stress Disorder and other mental disorders and of Traumatic Brain Injury. Then

proceed through the other body systems until the Rating Schedule has been comprehensively revised. The revision process should be completed within 5 years. VA should create a system for keeping the Rating Schedule up to date, including a published schedule for revising each body system.

Recommendation 5.28 **Chapter 5, section III.3**

VA should develop and implement new criteria specific to Post Traumatic Stress Disorder in the VA Schedule for Rating Disabilities. VA should base those criteria on the Diagnostic and Statistical Manual of Mental Disorders and should consider a multidimensional framework for characterizing disability due to Post Traumatic Stress Disorder.

Recommendation 5.30 **Chapter 5, section III.3**

VA should establish a holistic approach that couples Post Traumatic Stress Disorder treatment, compensation, and vocational assessment. Reevaluation should occur every 2–3 years to gauge treatment effectiveness and encourage wellness.

Recommendation 6.14 **Chapter 6, section IV.2**

Congress should eliminate the ban on concurrent receipt for all military retirees and for all servicemembers who separated from the military due to service-connected disabilities. In the future, priority should be given to veterans who separated or retired from the military under chapter 61 with

- fewer than 20 years service and a service-connected disability rating greater than 50 percent, or
- disability as a result of combat.

Recommendation 7.4 **Chapter 7, section II.3**

Eligibility for Individual Unemployability (IU) should be consistently based on the impact of an individual's service-connected disabilities, in combination with education, employment history, and medical effects of an individual's age or potential employability. VA should implement a periodic and comprehensive evaluation of veterans eligible for IU. Authorize a gradual reduction in compensation for IU recipients who are able to return to substantially gainful employment rather than abruptly terminating disability payments at an arbitrary level of earning.

Recommendation 7.5 **Chapter 7, section II.3**

Recognizing that Individual Unemployability (IU) is an attempt to accommodate individuals with multiple lesser ratings but who remain unable to work, the Commission recommends that as the VA Schedule for Rating Disabilities is revised, every effort should be made to accommodate such individuals fairly within the basic rating system without the need for an IU rating.

Recommendation 7.6 **Chapter 7, section III.2**

Congress should increase the compensation rates up to 25 percent as an interim and baseline future benefit for loss of quality of life, pending development and implementation of a quality-of-life measure in the Rating Schedule. In particular, the measure should take into account the quality of life and other non-work-related effects of severe disabilities on veterans and family members.

Recommendation 7.8 **Chapter 7, section III.2**

Congress should consider increasing special monthly compensation, where appropriate, to address the more profound impact on quality of life of the disabilities subject to special monthly compensation. Congress should also review ancillary benefits to determine where additional benefits could improve disabled veterans' quality of life.

Recommendation 7.12 **Chapter 7, section VI**

VA and DoD should realign the disability evaluation process so that the services determine fitness for duty, and servicemembers who are found unfit are referred to VA for disability rating. All conditions that are identified as part of a single, comprehensive medical examination should be rated and compensated.

Recommendation 7.13 **Chapter 7, section V.3**

Congress should enact legislation that brings ancillary and special-purpose benefits to the levels originally intended, considering the cost of living, and provides for automatic annual adjustments to keep pace with the cost of living.

Recommendation 8.2 **Chapter 8, section III.1.B**

Congress should eliminate the Survivor Benefit Plan/Dependency and Indemnity Compensation offset for survivors of retirees and in-service deaths.

Recommendation 9.1 **Chapter 9, section II.5.A.b**

Improve claims cycle time by

- establishing a simplified and expedited process for well-documented claims, using best business practices and maximum feasible use of information technology; and
- implementing an expedited process by which the claimant can state the claim information is complete and waive the time period (60 days) allowed for further development.

Congress should mandate and provide appropriate resources to reduce the VA claims backlog by 50 percent within 2 years.

Recommendation 10.11 **Chapter 10, section VII**

VA and DoD should expedite development and implementation of compatible information systems including a detailed project management plan that includes specific milestones and lead agency assignment.

Recommendation 11.1 **Chapter 11**

Congress should establish an executive oversight group to ensure timely and effective implementation of the Commission's recommendations. This group should be cochaired by VA and DoD and consist of senior representatives from appropriate departments and agencies. It is further recommended that the Veterans' Affairs Committees hold hearings and require annual reports to measure and assess progress.

One commissioner submitted a statement of separate views regarding four aspects of the report. His statement is in Appendix L.

Additional Resources:

Electronic access to the complete **report** of the Veterans' Disability Benefits Commission is available at: http://www.vetscommission.org

Also available on the Commission's website are:

- Bios of the Commissioners
- Commission Charter
- Commission Charter (renewed, 2–21–2007)
- Public Law 108–136 establishing the Commission
- Extension of the Commission's Charter in Public Law 109–163
- Legislative History of VA Disability Compensation Program, Economic Systems Inc., Dec 2004
- Appendices to the Legislative History (Dec 2004)
- Literature Review of VA Disability Compensation Program, Economic Systems Inc., Dec 2004
- Appendices to the Literature Review (Dec 2004)
- Commission's Approved Research Questions, October 14, 2005
- Institute of Medicine (IOM) Summary of the PTSD Review contracted by the Veterans Health Administration, Mar 2006
- A History and Analysis of Presumptions of Service Connection (1921–1993)
- An Updated Legal Analysis of Presumptions of Service Connection (1993–2006)

- Center for Naval Analyses (CNA) Literature Review (Final), May 2006
- Appendix to the CNA Literature Review (Final), May 2006
- Veterans' Claims Adjudication Commission (VCAC), also known as the Melidosian Commission Report (1996)
- *Blue Ribbon Panel on Claims Processing: Proposals to Improve Disability Claims Processing in the Veterans Benefits Administration,* November 1993
- Bradley Commission Report 1956
- IOM Report to VA on *Posttraumatic Stress Disorder: Diagnosis and Assessment,* 2006
- Testimony of Chairman Scott at a Joint Hearing of the Senate Armed Services & Veterans' Affairs Committees, April 12, 2007
- CNA Report: *Findings from Raters and VSOs Surveys,* May 2007
- IOM Report to VA on *PTSD Compensation and Military Service,* 2007
- *A 21st Century System for Evaluating Veterans for Disability Benefits,* IOM Final Report, June 2007
- *Improving the Presumptive Disability Decision-Making Process for Veterans,* IOM Final Report, and Executive Summary August 2007
- CNA Final Report: *Final Report for the Veterans' Disability Benefits Commission: Compensation, Survey Results and Selected Topics,* August 2007

Statement of Hon. Doug Lamborn,
a Representative in Congress from the State of Colorado

Thank you, Mr. Chairman, and thank you, General Scott for sharing your insight and for your hard work on the commission.

Fundamentally changing and improving the disability claims system in VA is one of the most important challenges facing this Committee and Congress.

We must ensure that a veteran's claim for disability benefits is adjudicated in a prompt and accurate fashion.

That is why, General Scott, I am so glad you are here today so the Committee can gain a better understanding of the Commission's recommendations.

Congress has helped transform the VA healthcare system from one of poor quality into one of the best healthcare systems in the country and it is now our responsibility to put this same effort toward improving the rest of VA.

Thank you, Mr. Chairman, I yield back.

Statement of Hon. Jeff Miller,
a Representative in Congress from the State of Florida

Thank you, Mr. Chairman.

The long-awaited release of the findings of the VDBC has finally arrived, and now Congress, the VA, and the veterans' community have some serious consideration ahead of them. Several years of careful research by the VDBC have led to their findings which can have an important impact on the future of veterans' benefits.

In the report issued by the VDBC, the Institute of Medicine (IOM), a key contributor, concluded that the VA rating schedule has not undergone a thorough revision since 1945. While change for the sake of change is not a good approach, this lengthy passage of time makes clear a need for careful review, and I applaud VDBC for having done so.

While not all of the recommendations require legislative action by Congress, many of the ones that do already exist as bills in both the House and Senate. I am proud to already cosponsor legislation that allows concurrent receipt of military retiree pay and VA benefit payments as well as legislation that eliminates the SBP/DIC offset.

I look forward to the Commission's testimony today that will give further detail on the research used and the recommendations put forth to Congress. Today's hearing will no doubt help this Committee work toward ensuring that the VA benefit system serves our veterans in the best way possible.

Statement of Hon. Harry E. Mitchell,
a Representative in Congress from the State of Arizona

Thank you, Mr. Chairman.

I would also like to thank Lieutenant General James Terry Scott for coming before this Committee to present the findings of the Veterans' Disability Benefits Commission.

Last month, we met to hear from Senator Dole and Secretary Shalala about the care of returning veterans, and just last week, we heard from a host of experts on the requirements for funding the VA into the future.

While the testimony varied . . . the distinguished panelists all echoed a similar concern . . . we have to change the way the VA does business.

Some of this change requires a monetary investment, yet the majority of the change requires us to work together in a bipartisan way to solve complicated problems.

Earlier this year we passed a VA appropriations bill which made the single-largest investment in veterans' healthcare in the 77-year history of the agency.

And while it represents an important step forward, I think we can all agree that we need to do more.

All veterans deserve the benefits they were promised in exchange for their service to our Nation, especially those veterans who sustained lifelong service-related injuries.

Unfortunately, the disability compensation system is outdated and burdensome. It fails to effectively address the wide range of disabilities that impact the lives of veterans, regardless of age and rank. The system also neglects the sacrifices made by the families of disabled veterans.

Next week, the Subcommittee on Oversight and Investigation will hold a hearing on disability rating disparities, which is one of the major problems identified by the Commission.

These courageous men and women put their life on the line for our country. The least we can do is move quickly to provide them with the best benefits possible.

I am looking forward to hearing from our guest on how we can accomplish this, and I yield back.

POST-HEARING QUESTIONS AND RESPONSES FOR THE RECORD

Committee on Veterans' Affairs,
Washington, DC.
October 16, 2007

LTG James Terry Scott, USA (Ret.)
Chairman
Veterans' Disability Benefits Commission
1101 Pennsylvania Ave., NW, 5th Floor
Washington, DC 20004

Dear General Scott:

In reference to our Full Committee hearing "Findings of the Veterans' Disability Benefits Commission" on October 10, 2007, I would appreciate it if you could answer the enclosed hearing questions by the close of business on November 14, 2007. In addition, please provide the side-by-side analysis of the Commission's findings as discussed during the hearing as well as any cost analyses conducted by the Commission.

In an effort to reduce printing costs, the Committee on Veterans' Affairs, in cooperation with the Joint Committee on Printing, is implementing some formatting changes for materials for all Full Committee and Subcommittee hearings. Therefore, it would be appreciated if you could provide your answers consecutively and single-spaced. In addition, please restate the question in its entirety before the answer.

Due to the delay in receiving mail, please provide your response by fax to 202–225–2034. If you have any questions, please call 202–225–9756.

Sincerely,

Bob Filner
Chairman

Veterans' Disability Benefits Commission,
Established Pursuant to Public Law 108–136
Washington, DC.
November 13, 2007

Honorable Bob Filner
Chairman
House Veterans' Affairs Committee
335 Cannon House Office Building
Washington, DC 20515

Dear Chairman Filner:

Thank you for the opportunity to appear before your Committee on October 10, 2007, to present the results of our Commission's analysis of benefits and services for disabilities and deaths resulting from military service.

The purpose of this letter is to provide follow up information discussed during the hearing (Enclosure 1) and to respond to eight post-hearing questions that you provided in your letter of October 16, 2007 (Enclosure 2.)

In addition, I would like to take this opportunity to clarify our recommendation 4.23 concerning updating the VA rating schedule. Our recommendation said that the revision of the rating schedule should be completed within 5 years and our report (Prepublication page 80) indicated that 5 years is a realistic timetable. Our Commission recognized that VA had undertaken a project to revise the rating schedule as a result of a critical 1989 GAO report and had published a notice of its intent to update the entire schedule in August 1989. IOM carefully reviewed the revisions to the rating schedule and found that 373 of 798 diagnostic codes (47 percent) had been revised since 1990. A substantial proportion (281, or 35 percent) of the schedule's diagnostic codes had not been revised at all since 1945 and 18 percent (144 codes) were revised between 1945 and 1989. Our Commission felt that it would be important to establish a deadline that could reasonably be met, considering VA's lack of progress in the past. We meant that deadline to be a maximum, not an estimate for how long the revision should take. In retrospect, we should have expressed this more carefully as an outside limit. We did not estimate how long a complete revision should take.

Sincerely,

James Terry Scott, LTG, USA (Ret.)
Chairman

Enclosures

Enclosure 1

Hearing Follow Up Information

During the October 10, 2007 hearing, additional information was promised on the following subjects: Side-by-Side Comparison of Recent Reports; Cost Estimates for Major Recommendations; Number of TBI Disabilities; Immediate Processing of Claims Subject to Post Award Audit; Inpatient PTSD Treatment; and Survey Results on Use of Pain Medications and Quality of Life.

Side-by-Side Comparison of Recent Reports

A matrix was prepared for the Commission's use comparing the Commission's recommendations with those of the Independent Review Group, the Global War on Terror Task Force, and the President's Commission on Care for America's Returning Wounded Warriors. The purpose of this matrix is to assist in understanding the relative positions of each report. It was not intended to be all inclusive or comprehensive. The matrix is enclosed.

Cost Estimates for Major Recommendations

The Commission considered cost estimates for recommendations on concurrent receipt of military retirement and disability compensation and on concurrent receipt

of Survivors Benefit Payments and Dependency and Indemnity Compensation. The source of these estimates was the DoD Office of the Actuary.

	Recipients	One Year Costs ($000)	Ten Year Costs ($000)
Concurrent Receipt			
Retirees 10–40 Percent	450,000	$1,500,000	$19,300,000
Chapter 61	95,000	357,000	4,600,000
TERA	3,000	10,000	129,000
Total	548,000	1,867,000	24,029,000
Survivors Concurrent Receipt	63,000	660,000	6,600,000

Number of Traumatic Brain Injury (TBI) Disabilities

The Commission analyzed all 83,008 of the servicemembers discharged as unfit during the period 2000 through 2006. During that 7-year period, 896 individuals were discharged with TBI. Veterans Benefits Administration reported to the Commission that there are currently 24,095 veterans service connected for TBI.

Immediate Processing of Claims Subject to Post Award Audit

During the hearing, the possibility was discussed of conducting a pilot of processing claims immediately as filed at some minimum level and conducting post award audits of a sample of these claims to identify and deter fraudulent claims. This approach was recommended by Linda Bilmes of the Kennedy School of Government, Harvard University in January 2007. While a pilot of this approach could certainly be conducted, another alternative authority already exists that could be used more frequently. This alternative is the Prestabilization Rating (38 CFR §4.28 enclosed.) These ratings can be assigned immediately after discharge and can continue for 12 months. They can be assigned at either the 50 percent or 100 percent levels and do not require a VA examination. Special Monthly Compensation can be assigned concurrently with the award.

Veterans Benefits Administration reported to the Commission that during the period FY 2005–2007 a total of 1,057 prestabilization awards were made: 726 at the 100 percent level and 331 at the 50 percent level. The number of these awards doubled from FY 2005 to FY 2007. VBA averaged 242 and 110 per year at the 100 percent and 50 percent levels, respectively. Over the 7-year period analyzed by the Commission, DoD averaged 211 servicemembers discharged at the 100 percent level and 512 at the 50–90 percent level. Thus, it appears that greater use of the prestabilization ratings could be made at the 50 percent level.

The number of servicemembers discharged each year as unfit through the DoD Disability Evaluation System is not large enough to have a great impact on the size of the claims backlog and expediting these cases through use of prestabilization awards will not reduce the backlog appreciably. However, it will provide immediate income at a time that is most urgent to the servicemembers.

Inpatient PTSD Treatment

Concerning whether VA has sufficient inpatient treatment capacity for PTSD, the Commission did not address this issue. However, I note that the recent report of the Institute of Medicine, *Treatment of Posttraumatic Stress Disorder: An Assessment of the Evidence,* did not specifically address inpatient versus outpatient treatment. IOM found that there is inadequate evidence to determine the efficacy of drug therapies and found that only exposure therapy had sufficient evidence to conclude that it was effective. IOM concluded that there is not even an accepted and used definition for PTSD recovery.

Survey Results on Use of Pain Medications and Quality of Life

The Commission survey of 23,853 disabled veterans asked those surveyed: *Do you take pain medication daily to regulate the effects of your service connected disability?* Forty-seven percent said that they did and 53 percent said that they did not take pain medications. In comparing those that take pain medications with those who do not, respondents who did **not** take pain medications reported that their overall qual-

ity of life is better and their physical and mental health scores are higher. The differences are statistically significant.

Other questions asked how much bodily pain they had over the past 4 weeks and how much did pain interfere with normal work. When comparing those who reported less pain or more pain with and without medications, the results are largely the same: those who do **not** take pain medications report better quality of life and higher physical and mental scores.

Veterans' Disability Benefits Commission

Table 1—Commission/Task Force Comparisons: Primary Topics and Areas of Overlap

Study Group Topic:	Veterans' Disability Benefits Commission	Independent Review Group	GWOT Task Force	PCCWW
VA/DoD Disability Process	Realign disability evaluation process—Services determine fitness for duty, VA rates disability	DoD should overhaul the DES system by implementing a single physical exam (as described by GAO 2004). The services should consistently be determining fitness for duty & VA provides disability rating. DoD should also expand the Disability Advisory Council, Conduct quality assurance reviews on previous 0–20 percent & EPTS cases, Evaluate loss of function due to burns similar to amputation.	Joint process whereby VA/DoD cooperate in assigning a disability evaluation, determining fitness for retention, level of disability retirement & VA compensation	Restructure disability & compensation systems—DoD/VA should create a single, comprehensive standardized medical exam that DoD administers, DoD maintains authority over fitness & pays for years of service while VA establishes rating, compensation & benefits
Case Management	Intensive case management with an identifiable lead agent	Create tri-Service policy & guidelines for case management services & training, Assign single primary care physician & case manager	System of case & co-management	Comprehensive Recovery Plans & Coordinators *with HHS as lead.*
Family Support	Authorize VA to provide family services, Extend healthcare & allowance to caregivers, Eliminate SBP–DIC offset, Eliminate TRICARE co-pays & deductibles for severely injured families	Provide family education on benefits, Survey families on their needs, Assign family advocates	None	Strengthen support for families through TRICARE Respite Care & *Aide and Attendant Benefit, Caregiver training, Extend FMLA for 6 months, All combat-related injured families should have full TRICARE coverage.

Table 1—Commission/Task Force Comparisons: Primary Topics and Areas of Overlap—Continued

Study Group Topic:	Veterans' Disability Benefits Commission	Independent Review Group	GWOT Task Force	PCCWW
IT Compatibility	Expedite development & implementation of compatible information systems with a detailed plan, milestones, & lead agency, Use IT to improve claims cycle time	Streamline transition by rapidly developing a standard automated system interface for a bilateral exchange of clinical and administrative info between DoD & VA (Described in 2003 PTF)	Enhance VA computerized Patient Record System & electronic enrollment, VA needs to develop a patient tracking application compatible with DoD, Create a TBI database, Improve VA's access to military health records & create an interface with DoD, Create OIF/OEF identifiers and markers for polytrauma, Improve IT interoperability between VA & HHS Indian Health Services.	Rapidly transfer patient information, Create a *MyeBenefits* website
PTSD	Holistic approach that couples treatment, rehabilitation, compensation & re-evaluation for wellness, Revise Rating Schedule for PTSD, Baseline level of benefits, PTSD exam process, Examiner & rater training & certification, research on Military Sexual Trauma	Functional/ cognitive measures & screenings upon entry & post-deployment, comprehensive & universal clinical practice & coding guidelines for blast injuries and TBI with PTSD overlay to include recording of exposures to blast in patient record. VA/DoD create center of excellence for TBI and PTSD treatment, research & training	Provide Outreach & Education to Community Health Centers on VA benefits & services (to reach vets with PTSD)	VA should care for all OIF/OEF vets with PTSD & (with DoD) improve prevention, diagnosis & treatment, reduce PTSD stigma. DoD should address its mental health shortage, Disseminate clinical practice guidelines to all providers
TBI	Update the Rating Schedule for TBI	Functional/ cognitive measures & screenings upon entry & post-deployment, comprehensive & universal clinical practice & coding guidelines for blast injuries and TBI with PTSD overlay to include recording of exposures to blast in patient record. VA/DoD create center of excellence for TBI and PTSD treatment, research & training	Screen all GWOT veterans for TBI	DoD/VA should prevent, diagnose, & treat TBI, Partner with the private sector on TBI care, Disseminate clinical practice guidelines to all providers

Table 1—Commission/Task Force Comparisons: Primary Topics and Areas of Overlap—Continued

Study Group Topic:	Veterans' Disability Benefits Commission	Independent Review Group	GWOT Task Force	PCCWW
Ancillary Benefits	Adjust & extend A&A, Extend auto & housing allowances to veterans with severe burns, Eliminate TSGLI premiums, Improve SDVI & VMLI, Increase benefits to original intention, Adjust automatically for inflation, Provide a Stabilization Allowance, Research additional ancillary benefits	DoD should partner with VA to provide treatment, education & research in prosthesis care, production & amputee therapy, Allow VA patients to use Military and private prosthetist	Expedite Adapted Housing and Special Home Adaptation Grants, Expand HUD National Housing Locator, Enhance capacity to provide Dental care through VA & private sector.	Transition (3 months of base pay or long-term) payments, Earnings-loss payments, All unfit combat-related injured should receive full TRICARE coverage.
Quality of Life	Compensate for 3 consequences: work disability, loss of functionality & QOL, VA develop measures for QOL loss, but in the meantime create up to 25 percent QOL payment, Research health-related QOL & need for additional ancillary benefits, Increase SMC to address impact on QOL,	Survey patients on their needs.	None	Determine appropriate QOL payments
Vocational Rehabilitation & Employment (VR&E)	Test VR&E incentives, Review & revise 12-year time limit, Expand VR&E to all medically separating servicemembers, & allow all service disabled veterans access to VR&E counseling, VR&E should screen all IU applicants, increase VR&E staffing, tracking, & resources,	None	Extend VR&E evaluation determination time limit, Expand eligibility for SBA Patriot Express Loans, Increase Career Fairs & integrate Hire Vets First Campaign, Provide Credentialing, Certification, Financial Aid Education Assistance, & Employment rights, Develop Wounded Warrior Intern & Wounded Veterans Readjustment Work Experience Programs,	VR&E effectiveness is not well established and should offer completion incentives of up to a 25 percent bonus
Concurrent Receipt	Eliminate the ban	None	None	Create a DoD Annuity payment based on rank & years of service

Table 1—Commission/Task Force Comparisons: Primary Topics and Areas of Overlap—Continued

Study Group Topic:	Veterans' Disability Benefits Commission	Independent Review Group	GWOT Task Force	PCCWW
Hazards & Exposures	Create a new structure for Presumption based on casual relationship using four categories	None	Create an embedded Fragment Surveillance Center and Registry	None
Combat/Combat-Related	Benefits based on severity of disability, not on circumstances or location.	None	None	Benefits and process specifically for combat/combat-related injuries only.
Social Security/Disability Compensation for Earnings	Compensation for earnings loss continues for life.			Compensation for Earnings Ends when retirement Social Security begins.
Walter Reed National Military Medical Center (WRNMMC)	None	Accelerate BRAC construction projects for WRNMMC & new complex at Belvoir, New command and control structure for WRNMMC, Apply regulatory relief to A–76 process, Survey patients & families, Staff & train Med Hold(over) personnel, reevaluate efficiency wedge, Assign a senior facility engineer to oversee non-medical maintenance, Modernize facility assessment tools & prioritize repairs	None	Recruit & retain first-rate professionals for WRAMC through 2011 with resources and incentives to hire civilian healthcare professionals & admin staff

*This refers to the Aide and Attendant benefit under TRICARE's Extended Care Health Option, and not VA's Aid and Attendance benefit.

Table 2—Other Veterans' Commissions & Task Forces: Purposes, Findings and Recommendations

Entity	Chair-person	Charged by	Purpose	Report Date	Findings & Rec-ommendations
IRG on Rehabilita-tive Care & Admin @ Walter Reed & National Naval (Bethesda)	Former VA Secretary Togo West & Former Army Secretary & Congressman John Marsh	Secretary of Defense	*Review continuum of care, leadership & oversight issues resulting in deficiencies reported at Walter Reed* ***Scope:*** *Walter Reed patients & families*	Final Report: April 11, 2007	Problems resulted from a failure of leadership, loss of resources & spending authority under BRAC, contracting out, nursing and other staff shortages, challenges of signature injuries, & failure of the Medical Holdover system. Other reports have recommended changes to the MEB/PEB process over the last 10 years, but none have been implemented, which the IRG endorsed as well as a combined DoD/VA evaluation system.
Task Force on Re-turning Global War on Terror (GWOT) Heroes	R. James Nicholson, Secretary of Veterans Affairs	Executive Order of the President	*Improve the delivery of Federal services and benefits to GWOT servicemembers & veterans* ***Scope:*** *All GWOT servicemembers & veterans*	Final Report: April 19, 2007	There were 25 recommendations. Action areas included healthcare, case management, continuity of care, TBI screening, VA Liaisons at military facilities, small business loans, education, career training, employment rights, financial aid, housing locator, electronic tracking between systems, dental, rural health, VA/DoD joint disability process & exams, VR&E extension, & home adaptation. Recommendations can be accomplished within existing authority & resources. Outreach should cover TAP/DTAP attendance, job fairs, vets preference, & a GWOT newsletter, comprehensive database of Federal services & benefits.

Table 2—Other Veterans' Commissions & Task Forces: Purposes, Findings and Recommendations—Continued

Entity	Chair-person	Charged by	Purpose	Report Date	Findings & Rec-ommendations
President's Commis-sion on Care for America's Return-ing Wounded War-riors (PCCWW)	Former Senator Bob Dole & Former HHS Secretary Donna Shalala	Executive Order of the President	*Recommend Improvements for transition, high-quality services for returning wounded troops, access to benefits & services* ***Scope:*** *Wounded OIF/ OEF servicemembers, veterans, families*	July 25, 2007	There were 6 recommendations: 1) Immediately creating a comprehensive recovery plan with a lead Recovery Coordinator; 2) Completely restructure the disability systems so DoD determines fitness and VA disability benefits; 3) Aggressively prevent & treat PTSD & TBI; 4) Significantly strengthen support for families with amendments to TRICARE & FMLA; 5) Rapidly transfer patient info, & develop a Federal benefits website, and; 6) Strongly support Walter Reed by recruiting & retaining 1st-rate professionals through 2011.
Veterans' Disability Benefits Commis-sion	LTG James Terry Scott (USA, Ret.)	*PL 108–136*	*Appropriateness of Benefit, level of Benefit, Determination Standards* ***Scope:*** *All disabled servicemembers, veterans, families*	Oct 3, 2007	113 recommendations that focused on: compensation for quality of life & a 25 percent allowance until VA develops measures; line of duty; earnings disparity for service connected veterans with mental disorders & young entry; VA Rating Schedule revisions, especially for PTSD, TBI, & IU; A holistic approach for PTSD that couples compensation, treatment, rehabilitation, & re-evaluation; caregiver healthcare & an allowance; presumption standards for exposures; DoD disability evaluations and separation exams with Services determining fitness for duty & VA adjudicating a rating; concurrent receipt and survivor concurrent receipt; IT interoperability; & joint ventures, sharing agreements, & integration.

Table 3—Total Recommendations

Veterans' Disability Benefits Commission	Independent Review Group	GWOT Task Force	PCCWW
113	20	25	6 (23 action items)

Prestabilization Ratings

The following ratings may be assigned for disability from any disease or injury from date of discharge from service. The prestabilization rating is not to be assigned in any case in which a 100 percent or total rating is immediately assignable or on the basis of individual unemployability. The prestabilization 50 percent rating is not to be used in any case in which a rating of 50 percent or more is immediately assignable.

	Rating
Unstabilized condition with severe disability:	
Substantially gainful employment is not feasible or advisable	100
Unhealed or incompletely healed wounds or injuries:	
Material impairment of employability likely	50

VA examination is not required prior to assignment of prestabilization ratings. If one was done; a prestabilization rating can still be assigned. Prestabilization ratings are for assignment in the immediate post-discharge period. They will continue for a 12-month period following discharge from service. However, prestabilization ratings may be changed to a regular scheduler total rating or one authorizing a greater benefit at any time. In each prestabilization rating, an examination will be requested to be accomplished not earlier than 6 months or more than 12 months following discharge. Special monthly compensation should be assigned concurrently whenever entitlement is shown.

Source: 38 CFR §4.28 Prestabilization ratings.

Enclosure 2

Questions from the Honorable Bob Filner
Before the House Committee on Veterans' Affairs Hearing
Findings of the Disability Benefits Commission
October 10, 2007

1. As you know, the current system of awarding disability compensation is based on loss of earnings capacity. Based on my reading of your report, you do not propose to do away with this premise. However, you do propose to allow for the award and computation of an additional quality of life benefit. Would you please elaborate on this recommendation—how did you reach this conclusion empirically?

The Commission reached a conclusion that all of the intended outcomes of disability compensation, other than loss of earnings capacity, should be better defined. It has been implicitly understood that disability caused by military service affects functionality and quality of life for such veterans. There is a large body of scientific, medical, and sociological literature that supports considering quality of life as well as loss of earnings capacity. In the current understanding of disability, earnings are no longer the only standard used to measure the effect of impairment. Issues such as reduced social interaction, diminished mortality, lessened ability to participate in activities of normal daily living, and decreased life satisfaction can and should be taken into account and compensated fairly.

a. On what data/study did you rely to reach this conclusion?

The majority of the research conducted for the Commission was accomplished by the Institute of Medicine (IOM) and the CNA Corp. (CNAC). The IOM issued a report on the VA's disability evaluation system that recommended that disability compensation should compensate for three consequences of service-connected injuries and diseases: work disability, loss of ability to engage in usual life activities other than work, and loss in quality of life. CNAC provided the Commission with survey data on veteran's qual-

ity of life and mortality as compared to non-disabled veterans. The survey data clearly shows increased consequences on quality of life as disability severity increases. In addition, the Commission reviewed Government Accountability Office (GAO) reports, which compared benefits for servicemembers to those of public safety officers from various states. The Commission also looked to foreign government veterans' programs—particularly those in the United Kingdom, Australia, and Canada and found that they explicitly compensate for loss of quality of life, or pain and suffering. Finally, the Commission also reviewed the World Health Organization (WHO) interpretations on quality of life and disability.

b. Did you draw on any parallels from private industry (insurance industry)?

The Commission considered aspects of a wide spectrum of disability programs. A member of the IOM Committee that studied VA's rating schedule, John F. Burton, Jr., Ph.D., is a nationally known specialist in workman's compensation. Also, the GAO report on public safety officers and their benefits was instrumental in shedding light on how other Federal, state, or county safety officers are compensated when injured or ill. However, there was a great deal of variance between these programs and the GAO report w conclusive. Additionally, the Commission looked at Federal Employees' Compensation Act (FECA) and the basis for which it awards workman's compensation. Overall, the Commission did not see insurance as relevant to disability compensation since insurance provides an amount of money based on the level of premiums paid, not on the level or severity of disability.

2. As an interim measure, you also propose to immediately increase all disability payments to include a quality of life payment available up to 25 percent. Based on your studies, empirical evidence or any other data used by the Commission, can you provide the Committee with any ideas on how this interim payment should be computed by the VA?

CNAC's analysis compared disabled veterans' earnings loss, impact on quality of life, and decreased mortality at various levels of disability and among various disabilities and compared the findings to non-disabled veterans. The Veterans Health Administration (VHA) routinely uses the same instruments (SF–12 and SF–36) to measure health status and quality of life. As mentioned previously, the survey data clearly shows that impact on quality of life worsens as disability severity increases. The Commission believed that a graduated scale would be consistent with that data and that veterans' scores from these could be used to calculate interim quality of life payments. For example, VA could categorize the level of quality of life loss as mild, moderate, or severe and compensate as 10, 15, or 25 percent of current compensation. We also developed a hypothetical example, graduated by severity of disability so that those rated 100 percent would receive a full 25 percent increase down to those rated 10 percent who would receive 2½ percent. This example is enclosed. The Commission felt that it would be more appropriate for Congress to establish this payment than to specify a specific scale.

3. I think we can all agree that the VASRD needs to be updated and I like your plan of doing so over a specific period of time so as not to disrupt the current system. My concern, like yours, is the current lack of consistency in the rating of PTSD and TBI claims, which is due to an outdated VASRD and poor training of the raters. In order to update the VASRD, did the Commission have any further recommendations on what the VA should look at when revising its PTSD and TBI related systems? For instance, in its report, did the IOM make specific recommendations in this area that this Commission gave more weight than others?

In order to update the PTSD criteria in the VA Rating Schedule, the Commission, along with the IOM, looked to the Diagnostic and Statistical Manual, 4th edition (DSM–IV) published by the American Psychiatric Association. The DSM outlines criteria for hundreds of mental disorders, including PTSD, and is the international psychiatric standard for diagnosis to evaluate levels of disability. The current Rating Schedule utilizes only one set of criteria for all mental disorders. The Global Assessment of Functioning (GAF) Scale is one of the measures used to arrive at a level of severity for mental disorders. The IOM found the GAF to be an ineffective instrument for measuring disability and recommended that VA replace it over time as an assessment instrument. In the meantime, IOM recommended increased training of examiners and raters to ensure that they are capable of using the GAF consistently.

For TBI, VA should begin by considering the definitions and criteria outlined by the World Health Organization (WHO) in its International Classification for Diseases, 10th edition (ICD–10). However, there is limited TBI knowledge overall, especially those resulting from blast injuries. VA has done research into blast injuries but will need to conduct expanded research in this realm in order to better diagnose the degree of severity of TBI and provide treatment that will maximize functioning. Also, the rating criteria for TBI will need to reflect the multiple body systems often affected by blasts.

4. Please elaborate on the Commission's recommendations regarding PTSD, particularly the holistic approach mentioned in Recommendation 5.30, which would include better case management, the coupling of treatment with compensation and vocational assessment and some interaction between the VHA and VBA.

a. What was the Commission's underlying premise in making these recommendations? What problems did you uncover, if any? Please elaborate.

The Commission was not satisfied that VA has done all it can to ensure veterans suffering from PTSD have been afforded the best possible recovery plan that incorporates benefits from VBA and care from VHA. Each veteran with PTSD should have a coordinated plan that includes compensation evaluation and a vocational rehabilitation assessment as an integrated component of their mental healthcare plan. A case manager should monitor adherence to the plan. The Commission recommended that these veterans be re-evaluated every 2 to 3 years to monitor progress and asses effectiveness of treatment. The ultimate goal should be the wellness and functionality of the veteran and his/her return to full participation in society.

The problems uncovered in relation to PTSD diagnosis, compensation, and treatment is the lack of fully trained and certified examiners and raters. The Best Practices for PTSD Compensation and Pension Examinations is not mandated, but should be. There is minimal interaction between VHA and VBA after an examination and a rating have been completed unless the rater decides to schedule a re-examination. There is no feedback loop between treatment providers and examiners and little communication between VBA and VHA. There is also little interaction between medical center clinicians and Vet Center counselors. The Commission believed that veterans with PTSD can be better served.

Although the IOM report, *Treatment of Posttraumatic Stress Disorder*, was not completed in time to be considered by the Commission, I reviewed the report and am troubled by its conclusions and recommendations. Basically, the IOM Committee concluded that there is inadequate evidence on the effectiveness of treatment for PTSD and that there is not even an accepted definition for recovery.

5. Please elaborate on the Commission's recommendation pertaining to presumptions and the causal relationship standard. For instance does the new standard proposed by the IOM increase the hurdle for veterans to prove presumptive disabilities? Would the implementation of an independent Scientific Review Board to determine presumptive conditions as proposed by the IOM allay these concerns?

A causal relationship standard would give veterans the benefit of a more rigorous scientific standard that would make determining presumption more equitable across exposures. This standard would be more reliable and valid for determining if and how cohorts of veterans were exposed to environmental or occupational hazards. However, the Commission was concerned that the association level of assigning presumption not be ignored if there is appropriate evidence that a presumption might still be warranted.

a. Did the Commission/IOM find that the VA's system of determining presumptions suffer from internal inconsistencies? If so, how?

Currently, VA does not have a written process followed whenever a decision must be made on a presumption. Without a written, standard process, variance can occur.

b. How has Congress impacted this system of determining presumptions?

Without a standard process soundly based on scientific evidence, Congress is faced with pressure from advocacy groups to approve presumptions

that might not be warranted. The proposed process should relieve some of that pressure.

c. What role does the Commission envision Congress playing in the future in determining presumptions?

The Commission hopes that if the IOM framework with its causal standard is implemented, Congress should be able to perform more of an oversight role and have less direct involvement in presumption decisions.

6. I know that there are a lot of similarities between how your Commission proposes to realign the VA and the DoD process for rating disabilities and those produced by the Dole-Shalala Commission. Please highlight the similarities and differences.

Both Commissions found the current disability rating process to be confusing, duplicative, and time-consuming from the veterans' perspective. Our Commission's analysis compared ratings by DoD and VA over a 7 year period and found that VA ratings were statistically significantly higher than DoD for the same individual conditions and combined ratings were higher overall. Both commissions recommended that the process be streamlined.

The Dole/Shalala Commission recommended that DoD restructure its disability and compensation systems and that DoD along with VA should create a single, comprehensive, standardized medical exam that DoD administers. The Services would maintain authority over fitness for duty determinations and compensate veterans for years of service. VA would establish the disability rating and award compensation and other benefits.

Our Commission did not specify which department should conduct the examinations. We believe that decision can best be made at the local level based on the capabilities of the clinical staffs. However, with the advice of the Institute of Medicine, we extensively reviewed the examination process and made several recommendations to improve the examinations and ensure consistency and reliability. These include greater use of templates, improved training and certification of examiners, and enhanced quality control. These recommendations should be implemented no matter which department conducts the examinations.

Our Commission believes that the process used and the benefits available should be appropriate for all veterans and all servicemembers found unfit for duty, not just the seriously injured and not just those whose injuries result from combat or are combat related. Less than 2 percent (1,478 of 83,008) of those separated or discharged as unfit from 2000 through 2006 were rated by DoD as 100 percent disabled and only 6 percent (5,060 of 83,008) were rated 50 percent or higher. A separate process for such a small volume of cases would not be advisable. And trying to decide whether individual circumstances were combat related would be very difficult and often subjective.

7. I know the VA's disability system is comparable to an insurance company that provides disability coverage and I wondered if your members were able to draw on these parallels in making your recommendations. Did the Commission meet with any private industry entities to help inform its recommendations pertaining to the disabilities system and how it should work?

Our Commission did not solicit information from private insurance companies since those populations insured and the circumstances of injuries are vastly different than those of the military. The Commission reviewed the GAO study of workman's compensation benefits of public safety officers and reviewed the Federal Employees' Compensation Act (FECA) that covers civilian Federal employees in the event of a work-related injury, illness, or death. GAO also briefed us on its report findings.

8. Your report indicates that based on surveys conducted, most claims raters find that their major source of learning was on-the-job training. In fact, over 50 percent of raters believe that they are ill-equipped to perform their jobs and over 80 percent of raters and VSOs believe that there is too much emphasis placed on speed relative to accuracy. Also, as the recent IDA Report (Analysis of Differences in VA Disability Compensation) on variances in VA's disability compensation awards recommends, the VA undoubtedly needs to:

1. standardize initial/ongoing training for rating Specialists;
2. increase oversight of rating decisions;

3. develop and implement metrics to monitor consistency in adjudication results; and,
4. increase oversight and review of rating decisions and improve and expand data collection and retention.

Would you elaborate on what you witnessed to be the primary problems with the VA rating system?

The Commission found several problems with the VA rating system. Perhaps the most important problem is the lack of trained raters. It takes 2 to 3 years to train a rater. Additionally, not all examinations are done using templates and the templates are not mandatory; some are still under development. Also, VA needs to encourage claimants to provide all of the evidence to support their claims at the time the claim is filed. These are crucial areas for improving the process and action should be expedited. Furthermore, VA has not sufficiently employed proven business techniques such as cycle time reduction and automated decision support system technology, which could greatly enhance the process and allow for real-time decisions once examinations and other evidence are submitted. Currently, many veterans do not use the electronic application to apply for benefits.

Concerning the results of the survey of raters, only 3.6 percent reported that they were not well trained. 49.8 percent reported that they felt very well trained and 46.5 percent felt they were somewhat well trained. The amount of time in the position correlated with how well the rater felt well trained.

The raters were asked to assess their top three challenges and 80 percent said having enough time to process a claim. 83.7 percent of raters said that there is too much emphasis on speed, but 61.8 percent said that there is the right amount of emphasis on accuracy. 43.1 percent said speed is more important than accuracy.

When asked to assess their own degree of proficiency in several categories, over 90 percent said their proficiency is good, very good, or excellent.

a. Other than updating the VASRD, where else would you begin in trying to fix the rating system, in other words to make it more objective and less subjective.

The utilization of an automated decision support system could apply the Code of law based on the results of an electronically completed medical examination template. Since the templates would be standardized, software could consistently apply the Code of law for a given set of variables. This technology is similar to that in use by professional certification boards that require an examination for licensure. Once the application and examination are completed online, the computer generates a score and a notification of certification if the applicant has met the requirements. This level of technological standardization would lessen the subjective nature inherent in the rating system since it would no longer rely predominately on the training and experience of raters, VSOs, or examiners.

9. The claims backlog is a serious concern to this Committee, the veterans' community, and I am sure it was to this Commission. Would you elaborate on your simplified and expedited process for well-documented claims as proposed in Recommendation 9.1 of your report. Please explain how you envision this would work in terms of the current claims structure. What would need to change to make it work?

The rationale behind Recommendation 9.1 was to improve the claims process in five ways:

1. Best business practices such as cycle time reduction and decision support information technology (IT) are techniques used extensively in the private sector and could be employed by VA to improve their claims processing time.
2. Allowing a veteran to bypass some of the "duty to assist" time requirements could accelerate processing. If a veteran has a claim that is well-documented and all evidence is present, then he/she should be allowed to state that the claim is "ready to rate" and waive the current 60 day time period allowed to submit additional evidence. Veterans could authorize VA to rate their claims based on the evidence submitted.
3. VA could reduce the current 60-day time period allowed for submission of additional information to 30 days allowing VA to follow up earlier on requests for evidence such as from doctors and hospitals. Requests by veterans for additional time could be routinely granted.
4. Hiring and training appropriate staff to meet the volume of claims.
5. Funding for expedited implementation of compatible electronic records and IT tools such a templates for examinations.

VETERANS' DISABILITY BENEFITS COMMISSION—GUESTIMATE

Hypothetical Example: Disability Compensation plus Prorated Quality of Life (QoL) Payment

Based on Service-Connected (SC) Disability Rating

Percent SC	FY 2007 Individual Compensation*	QoL Percent	Individual QoL Amount	Compensation plus QoL Payment	Number of Recipients	Annual Compensation in FY 2006	Annual QoL Amount of Total Compensation	Annual Compensation plus QoL Payment
100	$2,471	0.250	618	3,089	238,966	$7,085,819,832	$1,771,454,958	$8,857,274,790
90	$1,483	0.225	334	1,817	60,623	$1,078,846,908	$242,740,554	$1,321,587,462
80	$1,319	0.200	264	1,583	113,549	$1,797,253,572	$359,450,714	$2,156,704,286
70	$1,135	0.175	199	1,334	165,468	$2,253,674,160	$394,392,978	$2,648,067,138
60	$901	0.150	135	1,036	184,499	$1,994,803,188	$299,220,478	$2,294,023,666
50	$712	0.125	89	801	161,774	$1,382,197,056	$172,774,632	$1,554,971,688
40	$501	0.100	50	551	260,165	$1,564,111,980	$156,411,198	$1,720,523,178
30	$348	0.075	26	374	335,358	$1,400,455,008	$105,034,126	$1,505,489,134
20	$225	0.050	11	236	421,709	$1,138,614,300	$56,930,715	$1,195,545,015
10	$115	0.025	3	118	779,789	$1,076,108,820	$26,902,721	$1,103,011,541
				Totals	**2,721,900**	**$20,771,884,824**	**$3,585,313,074**	**$24,357,197,898**

*Basic rate, no dependents or Special Monthly Compensation (SMC)

Commission Staff: October 2007

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