

**EXAMINING QUALITY OF LIFE AND
ANCILLARY BENEFITS ISSUES**

HEARING
BEFORE THE
SUBCOMMITTEE ON DISABILITY ASSISTANCE AND
MEMORIAL AFFAIRS
OF THE
COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES
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FIRST SESSION

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EXAMINING QUALITY OF LIFE AND ANCILLARY BENEFITS ISSUES

THURSDAY, JULY 23, 2009

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

The Subcommittee met, pursuant to notice, at 10:00 a.m., in Room 334, Cannon House Office Building, Hon. John Hall [Chairman of the Subcommittee] presiding.

Present: Representatives Hall and Lamborn.

Mr. HALL. Good morning, ladies and gentlemen. The Veterans' Affairs Disability Assistance and Memorial Affairs Subcommittee hearing on Examining Ancillary Benefits and Veterans' Quality of Life (QOL) Issues will now come to order.

I would ask that we all rise for the Pledge of Allegiance.

[Pledge of Allegiance.]

Mr. HALL. Thank you very much.

I am going to defer my statement until after Congressman Lamborn, our Ranking Member, makes his because he has a double booking and needs to leave to take care of that business.

So, Mr. Lamborn, you are recognized.

Mr. LAMBORN. Yes. Thank you, Mr. Chairman, for taking me out of order. And I will submit my statement for the record.

I wish I could be in two places at once. This is a vital topic. But since I cannot, I am going to have to be here only momentarily so that we can have the quorum and start the meeting officially.

I do look forward to hearing the written comments from each witness and I will be looking at those.

Thank you and I know it will be a good hearing.

[The prepared statement of Congressman Lamborn appears on p. 35.]

OPENING STATEMENT OF CHAIRMAN HALL

Mr. HALL. Thank you, Mr. Lamborn.

This Subcommittee has actively tackled many complex and complicated issues that have been encumbering the Veterans Benefits Administration (VBA) and its ability to properly compensate veterans who file disability claims.

These issues have centered on U.S. Department of Veterans Affairs (VA) business processes and operations. Today's hearing will

focus on the actual appropriateness of available benefits in meeting the needs of disabled veterans and their families.

The expressed purpose of VA disability compensation as outlined in law (38 U.S.C. § 1151) is based upon the average impairment of earning capacity. This concept dates back to the 1921 rating schedule which had its roots in the then blossoming Workmen's Compensation Program.

Then, the primary concern was to ensure that the disabled World War I veterans would not become a burden on their families or communities when they could no longer perform the laborious tasks most civilian occupations required at that time.

Over the years, Congress has added several elements to the VA compensation package to assist disabled veterans in procuring shelter, clothing, automotive, employment, vocational rehabilitation, and in-home assistance.

In its expansion of these benefits, Congress has attempted to meet disabled veterans' and their families' social and adaptive needs and not solely their economic needs.

More recently, several commissions and institutions, a few of whose members we will hear from today, have studied the appropriateness of VA benefits, including a potential quality of life loss payment.

They have identified significant challenges in developing an instrument or rating schedule that could fairly calculate compensation for the loss of quality of life.

Much of what makes a life of quality is subjective and goes beyond fulfilling basic human needs or replacing impaired income.

Furthermore, I realize that there is no amount of money that can replace a limb or peace of mind. Ensuring that veterans impaired by amputation, blindness, deafness, brain injury, paralysis, and emotional distress are afforded the necessary resources to lead productive, satisfying lives is the debt a grateful Nation owes these brave souls.

VA has, in fact, attempted to recognize that in order to make some veterans whole, there is a need to provide additional compensation that accounts for noneconomic factors, including personal inconvenience, social inadaptability, and the profoundness of their disability.

Part of the problem may be that the formula and criteria used for adjudicating VA ancillary benefits and special monthly compensation is complex and often confusing to the beneficiaries themselves. Oftentimes disabled veterans are unsure of this added benefit, which leads to an inability to predict or plan for their future based on their VA assistance.

Without transparency, transitioning wounded warriors are at a severe disadvantage if they cannot count on and predict their VA benefits package. Having this knowledge could be a big help to these veterans and more transparency and outreach is definitely needed in the ancillary benefits area.

I am eager to hear from today's witnesses, many of whom are experts in the complexities and paradigms for compensating military-related disabilities.

I am also eager to hear from VA on its late-delivered VBA response to the Economic Systems (EconSys) quality of life, earnings

loss, and transition payment study, which was mandated in section 213 of Public Law 110-389.

Our veterans must be returned to their country, communities, and homes with the tools and resources to rebuild a life of quality.

So as we go forward, I once again remind all of our panelists that your complete written statements have been made a part of the hearing record. Please limit your remarks to 5 minutes so that we may have sufficient time to follow-up with questions once all of our witnesses have had the opportunity to testify.

On our first panel, which I would call now to the table, is Mr. Carl Blake, National Legislative Director for Paralyzed Veterans of America (PVA); Mr. Ronald B. Abrams, Joint Executive Director for National Veterans Legal Services Program (NVLSP); and Mr. Thomas Zampieri, Ph.D., Director of Government Relations for Blinded Veterans Association (BVA).

Welcome, Mr. Blake, Mr. Abrams, and Mr. Zampieri. It is good to see you all again. Thank you for coming to testify before us.

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

[The prepared statement of Chairman Hall appears on p. 34.]

STATEMENTS OF CARL BLAKE, NATIONAL LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA; RONALD B. ABRAMS, JOINT EXECUTIVE DIRECTOR, NATIONAL VETERANS LEGAL SERVICES PROGRAM; AND THOMAS ZAMPIERI, PH.D., DIRECTOR OF GOVERNMENT RELATIONS, BLINDED VETERANS ASSOCIATION

STATEMENT OF CARL BLAKE

Mr. BLAKE. Thank you, Mr. Chairman.

Mr. Chairman, Members of the Subcommittee, on behalf of Paralyzed Veterans of America, I would like to thank you for the opportunity to testify today on what we consider a very important topic, particularly for PVA's membership, that being ancillary benefits and quality of life issues.

PVA members represent one of the segments of the veteran population that benefit most from the many ancillary benefits provided by the VA. Without the provision of benefits such as special monthly compensation or SMC, specially adapted housing grant, and the clothing allowance, our members and other severely disabled veterans would experience a much lower quality of life and would in many cases be unable to live independently.

Special monthly compensation represents payments for quality of life issues such as loss of an eye or limb, the inability to naturally control bowel and bladder function, or the need to rely on others for the activities of daily living like bathing or eating.

To be clear, given the extreme nature of the disabilities incurred by most veterans in receipt of SMC, we do not believe that the impact on quality of life can be totally compensated for. However, SMC does at least offset some of the loss of quality of life.

PVA believes that an increase in SMC benefits is essential for our veterans with severe disabilities. Many severely injured veterans do not have the means to function in an independent setting and need intensive care on a daily basis.

To support our recommendation, we encourage the Subcommittee to review the recommendations of the Veterans' Disability Benefits Commission (VDBC) report.

One of the most important SMC benefits to PVA is aid and attendance. PVA would also like to recommend that aid and attendance benefits be appropriately increased. Attendant care is very expensive and often the aid and attendance benefits provided to eligible veterans do not cover this cost.

In accordance with the recommendations of the *Independent Budget (IB)*, PVA also believes that there are some necessary improvements in the Service Disabled Veterans' Insurance (S-DVI) and Veterans' Mortgage Life Insurance (VMLI) programs.

We recently supported legislation considered by this Subcommittee, H.R. 2713, that would increase the maximum amount of protection from \$10,000 to \$100,000 and would increase the supplemental insurance for totally disabled veterans from \$20,000 to \$50,000.

Ultimately, we would like to see the Subcommittee consider legislation that would increase S-DVI to the maximum benefit level provided by the Servicemembers' Group Life Insurance (SGLI) and Veterans' Group Life Insurance (VGLI) programs.

The *Independent Budget* also recommends that VMLI, veterans mortgage life insurance, be increased from the current benefit of \$90,000 to \$150,000. The last time VMLI was increased was in 1992. Since that time, housing costs have risen dramatically, but the VMLI benefit has not kept pace. As a result, many catastrophically disabled veterans have mortgages that exceed the maximum value of VMLI.

Recent hearings have demonstrated how far behind the VBA is in using information technology in its claims adjudication process. While we believe that the entire claims process cannot be automated, there are many aspects and steps that certainly can.

We have long complained to the VA that it makes no sense for severely disabled veterans to separately apply for the many ancillary benefits to which they are entitled. Their service-connected rating immediately establishes eligibility for such benefits as the specially adapted housing grant, adapted automobile equipment, and education benefits. However, they still must file separate application forms to receive these benefits. This just makes no sense whatsoever.

Mr. Chairman, one of the subjects that often generates a great deal of debate when discussing VA compensation benefits is the consideration of quality of life.

PVA has expressed serious concerns in the past, particularly during the deliberations of the Veterans' Disability Benefits Commission and the Dole-Shalala Commission, with the assertion that the schedule for rating disabilities are meant to reflect the average economic impairment that a veteran faces.

Disability compensation is, in fact, intended to do more than offset the economic loss created by a veteran's inability to obtain gainful employment. It also takes into consideration a lifetime of living with a disability and the every-day challenges associated with that disability. It reflects the fact that even if a veteran holds a job,

when he or she goes home at the end of the day, that person is still disabled.

There can be no question but that VA compensation includes a real and significant component that is provided as an attempted response to the impact of a disability on the disabled veteran's quality of life. And, yet, we would argue that compensation could never go too far in offsetting the impact that a veteran's severe disability has on his or her quality of life.

PVA would once again like to thank you, Mr. Chairman, for allowing us to testify and I would be happy to answer any questions that you might have.

[The prepared statement of Mr. Blake appears on p. 35.]

Mr. HALL. Thank you, Mr. Blake.

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

STATEMENT OF RONALD B. ABRAMS

Mr. ABRAMS. Thank you, Mr. Chairman.

NVLSP would like to focus on the quality of life increased payments under 38 U.S.C. § 1114(s). Essentially SMC(S) is paid to veterans who have a total disability and have independent service-connected conditions that amount to 60 percent or more.

A recent decision by the U.S. Court of Appeal for Veterans Claims (CAVC), the veterans' court, called *Bradley v. Peake* [22 Vet. App. 280 (2008)] reveals that the VA has unlawfully limited the impact of this section of the statute possibly as far back as 1960.

NVLSP believes that while it is good to improve the law, it is also vitally important to make sure that the VA correctly adjudicates current claims.

So we say that now VA, with the help of the veterans' service groups and Congress, should act quickly, promptly, efficiently to implement the *Bradley* decision.

Currently a veteran with SMC(S) gets about \$320 more a month than a veteran who has a total rating. That is because not only do they have one service-connected condition that would support 100 percent, they have other conditions that also impact their lives over and above the 100-percent rate.

The problem is that the statute says that the rating is based on a single condition noted as total, which would include benefits that are paid because the one condition causes individual unemployability. However, the VA has limited this to only conditions that are 100 percent schedular. And they have been doing this for 49 years. That does not seem right.

In *Bradley*, the court finally dealt with this issue. This was a compelling case. He was basically blown up in Vietnam. He suffered multiple shell fragment wounds from a booby trap. He is service-connected for 13 compensable scars and 10 separate muscle group injuries. He also gets service-connection for Post-traumatic stress disorder (PTSD) at 70 percent.

The VA awarded him individual unemployability (IU) benefits in 1983. And in 1992, he was granted a 100-percent rating. It took the VA 13 ratings to get to that level over many years.

The Court did a wonderful job on this case. First, they said that a veteran can get SMC(S) without a 100-percent schedular service-connected disability.

Then the CAVC actually said that even if you have 100 percent combined, if it would be better for the veteran to get IU based on one and then he had a separate combined 60 percent, they should pay him that because you get more money.

And, finally, they said that the effective date of payment is when the evidence shows that the veteran would be entitled without a specific claim. This case is a home run and should have a major impact.

What we need to do now is to encourage the VA to educate its regional offices (ROs) and to help the VA implement this. There are thousands of dollars for many, many veterans out there and this, of course, will improve their quality of life.

Thank you very much.

[The prepared statement of Mr. Abrams appears on p. 39.]

Mr. HALL. Thank you, Mr. Abrams.

Mr. Zampieri, you are now recognized.

STATEMENT OF THOMAS ZAMPIERI, PH.D.

Mr. ZAMPIERI. Mr. Chairman, Ranking Member, and other Members of this Committee, we appreciate the opportunity to testify here before you today on behalf of the Blinded Veterans Association.

BVA has joined with the veterans service organizations (VSOs) in awaiting action on recommendations provided by the Veterans' Disability Benefits Commission that would improve the benefits and the services for our Nation's wounded and disabled veterans.

After reviewing the recent 7-month report issued by Economic Systems, however, BVA has some concerns about some of the recommendations on quality of life for veterans with service-connected sensory and other disabilities.

We believe that the complex objective and subjective instruments for a new payment system will require careful consideration by Congress along with what is being presented here today.

Quality of life measurements themselves are not only objective measures of activities of daily living, but the subjective concepts of pain levels, negative emotions, social difficulties, and if not very carefully considered, the latter could be easily excluded from any determinations of fair measurements in looking at the impact of quality of life compensation for our Nation's wounded.

We have some concerns about some sections. One thing that alarmed us was a statement and some of the graphs that skin, ear, and eye body systems have the lowest level of quality of life loss for disabled veterans. I think and hope that you would also sort of ask what is that coming from.

Mr. Chairman, as fellow veterans who have lost sensory function could all testify, the reactions to blindness or deafness are varied. Fear, overwhelming stress and anxiety, depression, anger, those are just a few of the typical responses to those sensory losses.

Our degree of independence is dramatically diminished and our quality of life is completely disrupted and forever changed. Loss of vision is accompanied by the sudden loss of freedom to move about

safely and independently. We must constantly learn new ways of coping with and managing our lives in the absence of vision or sensory losses in our world.

There are amazing new technologies and assistive devices that have been developed, but those require continued updating and training. It is not as if someone gets one new technology device and that is the end of it.

I also want to emphasize, and this is commonly found in almost any medical articles, if you look at sensory losses, the one that is the single largest sensory system for all of us is our vision. Seventy percent of our ability to perceive our environment comes from vision. So if an individual was blinded, 70 percent of what they are able to tell about where they are, who they are is gone.

The other major sensory system, of course, which is frequently affected in the improvised explosive device explosions from Iraq and Afghanistan, is hearing loss. The VDBC was faced with a really complex task that for 2 years required a very difficult analysis of a complex issue when it comes to quality of life. Along with other Federal agencies, State governments, and local governments, this is a difficult area.

And I would like to point out that the VDBC said that no current compensation for the impact of disability on the quality of life currently exists within the current system.

Many national surveys demonstrated in the past decade since the passage of the "American Disabilities Act" that there has actually been very little progress made in the employment rates of the disabled. Among several sources, one being the very respected Cornell University's Center on Disability Statistics' annual disability status report, which you can find online, data indicates that the country's disabled, noninstitutionalized population of working age adults between the ages of 21 and 64 still have significantly lower rates of employment, lower earnings, and lower household incomes across multiple studies as compared to their nondisabled American counterparts.

The 2007 Census Bureau survey, for example, found that 60 percent of disabled men between those ages with one disability were employed, but when looking at individuals with severe disabilities affecting daily functioning skills, that rate falls to 32 to 34 percent in multiple different studies despite improvement in transportation accessibility for those individuals with disability that affect their ability to do daily functions. Almost 30 percent of the disabled in this country still have problems with access to public transportation.

The American communities survey in 2007 found individuals with sensory disabilities in that age group of a population with a median income of \$22,000 less than the average households containing nondisabled members.

And I have multiple other things in the testimony that I will let you look at rather than try and read through all of them.

I would also like to point out, though, the National Council on Disabilities' March 2009 report reveals that the percentage of disabled Federal workers has actually steadily declined and that Washington, DC, U.S. Department of Labor has found that Federal employees with disabilities is actually at the lowest level in almost

20 years. For those who like to say that technology is making everything equal and so I have to argue with that.

I have other things in here that unfortunately due to time constraints cannot go through all of them. I appreciate the ability to be able to testify here this morning in front of the Committee. Hopefully I will be able to answer some of your questions. Thank you.

[The prepared statement of Dr. Zampieri appears on p. 40.]

Mr. HALL. Thank you, Mr. Zampieri.

I want to thank all of you for your service to our country and to our country's veterans.

Mr. Zampieri, as you noted in your testimony, eye and ear injuries have been associated with Traumatic Brain Injury (TBI), with explosion of roadside bombs in Iraq and Afghanistan among other battlefields and theaters of combat.

Do you feel that VA has done a sufficient job evaluating all the face and head trauma completely and accurately to compensate veterans and to provide them with all necessary ancillary benefits?

Mr. ZAMPIERI. Thank you for the question.

I think it is actually a concern of ours and probably safe to say many of the other VSOs that individuals with Traumatic Brain Injuries (TBI) that have sensory associated symptoms have a very difficult time in getting their ratings because so many of those are subjective kind of complaints.

You know, we frequently hear a lot about the problems with tinnitus, for example. Frequently TBI patients complain of photophobia, which is extreme sensitivity to light. And those are very difficult to rate, but those things can have quite an impact on the individual's ability to function and also their relationship socially and employment-wise.

And so we are concerned about the way TBI assessments are done in regards to sensory losses. I know that the VA has put a lot of effort toward looking at new assessment methods, and congratulate them for, you know, recognizing this is a serious problem.

Mr. HALL. In its report, EconSys made policy suggestions regarding new assistive technologies and disabled veterans who use them.

Can technology sufficiently replace an actual ability that would negate the need to compensate the veteran for his or her loss of earning capacity? Are you aware of any new technologies that are around the corner and just becoming available that would substitute for one's natural vision? I am aware of some for hearing loss, but is there something similar for vision that you are aware of?

Mr. ZAMPIERI. Thank you for the question.

Yes. Actually, and we are very supportive, and I do not want it to come out the wrong way here today, by the way, of VA's efforts at research and new technology. And we commend Dr. Kupper-Smith for his leadership in research and development of new technologies.

And, for example, the VA does work with the universities doing research on a brain port device, which holds some promise of being able to allow part of the brain, the occipital area that perceives and processes vision, to get input from a camera and then through, believe it or not, the tongue transmits images to the occipital area.

But it is certainly in its early stages of research. And I think those individuals who have been involved in using it will say that it holds some hope, but it is not going to replace, you know, natural vision.

And I think individuals with deafness would also say that the advances made surgically and with new devices for deafness, you know, are not going to equal what normal sensory input would be.

Mr. HALL. Thank you. I would have to concur with your remarks about hearing loss.

Also, the mental health community, both secular and religious meditation groups and teachers, and so on believe that. One of the reasons that they teach meditation in a darkened room is because 70 percent of the input, sensory to your brain is coming through your eyes, the average person's vision and ocular nerves. So, it is only natural then that the loss of that much input is a severe loss indeed.

Mr. ABRAMS, do you have any further feedback on other SMC rates besides (S) and the usefulness of these benefits as a mechanism to compensate veterans for the loss of quality of life?

Mr. ABRAMS. I am not sure I am following the question.

Mr. HALL. I am asking if you have any feedback on the other SMC rates besides the (S)—

Mr. ABRAMS. Yeah. I think that the Aide and Attendance (A&A) rate should be bumped up. It is too low. I personally have a family member in a home and it costs over \$90,000 to \$100,000 to put somebody into a home. And home care, if you need 24-hour care, is hugely expensive. Real A&A is too low. We need to improve that.

Mr. HALL. Thank you for bringing to our attention the *Bradley* decision, which is certainly something that this Subcommittee and the full Committee will be looking at.

Mr. ABRAMS. Thank you. That is important and we can help right now with that.

Mr. HALL. We will be asking you for that help.

Mr. Blake, has the PVA and its fellow *Independent Budget* organizations reviewed the EconSys study and its recommendations regarding quality of life compensation and what further impressions do you have of that?

Mr. BLAKE. We have not as a group of organizations, but I would imagine as we develop the upcoming *IB* that it will be something of obvious consideration, particularly given the new focus on wanting to try to figure out a way to compensate for quality of life.

The one thing I would suggest is that this is not an easy task and for four organizations, I think it has already been discussed here a little bit, trying to figure out a way to make recommendations on how to adjust quality of life, I am not sure that any of the four organizations could come to a universal agreement on the best way to do it because I think at the end of the day, it is more subjective than objective in trying to figure out a way to compensate for that.

But I will say since I do not work chiefly on the benefits side of the *IB* that I would imagine that it would be one of the main things that they will look into, yes, sir.

Mr. HALL. Thank you.

Has the PVA studied the impact of in-home ventilator care and the costs associated with that care? Should there be an additional rate paid based on ventilator dependence?

Mr. BLAKE. I cannot say that I am aware that we have studied it, Mr. Chairman, but I can certainly go back and ask some of the folks who represent our research folks and see if they have looked into this issue particularly.

Mr. HALL. Thank you. That would be helpful.

Should there be a partial A&A awarded for veterans who can perform some of the activities of daily living, but not all of them?

Mr. BLAKE. A partial A&A, sir? I do not think there should be any partial benefit given period. I think the aid and attendance benefit is a benefit given in whole and that is it.

Mr. HALL. Should there be a new SMC rate created for cognitive impairments such as for PTSD or TBI?

Mr. BLAKE. I do not know if it would be a new rate or a way to reevaluate the current SMC schedule as it is developed and add that in there. Maybe it needs a new subsection of its own. I could not speak to that necessarily, sir.

Mr. HALL. Thank you.

How would the PVA recommend that a quality of life payment be made? Should it be inherent in a new rating schedule or should it be as an SMC?

Mr. BLAKE. I do not know that that question has ever been put before our Board of Directors. I am not sure that we have ever considered the best way to do it. But I will take it back to my leadership and see what their thoughts on that question might be, sir.

Mr. HALL. Would either Mr. Abrams or Mr. Zampieri like to comment on that question?

Mr. ZAMPIERI. Yes. Appreciate it.

I would be concerned about having it too fragmented with the determination, you know, because then you make an already slow process even more complex for the individual veteran who is trying to figure out why they are making this decision in the service-connected, economic replacement type payments and then a separate payment for something else and then another payment for, you know.

The last thing the VA needs I think at this point could safely say is something else that is going to add to the slowing down or cumulative effect of having to deal with all these various benefits decisions.

Mr. HALL. Good point.

Mr. ABRAMS.

Mr. ABRAMS. I think that if it can be determined that somebody comes back from Iraq, Afghanistan, Vietnam and because they suffered a blow that cost them a percentage of their ability to think, they should have an SMC code for that. It is not any harder than the current SMC codes which some VA raters find hard. But it is not going to add any more to the complicated process.

Mr. HALL. Well, thank you.

I want to thank all three of you for your testimony and for your answers. I am looking forward, as we move forward, to speaking with you all again. So our first panel, you are now excused.

We will invite in the changing of the guard our second panel to join us.

Dr. Lonnie Bristow is the Chairman of the Committee on Medical Evaluation of Veterans for Disability Benefits, Board on the Health of Select Populations at the Institute of Medicine (IOM), the National Academies; Mr. George Kettner, Ph.D., President of Economic Systems, Inc.; Ms. Kimberly D. Munoz, Executive Director for the Quality of Life Foundation; accompanied by Michael Zeiders, President of the Quality of Life Foundation; and Ms. Carol A. Glazer, President of the National Organization on Disability (NOD).

Thank you all for joining us today. I would remind you as always that your full written testimony is entered in the record and if you can limit yourselves to 5 minutes in oral testimony, then we will have time for questions.

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

STATEMENTS OF LONNIE BRISTOW, M.D., CHAIR, COMMITTEE ON MEDICAL EVALUATION OF VETERANS FOR DISABILITY BENEFITS, BOARD ON THE HEALTH OF SELECT POPULATIONS, INSTITUTE OF MEDICINE, THE NATIONAL ACADEMIES; GEORGE KETTNER, PH.D., PRESIDENT, ECONOMIC SYSTEMS INC., FALLS CHURCH, VA; KIMBERLY D. MUNOZ, EXECUTIVE DIRECTOR, QUALITY OF LIFE FOUNDATION, WOODBRIDGE, VA; ACCOMPANIED BY MICHAEL ZEIDERS, PRESIDENT, QUALITY OF LIFE FOUNDATION, WOODBRIDGE, VA; AND CAROL A. GLAZER, PRESIDENT, NATIONAL ORGANIZATION ON DISABILITY

STATEMENT OF LONNIE BRISTOW, M.D.

Dr. BRISTOW. Thank you. Good morning, Chairman Hall—

Mr. HALL. Please push your button so that your microphone is on.

Dr. BRISTOW. That helps.

Mr. HALL. Yes. Thank you.

Dr. BRISTOW. Good morning, Chairman Hall, Ranking Member Lamborn, and Members of the Subcommittee. I am Lonnie Bristow. I am a physician, a Navy veteran, a member of the Institute of Medicine, and a former President of the American Medical Association. And I am very pleased to appear before you again to testify about the improvement needed in the disability benefit system of the VA.

I had the great pleasure and honor of Chairing the Institute of Medicine (IOM) Committee on Medical Evaluation of Veterans for Disability Compensation that was established at the request of the Veterans' Disability Benefits Commission.

The Committee was asked to evaluate the VA's schedule for rating disabilities and related matters, including the medical criteria for ancillary benefits.

My task today is to present to you the Committee's recommendations on improving ancillary benefits, which are in Chapter 6 of our 2007 report entitled, "The 21st Century System for Evaluating Veterans for Disability Benefits." And I also intend to comment on our

recommendations concerning quality of life, which is in Chapter 4 of our report.

Specifically the IOM Committee was asked to comment on the appropriateness of medical criteria for five specific ancillary benefits, including vocational rehabilitation and employment (VR&E) services, automobile assistance, adapted housing grants, and clothing allowances.

And in each case, the Committee was asked to consider from a medical viewpoint the appropriateness of the specific conditions that a veteran is required to have in order to receive these ancillary benefits.

When we reviewed ancillary benefits, we found that they were created piecemeal over time. They were not designed as part of a comprehensive program of services and they are not systematically updated and, in some cases, not indexed for inflation. They are not based on an empirical analysis of veterans' actual needs or actual loss of quality of life. And except for vocational rehabilitation, there is no evaluation of their effectiveness in addressing veterans' actual needs or loss of quality of life.

We also noted that for most benefits, the medical eligibility criteria require a very high degree of obvious anatomic impairment and that they are so specific that they may not include veterans with other impairments that hinder mobility, such as multiple sclerosis.

I realize that this Committee does not have purview over vocational rehabilitation, but we concurred with the recommendation of a 2004 task force on VR&E that was appointed by VA, which suggested that VA should better coordinate its health, VR&E, and compensation programs in order to achieve a more individualized or veteran-centric approach to veteran services.

The IOM Committee offered four recommendations of its own for improving ancillary benefits. The first was based on the lack of data on the need for, or the effectiveness of, ancillary benefits and, therefore, we recommended that VA should sponsor research on ancillary benefits and obtain input from veterans about their needs. Such research could include conducting intervention trials to determine the effectiveness of ancillary services in terms of increasing functional capacity and enhancing health-related quality of life.

Second, since VA offers a number of services that might benefit a disabled veteran, we recommended that VA and the U.S. Department of Defense (DoD) should conduct a comprehensive, multidisciplinary medical, psychosocial, and vocational evaluation of each veteran applying for disability compensation at the time of service separation.

Third, we found no medical basis for the current 12-year limitation on eligibility for vocational rehabilitation (VR) services. VR might be beneficial after 12 years because of medical advances or the development of new assistance devices or new types of work for which veterans with disabilities might then be trained.

And, fourth, we were concerned about the low rate of participation in the Vocational Rehab Program and recommended that VA should develop and test incentive models that would promote vocational rehabilitation and return to gainful employment among those veterans for whom this is a realistic goal.

Concerning loss of quality of life, our report recommended that it be measured directly. Since quality of life measurement appropriate for compensation by VA does not exist at this time, we recommended that VA take a series of steps.

First, VA should develop a quality of life tool based on a lot of good work that has been done recently, some of it by VA's own researchers. In fact, VA already uses a quality of life measurement tool, the SF-36, but it is used in research on clinical outcomes, not compensation.

So, second, VA should either modify that tool or choose another it might select to determine if veterans experience an average loss of quality of life for any specific disabilities which exceeds the average loss of earnings capacity as measured by the rating schedule.

Third, if it turns out that veterans experience a serious loss of quality of life on average for a given condition that is not highly rated by the rating schedule, then the VA should compensate for that difference.

In summary, in our report, the main points concerning ancillary benefits and quality of life are, first, VA should more systematically research the needs of disabled veterans and the effectiveness of its ancillary benefit programs in meeting those needs and make the needed revisions in these programs based on this research.

Second, VA should assess the individual needs of disabled veterans at the time of separation from military service and coordinate the delivery of the services identified by that assessment.

Third and last, VA should develop a tool to measure the quality of life of disabled veterans, determine the extent to which the rating schedule already accounts for loss of quality of life, and for those disabling conditions in which average loss of quality of life is worse than the rating schedule indicates, compensate for those differences.

Thank you, Mr. Chairman.

[The prepared statement of Dr. Bristow appears on p. 44.]

Mr. HALL. Thank you, Dr. Bristow.

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

STATEMENT OF GEORGE KETTNER, PH.D.

Mr. KETTNER. Mr. Chairman, thank you for the opportunity to appear before you today. I am the President of Economic Systems, Incorporated and served as the Project Director of a recent study of loss of earnings and loss of quality of life of veterans with service-connected disabilities.

We compared veterans with service-connected disabilities to a match group of nonservice-connected veterans. Service-connected means that the condition occurred during or was aggravated by military service. It does not require that the disability be work related or be caused by conditions in the work environment.

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

On average, veterans rated 30 percent or less did not experience serious wage loss. Approximately 55 percent of 2.6 million veterans receiving disability compensation are rated at 30 percent or less.

Veterans rated 40 to 90 percent ratings experience wage loss, but their VA disability compensation more than made up for the loss. For veterans rated at 100 percent, their earnings and disability compensation was 9 percent less than expected.

We also found considerable differences in earnings loss across different diagnoses for a given rating level resulting in serious inequity in the disability payment system.

Several of the most prevalent diagnostic codes are candidates for changes to the rating schedule because there is no earnings loss at the 10 percent or 20 percent rating levels. Examples include arthritis, hemorrhoids, tinnitus, and diabetes.

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

Veterans receiving disability compensation have on average 3.3 disabilities that are rated. VA uses a certain look-up table for combining individual disability ratings into a combined degree of disability rating. The earliest known table dates from 1921 and little has changed since then.

The formulas result in ratings that overcompensate veterans for loss of earning, particularly when combining multiple disabilities with low ratings.

Veterans with a combined rating between 60 to 90 percent who are determined to be unemployable qualify for individual unemployability benefits or IU benefits. Veterans determined to be entitled to IU qualify for the same benefit payment amount as those rated at the 100-percent disability level.

Individual unemployability has increased by almost 90 percent since 2001 with PTSD cases making up one-half of new IU cases. Forty-four percent where veterans age 65 and older, age is clearly related to employment, but it is not considered in determining eligibility for IU. It appears that IU for veterans approaching or past retirement age is implicitly providing retirement income or recognition for loss of quality of life rather than for employment loss.

Special monthly compensation is a series of awards for loss of limb, organ, or functional independence. SMCs are not awarded to compensate for average loss of earnings capacity. Instead they can be viewed as payments for loss of quality of life.

The amount of SMC monthly payments above the regular schedule payment for the 100-percent rating ranges from about \$600 to \$1,900 for severely disabled veterans. SMC payments are generally not made for PTSD and other mental health conditions unless the veteran requires aid and attendance.

Certain SMCs are paid to veterans for assistance with activities of daily living. For example, SMC(L) provides \$618 per month above the normal 100 percent amount and SMC(S) for housebound veterans provides \$302 per month.

Survey results indicate that the monthly cost of hiring assistance for caregiving ranges from about \$500 to \$11,000 depending on how many hours of care are provided.

A recent study estimated the lost wages and benefits of family caregivers of severely injured, active-duty servicemembers at \$2,800 per month. The current amount of the SMCs for assistance is well below these estimated costs.

The literature generally defines quality of life as an overall sense of well-being based on physical and psychological health, social relationships, and economic factors.

We found that QOL loss occurred for veterans at all levels of disability. We also found that loss of quality of life increases as disability increases, but there is wide variation in loss of quality of life at each disability rating.

Putting an economic value on quality of life is subjective and value laden. Hence, we develop different options for quality of life loss payments ranging from an average amount of \$100 a month to about \$1,000 a month depending on the benchmark for measuring loss of quality of life.

Examples of benchmarks include veterans' self-assessment, societal views, awards made by foreign governments, SMC payments, and IU benefits for veterans over the age of 65.

Before any quality of life benefit is implemented, we recommend that the current system for rating disabilities be adjusted to reflect actual loss of earnings to ensure an overall equitable system. Otherwise, we may be compounding the inequities that we have in the current system.

Mr. Chairman, I thank you for the opportunity to appear before you today.

[The prepared statement of Dr. Kettner appears on p. 46.]

Mr. HALL. Thank you, Dr. Kettner.

Ms. Munoz, you are now recognized for 5 minutes.

STATEMENT OF KIMBERLY D. MUNOZ

Ms. MUNOZ. Thank you.

Chairman Hall and distinguished Members of the Subcommittee, thank you for inviting the Quality of Life Foundation to testify today.

As you know, the Veterans Affairs mission statement is based on the promise that President Lincoln made to America's Civil War veterans to not only care for them but also in the event of their death to ensure their widows and orphans were not forsaken.

We assert that today's equivalent of America's Civil War widows and orphans includes the families of catastrophically injured veterans and that they also must not be forsaken. As such, benefits must reflect the reality that when a veteran is dependent on a family caregiver, their family becomes dependent on their benefits.

As a nonprofit organization founded to develop, support, and implement strategies to improve the quality of life for those who face limiting barriers, we began researching the experiences of catastrophically wounded servicemember families in February of 2008. We published our findings in a report in April of 2009.

During our research, we heard repeated stories of families' struggles to receive the benefits their veterans had earned. The degree of this struggle is reflected in the fact that for fiscal year 2007, 5 of the largest, most well-known VSOs reported \$75 million in program expenses associated with VA claims assistance.

It is apparent that VA must reduce the burdensome process and wait times associated with the receipt of benefits these families need to rebuild independent and quality lives.

While timely processing is important, it cannot be achieved at the cost of accuracy. An accurate disability rating based on relevant eligibility criteria is the key to open doors to benefits these families desperately need. Special monthly compensation is one of those.

This compensation is awarded in consideration of the impact disabilities have on the veteran's independent living function. However, current eligibility criteria fails to fully consider cognitive and psychological impairments that also diminish the veteran's ability to live independently.

For example, a highly functioning veteran with 100 percent service-connected disability due to a stand-alone Traumatic Brain Injury who has been left with impaired cognitive, judgment, and short-term memory capabilities clearly cannot safely live independently. He requires oversight for activities like paying bills, cooking, driving, attending medical appointments, and taking medication.

However, because he has no physical disability, he is eligible for just one category of special monthly compensation resulting in approximately an additional \$600 a month.

When a family member has left their job to provide that oversight for their veteran, \$600 does not cover that financial burden.

Simply stated, we believe that if a veteran's service-connected disability requires a significant level of daily supervision and assistance, the VA must provide compensation to fully cover that caregiving expense.

The specially adapted housing grant is another benefit with eligibility criteria based largely on physical impairments. The maximum grant is \$60,000 and it is intended to only offset the cost to modify a home. The process is lengthy and as such prohibits modifications from being completed prior to the veteran's homecoming.

These grants must be awarded in time to allow the homeowner, including parent caregivers, to provide a safe and accessible environment for the day the veteran arrives home. Additionally, the grants should cover the total cost of the modification.

The VA provides health care to eligible veterans throughout the United States via their own facilities and in some instances through a fee-basis program. However, when VA facilities do not provide the best option for veterans and their families, the VA discourages access to private care.

When veteran families choose to pursue health care via the fee-basis program, the VA should accommodate that choice by timely issuance of preauthorization and full and timely payment to non-VA medical providers.

Family caregivers also require health care and many of them, especially parent caregivers, forfeit their own health insurance when they leave their job to provide daily care to their veteran. This loss of coverage results in a lower quality of life and potentially the inability to sustain caregiving for the veteran.

The VA must provide health care insurance to those family members who have forfeited their own insurance to provide care to their veteran.

In addition to health care, family caregivers require respite from the demands of 24/7 caregiving. However, respite eligibility criteria also does not fully consider cognitive and psychological impairments experienced by those with stand-alone PTSD or TBI.

For those who do qualify for respite, the VA provides 30 calendar days per year of in-home, 6 hours a day respite. Families who desire extended respite may place their loved one in a VA nursing home. Most families are reluctant to exchange the stress of moving a loved one into a nursing home for a much needed weekend vacation.

We believe the VA should provide respite to family caregivers of veterans who require aid and attendance and should extend the current in-home respite benefit beyond a 6-hour maximum to include overnight in-home care.

Family caregivers often voice heartfelt concern regarding the day they become unable to fulfill caregiver responsibilities and are forced to place their loved one in a VA nursing home. The VA must invest in long-term, age appropriate residential care geared to meet the needs of this generation of traumatically injured veterans.

In conclusion, the Quality of Life Foundation believes our country's response to the families of severely wounded veterans must be deserving of their response to their veteran's call of duty. We must provide compensation, medical care, and long-term support to allow severely wounded families to rebuild quality lives, to live with dignity in their homes, and to know that their sacrifices are appreciated and honored by a grateful Nation.

The time to study this issue is past. These families are struggling to sustain caregiving with too few resources. They do not need nor want a handout. They simply ask for the tools required to take care of their veteran and their families. We urge Congress to pass legislation this session that increases support to family caregivers.

That concludes my testimony and I look forward to answering any questions you may have.

[The prepared statement of Ms. Munoz appears on p. 54.]

Mr. HALL. Thank you, Ms. Munoz.

Ms. Glazer, you are now recognized for 5 minutes.

STATEMENT OF CAROL A. GLAZER

Ms. GLAZER. Thank you, Mr. Chairman and Members of the Subcommittee.

My name is Carol Glazer and I am the President of the National Organization on Disability or NOD. We are a 27-year-old national nonprofit organization that has long worked to improve the quality of life for people with disabilities by advocating for their fullest inclusion in all aspects of life.

We are well-known for our Harris polls, which measure quality of life indicators, including access to health care, transportation, employment, education, worship, and even political participation.

And we commend the Subcommittee for looking at quality of life indicators besides earning capacity in determining disability ratings and ancillary benefits for our country's service-disabled veterans.

Today I want to share with you what we are learning from the early phases of an Army wounded warrior career demonstration project, which is a privately funded, 4½ year demonstration conducted by NOD under a Memorandum of Understanding with the United States Army and its Army Wounded Warrior Program.

My observations on quality of life issues for veterans are derived from scouting reports from the field, from focus groups over the course of a year with over 200 soldiers and family members, and through our first year of this demonstration that is operating in three sites, the Dallas Metroplex, the State of Colorado, and the State of North Carolina.

In fact, just this morning, I returned from our Colorado site where I spoke with several officials at Fort Carson, veterans, family members, and the service providers who work with these veterans.

Through our demonstration with the Army, our career specialists ensure that career services and related assistance are provided, in this case to over 200 soldiers and their family members. We link these soldiers with existing career services in their community and in some cases we provide direct services ourselves where such services are inadequate.

We are demonstrating a model of intensive, proactive, long-term career support in what will ultimately be a caseload of several hundred soldiers.

The demonstration has a research component where we will analyze the results of our model, especially on outcomes related to education and work. And although this demonstration is related to education and employment, we believe that the service model and what we are learning from this demonstration is going to have applicability across a whole range of quality of life issues for veterans, especially those that are of concern to this Committee.

I wanted to share with you a few of the lessons that we are learning from this early stage. Our demonstration has been in place for about a year with the U.S. Army.

First observation, a fundamental mismatch. Many of the supports for veterans are constrained to a reactive service model placing the burden on veterans and their families to find and approach agencies. But we find that the most seriously injured soldiers, especially with cognitive injuries, are not really able to effectively access these services.

The model we are testing involves proactive support, in which we actively reach out to veterans who are in our caseload immediately upon their transition home. We contact them at least once month either electronically or by phone and we see them at least twice a year, much more often at the outset of our work with them.

Our surveys confirm that our veterans find this approach much more satisfying than those of many other services that are more reactive in nature.

Second observation, the need to deal with both the veteran and the family member. As others have stated, the process of recovering from injury and coming home and coming to terms with disability is a very complex process that impacts the entire family. It is our belief that ancillary benefits and services must be available to veterans and family members.

Third observation unaddressed mental health needs, as others have noted. More than half of the Army Wounded Warrior population, which is a group of veterans with a 50 percent or higher disability rating from the Army, suffers from a primary diagnosis of PTSD, often combined with Traumatic Brain Injury.

It is not a criticism of the VA to say that the level of mental health services is simply at this point insufficient to meet the large and growing demand. We believe that the VA should supplement the direct services that it provides in mental health with help from many good, quality community and other based mental health services.

Four, criminal charges. Several veterans' behavior associated with PTSD or TBI have resulted in their facing criminal charges—erratic driving, substance abuse, a whole range of other behaviors, some of them violent. Those serving veterans must intervene with the police, with the courts, and with prosecutors to request that notice be taken of a soldier's disability and considered as a mitigating factor in charges and sentencing.

Five, personal and family financial management. Young veterans often have little experience in managing properly their family finances and they are in dire financial straits. There is clearly a need for continuing personal and family financial management, training, and guidance.

Six, peer support mechanisms. Many veterans and families are isolated geographically, socially, and psychologically. Our career specialists employ peer support mechanisms with very, very good results. We encourage the VA to think about that type of an intervention as well.

And then education and job skills, we are very heartened by the new GI benefit structure, but offer a yellow warning light that these benefits are now so rich in relation to other benefits that in many cases we believe they may skew decisions toward a 4-year college for many veterans that could benefit more appropriately from job training or community college credentials that are going to be needed to succeed in the labor market of today and tomorrow.

Finally, the need for flexible work supports. The veterans and families we serve often have very low incomes and cannot pay for things like computers or work clothes or other types of improvements that will help them access the job market. To meet such needs, we provide small grants, flexible money from what we call work supports, but we would encourage the VA to consider that type of very, very flexible funding that can be administered very quickly in response to needs that arise.

These are just a few of the observations we have drawn from our demonstration which is now only a year into our model in Dallas and in North Carolina, it is even younger. We provided more information to you about the demonstration in our written comments and we would be happy to provide even more or answer any questions you have about our model.

Thanks for your invitation.

[The prepared statement of Ms. Glazer appears on p. 57.]

Mr. HALL. Thank you, Ms. Glazer.

Dr. Bristow, in its recommendations on ancillary benefits, the IOM observed that VA had not surveyed veterans about the effec-

tiveness of these benefits, so there was a serious lack of data to evaluate the medical criteria.

Do you think conducting this research would be an important step before VA could further consider how it might compensate veterans for the loss of quality of life or to revise the SMC rates?

Dr. BRISTOW. First of all, we cannot report on our Committee's assessment of SMC because that was not a part of our charge. I can give you a personal observation in a moment.

But certainly on the issue of whether or not additional research should be done assessing from the veterans, listening to the veterans themselves as to what their needs are, this is essential in order to be able to judge the adequacy and effectiveness of the ancillary benefits program and in order to be able to subsequently go back and find out how well are these benefits actually meeting those needs and actually accomplishing the goal, which would be to increase functional capacity and to improve to the extent possible the veteran's mobility and employability.

I would make a personal observation about SMC only to the extent that SMC as I have seen it seems to have a specific focus on anatomic loss. And as you have heard already, this virtually precludes its ability to be effective in use for conditions such as TBI and PTSD where the disability is largely neurological or psychiatric and not an anatomic or physical loss.

And so it is terribly important that we actually assess from the veterans themselves as to what they need and how well these programs may or may not fit their needs.

Mr. HALL. Thank you, Doctor.

IOM also looked at various veterans' programs from several other countries.

Would you say that any of them did a better job of compensating veterans for the loss of quality of life? Which models, if any, would you recommend and why?

Dr. BRISTOW. Well, one of the best examples of how you can effectively and credibly evaluate quality of life and put it into a compensation model is seen in Canada. We noted that in Ontario, Canada, the city had a workers' compensation program that took a very unique approach to the fact that there is a need to compensate workers not only for their loss of work capability, earning capability but also for quality of life.

They have 12,000 workers who are disabled. And what they did was they selected I think it was 76 disabling conditions such as blindness, such as the loss of a limb, such as stroke, things of that nature, and they took individuals who had those 76 conditions and made 5 to 6 minute long videotapes in which they had a therapist question the individual as to how this disability impacted their lives and allowed the individuals to demonstrate how they perceive this impacted their lives, things such as trying to catch a bus, trying to take care of your laundry, daily services of caring for yourself.

They then took those videos and they showed disabled workers four to six such videos in a 30-minute period of time, and asked them, how would you rate your preference for this condition, making sure that they did not show anyone a video of the condition

they already had, instead always showing them some other conditions.

The test subjects were then asked to rate each condition on a preference basis from 0 to 100, 0 being "this would not bother me at all," on up to 100 being "I would rather be dead than have this condition," and rates were assigned in this subjective fashion.

They were able by this methodology to come up with a credible rating system in which the "average person" would be able to say if I had this condition, this is the impact it would have on my life, my perception of my will to live, so to speak.

They then also were able to convert that system with those percentages to a monetary compensation. And this worked very effectively there.

It is possible to do. It is possible to measure quality of life in a way that is credible and reproducible statistically and to actually convert that assessment into a monetary or compensation platform.

The VA is close to that with the quality of life instrument that they are currently using. It would need to be modified. But were it to be modified to actually allow for preferences to be indicated, at the IOM we believe that this could serve as a vehicle for the actual measurements of quality of life that could be attributed to various conditions and then take a look to see whether or not that condition's quality of life assessment matches up reasonably well with what the current rating schedule is already giving to a veteran.

If it matches up well, fine. But if there is a significant disparity between the veteran's perception of their quality of life given this condition as contrasted with what the rating schedule gives, then we believe that a third step is needed, which the VA should make some adjustment in its compensation award to that veteran based on the difference in quality of life that they are experiencing.

Quality of life, Mr. Chairman, as I am sure you are aware, is terribly important.

Mr. HALL. Thank you, Doctor.

Dr. Kettner, there has been concern that the data that EconSys used to base its recommendations upon did not fully consider all of the veteran population, particularly VA's largest service-connected cohort, Vietnam veterans.

Can you provide more insight into how you conducted your study and what you might have done differently if data prior to 1980 were more readily available? How does your study take into account the demands of the baby boomer generation who are currently placing the greatest demand on VA?

Mr. KETTNER. Okay. Well, thank you for the question.

Our study focused on veterans who were discharged from military service post-1980. We attempted to look at pre 1980 data, but uncovered that the pre 1980 data was not adequate for purposes of our study. We could not get sufficient data on certain human capital characteristics and, therefore, we decided that the best approach to take would be to focus on the post-1980 group.

This post-1980 group is also relevant from the point of view that if you are going to grandfather the current payments for veterans already in the system, you want to look forward to the future on how you would set forth payments for veterans entering the system

in the future. Then we think it is appropriate from a methodological point of view to focus on the post-1980 veterans.

[Dr. Kettner subsequently provided additional remarks in response to Mr. Hall's question, which appears on p. 73.]

Mr. HALL. Thank you.

The study also found that VA has 54 possible combinations of SMC codes, which apply different degrees of compensation.

Are these combinations adequate to improve a catastrophically disabled veteran's quality of life or does the VA need to reassess the SMC awards that for the most part have been in place since the Civil War?

Mr. KETTNER. Okay. Well, the quick answer to your question would be by and large the SMCs are not adequate. We found overall that while with the regular schedule, there may be overcompensation, when it gets to the 100 percent rating level and the SMCs, generally speaking, there is undercompensation.

In particular, you can view SMCs as expounding into two parts, one part for implicit quality of life payment and another part for the aid and attendance. We know that for aid and attendance, the SMCs are not adequate. They fall quite a bit short on that account.

The SMC veterans are rated at 100 percent and we know from our earnings loss analysis that they are not adequately compensated for their loss of earnings.

The component of quality of life is much more subjective, but in general, our own judgment would be that the SMC veterans need more attention and more compensation than the regular schedule veterans who are rated below 100 percent.

Mr. HALL. You also noted that the rating schedule needs to be updated for mental disorders and PTSD especially. Veterans with mental disabilities are below income parity and the report suggests that the 10-percent rating begin at 30 percent and subsequent adjustments upward. However, that would still not solve the equity problem at the 100 percent.

You also noted the lack of SMCs for mental disabilities. Could the addition of an SMC for mental disorders bring these veterans to parity?

Mr. KETTNER. That would certainly help, but the SMCs are intended not to replace loss earnings. So there is still that shortfall in replacing earnings loss for veterans at 100 percent rating, including those that have PTSD.

Mr. HALL. Thank you.

Ms. Munoz, I understand from your report that families of severely wounded warriors deplete their savings and retirement accounts, go bankrupt, remortgage homes, lose jobs, along with other problems.

What would you estimate the average family spends to meet the needs of their wounded warrior that the Government does not reimburse them for undertaking?

Ms. MUNOZ. Well, it varies widely because some families have assistance to get the benefits that they need from VA and they have to use less out-of-pocket funds to get the services their veteran needs.

Other families who may have not had the guidance from perhaps a VSO or who do not have the education in our country, maybe

they have moved here from another country and they do not speak our language, it is hard for them to run through all the rules and regulations and applications. And so they have a difficult time accessing the benefits that they need.

There was a study that was released by the Center for Naval Analysis (CNA) that estimated 19 months of lost income of around 2,000 some odd dollars, I think, for a total of \$36,000 average loss per family of catastrophically injured servicemembers.

That is their income loss, which is not necessarily answering your question of how much do they spend out of pocket to get the services, but it is a figure that has been widely reported.

Mr. HALL. Thank you.

What additional factors do you think VA should specifically consider when it adjudicates aid and attendance or housebound rates?

Ms. MUNOZ. One of the key questions is can the veteran keep themselves safe from the hazards of daily living. There are many other questions related to a body part function or a loss of a body part, but buried deep in there is can the veteran keep themselves safe from the hazards of daily living.

For those who have Post-traumatic stress disorder and stand-alone TBI, I believe that that is a key to determining whether or not that veteran needs aid and attendance. The aid and attendance can also vary in terms of do you need physical aid and attendance or do you need oversight.

So one package of aid and attendance does not meet the needs of every single veteran.

Mr. HALL. It seems to me that a judgment about the safety of the veteran living independently is similar to a judgment that one would have to make about an Alzheimer's patient, for instance, and families that go through that difficult time when they realize that a stove or an electric socket is no longer a safe thing for this adult family member to be handling alone.

Ms. MUNOZ. Some of the family members have suggested specially adapted equipment be included in the grants available for home modifications like stoves that automatically turn off after a certain amount of time or other appliances that consider short-term memory loss for some of the Traumatic Brain Injury veterans.

Mr. HALL. And what else do you think, Ms. Munoz, could VA do to improve the quality of life of disabled veterans and their families?

Ms. MUNOZ. It sounds simple, but I know it is very difficult, and that it makes it easier for families to get what they need. Any time you look at title 38 and try to determine, well, what is this veteran eligible for or how do I go about it, it is so hard to know who is eligible for what.

One family caregiver told me the story of, you know, we thought we were eligible for respite care and then when we called, my son's rating was not high enough or the SMC code was not the right code. So they work very hard then to find out, well, how do I get that code. And that is a backward way to work a system.

You need to find out what does that veteran need, much like you suggested, what is the need of that veteran and what is the need of that family so that they can live safely and live independently,

not how do we get you pigeonholed into the right code so you get the services that that code offers.

Mr. HALL. Thank you.

Ms. Glazer, in the program that you operate with the Army, what kind of feedback have you had from soldiers and their families regarding their VA benefits?

Ms. GLAZER. We are serving soldiers in two ways. One is we are collecting data about the demographics and then all the way through from the services they get all the way through to their career, pursuing a job and then advancing in their career.

We are also serving them by administering direct questionnaires that are done in person. What we hear is that among the services that they are accessing not only from the VA, from the Department of Labor, some of the other public agencies, as well as even some of the community supports that the services that we are providing them, they rank very, very highly, higher than the others.

And we believe that is because it is such an intense, proactive model where we are actually going out and finding them and we are staying in touch with them and we are taking them by the hand when they go into a job interview or walking in with them. Once they get a job, we are staying with them and staying with the employer after they become employed.

So in summary, we are finding that they do appreciate these services. They do not always feel that they have the wherewithal to go out and get them which is typically the way the VA process works. They benefit much more greatly from somebody going out and finding them.

Mr. HALL. Does your organization work with all disabled people?

Ms. GLAZER. Yes, we do.

Mr. HALL. How would you say that the VA compensation program compares to other programs? Are there other benefits that could be added to the VA package that would improve or enhance a disabled veteran's quality of life?

Ms. GLAZER. Well, if you just think about cash benefits and then medical benefits, their cash benefits are much richer for a veteran because a veteran might be getting Social Security disability income or even supplemental security income (SSI) in addition to the VA benefits that they are receiving. TRICARE and VA offer some of the best health care around.

So I think in terms of comparing benefits for a civilian to benefits for somebody in the military, those benefits tend to be richer than for civilians.

Having said that, the benefit system both on the civilian side as well as on the military side does tend to be skewed away from work very frequently. Work and career are a focus of NOD. And what you find is that when a veteran is getting a combination of disability pay, there could be veterans' benefits, just regular cash benefits. That same veteran might also be getting Social Security Disability Insurance. And then if you layer on top of that accessing the new GI Bill, which provides not only books and tuition but also a \$1,400 a month housing allowance, that combination of benefits tends to be very, very, very rich.

And, unfortunately, what we find is it often skews the decision away from work for a veteran who would otherwise become a pro-

ductive, contributing member of their society and their community. And sometimes, frankly, it is irrational to make a decision to go back to work and forsake some of those cash benefits that you are receiving from a combination of the military and the civilian benefits that you are entitled to.

Mr. HALL. Thank you.

Incarcerated veterans have had their VA benefits reduced or terminated.

Do you think that Veterans' Courts could help facilitate keeping more veterans involved in the VA system so veterans do not fall deeper into poverty or homelessness upon their release?

Ms. GLAZER. Yes, we do. We think it is a very important model that bears close scrutiny. A number of States are now adopting these courts. Not only do they divert a veteran out of the prison system and provide alternatives to incarceration, but often they have specially trained magistrates who really understand the mental health conditions that are driving many veterans to do things that they would not otherwise do, whether it is substance abuse or domestic violence or you name the kind of abhorrent behavior that is a result of mental health problems.

And with specially trained magistrates who really understand—I just came back from Fort Carson. There is actually a two-star General retired who is now becoming a magistrate in the veterans' court in the State of Colorado which is, in fact, leading the Nation in veterans' courts.

Besides having specially trained magistrates, they often have collocated on the site of the court a whole range of support services, whether it is housing or mental health services or places where you can go and, in fact, get your VA benefits. The concept of a veterans' court, we believe, has a lot of promise in keeping people out of the court system, out of the justice system, and more productively engaged.

Mr. HALL. Last, other countries provide veterans receiving compensation with financial planning services and advisors.

Is that something you think the VA should do when a veteran receives an initial award?

Ms. GLAZER. Absolutely. We find that a lot of these young men and women do not really know how to budget, how to plan for the future, how to save money.

Those particularly who are getting Traumatic Servicemembers' and Veterans Group Life Insurance (TSGLI), which is a one-time only cash payment of \$100,000 with a 100 percent disability rating, what many of these young men and women do is they will go out and buy a house and mortgage to a level that they really cannot afford or they will go out and buy a fancy car. If they had a little bit of financial literacy support, that money would be used much more wisely, not only the TSGLI, but, of course, all the other benefits they are getting.

Mr. HALL. Thank you, Ms. Glazer.

Thank you to all of our panelists, Drs. Bristow and Kettner, and Ms. Munoz. Your testimony has been very helpful to us. We will now excuse you from your duty here and wish you a good day. Thank you again for your work.

Our third panel is now invited to come to the witness table, Mr. Bradley G. Mayes, Director of Compensation and Pension Service for the Veterans Benefits Administration of the U.S. Department of Veterans Affairs; accompanied by Mr. Thomas Pamperin, Deputy Director of Policy and Procedures, Compensation and Pension Service for the VBA; and Mr. Richard Hipolit, Assistant General Counsel of the Office of General Counsel for the U.S. Department of Veterans Affairs.

Gentlemen, welcome. It is always good to see you here and to hear what you are doing for our Nation's veterans. We know you are working hard to sort through these complex problems. Your written testimony as always is entered into the record, so feel free to use your 5 minutes however you choose.

Mr. Mayes, you are now recognized.

STATEMENT OF BRADLEY G. MAYES, DIRECTOR, COMPENSATION AND PENSION SERVICE, VETERANS BENEFITS ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY THOMAS PAMPERIN, DEPUTY DIRECTOR, POLICY AND PROCEDURES, COMPENSATION AND PENSION SERVICE, VETERANS BENEFITS ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; AND RICHARD HIPOLIT, ASSISTANT GENERAL COUNSEL, OFFICE OF GENERAL COUNSEL, U.S. DEPARTMENT OF VETERANS AFFAIRS

Mr. MAYES. Thank you, Mr. Chairman. Thank you for inviting me to speak today on the timely and important issues related to providing compensation for quality of life loss to our Nation's disabled veterans.

Definitions of quality of life loss vary widely and may focus on aspects of an individual's physical and mental health or may address an individual's overall satisfaction associated with life in general.

The Institute of Medicine traces the concept back to the Greek philosopher Aristotle's description of happiness. Then they go on to provide a definition that encompasses the cultural, psychological, physical, interpersonal, spiritual, financial, political, temporal, and philosophical dimensions of a person's life.

A more succinct definition utilized by EconSys refers to an individual's overall sense of well-being based on physical and psychological health, social relationships, and economic factors.

The most recent study of quality of life loss by EconSys titled, "Study of Compensation Payments for Service-Connected Disabilities, Earnings and Quality of Life Loss Analysis," was released in September 2008.

VA tasked EconSys with analyzing potential methods for incorporating a quality of life loss component into the current rating schedule and with estimating the cost for implementing these methods.

The EconSys study proposed three options that could be utilized by VA. The first and simplest method would be to establish statutory quality of life loss payment rates based on combined degrees of disability. EconSys has estimated that additional annual program costs for implementing this method range from \$10 billion to \$30.7 billion.

A second optional method proposed by EconSys would key quality of life loss payment amounts to the medical diagnostic code of the primary disability as well as to the combined percentage rate of disability. EconSys estimated that this method would result in annual program costs of \$9 billion to \$22.2 billion.

A third option proposed by EconSys would involve an individual assessment of each veteran for quality of life loss by both a medical examiner and a claims adjudicator. Estimates for this method range from \$10.5 billion to \$25.7 billion.

Implementing a disability rating system that compensates for quality of life loss would involve at least two major challenges for VA as we have heard today. The first would be to accurately and reliably determine whether and to what extent a disabled veteran suffers from quality of life loss. The second would be to establish equitable compensation payments for varying degrees of quality of life loss, which is arguably the more difficult of the two challenges.

Most of the organizations that have provided input to VA on quality of life loss have stated that VA has a number of special benefits that implicitly if not expressly compensate for quality of life loss such as ancillary benefits, special monthly compensation, and total disability based on individual unemployability.

Special monthly compensation and ancillary benefits are provided to veterans in addition to compensation paid on the basis of the schedular rating assigned to service-connected disabilities.

The ancillary benefits to which these organizations refer are intended to provide assistance to veterans with special needs resulting from exceptional disabilities. They include assistance with purchasing of an automobile or other conveyance, obtaining the adaptive equipment necessary to ensure that a veteran can safely operate the vehicle, acquiring housing with special features, adapting a residence or acquiring an already adapted residence, and, finally, providing an annual clothing allowance.

These benefits are described in more detail in my written statement which was submitted for the record.

Through this testimony we are attempting to outline some of the issues and challenges that VA would face if authorized to provide quality of life loss compensation. If VA is to provide quality of life loss compensation consistent with the proposed options in the EconSys study, statutory changes would be required.

Additional administrative costs for training VA personnel and reconfiguring VA computer systems, as well as the cost for providing additional benefits to veterans would be considerable. The implications for adopting such a policy are significant for VA.

This testimony also illustrates how, in addition to compensation provided under the rating schedule, VA provides special monthly compensation, ancillary benefits, and extra schedular ratings to veterans with certain service-connected disabilities, which multiple studies have recognized as existing tools to promote the quality of life of veterans.

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

Mr. Chairman, this concludes my testimony and I would be pleased to answer any questions you or the Subcommittee might have on this very important subject.

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

Mr. HALL. Thank you, Mr. Mayes.

Speaking for the Subcommittee, it appears that VA has basically not accepted, at this point, any of the options presented by the EconSys study. If that is the case, then what does the VA propose to do about loss of earnings, special monthly compensation, quality of life, and a transition payment? Is there an approach in the works?

Mr. MAYES. The EconSys study, the Veterans' Disability Benefits Commission, and Institute of Medicine recommended that VA periodically review the current rating schedule to ensure that the schedule serves as an effective proxy for average lost earnings, which is the intent of our disability compensation program.

We have done that four times in our history that I am aware of: in 1956 with the Bradley Commission, the ECVARS study in 1971, the Center for Naval Analyses study that was done for the VDBC, and the EconSys study.

Generally, CNA found that we were on par with average lost earnings. EconSys found that we were within, I believe, 2 percentage points of average earnings in the 0 to 30 percent-range of combined degree of disability and above par, in other words, earnings plus VA compensation were above par up to the 100 percent rate. We were below par at the 100-percent rate.

We have two recent studies that are somewhat different. One thing they both found was that for mental disorders, we are below par. So what are we doing?

I believe we do need to take those recommendations to heart and institute a periodic validation of the schedule across diagnostic codes. Further, we are in the process of evaluating our criteria for setting the disability compensation rate for veterans suffering from mental disorders, including Post-traumatic stress disorder.

Those are a couple of things that we are doing right now that I believe both studies recommended.

Mr. HALL. In your spare time? What did you think of Dr. Bristow's description of the Ontario evaluation system? Is that something you were aware of before?

Mr. MAYES. We were aware of it. I believe that was described in the IOM's report, if my recollection serves me correctly.

EconSys also came up with a construct for arriving at an amount to equate to certain levels of loss in quality of life. That construct was based on the average annual payout for loss in quality of life in Canada.

Both studies took a look at that, and it certainly sounds like a reasonable approach. All studies that I am aware of have taken a look at a certain cohort of the population, in this case, disabled veterans, and tried to make a comparison between that cohort and the nondisabled veteran population. There are a number of ways of doing that.

Mr. HALL. Thank you.

You have already partially answered this question, I think, but veterans have complained that the application for A&A is very focused on ambulation and activities related to standing, walking, and balance, which for arm amputees or for brain injuries might not be applicable.

When was the last time that the VA reviewed the A&A application and exam criteria? Has consideration been given to revising it's A&A criteria to give consideration to these other disabilities and levels of need?

Mr. MAYES. Consideration has been given. We are considering revising the eligibility criteria for the higher level of aid and attendance. That would be aid and attendance at the R2 level. The R2 level provides a monthly benefit amount of a little over \$7,600.

So the real issue, and it has been raised here today at this hearing, is how you reach veterans who have significant cognitive impairment, and we certainly are taking a close look at that.

Do you, Dick or Tom, want to add anything to that?

Mr. HIPOLIT. Yes. I think it is accurate that we are considering various approaches to how we might better serve those veterans through the aid and attendance allowance.

Now, there are various levels of aid and attendance. Of course, we can pay aid and attendance under the (L) rate. That is a less generous benefit. But then for veterans who have more serious disabilities and also have requirements for aid and attendance at various levels, we can pay a greater benefit.

And we are assessing whether there needs to be improvements in eligibility for the greater benefit for veterans with cognitive disabilities.

Mr. HALL. Can a veteran, Mr. Hipolit, you can answer this if you like, can a veteran receive a partial A&A award if they can perform some activities of daily living but not all?

Mr. HIPOLIT. There are basically fixed aid and attendance rates; there is not a half rate for aid and attendance. You have to meet that criteria for aid and attendance. There are various factors we consider. So we look at a total picture when we consider eligibility for aid and attendance.

Mr. HALL. We also asked one of the earlier witnesses, and I do not want to add another level of complication to the system, but I am just curious if a veteran who can perform some essential activities but not all, if there was a usefulness or a rationale for a partial award for A&A.

Mr. PAMPERIN. Congressman Hall, we would like to emphasize that we did relatively recently look at the TBI rating criteria, which had previously been limited to a 10-percent evaluation for subjective complaints only and published after two summits on TBI and a lot of comments from everybody over our proposed rule a new TBI regulation that does allow for a 100-percent evaluation, which now gets you at least to the potential for the aid and attendance at the L level.

Mr. HALL. Thank you.

The VA notes that several studies dating back to 1956 have identified veterans with mental disabilities as being below income parity with their peers.

Why has it taken this long for VA to address this disparity and what steps is the VBA taking to address this serious compensation discrepancy besides the review of the rating schedule for mental disorders? Can something be done more immediately for our veterans?

Mr. MAYES. Mr. Chairman, with the conflicts in Iraq and Afghanistan, we were seeing veterans coming back suffering from Traumatic Brain Injury. We knew that our evaluation criteria and the rating schedule were not adequate to address the number of servicemembers that we were seeing coming back with disabilities.

As Mr. Pamperin said, we undertook an effort to update and put in place a system to properly evaluate veterans suffering from these disorders.

The way we went about that, I think, was very successful. We engaged the veterans' health community, Veterans Health Administration (VHA), DoD, and stakeholders from the private sector to learn about Traumatic Brain Injury and the classifications of the disorder. Then we incorporated that learning into what I think is a very meaningful regulation that is helping veterans. I am very proud of that occurring on our collective watch here.

What we want to do is replicate that approach for mental health. The Institute of Medicine looked closely at PTSD. They did at least two studies, I believe, for the Veterans' Disability Benefits Commission. So we have information there. But we wanted to engage the medical community again to answer some critical questions for us so that when we write a new regulation serving as the proxy for lost earnings, we get it right.

We are working with the VHA right now to host a summit similar to what we did with the TBI regulation, and we will invite those stakeholders to participate and help us learn. Then we will set about crafting a new regulation that I think will do a better job.

You combine that with periodically validating the effectiveness of our regulations, the rating schedule, and I think we can begin to do a better job for veterans.

Mr. HALL. Well, I appreciate that. And I know our veterans will as well.

Some veterans have noted that they must go to a Veterans Affairs Medical Center to apply for the clothing allowance. For some retirees using TRICARE, this is an inconvenience.

Why is the clothing allowance no longer adjudicated as an inferred benefit by the RO?

Mr. MAYES. That was an attempt by us to make the process a little bit more streamlined. Veterans were going to medical centers for treatment. The medical centers were, for example, prescribing medications that would soil clothing, clothing that would then serve as the basis for entitlement for a clothing allowance award.

Those applications were coming into VBA and to our VA Regional Offices, and then we were asking VHA to certify that the disability warranted the award of benefits.

What we were trying to do was eliminate some hand-offs and allow VHA to make that award at the time that they are delivering the services.

Mr. HALL. That makes sense in a lot of cases. I do not know whether some flexibility might be a good idea or not in the case of those veterans who are used to TRICARE, but just a thought.

If EconSys has already mapped the ICD9 codes, wouldn't this standardization with other medical models, including DoD and private providers, make it easier for raters to match treatment records and diagnoses to claimed disabilities?

Mr. MAYES. I do not know that it would make it easier for our decision makers. What it would have the potential to do is to allow us to do some data mining and compare our evaluations with, for example, information out there on treatment since the coding would be similar.

Our decisionmakers, though, are required to review all of the evidence at the time they render a decision because we do not want to disadvantage a veteran by missing a piece of evidence. So we look at all of the medical evidence, whether that be treatment records, exam reports, or psychiatric treatment records. Then they are going to match that up against the schedule to determine the level of severity.

It would allow us to look a little bit more after the fact once we have assigned the evaluations.

Tom, do you want to add anything to that?

Mr. PAMPERIN. The question has been raised a number of times about ICD9, and it is a very complex system of over 10,000 codes. But we do see the merit in cross-referencing with ICD9. What we are proposing to do is to retain our current numbering system and add a new field for service-connected disability at the back end of what the ICD9 is that was assigned. That way, you can compare apples to apples in terms of doing research.

But that would be, I think, far less difficult to do than to completely overhaul the rating schedule with a new numbering system, which then would drive major modifications to computer systems, whereas if you just put another field into the service-connected numbering system, I think you achieve the objective.

Mr. HALL. Mr. Mayes, can you further explain how the VA would go about reviewing ancillary benefits to determine where additional benefits such as assistive devices may be appropriate to improve a veteran's quality of life? What do you envision a benefits package as such would look like?

Mr. MAYES. I heard the previous panel, and the design initially for ancillary benefits I do not believe was to per se compensate for lost quality of life, but really to meet needs that were identified by veterans suffering from severe disabilities, for example, the clothing allowance and the automobile grant, the home adaptation grant.

As those needs change, and I heard two panelists previously say this we need to evolve. An example would be veterans who are suffering from severe burn injuries; they are surviving today when they possibly did not survive in previous conflicts because of advances in health care. So we need to adjust.

We have worked on modifying the eligibility criteria for the specially adapted housing grant to accommodate veterans suffering from severe burn injuries.

Those are the kinds of things we need to do. I think we need to take a look at the automobile grant. It is currently \$11,000. We are taking a look at that to see if that is meeting the needs of veterans to help offset the cost of the purchase of an automobile.

We need to continually do that, and I am going to take that away from today's hearing.

Mr. HALL. Thank you.

Two more questions, Mr. Mayes, and I think we may actually have our first hearing that is not interrupted by a vote.

Mr. MAYES. The one that went to about 8:30 that night—

Mr. HALL. I am sorry.

Mr. MAYES [continuing]. Will stick in my memory forever.

Mr. HALL. Well, we all remember that one.

Do you have a rough estimate at this point of the percentage of returning OEF/OIF veterans who are suffering from TBI?

Mr. MAYES. Do you have that, Tom?

Mr. PAMPERIN. We will get the exact number for you. But when we revised the TBI regulation, I believe the total number of people in the system from all wars who had a service-connected diagnostic code was about 12,000.

TBI is not in the top ten list of returning veterans filing claims for benefits. I cannot honestly say where it is, but we can easily get that number for you.

Mr. MAYES. We will provide that for the record, Mr. Chairman. [The VA subsequently provided the following information:]

Nine thousand two hundred sixteen living veterans discharged on or after September 11, 2001, are service-connected for TBI. Based on Department of Defense data from May 31, 2009, and VA records of veteran-reported Global War on Terror (GWOT) service through July 31, 2009, approximately 1,135,000 living Veterans had GWOT service.

Mr. HALL. Thank you.

Has the VA considered revising its policies on the SMC(S) rate as suggested by Mr. Abrams in light of the *Bradley v. Peake* decision?

Mr. MAYES. Interestingly enough, we sent policy guidance out yesterday on that. This is a case where the court interpreted a longstanding regulation interpreting a statutory requirement. The court held that our interpretation was overly restrictive. It is binding on VA, and we are going to administer the housebound benefit at the (S) rate per the court's decision.

Dick, did you want to elaborate on that?

Mr. HIPOLIT. Yes. I think that is correct. We have actually recognized in our regulation for some time that you could get the (S) rate for a single disability found to be totally disabling, based on individual unemployability plus an additional disability of 60 percent or more. That may not have been applied consistently across the board.

We do recognize the court's decision. We are working to implement it. Guidance is going out now. We are also looking at whether we need to amend our regulations to further incorporate changes in our system.

Mr. HALL. Could you supply this Subcommittee with a copy of the guidance that you just referred to that you sent out yesterday, please?

Mr. MAYES. Sure.

[The VA subsequently provided Fast Letter 09-33, to Director, All VA Regional Offices and Centers, regarding Special Monthly Compensation at the Statutory Housebound Rate, dated July 22, 2009, which appears on p. 74.]

Mr. HALL. And we are also still curious to see the Booz Allen Hamilton report.

Mr. MAYES. As soon as that is cleared, Mr. Chairman, we will get it over to the Hill.

[The Booz Allen Hamilton report entitled, "Veterans Benefits Administration Compensation and Pension Claims Development Cycle Study," dated June 5, 2009, is being retained in the Committee files.]

Mr. HALL. Okay.

Mr. MAYES. It is still in draft. I checked before I came over.

Mr. HALL. Well, thank you very much. We are looking forward to that as well.

Thank you for the work that you are doing.

I would like to remind the Members that they have 5 legislative days to revise and extend their remarks.

Thank you for the work that you are doing. I know it is a terribly busy, complex time, and we here in Congress keep making more requests and adding to your workload and to VA's workload, which is already impressive and staggering. But, we are all pulling, I think, pulling the oars in the same direction and trying to better the care, treatment, and quality of life of our veterans who have served this country.

So, thank you for your statements today, your insight, and your opinions.

This hearing stands adjourned.

[Whereupon, at 11:55 a.m., the Subcommittee was adjourned.]

A P P E N D I X

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

Good Morning Ladies and Gentleman:

The Subcommittee on Disability Assistance and Memorial Affairs of the House Committee on Veterans' Affairs' hearing on, "Examining the Ancillary Benefits and Veteran's Quality of Life Issues" will now come to order.

I ask that you please rise for the Pledge of Allegiance.

This Subcommittee has actively tackled many complex and complicated issues that have been encumbering the Veterans Benefits Administration's ability to properly compensate veterans who file disability claims. These issues have majorly centered on VA business processes and operations. Today's hearing will focus on the actual appropriateness of available benefits in meeting the needs of disabled veterans and their families.

The expressed purpose of VA disability compensation as outlined in 38 United States Code Section 1155 is based upon the average impairment of earning capacity. This concept dates back to the 1921 Rating Schedule, which had its roots in the blossoming workman's compensation programs. Then, the primary concern was to ensure that disabled World War I veterans would not become a burden on their families or communities when they could no longer perform the laborious tasks most civilian occupations required at that time. Over the years, Congress has added several elements to the VA compensation package to assist disabled veterans procure shelter, clothing, automotive, employment, vocational rehabilitation and in-home assistance. In its expansion of these benefits, Congress has attempted to meet disabled veterans and their families' social and adaptive needs, and not solely their economic needs.

In recent years, several commissions and institutions—many of whose members we will hear from today—have studied the appropriateness of VA benefits including a potential quality of life loss payment. They have identified significant challenges in developing an instrument or rating schedule that could fairly calculate compensation for the loss of quality of life. Much of what makes a life of quality is subjective and goes beyond fulfilling basic human needs or replacing impaired income. Furthermore, I realize that there is no amount of money that can replace a limb or peace of mind. Ensuring that veterans impaired by amputation, blindness, deafness, brain injury, paralysis, and emotional distress are afforded the necessary resources to lead productive, satisfying lives is the debt a grateful Nation owes these brave souls.

VA has in fact attempted to recognize that in order to make some veterans whole, there is a need to provide additional compensation that accounts for non-economical factors, including personal inconvenience, social inadaptability and the profoundness of the disability. Part of the problem may be that the formula and criteria used for adjudicating VA ancillary benefits and special monthly compensation is complex and often confusing to the beneficiaries themselves. Often times, disabled veterans are unsure of this added benefit, which leads to an inability to predict or plan for their future based on their VA assistance. Without transparency, transitioning wounded warriors are at a severe disadvantage if they cannot count on and predict their VA benefits package. Having this knowledge could be a big help to these veterans and more transparency and outreach is definitely needed in the ancillary benefits area.

I am eager to hear from today's witnesses many of whom are experts in the complexities and paradigms for compensating military related disabilities. I am also eager to hear from VA on its late-delivered VBA Response to the EconSys Quality of Life, Earnings Loss and Transition Payments study as mandated in Section 213 of P.L. 110-389. These veterans must be returned to their country, communities, and homes with the tools and resources to rebuild a life of quality.

I now yield to Ranking Member Lamborn for his Opening Statement.

**Prepared Statement of Hon. Doug Lamborn, Ranking Republican Member,
Subcommittee on Disability Assistance and Memorial Affairs**

Thank you Mr. Chairman,

I welcome our witnesses to this hearing to discuss the important issues of ancillary benefits and quality of life.

It is a terrible tragedy when one of our Nation's servicemembers are severely injured, and no amount of compensation can ever make up for the immeasurable sacrifice they have made in defense of our country.

It is these veterans with whom we should be most concerned, and every effort should be expended to ensure that they are able to lead lives that are as close to normal as possible.

I am particularly concerned about veterans in need of Aid and Attendance.

Much discussion has taken place recently with regard to family caretakers and what services should be available for them.

In my opinion, care for severely disabled veterans is the sole responsibility of the government that sent them to war, and zero burden should be placed on veterans' family members.

Obviously, many of our veterans' family members WANT to be there to care for their injured soldier, and that is wonderful if it is by choice, but it should never be out of necessity.

Compensation paid to the severely injured servicemembers should be more than adequate enough to obtain services necessary to meet the needs of daily living.

I look forward to our witnesses' testimony and working with Mr. Chairman Hall to address any shortcomings that might be revealed as a result of these proceedings.

Thank you, I yield back.

**Prepared Statement of Carl Blake, National Legislative
Director, Paralyzed Veterans of America**

Mr. Chairman and Members of the Subcommittee, on behalf of Paralyzed Veterans of America (PVA) I would like to thank you for the opportunity to testify today on the ancillary benefits provided by the Department of Veterans Affairs (VA) and how they impact the quality of life issues that veterans must deal with. PVA appreciates the efforts of this Subcommittee to address the varying needs of our veterans, particularly veterans with severe disabilities, such as spinal cord injury. We hope that addressing these particular issues will better benefit today's veterans and the veterans of tomorrow.

PVA members represent one of the segments of the veteran population that benefit most from the many ancillary benefits provided by VA. Without the provision of benefits such as Special Monthly Compensation (SMC), the Specially Adapted Housing (SAH) grant, and the Clothing Allowance, our members, and other severely disabled veterans, would experience a much lower quality of life and would in many cases be unable to live independently. With these thoughts in mind, we will focus our statement on some of the key ancillary benefits that PVA members receive, improvements that might be made, and the relationship quality of life has to these benefits.

Also, we would like to encourage the Subcommittee to review the final report of the Veterans' Disability Benefits Commission (VDBC) released in October 2007. The VDBC conducted one of the most thorough evaluations of ancillary benefits, as well as the entire VA claims process, ever completed. PVA tended to agree with many of the recommendations included in the VDBC report, particularly as it relates to improving ancillary benefits and addressing quality of life issues.

Special Monthly Compensation (SMC) and Aid and Attendance Benefits

Special Monthly Compensation represents payments for “quality of life” issues, such as the loss of an eye or limb, the inability to naturally control bowel and bladder function, the inability to achieve sexual satisfaction or the need to rely on others for the activities of daily life like bathing, or eating. To be clear, given the extreme nature of the disabilities incurred by most veterans in receipt of SMC, we do not believe that the impact on quality of life can be totally compensated for; however, SMC does at least offset some of the loss of quality of life.

PVA believes that an increase in SMC benefits is essential for our veterans with severe disabilities. Many severely injured veterans do not have the means to function in an independent setting and need intensive care on a daily basis. Many veterans spend more on daily home-based care than they are receiving in SMC benefits. This can place a significant financial strain on these veterans and often results in them being forced to opt for institutionalization.

To support our recommendation, we encourage the Subcommittee to review the recommendations of the VDBC report. As explained by the VDBC:

Veterans with catastrophic disabilities and their families face many challenges that make it harder for them to maintain a reasonable standard of living and compete with their peers. SMC adjustments help protect the health and welfare of severely disabled, service-connected veterans and their families. However, after considering the studies conducted by IOM (Institute of Medicine) and CNAC (Center for Naval Analysis) and other information, the Commission concluded that there are some instances, such as Aid and Attendance, in which the level of SMC is inadequate to offset the burden placed on veterans by their disabilities.

In the VDBC report, Recommendation 6.1 states that “Congress should consider increasing special monthly compensation where appropriate to address the more profound impact on quality of life.” PVA supported that recommendation then, and we continue to advocate for this important change.

One of the most important SMC benefits to PVA is Aid and Attendance (A&A). PVA would like to recommend that Aid and Attendance benefits should be appropriately increased. Title 38 U.S.C. establishes eligibility for Aid and Attendance benefits. Furthermore, 38 CFR sets the conditions for receipt of Aid and Attendance benefits as follows: (1) they (the veteran) cannot keep themselves ordinarily clean and presentable, (2) they cannot dress and undress themselves, (3) they frequently need adjustment of special prosthetic or orthopedic appliances, which by reason of the particular disability cannot be done without aid, (4) they cannot feed themselves due to the loss of coordination of upper extremities or extreme weakness, (5) they cannot attend to the wants of nature, (6) they have physical or mental issues that prevent them from avoiding the hazards or dangers of daily life. Attendant care is very expensive and often the Aid and Attendance benefits provided to eligible veterans do not cover this cost.

As an example, a particular PVA member who lives in Florida incurred a spinal cord injury while serving in Vietnam. He was shot through the neck and his spinal cord was severed at the C2/C3 level resulting in quadriplegia. In order to operate his power wheelchair, he has to use a “sip-and-puff” mechanism. Fortunately, his mother provided most of his attendant care to him throughout his adult life. A couple of years ago, his mother passed away, and he has no other immediate family to take care of him. He is now paying for a full-time attendant, but his cost for attendant care far exceeds the amount he receives as an SMC-Aid and Attendant beneficiary at the R2 compensation level (the highest rate available).

Finally, PVA would like to suggest that the Veterans Benefits Administration (VBA) should develop experts who deal expressly in SMC benefits. The complex nature of this particular component of VA compensation can be overwhelming for many claims rating specialists who work secondarily on SMC. With in-house experts who deal specifically with SMC cases, the VA could more accurately and efficiently decide these claims. In order to promote this demonstrated need, PVA has prepared a Guide for Special Monthly Compensation (SMC) that has been adopted by the VA for use when training ratings specialists. This information has been included on the VA’s intranet. The PVA Guide has also been distributed through VBA’s Special Monthly Compensation training. We would also suggest that the claims process could likewise benefit from specialized staff members who deal strictly with radiation claims and claims of former prisoners of war.

Specially Adapted Housing Grant and Adaptive Automobile Assistance

In recent years, Congress has taken significant steps to improve the Specially Adapted Housing grant program. Unfortunately, less has been done to improve Adaptive Automobile assistance. These two benefits in particular are keys to a veteran living an independent life.

PVA is pleased that Congress recently made significant improvements to the Specially Adaptive Housing benefits provided by the VA to severely disabled veterans. These changes were incorporated into P.L. 110-289, the "Housing and Economic Recovery Act of 2008." The new housing law makes an appropriate increase in the maximum dollar amount for the Specially Adaptive Housing (SAH) Grant. That amount is increased to \$60,000. The last increase was in 2003, when it was increased to \$50,000 from \$48,000. Construction materials cost for single family homes in recent years has increased approximately 16 percent (U.S. Bureau of Labor Statistics). The new law also makes an adjustment to the maximum amount each year based on the residential home cost-of-construction index. This needed increase was recommended in *The Independent Budget*, co-authored by Paralyzed Veterans of America, Disabled American Veterans, Veterans of Foreign Wars, and AMVETS.

The law allows for the VA to pay for home improvements and structural alterations for members of the Armed Forces that incur a severe disability and who would otherwise qualify for the SAH grant as a veteran. In the past, active duty servicemembers had to be discharged from military service to apply for the SAH benefit. This new change in the law allows a servicemember who will not return to active duty because of a service-connected disability, to make the necessary alterations to their home while waiting for their final discharge. Additionally, the law allows an individual that qualifies for the home modification grant, to use that grant to modify the home of a family member while residing with that family member (known as Temporary Residence Adaptation). It is common for a servicemember that has suffered a traumatic injury to live with family members during their rehabilitation and a period afterward.

Unfortunately, few eligible claimants have taken advantage of the Temporary Residence Adaptations (TRA) grant, which are limited to \$16,000 and counts against the SAH allowance of \$60,000. In a recent report, the Government Accountability Office (GAO Report GAO-09-637R June 15, 2009) found that only nine recipients have used the grant since the change in law and suggested that the low usage may be improved if the grant were a stand alone program. We believe Congress should consider this option.

One of the common injuries associated with service in Operation Enduring Freedom and Operation Iraqi Freedom is severe burns. This change in law for the overall SAH program will allow individuals that have suffered severe burns to use the Specially Adaptive Housing Grant for necessary modifications in their home environment. These modifications could involve expensive air filter systems and electronic temperature controls for the home.

We would encourage the Subcommittee to further examine some of the recommendations included in the FY 2010 *Independent Budget* regarding the adaptive housing benefits. Specifically, *The Independent Budget* calls for establishing a grant for adaptation of a second home when a veteran chooses to replace his or her current adapted home. *The Independent Budget* also calls for an increase in the grants for adaptation of homes for veterans living in family owned temporary residences from the current \$14,000 to \$28,000 for veterans with a total and permanent service-connected disability and from \$2,000 to \$5,000 for veterans with service-connected blindness.

As previously mentioned, we are concerned that the automobile grant and adaptive automobile assistance has not kept pace with the current market. Currently, the automobile grant provides \$11,000 toward the purchase of a new car for severely disabled veterans. However, in 2008, the average cost of a new car was \$28,500. When the automobile grant was first created by Congress, it covered the full cost of a new vehicle. In 1946, the benefit covered 85 percent of the cost of a new vehicle; today the grant only covers 39 percent of the cost. *The Independent Budget* recommends that the grant be increased to 80 percent of the cost of a new vehicle (\$22,800) and be indexed annually based on the rising cost of living.

Service-Disabled Veterans' Insurance and Veterans' Mortgage Life Insurance

In accordance with the recommendations of *The Independent Budget*, PVA also believes that there are some necessary improvements in the Service-Disabled Veterans' Insurance (SDVI) and Veterans' Mortgage Life Insurance (VMLI). With re-

gards to the SDVI benefit, *The Independent Budget* for FY 2010 recommended that the insurance benefit be increase from \$10,000 to \$50,000. However, we recently supported legislation—H.R. 2713—considered by this Subcommittee that would increase the maximum amount of protection from \$10,000 to \$100,000, and would increase the supplemental insurance for totally disabled veterans from \$20,000 to \$50,000. Ultimately, we would like to see the Subcommittee consider legislation that would increase SDVI to the maximum benefit level provided by the Servicemembers' and Veterans' Group Life Insurance (SGLI/VGLI) programs. We also believe that the premium waiver for 100 percent total and permanent service-connected veterans should be automatic, rather than require an unnecessarily long application process for the waiver.

The Independent Budget also recommends that VMLI be increased from the current benefit of \$90,000 to \$150,000. The last time VMLI was increased was in 1992. Since that time, housing costs have risen dramatically, but the VMLI benefit has not kept pace. As a result, many catastrophically disabled veterans have mortgages that exceed the maximum value of VMLI.

Expediting Provision of Benefits

Recent hearings have demonstrated how far behind the VBA is in using information technology in its claims adjudication process. While we believe that the entire claims process cannot be automated, there are many aspects and steps that certainly can. We have long complained to the VA that it makes no sense for severely disabled veterans to separately apply for the many ancillary benefits to which they are entitled. Their service-connected rating immediately establishes eligibility for such benefits as the Specially Adapted Housing grant, adaptive automobile equipment, and education benefits. However, they still must file separate application forms to receive these benefits. That makes no sense whatsoever.

Moreover, certain specific disabilities require an automatic rating under the disability ratings schedule. For example, it does not take a great deal of time and effort to adjudicate a below knee single-leg amputation. An advanced information technology system can determine a benefit award for just such an injury quickly. We believe that it is time for the VA to automate consideration of ancillary benefits and specific ratings disabilities that are generally automatic.

Quality of Life

Mr. Chairman, one of the subjects that often generates a great deal of debate when discussing VA compensation benefits is the consideration of quality of life. PVA has expressed serious concerns in the past, particularly during the deliberations of the Veterans' Disability Benefits Commission and the Dole-Shalala Commission, with the assertion that the schedule for rating disabilities is meant to reflect the average economic impairment that a veteran faces. Disability compensation is in fact intended to do more than offset the economic loss created by a veteran's inability to obtain gainful employment. It also takes into consideration a lifetime of living with a disability and the every day challenges associated with that disability. It reflects the fact that even if a veteran holds a job, when he or she goes home at the end of the day, that person is still disabled.

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

There can be no question but that VA compensation includes a real and significant component that is provided as an attempted response to the impact of a disability on the disabled veteran's quality of life. And yet, we would argue that compensation could never go too far in offsetting the impact that a veteran's severe disability has on his or her quality of life.

Mr. Chairman and Members of the Subcommittee, PVA would once again like to thank you for the opportunity to provide our views on ancillary benefits and quality of life issues. We look forward to working with you to improve these benefits.

Thank you again. I would be happy to answer any questions that you might have.

**Prepared Statement of Ronald B. Abrams, Joint Executive Director,
National Veterans Legal Services Program**

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

Thank you for the opportunity to present the views of the National Veterans Legal Services Program (NVLSP) on ancillary VA benefits and veterans' quality of life issues.

NVLSP is a nonprofit veterans service organization founded in 1980. Since its founding, NVLSP has represented thousands of claimants before the Board of Veterans' Appeals and the Court of Appeals for Veterans Claims. NVLSP is one of the four veterans service organizations that comprise the Veterans Consortium Pro Bono Program, which recruits and trains volunteer lawyers to represent veterans who have appealed a Board of Veterans' Appeals decision to the CAVC without a representative. In addition to its activities with the Pro Bono Program, NVLSP has trained thousands of veterans service officers and lawyers in veterans benefits law, and has written educational publications that thousands of veterans advocates regularly use as practice tools to assist them in their representation of VA claimants.

The VA, under 38 U.S.C. § 1114 and 38 CFR § 3.350 has a level of monetary benefits, described as *Special Monthly Compensation* (SMC). SMC benefits are paid in addition to the basic rates of compensation payable under the Schedule for Rating Disabilities. SMC is paid to compensate veterans for service-connected disabilities such as loss of use of a hand or a foot, impairment of the senses, loss of vision or hearing, and for combinations of severely disabling service-connected disabilities. While the basic rates of compensation are predicated on the average reduction in earning capacity, special monthly compensation benefits are based on noneconomic quality of life issues such as personal inconvenience, social inadaptability, or the profound nature of the disability.¹

A recent decision by the United States Court of Appeals for Veterans Claims (CAVC or Court) reveals that the VA has unlawfully limited the impact of a section of 38 U.S.C. § 1114. The Department of Veterans Affairs, the veterans service organizations and the Congress should act now to implement this CAVC decision.

The statute involved, Section 1114(s), mandates increased benefits for veterans who are so unlucky as to have a service-connected disability rated as total, and suffer from additional service-connected disability or disabilities independently ratable at 60 percent or more. This benefit is usually called SMC(s).

Currently, a veteran entitled to SMC(s) without dependents is paid \$320 more per month than a veteran entitled to a total evaluation (\$2,993 as opposed to \$2,673). The idea behind this benefit is that a veteran who has a service-connected condition that causes total disability and has significant other disabilities should be paid more than a veteran who just has the one disability.

The problem is that for many years the VA implemented Section 1114(s) with a regulation that unlawfully limited the beneficial impact of the statute. The regulation, 38 CFR § 3.350(i)(1), requires a veteran to have one service-connected disability rated as 100 percent disabling to be considered for SMC(s) benefits. This regulation, 38 CFR § 3.350(i)(1) states:

[T]he special monthly compensation provided by 38 U.S.C. 1114(s) is payable where the veteran **has a single service-connected disability rated as 100 percent** and, has additional service-connected disability or disabilities independently ratable at 60 percent, separate and distinct from the 100 percent service-connected disability and involving different anatomical segments or bodily systems.

The language of the statute, however, requires total disability based on a single condition—not a single disability that qualifies for a 100 percent schedular evaluation. In other regulations, the VA has acknowledged that a service-connected disability that causes impairment of mind or body which is sufficient to render it impossible for the average person to follow a substantially gainful occupation is a total disability. See 38 CFR §§ 3.340(a), 4.15, 4.16(a).

In *Bradley v. Peake*,² the Court of Appeals for Veterans Claims (CAVC) finally dealt with this issue. This veteran sustained multiple shell fragment wounds from a booby trap in Vietnam. He is service-connected for thirteen compensable scars and 10 separate muscle group injuries. He is also entitled to compensation benefits for Post-traumatic stress disorder (PTSD).

The veteran was granted total disability based on individual unemployability (TDIU) from March 25, 1983, until June 8, 1992, and then he was granted a 100

¹ VA Gen. Coun. Prec. 5-89 (Mar. 23, 1989).

² 22 Vet. App. 280, (2008).

percent combined rating from June 8, 1992. Between 1971 and 2006, the VA made thirteen different adjudications to come to the above conclusions.

The Board of Veterans' Appeals (BVA or Board) denied Mr. Bradley's claim for SMC(s) and he appealed that decision to the CAVC. The CAVC held that:

- Section 1114(s) does not limit "a service-connected disability rated as total" to only a schedular rating of 100 percent—it includes a disability that would support the grant of TDIU.
- When a veteran has several service-connected conditions that combine to a 100 percent evaluation, if the veteran would be monetarily advantaged by a having just one service-connected condition support a total TDIU rating and the veteran has other service-connected conditions that combine to 60 percent, the VA is obligated to rate the case to maximize the benefits that can be paid to the veteran. This is true because under 38 CFR § 3.103(a) the VA is obligated to render a decision which grants every benefit that can be supported in law.
- Because SMC benefits must be granted when a veteran becomes eligible without need for a separate claim,³ any effective date must be based on that point in time when the evidence first supported an award of SMC, which may be well before the veteran raised this issue. *See* 38 U.S.C. §§ 5110(a), 1114(s); 38 CFR § 3.400(o).

The Bradley decision should have a major impact both on current claims and claims that have been previously adjudicated. Many severely disabled veterans should receive significant retroactive payments.

The positive impact of Bradley will improve the quality of life for those veterans who are unfortunate enough to suffer from several severe service-connected disabilities. In addition, now the VA, upon request, will have to readjudicate Bradley type claims and pay increased benefits from the date the evidence first supported an award of SMC(s). We hope that the VA will take it upon itself to encourage its raters to review previous rating for these potential retroactive benefits.

The Bradley decision gives the VA the opportunity to quickly improve the financial situation of many veterans. Therefore, we have contacted the VA and asked them to consider amending certain sections of Adjudication Procedures Manual M21-1 MR that may be interpreted as requiring a single schedular 100 percent rating as a requirement for SMC(s).⁴ In addition we have asked that the VA to re-rate cases that it recognizes as having the potential for increased benefits under the holding in Bradley.

That completes my testimony. I would be pleased to answer any questions the Members of the Subcommittee may have.

**Prepared Statement of Thomas Zampieri, Ph.D.,
Director of Government Relations, Blinded Veterans Association**

INTRODUCTION

Chairman Hall, Ranking Member Lamborn, and Members of the House Veterans' Affairs Subcommittee on Disability Assistance and Memorial Affairs:

On behalf of the Blinded Veterans Association (BVA), thank you for this opportunity to present our testimony today regarding veterans' ancillary benefits and quality of life issues affecting them.

BVA was founded in 1945 and Congressionally chartered in 1958 as the only Veterans Service Organization (VSO) exclusively dedicated to serving the needs of our Nation's blinded veterans and their families. The organization's governing body and members are proud of BVA's continuing advocacy of the important benefits and health care issues affecting them.

BVA has joined with other VSOs in awaiting action on recommendations provided by the Veterans Disability Benefits Commission (VDBC) that would improve the benefits and services for our Nation's wounded. After reviewing the recent 7-month report issued by Economics Systems, Inc. (Econsys), however, BVA questions some of the recommendations on Quality of Life for veterans with service-connected sensory disabilities. As this Subcommittee is already aware, VDBC was created by Public Law 108-136. With the assistance of the Institute of Medicine and many other organizations, appointed commissioners spent more than 2 years reviewing extensively current VA benefits and compensation for disabled veterans. Its final report

³ *Akles v. Derwinski*, 1 Vet.App. 118, 121 (1991).

⁴ M21-1 MR Part IV, Subpart II, Chapter 2, par. 56a.

made clear that the current system required fundamental changes, one of which was the mechanism used in determining benefits affecting Quality of Life payments.

BVA is concerned that Econsys presented this research in order to develop a Quality of Life measurement tool based on the 7-month time frame on reporting. We believe that the complex objective and subjective “instruments” for a new payment system will require more consideration by Congress than what is being presented here today. Quality of Life measurements themselves are not only objective measures of Activities of Daily Living (ADL), but the subjective concepts of pain levels, negative emotions, and social difficulties and if not carefully considered, the latter could easily be excluded from determinations of fair measurement in looking at the impact of Quality of Life compensation for service-connected disabilities. We strongly refute the statement on Page 22 of the Econsys report that “the lowest level of Quality of Life loss for disabled veterans was for skin, ear, and eye body systems.” We believe that Members of Congress would also question such a claim.

BLINDED VETERANS’ QUALITY OF LIFE

Mr. Chairman, as fellow veterans who have lost sensory function could all testify, the reactions to blindness and disability are varied. Fear, overwhelming stress and anxiety, depression, and anger are just some of the typical responses to the loss of vision. Our degree of independence is dramatically diminished and our quality of life completely disrupted and forever changed. Loss of vision is accompanied by the sudden loss of freedom to move around safely and independently. In order to overcome the limitations imposed by vision loss, it has been necessary for us to undergo the type of continuous and comprehensive rehabilitation that is always changing as we adapt to new challenges—and as the field of rehabilitation and technology evolve.

We must constantly learn new ways of coping with and managing our lives in the absence of vision as these changes in our world bring with them the requirement for more training and education in new methods and techniques in order to optimize their relevance for us personally. It would be wrong to think that once a veteran has received some training that the support and current benefits rating system assistance needed is entirely sufficient. Impact on Quality of Life from the catastrophic loss incurred must be considered. Blinded veterans have been successful in adapting to adversity in large part through the support and assistance received from families and also through the benefits and services provided by VA Blind Rehabilitation Service programs and a variety of VA benefits. BVA found this statement in the Econsys report “That consensus on a definition of overall QoL still eludes many researchers. QoL is a multi-dimensional construct that is typically defined on the basis of the specific form of the research.”

Please consider, Mr. Chairman, that the process of recovery from any tragic or traumatic event is characterized by a period of grieving followed by rehabilitation and restoration. Substantial changes are normally required as a result of such shattering events before a new and productive life can be discovered. Similar to the grief experienced by those who have experienced any type of catastrophic event, blinded veterans also must grieve their loss of vision. The late Father Thomas Carroll, a recognized expert in the field of blindness and rehabilitation after World War II, wrote that people who lose their vision must first grieve for the death of the sight itself. Grieving is a very individualized process that lacks definite time limits. Only as the grieving process ends is the individual ready to engage in rehabilitation. Perception plays the one major role in an individual’s ability to live life. Although all five of our body’s senses play a significant role, the visual system is critical to perception, providing more than 70 percent of human sensory awareness of everything we know, with hearing being another critical component of our sensory awareness. Considering that hearing losses and visual impairments are two common sensory losses that have also occurred from Improvised Explosive Devices (IED) in Iraq and Afghanistan, we cannot overemphasize the importance of assessing them carefully in the process of rating such sensory injuries common with Traumatic Brain Injuries.

Vision also provides information about environmental properties. It allows individuals to act in relation to such properties. In other words, perceptions allow humans to experience their environment and their Quality of Life in order to live within it. Individuals perceive what is in their environment by a filtered process that occurs through a complex, neurological visual system. With various degrees of visual loss come greater difficulty to clearly adjust and see the environment, resulting in increased risk of injuries, loss of functional ability, and unemployment. Impairments range from losses in the visual field, visual acuity changes, loss of color vision, light sensitivity (photophobia), and loss of the ability to read and recognize facial expressions. Complete blindness is considered by VA to be a catastrophic loss of a body system in determining service-connected benefits.

CURRENT SYSTEM REVIEW

VDBC was faced with a complex task that has confronted all levels of local, State, and Federal Government agencies trying to regulate disability ratings over many decades. Their comprehensive findings included the recommendation that VA should develop Quality of Life compensation. On February 26, 2008, before this Committee, VDBC Chairman Terry Scott testified that “there has been an implied but unstated congressional intent to compensate disabled veterans for impairment of quality of life due to their service-connected disabilities.” The attempt to determine the validity of the current rating and disability compensation systems for economic loss is appropriate but VDBC found “no current compensation for the impact of disability on the quality of life.” The Veterans Benefits Administration (VBA) does not adequately compensate a veteran who has suffered from a significant life-altering disability that impacts daily activity and functioning.

Veterans who cannot be classified as permanent service-connected disabled should indeed be considered as such on the basis of Quality of Life. Assessments should be done on impact regarding their ability to perform daily activities. BVA feels strongly that the soldiers, airmen, sailors, or marines who have developed blindness or another catastrophic disability should all be rated and treated equitably and with the appropriate support needed in the processing of their claims, both for economic loss as well as Quality of Life losses. A system in which one severely disabled veteran receives a lower percentage of compensation for an injury than that of another veteran will be viewed as unfair and add to an already existing perception that the system is adversarial for some veterans.

Many national surveys demonstrate that in the past decade, since the passage of the Americans with Disabilities Act, very little progress has been made in the employment rates of the disabled. Among several sources, one being the respected Cornell University Centers on Disability Statistics Annual Disability Status Report for FY 2007 (www.disabilitystatistics.org), data indicate that the country’s disabled non-institutionalized population of working adults age 21–64 still have significantly lower rates of employment, lower earnings, and lower household income than the non-disabled when comparisons are made using several disability types. Examples of such research findings follow:

- The 2007 Census Bureau’s survey found that 60.1 percent of disabled men between ages 21–64 and with one disability were employed. When reviewing data on those with a severe disability affecting daily functioning skills, the rate is only 32 percent.
- Despite improvements in transportation accessibility, levels of participation in social, cultural, and commercial activities have not increased measurably during the past decade and 30 percent of the disabled in rural regions of the country have no access to public transportation.
- The Survey of Income and Program Participation (SIPP) found that, in 2007, 24.7 percent of working age adults who were limited in their ability to work lived at or below the poverty level. Some 22.1 percent with a sensory disability lived at or below that level.
- Census Bureau American Community Survey (ACS) in 2007 found that individuals with a sensory disability age 16–64 in the general population lived in households with a median income \$22,600 lower than that of average households containing non-disabled members.
- From FY 1996 to FY 2005, the total Federal workforce increased by more than 78,000 employees. The total represents a net increase of about 3 percent. During that same time period, the number of Federal employees with targeted disabilities decreased from about 30,000 to approximately 25,000. The drop represents a net decrease of 16 percent.
- The National Council on Disabilities’ March 2009 Report reveals that the percentage of workers has declined steadily since 1994 and is now at its lowest level in two decades. Even with ADA and other attempts to increase disability participation in the workforce, public discrimination and negative attitudes toward those with disabilities persist in the workforce environment.

The claim has been made in recent times that emerging technology has made access to employment and independent living for the disabled easier than ever before. We believe evidence strongly suggests that this is not the case. According to National Council on Disability (NCD) Chairperson John R. Vaughn, the United States already has in place a string of Federal laws and regulations designed to guarantee various levels of access to telecommunications products and services. He states further that such service nevertheless leaves gaps in coverage and are rapidly becoming outdated as the analog technologies upon which they were premised are being substituted with technologies that are digitally and Internet-based. As Congress, the

Federal Communications Commission, and other Federal or State agencies take on the daunting task of defining regulatory measures that will govern the deployment of these next generation communication technologies, Mr. Vaughn believes that they should include safeguards to ensure that individuals with disabilities not be left behind. Representative Ed Markey (D-MA-7) introduced H.R. 3101 to help individuals with sensory difficulties deal with problems of access to new technology. BVA cautions that while advances in technology for the blind help with some daily activities, they do not replace the overall losses in Quality of Life experienced while trying to perform all of life's routine but vitally important functions.

Too many potential and actual accessibility barriers to new technologies already exist. Section 508 compliance has even been a problem for VA. Our blinded and visually impaired veterans working as Field Service Representatives, have, for example, had problems using the information technology system as it relates to benefits and filing claims. Inaccessible user interfaces on consumer equipment, lack of interoperable and reliable text transmissions, and obstacles to video and web programming all threaten the ability of individuals with functional limitations to gain equal access to these products and services. Legislative and regulatory actions are needed to eliminate such barriers and to safeguard future access to modern communications and information technologies and services, regardless of the form (text, video, or voice) and nature of the transmission media (i.e., Public Switched Telephone Network [PSTN]; Internet Protocol [IP]; wireless, cable, satellite, copper wire, fiber-optic network; dial-up or high speed) over which such information or communication travels. While technology may be constantly changing with the intent to benefit work environments universally, the results are not always equal or even similar. We request that this perspective be included when considering such complex issues as the catastrophically disabled veteran's individual Quality of Life compensation.

Representatives Edolphus Towns (D-NY-10) and Cliff Stearns (R-FL-6) recently introduced The Pedestrian Safety Enhancement Act of 2009 (H.R. 734) with 124 cosponsors. The proposed act mirrors legislation introduced in the 110th Congress. The Pedestrian Safety Enhancement Act would require the Department of Transportation to research and ultimately set forth a minimum sound standard that must be met by hybrid and electric vehicles so that blind and other pedestrians may travel safely and independently in urban, rural, and residential environments. For the blind disabled, emerging new technology in many cases presents dangers in the pedestrian environment of crossing streets. This factor is definitely a Quality of Life factor for blinded veterans. BVA very much appreciates Mr. Stearns' leadership especially on this issue. BVA has also found complaints from the deaf and blind with warning systems failing during natural disasters and barriers to accessing shelters for the disabled in these disasters as examples of QoL fear for those seriously disabled.

CONCLUSIONS

Mr. Chairman and Members of this Subcommittee, the Blinded Veterans Association would appreciate inclusion of the following issues in your list of changes as VA moves forward in attempting to compensate service-connected veterans suffering catastrophic injuries as result of their service to our Nation. It is essential that physical health, psychological health, social relationships, and economic situations be considered as these benefits changes occur.

1. The quality, timeliness, accuracy, and consistency of the disability rating system and scale should be improved to include Quality of Life for catastrophically disabled veterans as defined by VA. Both objective and subjective measurements should be included. Recommendations should consider factors such as education level of the disabled veteran and the impact of the veteran's injuries on the caregivers. In short, physical health, psychological well-being, social relationships, and economic situations are all essential aspects of Quality of Life that must be adequately included in a measurement tool.
2. Blinded veterans must experience a seamless transition from the DoD to the VA disability rating of benefits. Accomplishment of this objective requires that DoD and VA complete the integration of medical computer health records systems. It also requires that the continuum of health care and benefits processing be done efficiently—through a special office of compliance if necessary.
3. Benefits and services should be provided to collectively compensate for the negative consequences of service-connected disability on average earning capacity, the ability to engage in normal life activities, and Quality of Life. They should not establish a dual compensation system that further fragments the disability claims process.
4. The VDBC's "Institute of Medicine 21st Century System for Evaluating Veterans for Disability Benefits" and other studies have found that those with

Post-traumatic stress disorder and Traumatic Brain Injury need new and updated scientific methods for determining benefits. This would involve an advisory Committee, which would include stakeholder representatives within VBA, to ensure transparency in this evolving process. Multiple reports reference problems for TBI and PTSD veterans not receiving benefits appropriate for their service connected injuries or mental health problems.

**Prepared Statement of Lonnie Bristow, M.D., Chair, Committee on
Medical Evaluation of Veterans for Disability Benefits, Board on the Health
of Select Populations, Institute of Medicine, The National Academies**

Good morning, Chairman Hall, Ranking Member Lamborn, and Members of the Committee. My name is Lonnie Bristow. I am a physician and a Navy veteran. I am a member of the Institute of Medicine and have served as the president of the American Medical Association. I am pleased to appear before you again to testify about improving the disability benefits system of the Department of Veterans Affairs (VA).

I had the great pleasure and honor of chairing the Institute of Medicine (IOM) Committee on Medical Evaluation of Veterans for Disability Compensation, which was established at the request of the Veterans' Disability Benefits Commission and funded by the Department of Veterans Affairs. The IOM was established in 1970 under the charter of the National Academy of Sciences to provide independent, objective advice to the Nation on improving health.

The Committee I chaired, which reported in 2007, was asked to evaluate the VA Schedule for Rating Disabilities and related matters, including the medical criteria for ancillary benefits. My task today is to present to you the Committee's recommendations on improving ancillary benefits, which are in Chapter 6 of our report, *A 21st Century System for Evaluating Veterans for Disability Benefits*. I will also comment on our recommendation concerning quality of life, which is in Chapter 4 of the report.

Medical Criteria for Ancillary Benefits

The Veterans' Disability Benefits Commission asked the Committee to focus on the appropriateness of medical criteria for five specific ancillary benefits available to veterans being compensated for service-connected disabilities. These were:

1. Vocational rehabilitation and employment (VR&E) services,
2. Automobile assistance and adaptive equipment,
3. Specially adapted housing grants,
4. Special housing adaptation grants, and
5. Clothing allowances.

The Committee was asked to consider, from a medical viewpoint, the appropriateness of the specific conditions that a veteran is required to have in order to receive these ancillary benefits. For example, assistance in purchasing a specially adapted automobile or other vehicle requires

- loss, or permanent loss of use, of one or both feet; or
- loss, or permanent loss of use, of one or both hands; or
- permanent impairment of vision in both eyes with a central visual acuity of 20/20 or less in the better eye with corrective glasses, or central visual acuity of more than 20/200 if there is a field defect in which the peripheral field has contracted to such an extent that the widest diameter of visual field has an angular distance no greater than 20 degrees in the better eye.

To qualify for assistance in purchasing a specially modified home, a veteran must have a permanent and total service-connected condition or conditions due to

- the loss or loss of use of both lower extremities, such as to preclude locomotion without the aid of braces, crutches, canes, or a wheelchair; or
- the loss or loss of use of both upper extremities, such as to preclude use of the arms at or above the elbows; or
- blindness in both eyes, having only light perception, plus loss or loss of use of one lower extremity, or
- the loss or loss of use of one lower extremity together with residuals of organic disease or injury, or the loss or loss of use of one upper extremity, which affects the functions of balance or propulsion as to preclude locomotion without the aid of braces, crutches, canes, or a wheelchair.

These medical eligibility criteria are very specific and require a very high degree of impairment. They are so specific that they may not include veterans with somewhat different impairments that hinder mobility, such as multiple sclerosis.

Assessing Ancillary Benefit Criteria

When the Committee reviewed ancillary benefits, we found that they were

- created piecemeal over time.
- not designed as part of a comprehensive program.
- not systematically updated and, in some cases, not indexed for inflation.
- not based on an empirical analysis of veterans' actual needs or loss of quality of life.
- not evaluated for their effectiveness in meeting veterans' needs or loss of quality of life (except for VR&E).

In 2004, a VA-appointed task force on VR&E recommended that VA coordinate its health, VR&E, and compensation programs to achieve a broader, more integrated approach to assisting veterans move from military to civilian life. The task force suggested a more individualized approach including

- continuing and systematic medical examinations of veterans for better informed career and employment decisions;
- early, routine functional capacity assessments by vocational experts for both disability compensation and rehabilitation decisions; and
- a change from a sequential series of required steps to a more individualized sequence taking into consideration the veteran's education, vocational rehabilitation, and compensation needs.

The Committee agreed with these recommendations—and the veteran-centered concept of service delivery underlying them—and added some recommendations of its own.

IOM Recommendations for Improving Ancillary Benefits

The Committee offered four recommendations for improving ancillary benefits.

- The lack of data on the need for or effectiveness of ancillary benefits made it impossible for the Committee to assess the appropriateness of the medical criteria requirements. The eligibility requirements were not based on research relating needs to rating level or type of impairment, so it is possible that the benefits could be changed to serve veterans better or to address other needs. Accordingly, we recommended that *“VA should sponsor research on ancillary benefits and obtain input from veterans about their needs. Such research could include conducting intervention trials to determine the effectiveness of ancillary services in terms of increased functional capacity and enhanced health-related quality of life.”*
- In addition to obtaining data on the mitigating effects of each type of benefit on functional limitations, work disability, and quality of life, a better approach to assessing the needs of individual veterans is needed. The Committee concluded that *“An assessment of health care and rehabilitation needs should be performed in conjunction with the assessment of compensation needs, so that the veteran will benefit from all services VA provides to help veterans with disabilities succeed in civilian life . . . The assessment should also include the need for education, vocational rehabilitation, and other VA ancillary services and benefits, which, together, could enhance a veteran's ability to succeed in civilian life.”* Specifically, we recommended that *“VA and the Department of Defense should conduct a comprehensive multidisciplinary medical, psychosocial, and vocational evaluation of each veteran applying for disability compensation at the time of service separation.”*
- There is no medical basis for the current 12-year limit on eligibility for vocational rehabilitation services, although there may be administrative convenience or fiscal control reasons. Some employment and training needs may not adhere to a 12-year deadline. For example, emerging assistive and workplace technologies (e.g., computing) may provide training or retraining opportunities for veterans with disabilities through continuing education of various kinds. New types of work may also emerge for which veterans with disabilities could be trained. Advancements in medical knowledge and breakthroughs in medical technology also do not abide by a 12-year limit. The Committee recommended that *“The concept underlying the extant 12-year limitation for vocational rehabilitation for service-connected veterans should be reviewed and, when appro-*

priate, revised on the basis of current employment data, functional requirements, and individual vocational rehabilitation and medical needs.”

- Finally, the Committee was concerned about low rate of participation in the VR&E program. For example, in FY 2005, about 40,000 veterans applied for VR&E services and were accepted. But 160,000 veterans began receiving benefits for service-connected disabilities that year, and the pool of those potentially eligible from prior years is much larger. Also, in recent years, between a quarter and a third of the participants had not completed the program. We concluded that VA should explore ways to increase participation in this program, and we recommended that “VA should develop and test incentive models that would promote vocational rehabilitation and return to gainful employment among veterans for whom this is a realistic goal.”

IOM Recommendation on Compensating for Loss of Quality of Life

The Committee did not view the ancillary benefits that it was asked to review as a form of compensation for loss of quality of life. We considered them as services to improve functional mobility and employability.

Rather than consider if and to what degree that benefits such as adapted housing and automobiles, or Special Monthly Compensation, help to compensate for loss of quality of life, the Committee recommended that quality of life be measured directly. Then, if it is found that veterans experience an average loss of quality of life for a given disability that exceeds the average loss of earning capacity as measured by the Rating Schedule, we recommended that VA compensate for the additional loss.

We noted that VA already uses a quality of life measurement tool, the SF-36, in research on clinical outcomes. We cited a quality-of-life methodology used on injured workers in Ontario, Canada, that found that impairment ratings systematically underpredicted the loss of quality of life that workers associated with certain disabilities. We said some additional work would have to be done by VA to adapt the SF-36 or Canadian or possibly some other quality of life tool for veterans' compensation purposes. If such a tool could be developed, and we believe that it could be, VA could use it to determine average quality of life of veterans with different disabilities, relative to nondisabled veterans. If it turns out that veterans experience a serious loss of quality of life for a condition that is not highly rated by the Rating Schedule, then VA should compensate for the disparity.

Conclusions

In summary, the main points of our report *A 21st Century System for Evaluating Veterans for Disability Benefits* concerning ancillary benefits and quality of life are:

1. VA should more systematically research the needs of disabled veterans and the effectiveness of its ancillary benefit programs in meeting these needs and make needed revisions in these programs based on this research.
2. VA should assess the individual needs of disabled veterans at time of separation from military service and coordinate the delivery of the services identified in the assessment.
3. VA should develop a tool to measure the quality of life of disabled veterans, determine the extent to which the Rating Schedule already accounts for loss of quality of life, and—for disabling conditions in which average loss of quality of life is worse than the Rating Schedule indicates—compensate for the difference.

Prepared Statement of George Kettner, Ph.D., President, Economic Systems Inc., Falls Church, VA

Mr. Chairman and Members of the Subcommittee, thank you for the opportunity to appear before you today to present my views on the effectiveness of ancillary benefits and ways that VA can improve the quality of life for disabled veterans. I present the major results of Economic Systems' *Study of Compensation Payments for Service-Connected Disabilities* completed last year for VA.

VA Disability Compensation Rating System

The VA Disability Compensation Program provides monthly benefit payments to veterans who become disabled as a result of or coincident with their military service. Payments generally are authorized based on an evaluation of the disabling effects of veterans' service-connected physical and/or mental health impairments. Monthly payments are authorized in percentage increments from 10 percent (\$117

in 2008) to 100 percent (\$2,527 in 2008). The process for determining ratings for disability compensation benefits uses the VA Schedule for Rating Disabilities (VASRD) to assign the level of severity of the disabilities.

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

Eligibility requires that a determination be made that the condition is a service-connected disability. Service-connected means that the condition occurred during or was aggravated by military service or, for chronic conditions, became evident within 1 year of discharge from the military. It does not require that the disability be work-related or be caused by conditions in the work environment. In this regard the VA Disability Compensation Program combines elements of both disability insurance voluntarily provided by employers and workers' compensation programs mandated by Government.

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

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

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

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

Adequacy of Disability Compensation

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

We found that overall, veterans with service-connected disabilities have earnings plus disability compensation 7 percent above their average expected earnings. The average was higher at each rating level except at the 100 percent rating level where the combined earnings and compensation was 9 percent less than expected. On average, veterans with a 30 percent or less combined disability rating did not experience serious wage loss. Approximately, 55 percent of 2.6 million veterans receiving disability compensation in 2007 were rated at 30 percent or less. Earnings losses for veterans with 40 percent to 90 percent combined rating did have wage losses, but their VA disability compensation more than made up the loss. In contrast, actual

earnings losses plus disability compensation for veterans with 100 percent combined rating fall short of average expected earnings by about 9 percent. In 2007, 9.1 percent of veterans receiving disability compensation had a combined rating of 100 percent, up from 7.5 percent in 2001.

On the other hand, we found considerable differences in earnings loss across different diagnoses for a given rating level, resulting in serious inequity in the payment system. For example, for veterans with a 50 percent combined rating, the range was from no earnings losses for genitourinary or endocrine medical conditions to over 40 percent earnings losses for non-PTSD mental conditions. Veterans with PTSD, Other Mental Disorders, and infectious diseases experience greater earnings losses than veterans diagnosed with other medical conditions rated at the same level.

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

Disabilities without Earnings Loss

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

Additional Diagnostic Codes

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

PTSD, Other Mental Disorders, and TBI

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

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

Methodology Used to Calculate Combined Degree of Disability

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

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

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

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

An option to the current single lookup table is to replace it with tables that reflect specific combinations of different disabilities. The tables could be programmed for ease of use rather than manually applied as is the current practice.

Medical science has established for many years that certain diseases are prevalent together, examples of which include PTSD and major depressive disorder, and diabetes and cardio-vascular diseases. It is quite likely that there are many diseases that are present together in individuals and that they cause a greater impact on the individual's earning capacity than would be the case with multiple unrelated minor ailments. Analysis of the impact of multiple diseases or disabilities would result in an enhanced approach to ratings for combinations of diagnoses.

Individual Unemployability Benefits

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

Although age is clearly related to employment, it is not considered in IU determinations. While IU is not intended for veterans who voluntarily withdraw from the labor market because of retirement, new awards are often made to veterans who are near or past normal retirement age for Social Security. In light of these circumstances it appears that IU determinations are made for veterans approaching or past retirement age based on providing retirement income or in recognition of loss of quality of life rather than for employment loss.

IU determinations depend on decisions about substantially gainful employment. In order to further facilitate the decisionmaking process for IU determinations, a

work-related set of disability measures would be worth assessing. Consideration of this could supplement the medical impairment criteria in the VASRD.

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

Special Monthly Compensation

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

SMC for Assistance

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

In 2007, 45,773 veterans received SMC L, S, R1, or R2 for assistance and \$30,506,362 above the amount paid for the 100 percent rating. This was an average of \$660 per month.

**Special Monthly Compensation Rates
Compared with Scheduling 100% Rating**

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

**Special Monthly Compensation Rates
Compared with Scheduler 100% Rating—Continued**

SMC Code	Veteran Alone	Amount for 100% or O/P	Increased Amount for SMC	Number of Veterans	Monthly Benefit
Total				14,119	\$14,572,779
Assistance					
L	\$3,145	\$2,527	\$618	4,944	\$3,055,392
L½	\$3,307	\$2,527	\$780	1,742	\$1,358,760
S	\$2,829	\$2,527	\$302	31,361	\$9,471,022
R1	\$6,305	\$4,412	\$1,893	5,576	\$10,555,368
R2	\$7,232	\$4,412	\$2,820	2,151	\$6,065,820
Total				45,773	\$30,506,362

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

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

Quality of Life Payment Options

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

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

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

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

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

Payment rates for QOL would have to be set by policy or statute and placing an economic value on QOL would be subjective and value laden. Options that use empirical data are provided in our report as examples of how such rates could be estab-

lished. The monthly amounts depicted in the options range from \$99 to \$974. Volume III of our report contains an extensive description of the findings of the QOL analysis and of the possible rationale or basis for setting the amounts.

Foreign countries that award QOL payments link them closely to impairment and consider the circumstances of the individual veteran. QOL payments are considered the primary disability benefit and earnings loss payments are made only for actual earnings loss or a specified loss of earnings capacity. A veteran in Canada, for instance, must demonstrate inability to work in order to receive an earnings loss payment in addition to a QOL payment and must complete 3 years of vocational rehabilitation that results in unemployment before receiving ongoing earnings loss payments.

VA could structure its disability benefits like the foreign programs so that they are based primarily on QOL. QOL could be inferred from impairment, or it could be measured directly, with earnings loss paid only when an actual earnings loss occurred. The systems used in both the United Kingdom (UK) and Canada pay QOL in lump sum payments and have several low rating levels for QOL payments. While making QOL payments in all 15 of its ratings, the UK system does not pay for earnings loss in the 4 lowest ratings of its 15-point rating scale. The Canadian schedule increases proportionally. In 2008, after the 10 percent rating, each 5 percent rating increase in Canada has a payment increase of \$12,909. The UK payments do not increase with a multiplicative constant. For instance, the highest payment is \$565,000, the second highest payment is \$399,000, the third highest is \$228,000. The lowest pain and suffering payment in UK is \$2,080. These payment schedules reflect society's view that severe disability merits very high QOL payments and low levels of disability merit recognition payments. These benchmarks suggest great flexibility for VA in establishing payment levels.

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

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

Transition Benefit Options

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

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

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

We identified several groups of veterans who could be eligible for such payments based on medical discharges, severity of disability, and time since discharge. The possible eligibility groups would range from a small group consisting of severely injured/ill who are medically discharged with ratings of 70 percent or higher who enter rehabilitation within 2 years of discharge, to a much larger group that would include all veterans currently eligible for VR&E. The most limited option would include 3,400 applicants per year and the most inclusive option would include approximately 29,000 each year.

Methodology Differences with the Previous Study

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

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

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

Concluding Remarks

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

While the findings cited in this testimony provide accurate and reliable information upon which to base policy decisions, the time frame for that study (7 months)

did not permit a thorough analysis of certain aspects of the disability compensation program and of the inter-related nature of the findings. We would recommend that additional analyses be conducted. Restrictions intended to safeguard the privacy of individuals prevented the Social Security Administration from providing earnings at the individual veteran level. This meant that we could not analyze the impact on earnings of combinations or comorbidities of disabilities. We have discussed this issue with the Social Security Administration and believe a methodology could be used that safeguards the privacy of individuals yet enables such analysis.

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

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

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

Federal contracts relevant to the subject of this hearing: Study of Compensation Payments for Service-Connected Disabilities, February 2008–September 2008, \$3.2 million; Evaluation of VA's Vocational Rehabilitation and Employment Program, September 2008–September 2010 (ongoing), \$2.9 million. Both contracts are with the Department of Veterans Affairs.

**Prepared Statement of Kimberly D. Munoz, Executive Director,
Quality of Life Foundation, Woodbridge, VA**

Chairman Hall, Ranking Member Lamborn and distinguished Members of the Subcommittee—thank you for inviting the Quality of Life Foundation to testify today regarding the quality of life impacts the Department of Veterans Affairs has on Veterans and their families. *We offer our testimony as a loud and clear voice for the severely wounded family, who along with their veteran, faces lifelong physical, emotional, and financial challenges as a result of service to country.*

The Quality of Life Foundation does not receive grants or contracts from the Federal Government.

We are a small not-for-profit organization with a mission to develop, support, and implement strategies that improve the quality of life for those who, through no fault of their own, face limiting barriers. Our first initiative was launched in February 2008 shortly after a chance meeting between our President, Michael Zeiders, and the spouse of a severely injured Marine. After hearing her compelling story of the challenges she and her family faced as she left her home, job and children behind to provide bedside care to her wounded Marine and then took the heavy responsibility of transitioning her family from an active duty military life to community-based living, Mr. Zeiders knew this family represented the very population his Foundation was formed to serve.

As a result, he launched the Wounded Warrior Family Care Project and assigned staff to research the experiences of severely wounded servicemember families and the resources they rely on to help them recover from such a traumatic loss. Eight months of research culminated in the publication of the Wounded Warrior Family Care Report in April 2009. The report clearly defined the population reviewed, their unique support needs, existing resources, and a comprehensive Model of Support from the moment the family is notified of their loved one's injury, through inpatient care, to after they transition to home-based care. Quality of Life shared the report with leaders of the Department of Defense, the Department of Veterans Affairs, other not-for-profit organizations (including veterans' service organizations), and the Senate and House Committees on Veterans Affairs. In fact, a copy was sent to every Member of this Subcommittee in April.

The Veterans Affairs Mission Statement is based on a pledge President Lincoln made to America's Civil War Veterans during his second inaugural address—"To care for him who shall have borne the battle and for his widow and his orphan." This promise gave Civil War era military members peace of mind that in the event

their lives were lost in the line of duty, and they were no longer able to provide for their families, that our country would step in to fill that void.

Today's equivalent of America's Civil War widows and orphans includes families of catastrophically injured veterans who can no longer care for themselves nor provide for their families.

As such, catastrophically injured veterans' benefits must reflect the reality that when a veteran is dependent on their family for his/her daily living needs, that family's quality of life then becomes dependent on the veterans' benefits. Our country, in addition to providing care for severely disabled veterans, must also address the quality of life impact that veteran's injuries have on the family.

During our research, we heard repeated stories of family caregivers struggling to learn about the compensations, services and programs provided by the VA, and which, if any, their veteran was eligible for. We also heard of many families applying for benefits, waiting months to receive a determination on their application, then submitting appeals before finally receiving the resources they desperately needed to provide daily care for their veteran.

Their experiences are telling and highlighted by a quick analysis of IRS 990 data for FY 2007 of 5 of the largest, most well known Veterans' Service Organizations. That review revealed an aggregate annual program expense of over 75 million non-profit dollars to provide claims assistance to veterans.

The VA must reduce the burdensome process and wait times associated with the receipt of benefits and services required by families who are striving to rebuild independent, quality lives after their veteran has endured catastrophic disability associated with his/her service-connected injuries.

Disability Ratings

While timely processing is important, it cannot be accomplished at the expense of accuracy. Assigning an accurate and timely initial determination regarding the veteran's disability rating is critical to the overall well-being of the veteran and family.

The disability rating is the eligibility key required to open doors to additional, ancillary benefits required by families to rebuild quality lives after devastating injury.

The following provides our comments regarding how some of the most critical ancillary benefits can be improved to increase the quality of life for severely wounded veterans and their families.

Special Monthly Compensation

If the initial disability rating is accurate, most severely injured veterans will be awarded additional Special Monthly Compensation (SMC) in consideration of the impact **physical** disabilities have on their ability to function. However, for those whose disability is primarily cognitive or psychological [i.e., Traumatic Brain Injury (TBI) or Post-traumatic stress disorder (PTSD)]—SMC fails to fully compensate for the requirement these veterans have for Aid and Attendance.

Within SMC, there are 9 broad categories—7 of which are based solely on physical impairments (k,m,n,o,p,q,s), leaving only 2 categories based on cognitive or psychological impairments (l,r). This method of coupling eligibility to a body part, does not fully consider the range of impact TBI or PTSD has on a veteran's ability to function independently and the resulting dependency on a family member (or hired help) to provide daily Aid and Attendance.

For example, a veteran with a 100 percent service-connected disability rating for a stand-alone Traumatic Brain Injury who is highly functioning on a physical level (i.e., able to walk, talk, dress, and perform activities of daily living) but has impaired cognitive, judgment, short-term memory, and emotional-control capabilities; is eligible for just one category of SMC, SMC-L. This category allows an additional monthly compensation of approximately \$650. When a family member has left their job to provide the Aid and Attendance required to keep this veteran safe from harm, or has hired an attendant to provide that oversight, \$650 simply does not cover the additional financial burden borne by the family. The only other category which considers cognitive or psychological impairments is SMC-R, a category that also requires extreme physical impairments.

SMC must fully consider the complete range of impact TBI and PTSD have on the veterans' ability to function independently and safely. If a veteran's service-connected disability (physical, cognitive, or psychological) results in the inability to function safely and independently and thus requires a significant level of daily supervision and/or assistance, SMC must be awarded

to cover the full expense required to provide the appropriate level of Aid and Attendance to the veteran.

Specially Adapted Housing Grants

The Specially Adapted Housing Grant (SAH) also has eligibility criteria based primarily on physical impairments and is available to veterans with injuries that preclude them from locomotion.

The application processing time for the SAH is lengthy and as a result, prohibits home modifications from being completed prior to the veteran's homecoming. Families who have spent months away from home to provide bedside care to their loved one should not return to an environment that does not meet the disabled veteran's needs.

In addition, when grants are approved, the maximum allowable is \$60,000—an amount used across the Nation, without any adjustment in consideration of regional cost of living factors. The grant is intended to offset the cost of the modification as opposed to covering the cost of the modification.

Another hurdle faced by veterans who do not own their own home, but instead are living in the home of a family caregiver (i.e., a parent), is that they must acquire a fee simple interest in the home to be eligible for the SAH maximum grant. This creates another bureaucratic burden for already strapped family members.

The grant is meant to offset the cost to modify a house to meet the veteran's new accessibility needs with no consideration to how that modification may affect the needs of other family members. For example, if a home is modified to enlarge a bathroom and bedroom to meet a disabled veteran's needs—and that modification results in the loss of a bedroom or bathroom from the rest of the family—the family bears a hardship.

SAH grants must be awarded in time to allow the homeowner to modify the home to provide a safe and accessible environment for the veteran's arrival; must cover the total actual cost to modify the home; and the modification must be completed in a manner that meets the other residing family members' needs.

Health Care

Veteran Health Care

The VA provides excellent health care to eligible veterans throughout the United States via their Veterans Integrated Service Networks (VISNs) and Fee-Basis Program, predominately through the VISNs. There are instances when VA facilities do not meet the needs of the veteran and their families—for example, a veteran may require a specialist to perform a certain surgery, or a private physical therapy clinic may be closer to the family home, or higher quality rehabilitation care may be available for a brain-injured veteran. In these instances, two hurdles exist for families to pursue the best approach for them. The first is that the VA strongly discourages families from pursuing medical care outside of the VA system and is hesitant to issue the required preauthorization for fee-basis care. The second is that some medical providers are unwilling to provide care to veterans for fear of insufficient payment from the VA Fee-Basis Program.

The quality and ease of access to veteran health care affects the whole family. When the veteran and family desire to pursue care outside of the Veterans Affairs Health Administration to obtain higher quality care for the veteran and reduce the burden associated with obtaining care far from home, the VA should accommodate the veteran and their family by facilitating access to Fee-Basis services. In addition, VA must ensure they pay Fee-Basis medical providers in a full and timely manner.

Family Member Health Care

Non-dependent family caregivers (i.e., a parent or a sibling) often forfeit employer-sponsored health coverage when they leave their job to provide daily care for their loved one. This loss of coverage often leads to diminished wellness and acute medical care, resulting in a lower quality of life and potentially the inability to sustain care giving for the veteran.

The VA should provide health care insurance to those family members who have forfeited their health care insurance to provide care to their veteran.

Respite Care

Respite care is intended to give family caregivers a break from the demands of 24/7/365 care giving. Similar to the eligibility criteria for Special Monthly Compensation, respite care eligibility does not fully consider non-physical impairments

experienced by those veterans with stand-alone TBI or PTSD, and as such, precludes their families from receiving services associated with this benefit.

The VA currently provides an annual respite benefit of up to 30 calendar days. In-home respite care is available from VA-approved providers for up to 6 hours per day. A 6-hour respite, while better than nothing, is very brief considering the 24/7/365 responsibility of caregivers. Additionally, for families who desire overnight respite care (perhaps to allow for a vacation or to receive inpatient medical care), their only VA-provided option is to place their loved one in a VA-approved residential care facility. Most veterans and their families are extremely reluctant to utilize institutional care, strongly preferring the dignity of receiving care in the comfort of home, the security of familiar surroundings, and the receipt of one-on-one care. Families simply choose to forego respite care when institutional care is their only option.

VA should provide respite care for all veterans who require a caregiver and should extend the current in-home respite benefit to include overnight care to allow veterans to stay in their own homes when family caregivers take the respite they need.

Long-Term Care Planning for Severely Disabled Veterans

Family caregivers for severely disabled veterans face a daunting concern when it comes to planning for the day they are unable to provide the care their loved one needs. While severely disabled veterans are certainly eligible for VA-provided long-term care, existing facilities and staff are oriented more toward the care of chronic and age-related illnesses as opposed to the “signature injuries” (TBI and PTSD) of this generation of severely wounded veterans. Families need long-term care options that meet their loved ones needs.

VA should invest in long-term, age-appropriate residential care that is geared to meet the needs of OEF/OIF traumatically injured veterans.

Beneficiary Travel

VA currently pays eligible veterans 28½ cents per mile traveled to receive medical care and certain VA-required examinations. However, they deduct \$15.54 per round trip (deductibles not to exceed \$46.62 per month). Families of severely injured servicemembers are already strapped for time and money and should not be further burdened by fuel and auto maintenance expenses associated with long distance travel to VA facilities.

VA should provide mileage reimbursement based on standard GSA rates and eliminate the deductible.

Conclusion

The Quality of Life Foundation believes it is the moral and ethical obligation of our Nation, Government and private citizen alike, to care for veterans and families who, through service to country—have sacrificed for us all. The veteran certainly faces the most personal challenge, that of living every day with severe disabilities resulting from their wounds and must be provided with the very best medical, rehabilitative and long-term care to restore independence and quality to their lives. We must remember that their family members also face lifelong emotional, physical and financial challenges as a result of this traumatic injury.

Our country’s response to severely wounded families must be deserving of their sacrifices. We must provide compensations, medical care, and long-term supports to allow families to rebuild quality lives, to live comfortably and with dignity in their homes, and to be secure in the knowledge that their sacrifices are appreciated and honored by a grateful Nation.

Prepared Statement of Carol A. Glazer, President, National Organization on Disability

Mr. Chairman, Members of the Committee: I am Carol Glazer, President of the National Organization on Disability, or NOD. I was pleased to accept your invitation to testify before your oversight hearing on “Examining Ancillary Benefits and Veterans Quality of Life Issues.”

NOD is a 27-year old national nonprofit organization that has long worked to improve the quality of life of people with disabilities by advocating their fullest inclusion in all aspects of life. We are one of only three so-called “cross-disability” organizations working to improve the quality of life for all of America’s 54 million people with disabilities.

Over our nearly 30-year history, we've worked with scores of communities across the country to help them improve the quality of life for their citizens with disabilities and honor those that do it well. The World Committee on Disability has honored countries that do the same with an award presented by the Secretary General of the United Nations.

We're perhaps best known for our Harris polls, which have tracked various quality of life indicators through statistically valid sampling of 1,000 people with disabilities. For more than 20 years, the Harris Interactive firm's researchers have tracked everything from access to health care, to transportation, degree of optimism about the future, social interactions with friends and community, religious participation, and even voting.

Needless to say, the gaps in these quality of life indicators between people with and without disabilities remain very wide, notwithstanding gains we've made through the ADA and other policy reforms in the last 10 to 20 years. Among these indicators, it should be no surprise that economic self sufficiency displays the greatest gap. People with disabilities suffer a poverty rate that is three times the national average and our Harris polls have reported a 67-percent rate of unemployment, a number that's remained virtually unchanged since the end of WWII.

For this reason, the NOD board, led by our Chairman, former Secretary of Homeland Security Tom Ridge, has decided that for the next 5 years NOD will devote the bulk of our resources to promoting economic self sufficiency among America's 33 million working-age people with disabilities. Within this focus, we are working on helping the most severely injured veterans returning from Iraq and Afghanistan become productive, contributing members of their communities by entering or resuming careers upon their transition home. (We have other programs in this arena, described in more detail in Attachment 1.)

We highly commend your Subcommittee for taking an honest appraisal of the way in which ancillary benefits are adjudicated, disability ratings are determined, and the kinds of ancillary benefits that can help soldiers who've been injured in service of their country resume a high quality of life upon their transition home.

Today, I want mainly to share with you what we are learning from the early phases of our Army Wounded Warrior Career Demonstration Project (AW2 Careers). While this demonstration is focusing on helping the most severely injured soldiers in the Army's AW2 Program access careers upon transitioning home, the model we are piloting has applicability to a broad range of services beyond those devoted to increasing economic self sufficiency. It is a model that deals not only with veterans but with their families. We strongly believe that the population of severely injured servicemembers, like the rest of the country's people with disabilities, faces a very complex recovery process that affects a family over a prolonged period and requires an array of services and supports for it to gain a semblance of a good quality of life.

Our AW2 Careers Demonstration is an entirely privately funded initiative conducted by NOD under a Memorandum of Understanding with the U.S. Army and its Army Wounded Warrior Program. Today, NOD Career Specialists ensure that career services and other assistance are provided to over 150 soldiers, veterans, and their families* in the Dallas Metroplex and the States of Colorado and North Carolina. We link soldiers/veterans and family members to existing career services in the community—or provide them directly ourselves where such services are inadequate.

I want to proceed directly to address the Subcommittee's interest in the benefits for and quality of life issues of our veterans. Let me stress that to understand fully what I will present it is important to know something about the nature of both the Army's Wounded Warrior Program and of the NOD AW2 Careers Demonstration. Brief descriptions of both (and of NOD) are in Attachment I and I urge those not familiar with these programs to read Attachment I before proceeding here. Finally, Attachment II is a one-page summary of AW2 Careers outcomes and progress to date, drawn from our evaluation records.

My observations on the benefits and quality of life issues of our veterans are in the nature of "scouting reports from the front," so to speak. They derive from a year of preparatory study (including focus groups with over 200 veterans), project design, project set up, and just over 1 year of the planned 3 years of field operations. Moreover, they are subject to confirmation by a comprehensive external evaluation that we have commissioned whose full results will be available at the end of March 2012.

* We will henceforth mainly use "veterans" to represent all of those served by AW2 and AW2 Careers—Regular Army, Reserve, or National Guard soldiers who mainly veterans separated from active duty, though in some cases still on active duty or still in the Reserves or National Guard—and their family members.

That caveat should be balanced against the fact that these observations derive from the considered judgments of the NOD Career Specialists now providing direct career services to our caseload of veterans as well as those of us in NOD management who have designed and now manage the project. All of us have considerable experience in disability, career development, employment and training, human services, and/or personnel services and issues.

So, let me begin by noting that many of the most severely injured OEF/OIF veterans would have died in previous wars. Battlefield medicine, however, has advanced to the point that their lives endure but are frequently deeply impaired in both the physical and mental realms. Many observers still expect many of these veterans to live out lives in dependency, but we at AW2 and NOD strongly believe that most of these young men and women can become “independent, contributing members of their communities.” (the Army’s admirable vision for its AW2 soldiers/veterans) by returning to school and some form of work. We, the Nation that placed these young men and women in harm’s way, need to see this situation as an opportunity to learn “what works” to do that.

This, indeed, is the purpose animating AW2 and NOD’s AW2 Careers. It is important to note, however, that many of the challenges facing these veterans will not be surmounted quickly or easily. The effort must be long term in nature.

1. *A Fundamental Mismatch: Seriously Injured Veterans and Reactive Agencies:* Sometimes by design and more often from funding limitations, many of the government, and, indeed, private programs in place to help veterans returning from Iraq and Afghanistan are constrained to a reactive service model, only responding when a veteran seeks services and thus placing the burden on veterans to find and approach the agencies. But we find that the most seriously injured veterans with whom we work are not really able to effectively access services from reactive agencies.

Many veterans, especially the most severely injured who often also suffer from cognitive disabilities, do not know the benefits to which they are entitled, which agencies offer them, and how to approach them.** Further, many are isolated, geographically, socially, and/or psychologically. Their needs call for an entirely different service model—in our view along the lines of what we are testing in AW2 Careers. *That model is to actively reach out to the veterans and ensure their needs are being met.* The terms NOD uses to describe our service model are “pro-active, intensive, and prolonged case management relationships” with the veterans being served. It is important to note that few, if any, other government agencies and or private veterans’ service organizations can employ the service model adopted by AW2 and AW2 Careers.

When a soldier is going through the Army Board process leading to medical discharge—or shortly thereafter—that soldier, if s/he meets AW2 admission criteria regarding severity of injury, is, in effect, automatically enrolled as a “member” of AW2. His/her name is added to a caseload list of an Army Advocate (and later, where applicable, an NOD Career Specialist) serving the geographical region that soldier calls home. That Advocate and Career Specialist are charged with finding that soldier/veteran; establishing a close, supportive relationship; and ensuring s/he gets the benefits and services due her/him.

In NOD’s case, we require Career Specialists to contact “their” veterans at least once a month, usually electronically (but including face-to-face meetings early on and, later, once every 6 months, often by getting in their cars and going to see the veteran at home, where we get a much fuller picture of his/her situation). We do not sit in our offices and wait for a veteran to knock on our door.

Further, we have early indicators and even some evidence that this service model is much better received by the veterans. Anecdotally, it is clear that the close NOD Career Specialist outreach relationships have lifted some veterans out of their isolation and immobility and started them re-engaging in both their lives and careers. These relationships have also resulted in spouses and children moving forward on career paths. This is reflected in early survey results, including the below veterans’ ratings of satisfaction with “how helpful” the services to date of various agencies have been:

**The Army Career and Alumni Program (ACAP) briefing syllabi for soldiers departing active duty are comprehensive and thorough, but many veterans report that they didn’t get these briefings or understand them or remember them. Some may have been diverted by their injuries—or simply young enough to not pay attention to seemingly remote matters until they become very proximate, back home.

	<i>A Lot</i>	<i>Some</i>	<i>A Little</i>	<i>Not at All</i>
NOD Career Specialist	61%	30%	7%	2%
AW2 Advocate	56%	29%	14%	2%
One Stop Center	29%	29%	29%	14%
Voc Rehab & Empt	28%	48%	20%	4%
ACAP	16%	43%	39%	11%
Other Agencies	0%	67%	33%	0%

Finally, we acknowledge that the AW2/AW2 Careers service model is more expensive than office-based, reactive models. To this we respond that our final evaluation is likely to confirm our early operating judgment that this model works more effectively, certainly for this population of most severely wounded veterans. Moreover, a broadly based cost-benefit analysis should weigh direct program costs against the benefits of reduced dependency costs, increased tax revenues from veterans' earnings, reduced costs for shelters and imprisonment, more successful marriages and parenting, and the restoration of self-confidence from a veteran's again an "independent, contributing member of his/her community."

2. *The Need to Deal with both the Veteran and the Family:* The process of recovering from injury and coming to terms with disability is a complex process that is all consuming not only for the veteran but the entire family. Retired parents may have to become caregivers to a veteran. Spouses whose job it was to take care of the children and household find them-selves suddenly in the role of caregivers to the veteran and/or even family breadwinners. Children may have to come to grips with a parent they no longer recognize. Investing in support for spouses, parents of veterans, and veterans' children who are drawn into this process is, in our view, a necessary and cost effective investment that the VA must consider as it administers ancillary benefits. And these benefits must be as flexible as are many of the benefits available through VR and E.
3. *Unaddressed Mental Health Needs:* More than half the AW2 population, including those in AW2 Careers, suffers from primary diagnoses of Post-traumatic stress disorder or Traumatic Brain Injury, with many having both, often along with other injuries. But the behavioral/mental health concerns do not stop there. Many veterans suffer depression or other mental health issues (including violent or suicidal ideations) that require appropriate mental health services (especially including marital/family counseling). But, we find that these needs are largely unaddressed and can impede career progress by contributing to veterans' dropping out of education or training or losing a job. It is not a criticism of the VA to say that despite its efforts to expand such services, it simply isn't able to adequately service these needs. Sometimes the veteran denies these needs; or finds the local VA has no or limited mental health services or they are not close enough; or does not like what they perceive as the VA's reliance on problematic medications (not uncommon in other populations using psychotropic medications), with only limited therapy. We feel that the VA should supplement its direct mental health services by mobilizing and applying mental health services from other local agencies that are anxious to be helpful to veterans but need to be recruited, supported, and trained to do so.
4. *Criminal Charges:* We have encountered several situations where some behaviors associated with PTSD/TBI have resulted in veterans facing criminal charges (e.g., erratic driving, substance abuse, violence, including family abuse, etc.). It is hard to help a veteran stay on a career path when s/he is in court or jail. We have examples of our Career Specialists intervening with police, prosecutors, or the courts to request that notice be taken of the soldier/veteran's disability and considered as a mitigating factor in charges or sentencing. This has sometimes resulted in remanding the soldier/veteran to treatment rather than incarceration. There is need for all agencies serving this population to intervene in such circumstances, bringing these factors to the consideration of such local authorities. (Indeed, one of our Career Specialists has led the effort in his part of his State to create a "Veterans Court" to which criminal charges against soldiers or veterans are referred for disposition taking such factors into account.)

5. *Personal/Family Financial Management*: Young veterans often have little or no experience or knowledge of properly managing family finances, despite ACAP and other Army training thereon. Our Career Specialists frequently find veterans in dire financial straits requiring emergency advice, training, and assistance. There is clearly a need for continuing personal/family financial management training and guidance.
6. *Peer Support Mechanisms*: The fact that so many of our veterans/families are isolated geographically, socially, and psychologically has led our Career Specialists to try various peer meetings and other peer supports, often with heartening results. Our sense is that this needs broader application.
7. *Inadequate Education and Job Skills*: We have not been surprised to find that many of our veterans lack the education credentials and job skills needed to succeed in the labor markets of today and the foreseeable future. Our response is to urge veterans to use the education and training benefits available to them to upgrade their credentials on either or both fronts. Many have responded positively. But others working with these veterans need to adopt the same emphasis.
8. *The Need for Flexible Work Support Funds*: The soldiers, veterans, and family members we serve frequently have very limited incomes. In addition, they face the need to spend modest amounts of money on things that can advance their career prospects—or impede them if such expenditures are not possible. These needs include things like tuition payments where Federal educational benefits are delayed and the veteran cannot afford payments up front. Or, books, work clothes, computer repairs or software, travel expenses for a job fair or interview, license or other work related fees, and more. To meet such needs, we provide small grants from our work support funds that can facilitate career progress.

Next Steps:

As indicated above, our sense is that our model of services is highly promising and that its early indicators confirm this. But, we think we should take this developmental and testing phase further to generate firmer results, outcomes, and lessons.

The present model of three sites over three operating years was devised three or so years ago, early in the then understandably chaotic period of our Nation becoming aware of the challenge and opportunity of responding to these severely wounded returning veterans—and of the initially chaotic and understaffed period of establishing the AW2 program. The private sector then stepped forward, with an impressive, welcome, but still limited support of our demonstration program.

Our sense, as experienced operators of demonstration projects, is that the present pilot project, while important as a source of early lessons, is nonetheless too limited. Three sites are too few; 3 years are too few. Far better in terms of both serving more people but more important in generating more reliable data to support lessons learned, would be more sites for more time. We feel that expanding our present three sites to 5 instead of 3 years would yield important dividends in lessons learned and confirmed. Moreover, expanding the number of sites would yield similar dividends. Hence, we argue for up to nine additional sites, or a dozen in all.

Moreover, additional sites would allow clusters of sites to focus on potentially important themes. For instance, we would envision a cluster including concentrated mental health services; another including concerted advice to employers on both ways to accommodate the needs of disabled veterans in order to be productive and ways to “sculpt” or structure job requirements to the same end; yet others emphasize peer group supports. Then, too, some or all of the additional sites should provide career services to the severely disabled veterans from all DoD uniformed services. To these ends, we seek Congressional and agency support as well as the continuation of private funding.

Thank you for your invitation and attention.

**Attachment I to Testimony of Carol A. Glazer: Brief descriptions of
NOD, of the Army’s Wounded Warrior Program (AW2), and of
NOD’s AW2 Careers Demonstration Project.**

The National Organization on Disability

The mission of the National Organization on Disability (NOD) is to expand the participation and contribution of America’s 54 million men, women, and children with disabilities in all aspects of life. NOD was established in 1982 with the goal of inclusion for people with disabilities. It was a key player in the passage of the

Americans with Disabilities Act (ADA) in 1990 and the placement of the statue of Franklin Delano Roosevelt in a wheelchair in the Nation's Capital.

With offices in New York City and Washington, DC, NOD works nationally in partnership with international, national, and local organizations. NOD has earned respect for its work as an advocate, program developer, and provider of the field's most important research on the status of Americans with disabilities (the NOD/Harris Surveys). NOD provides direct services to clients only as a part of demonstration programs aimed at developing new approaches and scaling up those that work.

NOD focuses on economic self-sufficiency for people with disabilities. Our most significant projects are AW2 Careers as described below and Start on Success (SOS), a student internship program that transitions young people with disabilities into the workforce and helps prepare special education students—especially from racial or ethnic minorities and low-income, urban families—for competitive employment.

Despite a primary focus on education and employment, NOD remains vigorously involved in the wider range of concerns affecting people with disabilities, including those that arise at the moments of greatest vulnerability. NOD/Harris Surveys reveal that 56 percent of people with disabilities do not know whom to contact in the event of a disaster. NOD's Emergency Preparedness Initiative (EPI) promotes the inclusion of people with disabilities in emergency preparedness planning and response by participating in emergency planning exercises, hosting conferences and by providing information, technical assistance, and other resources to emergency planners, first responders, disability advocates, and people with disabilities.

NOD is the only disability organization with credentialed personnel experienced in emergency management and disability issues.

The U.S. Army Wounded Warrior Program (AW2)

At this writing, the U.S. Army Wounded Warrior (AW2) Program^{***} assists close to 5,000 of the most severely injured soldiers and veterans of the wars in Iraq/Afghanistan. To be "in" AW2, a soldier/veteran must have one or more severe physical disabilities (e.g., burns, blindness, amputations, spinal cord injuries), often combined with Post-traumatic stress disorder (PTSD) and/or Traumatic Brain Injury (TBI).

Assistance is provided by a cadre of over 135 "Advocates," Army employees or contractors who are stationed around the country with caseloads averaging 37. Advocates are counselors, advisors, navigators, case managers, and, yes, advocates with respect to the many and often confusing benefits and services available to and needed by such soldiers and veterans. The Advocates' mission is to pro-actively facilitate soldiers/veterans' receipt of the supports and services they need to become "contributing members of their communities," the Army's admirable vision for those in the AW2 caseload. The Advocates are charged with staying engaged with veterans for "as long as it takes." (Family members are also served.)

A culminating step to this goal is sometimes for AW2 soldiers/veterans to return to active duty, or, more commonly, to leave active duty and resume or enter civilian careers as veterans, where one of their options is to resume or enter civilian careers.

But civilian career development is a specialized activity that the Army and its Advocates have little experience with and limited time to devote to. To develop and learn what approaches the Army could most effectively use to assist severely disabled AW2 soldiers and veterans to move forward on their career paths, the AW2 Program and the nonprofit NOD concluded a Memorandum of Understanding (MOU) in 2007 for a public/private collaboration under which NOD would assist AW2 in advancing the careers of the soldiers/veterans it serves (including their family members, as well).

NOD's activities with AW2 under this MOU have had two major focuses: First, NOD drafted a *Field Manual on Careers: Education, Training, and Work* for the AW2 Advocates. This primer on career goals and services will shortly be promulgated to AW2 field staff as official guidance for their work on the careers front. Our major project is the AW2 Careers Demonstration Project, the focus of my testimony today. AW2 Careers is a pilot project whose lessons are to be transferred to AW2 both during the project and at its scheduled completion in 2012, when AW2 plans to assume full responsibility for career services and may conduct them in large part on the basis of the demonstration's experiences.

^{***} Several years ago, then Secretary of Defense Donald Rumsfeld ordered all uniformed services to establish programs for severely wounded members that would aggressively facilitate their obtaining the services and benefits they need, including when medically separated from active duty. The Army's AW2 Program is the largest of these.

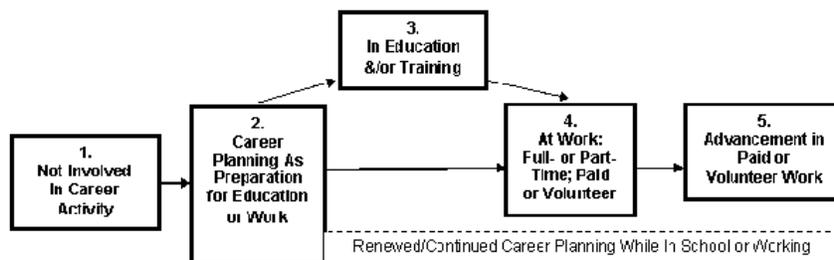
AW2 Careers

NOD's AW2 Career Demonstration Program is a 4½-year**** pilot project (now just into its second full operating year) under which NOD has placed one or more NOD Career Specialists in three locations (the Dallas, Texas, Metroplex; Colorado Springs, serving the State of Colorado; and Fayetteville, serving the State of North Carolina), where, over a 3-year period, they team with the local Advocates, concentrating on career development for soldiers, veterans, and family members who are ready for such services.

Operational Model

Like the Advocates, the Career Specialists employ a pro-active, intense, prolonged case management model helping the veterans think about and explore career options; obtain education, skill, aptitude, and interest assessments; devise resumes and career plans; acquire additional education and training; enter into work of various kinds (full- or part-time, paid or volunteer, for nonprofit, for-profit, or governmental employers—or self-employment as entrepreneurs or individual contributors); and advance in that work once so engaged. They do this by finding and linking veterans/families to relevant career services locally or providing the services themselves where local resources are inadequate.

The AW2 career process is represented by the flow chart below, through all or some of which will move an AW2 veteran/family member. This is not necessarily a linear, forward only, process. Some veterans may backtrack to an earlier cell, to plan a different career or go to college, etc. Some may both work and go to school at the same time—or, may volunteer while working and/or in school. Career planning may be preparation for work or school and/or may occur while working or in school. Note, too, that Career Specialists “stick with” veterans after job placement for the full duration of the project.



A goal of a Career Specialist is to assist the veteran to move as far and as quickly through these cells as possible during the project's duration. Job placement is not the only criterion of success; equally important is motion forward. A closely linked goal is to learn “what works” to help the veteran move from step to step (see evaluation, below).

Some veterans have already, on their own, entered school or at work, but many are in cell #1 and are our prime target population. They may be still in outpatient rehabilitation, still too injured to consider career steps at this time. Or, they may still be adjusting to the home environment and family situation; content to live on benefits at this time; discouraged from trying and not making progress; or just not ready or interested at this time. Many need time and encouragement to move forward.

Others are dispersed across the other cells of the flow chart. Wherever they find the veterans, our Career Specialists find and establish relations with them, assess their needs, and assist them in moving forward. Attached is our most recent statistical status and progress report as of the end of June 2009.

NOD has undertaken this Careers Demonstration mindful that it must utilize, not duplicate, other resources with the mission of assisting wounded veterans. In AW2 Careers local sites informal collaborators include the public agencies serving disabled veterans (Department of Labor and its VETS and “Real Lifelines” programs; the Veteran's Administration Vocational Rehabilitation and Employment offices; and the Social Security Administration offices); private nonprofit Veteran's Service Orga-

****This comprises several months for planning and start up, over 3½ years for site operations on a staggered startup basis, and several months to finalize the project's evaluation and promulgate its findings.

nizations (including Disabled American Veterans, VFW, Paralyzed Veteran's Association, AMVETS and American Legion) and a host of new voluntary organizations operating both nationally and locally, such as the Wounded Warrior Project and Yellow Ribbon Fund, that have formed since September 11th. The roster of such collaborators varies from site to site.

In addition, NOD is collaborating with the nonprofit, foundation-funded Give an Hour network, which stimulates local mental health providers to donate, *gratis*, an hour of mental health services per week to returning Iraq/Afghanistan veterans needing such services. Give an Hour advises both AW2 Advocates and NOD Career Specialists on how to make appropriate mental health interventions when needed, and assists in providing such services where appropriate.

Evaluation

The Economic Mobility Corp. (Mobility), a nonprofit organization led by Mark Elliott, a workforce development specialist who helped design the program, is responsible for conducting the program evaluation. AW2 Careers' two main goals: 1) developing effective ways to help veterans achieve better employment and education outcomes; and 2) using what we learn to inform the military and the helping professions and agencies about how best to assist such severely disabled veterans meet career goals.

A final evaluation after the completion of Year 3 will report on: 1) how effectively the program is implemented at each site; 2) the extent to which the initiative increases the level and quality of the employment and educational services that veterans and their families receive; 3) what employment and educational outcomes veterans/families achieve after receiving program services; and 4) what career supports or other factors were most helpful in generating such outcomes.

Funding

NOD designed AW2 Careers to be privately funded (to enable quick actions devoid of bureaucratic impediments) with national funders supporting the national office's management, technical assistance, evaluation, and communication/promotional activities, and local funders supporting each site. At present, AW2 Careers is supported by 17 national and local foundations and two private corporate donors. These funders (counting grants provided and renewals that are likely) support 93 percent of the present 4½-year project budget of \$4.6 million. NOD is seeking to fill the remaining gap through additional support from present and other potential funders.

Attachment II: AW2 Careers Status Report as of June 30, 2009

	TX	CO	NC	All
Number of Soldiers/Veterans on the Careers Caseload as of June 30	61	49	50	160
Current Status of Soldiers/Veterans				
Currently employed, ¹ in education or training and/or volunteering	37	29	21	87
Engaged in career planning	32	22	20	74
Still on active duty	1	2	9	12
Engaged in career planning	0	2	7	9
Currently not on active duty, employed, in education/training or volunteering	16	16	20	52
Engaged in career planning	8	12	17	37
Status not confirmed (Soldier/Veteran not contacted or status not recorded)	7	2	0	9
Outcomes Achieved After Receiving Services				
<i>Soldiers/Veterans who ever achieved any outcome after receiving services²</i>	17	20	4	41
Soldiers/Veterans who achieved any outcome in June 2009	0	0	1	1
Soldiers/Veterans currently in an outcome achieved after receiving services	17	19	4	40
Family members currently in an outcome achieved after receiving services	2	0	1	3
Employment among Soldiers/Veterans				
Ever employed in a civilian job since on the caseload	24	22	11	57

	TX	CO	NC	All
Currently employed in a civilian job ³	20	19	11	50
<i>Ever obtained a civilian job after receiving services⁴</i>	6	14	1	21
Obtained a civilian job in June 2009	0	0	1	1
Currently in a civilian job obtained after receiving services	6	12	1	19
Education Among Soldiers/Veterans				
Ever attended education/training since on the caseload	21	12	10	43
Completed education or training	0	1	0	1
Currently attending education or training	19	10	10	39
<i>Ever started education /training after receiving services</i>	8	6	2	16
Started education/training in June 2009	0	0	0	0
Currently in education/training begun after receiving services	8	5	2	15
Volunteering among Soldiers/Veterans				
Ever volunteered since on the caseload	9	6	6	21
Currently in a volunteer activity	9	6	5	20
<i>Ever started a volunteer activity after receiving services</i>	5	3	1	9
Started a volunteer activity in June 2009	2	0	0	2
Currently in a volunteer activity begun after receiving services	5	3	1	9
Contact Since the Start of the Demonstration at Each Site				
Soldiers/Veterans ever contacted	55	47	50	152
Soldiers/Veterans who ever received a service or referral	53	40	48	141
Soldiers/Veterans seen in person from December 2008 through June 2009 ⁵	42	20	39	101
Family members who ever received a service or referral	24	0	6	30
Contact in June 2009				
Soldiers/Veterans contacted (service, referral or follow up)	30	2	30	62
Soldiers/Veterans who received a new service or referral	25	0	25	50
Soldiers/Veterans who had follow up or update contacts	24	2	10	36
Soldiers/Veterans where contact attempted but not made	14	1	4	19
Soldiers/Veterans seen in person	3	1	14	18
Family members who received a service, referral or follow up	24	0	5	29

¹ Includes civilian jobs only.

² 5 Soldiers/Veterans achieved 2 outcomes: 4 are employed and in education; 1 is employed and volunteering.

³ Currently employed means the last employment assessment entered indicates that the Soldier/Veteran is employed. However, most assessments were entered months ago, and "current" does not indicate that the status was verified in the current month. The same applies to the education assessments and volunteer information.

⁴ The 20 Soldiers/Veterans have obtained a total of 23 jobs since receiving services.

⁵ December 2008 is when CSs started tracking whether contacts were in person, by phone or by email.

**Prepared Statement of Bradley G. Mayes, Director,
Compensation and Pension Service, Veterans Benefits Administration,
U.S. Department of Veterans Affairs**

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

I. Quality of Life Loss Issues

Background

Department of Veterans Affairs (VA) compensation for service-connected disability is based on average lost earnings due to an injury or disease incurred in or aggravated by military service. Benefits are paid according to a rating assigned to a Veteran's disability based on the VA Schedule for Rating Disabilities. The statute at 38 U.S.C. § 1155 states that "ratings shall be based, as far as practicable, upon the average impairments of earning capacity." As a result, the VA rating schedule compensates Veterans for the average loss in income resulting from their service-connected disabilities. In recent years, this approach to compensation has been challenged as inadequate because it focuses only on earnings loss and not on the larger issue of QOL loss. VA has received input on the QOL loss issue from numerous sources and has sought to identify the implications of adopting a policy of compensating Veterans for QOL loss in conjunction with the current earnings loss compensation system. Those sources providing information and recommendations to VA have included: the President's Commission on Care for America's Returning Wounded Warriors (Dole-Shalala Commission); the Veterans' Disability Benefits Commission (Benefits Commission); the Center for Naval Analyses (CNA); the National Academy of Sciences' Institute of Medicine (IOM); and, most recently, Economic Systems, Incorporated (EconSys).

Definitions of QOL loss vary and may focus on aspects of an individual's physical and mental health or may address the individual's overall satisfaction associated with life in general. The IOM traces the concept back to the Greek philosopher Aristotle's description of "happiness" but the IOM's definition encompasses the cultural, psychological, physical, interpersonal, spiritual, financial, political, temporal, and philosophical dimensions of a person's life. A more succinct definition utilized by EconSys refers to an individual's overall sense of well-being based on physical and psychological health, social relationships, and economic factors.

Dole-Shalala Commission

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

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

Veterans' Disability Benefits Commission

The Benefits Commission was created by the National Defense Authorization Act of 2004 and produced a final report in 2007 that provided recommendations on a wide range of issues related to the claims process and the benefits award system. Among the issues addressed was QOL loss. The Benefits Commission incorporated information from the CNA and IOM studies into its final report, agreeing with these organizations that QOL loss exists among disabled Veterans. The Benefits Commission also supported the idea that VA should undertake studies to research and develop QOL measurement tools or scales and ways to determine the degree of loss of QOL on average resulting from disabling conditions listed in the rating schedule. However, it acknowledged that QOL loss assessment is relatively new and still at

a formative stage, which indicates that implementation would be a long-term, experimental, and costly activity. In addition, it recognized special monthly compensation benefits and ancillary benefits as existing vehicles to assist with QOL loss among disabled Veterans.

Center for Naval Analyses

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

Institute of Medicine

The Benefits Commission considered QOL loss findings documented in *A 21st Century System for Evaluating Veterans for Disability Benefits*, produced by IOM at the commission's request. This lengthy IOM review of the VA disability benefits process addressed QOL loss. A distinction was made by IOM between current VA compensation for a Veteran's work impairment and a compensation system based on "functional limitations" on usual life activities. IOM concluded that the Veterans' disability compensation program should compensate for: work disability, loss of ability to engage in usual life activities other than work, and QOL loss. IOM also recommended that VA develop a tool for measuring QOL loss validly and reliably in the Veteran population and develop a procedure for evaluating and rating the QOL loss among disabled Veterans.

Economic Systems, Incorporated

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

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

A second optional method proposed by EconSys would key QOL loss payment amounts to the medical diagnostic code of the primary disability, as well as to the combined percentage rate of disability. This option anticipates that Congress would create a separate pay scale based on the Veteran's combined degree of disability and primary disability. This method would arguably produce more accurate QOL loss payments because two variables rather than one would be involved and previous studies have shown that some disabilities, such as mental disorders, are associated with greater actual QOL loss than others. However, implementing this would involve conducting large sample-size surveys to assess the average QOL loss for each of over 800 diagnostic codes and then factoring in the additional loss for each of the 10 percent increments of the rating schedule up to 100 percent. No surveys like this have been conducted in the past as a means to assign a dollar value to QOL loss. Inherent in such surveys is the potential for inconsistency and inaccuracy because

the data would involve Veterans' self-reported answers to subjective questions. Given the number of "diagnostic code-evaluation percentage" combinations involved, a QOL loss scale developed under this method would be extremely complex and require extensive program and system modifications. In the event this method were implemented, it would likely be subject to the same issues of fairness as the first method. A Veteran with a low combined disability percentage rating may receive more total compensation than a Veteran with a high combined disability percentage rating because of a difference in the QOL loss value assigned to different diagnostic codes. Moreover, the disability identified as primary for existing compensation may not be the primary cause of a Veteran's QOL loss. EconSys has estimated that this method would result in annual program costs of \$9 billion to \$22.2 billion.

A third option proposed by EconSys would involve an individual assessment of each Veteran for QOL loss by both a medical examiner and a claims adjudicator. It would also involve establishing separate rating tables for earnings loss and QOL loss and using these in combination with subjective information received from the Veteran about his or her QOL loss. This method would arguably allow for the most accurate assessment of QOL loss because of its individualized nature. However, it would require extensive training of VA personnel to administer and interpret QOL loss assessment tools and then apply them in the rating process. Once again, issues of subjectivity and fairness would likely be involved. EconSys has estimated that this method would result in annual administrative costs of approximately \$71.5 million, in addition to program costs of \$10.5 billion to \$25.7 billion.

II. Implementing Quality of Life Loss Compensation

VA Challenges

Implementing a disability rating system that compensates for QOL loss would involve at least two major challenges for VA. The first would be to accurately and reliably determine whether, and to what extent, a disabled Veteran suffers from QOL loss. The second would be to establish equitable compensation payments for varying degrees of QOL loss. The first challenge has been addressed by other organizations and has led to the development of QOL loss assessment tools. The most well-known of these is the RAND Corp.'s Short Form 36 Health Survey Version 2 (SF-36) and Short Form 12 Health Survey (SF-12). These are survey questionnaires that measure physical functioning, role limitations due to physical health, bodily pain, general health perceptions, vitality, social functioning, role limitations due to emotional problems, and mental health. The questionnaires yield a score that is interpreted to measure QOL loss in relation to the non-disabled population.

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

As EconSys stated in its study, users of existing QOL loss assessment instruments seek to make comparisons of QOL loss between different groups or to measure improvements in QOL loss as a result of treatment interventions. However, they are not trying to attach a dollar value to differences in loss of QOL. Therefore, although the CNA study indicates a greater QOL loss among disabled Veterans compared to non-disabled Veterans, it does not provide VA with a means to measure the extent of differences and provide equitable compensation accordingly.

The EconSys study, described above, provides options for implementing a compensation procedure for QOL loss among Veterans, but is not specific about how new assessment instruments would be developed. For example, in the second option offered by EconSys, part of the QOL loss payment would be tied to the medical diagnostic code that represents the disability which is service-connected. This is based on the assumption that certain medical disabilities generally produce greater QOL loss than others. To implement this, VA would be required to develop new survey instruments that target specific diagnostic codes. Surveys now in use, such as the SF-36 and SF-12, are generic and would be of little help. When developing any new survey instrument, the issue of minimizing subjectivity would always be present. Additionally, the EconSys study does not address a viable means to assign a dollar value to the different degrees of QOL loss that may be experienced by individual Veterans. This burden would remain with VA and Congress.

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

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

Current VA Compensation

Most of the organizations that have provided input to VA on QOL have stated that VA has a number of special benefits that implicitly, if not expressly, compensate for QOL loss, such as ancillary benefits, special monthly compensation, and total disability based on individual unemployability. Special monthly compensation and ancillary benefits are provided to Veterans in addition to compensation paid on the basis of the schedular rating assigned to service-connected disabilities.

The ancillary benefits to which these organizations refer are intended to provide assistance to Veterans with special needs resulting from exceptional handicaps due to certain service-connected disabilities. Assistance with the purchase of an automobile or other conveyance, with obtaining the adaptive equipment necessary to ensure that the Veteran can safely operate the vehicle, is authorized by 38 U.S.C. § 3902. Eligible Veterans include those with service-connected loss, or permanent loss of use, of one or both feet or one or both hands, and those with permanent significant visual impairment.

Another ancillary benefit that provides assistance to Veterans and servicemembers with certain service-connected disabilities is assistance in acquiring housing with special features, which is authorized by 38 U.S.C. § 2101(a). Eligible Veterans and servicemembers include those with permanent and total service-connected loss, or loss of use, of both lower extremities that precludes locomotion without the aid of a mechanical device; blindness in both eyes plus loss, or loss of use, of one lower extremity; loss, or loss of use, of one lower extremity plus residuals of organic disease or injury that precludes locomotion without the aid of a mechanical device; loss, or loss of use, of one lower and one upper extremity that precludes locomotion without the aid of a mechanical device; loss, or loss of use, of both upper extremities that precludes use of the arms at or above the elbows; or disability due to a severe burn injury. In addition, VA is authorized by 38 U.S.C. § 2101(b) to provide assistance in adapting a residence or acquiring an already adapted residence to Veterans who are not eligible for assistance under § 2101(a) and are entitled to compensation for a permanent and total service-connected disability due to blindness in both eyes; including anatomical loss, or loss of use, of both hands; or due to a severe burn injury.

Additionally, a yearly clothing allowance is authorized by 38 U.S.C. § 1162 for a Veteran who, because of a service-connected disability, wears or uses a prosthetic or orthopedic appliance, including a wheelchair, which tends to wear out or tear the Veteran's clothing. A clothing allowance is also authorized when a physician prescribes medication for a service-connected skin condition that causes irreparable damage to a Veteran's outer garments.

In addition to these ancillary benefits, VA is authorized by 38 U.S.C. § 1114 to provide special monthly compensation in addition to schedular disability compensation to Veterans with service-connected disabilities who are housebound, are in need of aid and attendance to accomplish daily living activities, have severe hearing loss or visual impairment, or have loss, or loss of use, of extremities or reproductive organs. In addition, VA is authorized to pay special monthly compensation to female Veterans for breast tissue loss.

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

III. Conclusion

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

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

Statement of Sarah Wade, Chapel Hill, NC

Chairman Hall, Ranking Member Lamborn, Members of the Subcommittee, thank you for allowing me the opportunity to provide testimony regarding quality of life and ancillary benefit issues. My name is Sarah Wade, wife of Army Sergeant (Retired) Ted Wade.

My husband served first in Afghanistan, later Iraq, and on Valentine's Day 2004, his Humvee was hit by an Improvised Explosive Device (IED) on a mission in Mahmudiyah. Ted sustained a severe Traumatic Brain Injury (TBI), his arm was completely severed above the elbow, suffered a fractured leg, broken foot, shrapnel injuries, as well as other complications, and later would be diagnosed with Post-traumatic stress disorder (PTSD). He remained in a coma for over 2½ months, and withdrawal of life support was considered, but miraculously he pulled through.

After the battle for his life was won, the war for the necessary mix of benefits and services began, and continues today. Due to the severity of his brain injury, Ted is sometimes unable to fight for himself, so his struggle has become my own. I am consumed 24 hours a day assisting my husband with managing his special diet, preparing meals, providing transportation, enforcing medication management and other necessary routines, overseeing his medical care, checking his blood glucose level, administering injections of insulin because of blood sugar issues, or for hormone replacement therapy due to residual pituitary damage secondary to the brain trauma, and much more.

These responsibilities have left no time for me to return to school, full-time employment, or have a life of my own, because this is more than one person can keep up with. Five-and-a-half years later, my schedule continues to be hectic and we still struggle to maintain a reasonable standard of living. Updating section 1114, Title 38, United States Code, to include impairment specific to Traumatic Brain Injury (TBI) would create a less restrictive option for providing more appropriate and individualized long-term supports, allowing the veteran reasonable access to the community, maximizing quality of life, and rehabilitation outcomes.

The new schedule for rating Traumatic Brain Injury, which was updated last fall, is an enormous improvement for the mild to moderate range of TBI. It will allow veterans within this range of disability, deserving of a 100 percent rating, to be granted that decision. But, there were no changes made to special monthly compensation (sec. 1114), as VA felt "the SMC regulations potentially apply in all cases and therefore need not be repeated," or as Mr. Tom Pamperin, Deputy Director of VA Compensation and Pension Service was quoted as saying in USA Today, "Veterans who have suffered the most severe brain injuries will not receive much, if any, extra money because existing regulations provided adequate compensation in serious cases." However, the SMC regulations have not been updated to include impairment specific to TBI, and therefore, fail to address a group within the moderate to severe range, that are functioning individuals with serious disabilities and significant needs.

My husband is not seeking monetary compensation for his loss, but the wherewithal for veterans with severe TBI to live in their own homes and communities as independently as possible. They have paid a high price, and if these veterans are not able to be fully independent, they should be self-managed as much as possible, and have choices. It is our belief these veterans who were severely injured while serving their country should be given the tools to live as normal a life as possible and integrate into their communities to the fullest extent that they are capable. And unfortunately, this does require additional financial resources.

One of our concerns with special monthly compensation is the criteria for “regular” aid and attendance (A&A) at the “L” rate. The new schedule “added a note defining ‘instrumental activities of daily living’ as referring to activities other than self care that are needed for independent living, such as meal preparation, doing homework, and other chores, shopping, traveling, doing laundry, being responsible for one’s own medication, and using the telephone.” This is certainly an improvement and 3.352(a), the basic criteria for regular A&A, should be updated to include instrumental activities of daily living as a qualifying disability, as these activities require the regular assistance of another person.

Some instrumental activities of daily living could potentially apply under the basic criteria for regular A&A, where it states, “The following will be accorded consideration in determining the need for regular aid and attendance ... incapacity, physical or mental which requires care or assistance on a regular basis to protect the claimant from hazards or dangers incident to his or her daily environment.” However, meal preparation, homework, chores, shopping, traveling, or laundry, for example, may not be interpreted this way. A&A should be updated to include instrumental activities of daily living so these veterans may be eligible for compensation under section 1114(l), Title 38, United States Code.

The other major issue we have is that needing “assistance on a regular basis to protect the claimant from hazards or dangers incident to his or her daily environment,” does not qualify a veteran for the higher level aid and attendance allowance at the “R1” or “R2” rate. The regular “L” rate works out to only be an additional \$21.50 a day. These are not adequate resources for someone who needs the assistance of another person most or all of the time. This may only be enough to provide 16 hours of support to the veteran each week, not including the cost of transportation or other expenses. Depending on schedule and fuel cost, a family in our situation could spend \$1500.00 a year on gasoline to get to and from appointments. This does not include recreation, shopping, socialization or community reintegration that is so important to rehabilitation after a severe TBI. And Ted and I live in an urban area where he is able to walk to the grocery store, gym, and other activities, *with the appropriate supervision*. That is not the case for many veterans.

The support services currently offered by VHA are not appropriate either and are too restrictive for someone who is active, self aware, and whose needs are largely non-medical. Someone like my husband needs supports and services that will allow him to continue to live and be cared for in his own home and community. My current respite options are to leave Ted in a VA extended care facility up to 30 days a year. He can go to an adult day care program or TBI group, though he feels this is belittling and will not go voluntarily. VA has offered to provide a home health aide that is unable to take him outside of the home, even though he does not need regular skilled care, and his needs are often outside of the home. The fee basis program, when pursued, will pay for an assisted living facility at a per diem higher than the additional money he receives monthly at the “L” rate. However, he would prefer to live at home, not in an institutional setting. Forcing Ted to be homebound or forcing him out of his community, in my opinion, is a serious quality of life concern. And it is also important to note that none of these options would help him achieve a higher level of functioning, independence, and will set back his recovery.

Veterans with severe TBI need the option of supported living in their own homes and out in their own communities. The VHA options I have mentioned will allow Ted to merely exist, not truly live, or be included in society. These veterans need to be involved in decisions about their own lives, allowed to choose what, when and where they eat, where they live and shop, what they do with their time, what their needs are, how they are provided, who provides this support, and who is involved in their life. A higher level of aid and attendance would give them the same autonomy, dignity, flexibility, and quality of life afforded to veterans with physical disabilities. This would allow them to be spontaneous and obtain more appropriate, individualized, timely assistance, with less bureaucracy. It would also enable these veterans to achieve their maximum potential, becoming more capable, and as a result, may not require this level of benefit for life.

Some veterans diagnosed with severe Traumatic Brain Injury only meet one of three criteria for the higher level aid and attendance rate. To qualify, one, the Veteran must be entitled to compensation under section 1114(o) of Title 38, United States Code, which is based on anatomical loss, or loss of use of extremities, some organs (not including the brain), hearing, or sight. Anatomical loss of part of the brain, loss of use of cognitive capability, such as loss of use of working memory, for example, does not apply. Two, they must be entitled to the regular aid and attendance allowance, or “L” rate described in 3.352(a), which I mentioned above. Three, they must have a higher level of need for personal health care services provided on a daily basis in the home, described in 3.352(b), paragraph 2, and in the absence,

would require hospitalization, nursing home care, or other residential institutional care.

Though veterans with severe TBI may require 24-hour care, supervision for safety, or assistance with most, or all, higher level activities, they are not always provided a comparable level of compensation to a veteran with severe physical residuals. Though a veteran with a severe TBI may be able to perform some instrumental activities of daily living, they may require queuing or it may take much longer to complete these tasks than it would have pre-injury. These veterans not only need assistance with tasks they can no longer perform, but also someone to facilitate, or to accomplish ones they cannot keep up with. Without the aid of a family member with additional resources, although having no major physical disabilities, these veterans are not able to reside in their own homes, and therefore, will require residential care.

A veteran who requires a greater amount of assistance, in the home or out in the community, medical or non-medical, should be considered for compensation under sections 1114(r)(1) and (r)(2), Title 38, United States Code. We believe all veterans should be given access to the community whenever medically possible, not homebound, and the criteria for the higher level special monthly compensation rates should be updated to allow that.

Ted and I feel H.R. 3407, the Severely Injured Veterans Benefits Improvement Act of 2009, is a step in the right direction toward eliminating the disparity in benefits. We applaud Congressman Buyer, the Ranking Member of the House Committee on Veterans Affairs, along with Chairman Michaud and Ranking Member Brown of the Subcommittee on Health, for introducing this bill.

It appears that the intent of H.R. 3407 is to move veterans with Traumatic Brain Injury up to the 1114(o) rate, which will then potentially qualify them for the "R1" or "R2" rate, if they meet the aid and attendance requirements. However, we are concerned that this may be too broad, if anyone who qualifies for SMC, and has a TBI, will automatically qualify for the "O" rate. For example, an above elbow amputee with a mild TBI, who is able to live independently, would be granted the same compensation as my husband, an above elbow amputee with a severe TBI, who requires the assistance of another person around the clock. An able-bodied veteran with a mild TBI would not be granted any SMC at all. We feel the language of the bill should be modified to compensate TBI by itself, according to the severity of consequences.

In contrast, H.R. 3407 may be too narrow if the criteria for the higher level of aid and attendance is interpreted to only include veterans with a TBI that has caused physical limitations. We feel the bill should also include an amendment to 3.352(b), paragraph 2, to address cognitive or other neurological impairment, and assistance to protect the safety of the veteran from his or her environment. Without this higher level of support or supervision, the veteran with severe impairment (other than physical limitations), will also "require hospitalization, nursing home care, or other residential institutional care." Preventing the veteran from being placed in institutional care appears to be the intent of the A&A benefit. Ted and I would like to see special monthly compensation updated to prevent this for all service-connected disabilities.

My husband will continue to face significant challenges for the rest of his life, as a severe TBI is never static, but a progression of peaks and valleys. Veterans like Ted need support that will be around as long as the injuries they sustained in service to their country. Passing legislation to update section 1114, Title 38, United States Code, to address impairment specific to Traumatic Brain Injury, will restore a lot of freedoms he has lost since being wounded. Mr. Chairman, thank you again for the opportunity to share my story with you and please feel free to contact me if there are any questions you may have.

MATERIAL SUBMITTED FOR THE RECORD

Economic Systems Inc
 Falls Church, VA
July 27, 2009

Hon. John J. Hall
 Chairman
 Subcommittee on Disability Assistance
 and Memorial Affairs
 Committee on Veterans' Affairs
 335 Cannon House Office Building
 Washington, DC 20515

Dear Mr. Chairman:

As requested, I would like to extend my remarks to your question regarding including Vietnam Era veterans in a future analysis of earning loss. My oral answer should be extended as indicated in the enclosed statement.

Thank you for the opportunity to appear before your Subcommittee. If you have any further questions, please feel free to contact me.

Sincerely,

George Kettner, Ph.D.
President

Enclosure

**EXTENSION OF REMARKS
 GEORGE KETTNER, Ph.D.
 PRESIDENT, ECONOMIC SYSTEMS INC.
 BEFORE THE HOUSE COMMITTEE ON VETERANS' AFFAIRS
 SUBCOMMITTEE ON DISABILITY ASSISTANCE & MEMORIAL AFFAIRS
 JULY 23, 2009**

Chairman Hall recognized that the 2008 EconSys study focused on veterans who were discharged from the military after 1980 which omitted a large segment of the veteran population, especially Vietnam Era veterans. He asked how the analysis could be done differently if data were readily available to include the baby boom generation that is placing the greatest demand on VA.

Demographic and human capital data available from the Defense Management Data Center (DMDC) is not considered accurate on veterans discharged prior to 1980. Therefore, it is not possible to identify a sample of non service-connected veterans from DMDC data closely matched on human capital characteristics to serve as a comparison group in an analysis of the impact of disability on earnings. However, it could be possible to randomly select a sample of non service-connected veterans from either the DMDC data or from the VA Beneficiary Identification and Records Locator Subsystem (BIRLS) matched on a more limited set of known characteristics such as age, military rank, and date of discharge. This sample would lack key characteristics such as education level, military occupational series, and Armed Forces Qualification Test scores as are available on the post 1980 group and may not be as well matched to the service-connected veteran population. This limitation would need to be recognized.

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

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

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

DEPARTMENT OF VETERANS AFFAIRS
Veterans Benefits Administration
Washington, D.C. 20420

July 22, 2009

Director (00/21)
All VA Regional Offices and Centers

In Reply Refer To: 211B
Fast Letter 09-33

SUBJ: Special Monthly Compensation at the Statutory Housebound Rate

This letter provides guidance for adjudicating claims involving entitlement to special monthly compensation (SMC) at the housebound rate based on a decision by the U.S. Court of Appeals for Veterans Claims (CAVC or Court) in *Bradley v. Peake*.

Background

38 U.S.C. § 1114(s) provides that SMC at the (s) rate will be granted if a veteran has a service-connected disability rated as total, and (1) has additional service-connected disability or disabilities independently ratable at 60 percent or more, or (2) is permanently housebound by reason of a service-connected disability or disabilities. VA's implementing regulation at 38 CFR § 3.350(i) essentially mirrors the statutory language.

Prior to the CAVC's decision in *Bradley v. Peake*, VA excluded a rating of total disability based on individual unemployability (TDIU) as a basis for a grant of SMC at the (s) rate. VA relied upon language in citing VAOPGCPREC 6-99, dated June 7, 1999, in which the General Counsel stated that a TDIU rating takes into account all of a veteran's service-connected disabilities and that considering a TDIU rating and a schedular rating in determining eligibility for SMC would conflict with the requirement for "additional" disability of 60 percent or more by counting the same disability twice.

On November 26, 2008, the Court, in *Bradley v. Peake*, disagreed with VA's interpretation and held that the provisions of section 1114(s) do not limit a "service-connected disability rated as total" to only a schedular 100 percent rating. The Court found the opinion too expansive because it was possible that there would be no duplicate counting of disabilities if a veteran was awarded TDIU based on a single disability and thereafter received disability ratings for other conditions.

The Court's holding allows a TDIU rating to serve as the "total" service-connected disability, if the TDIU entitlement was solely predicated upon a single disability for the purpose of considering entitlement to SMC at the (s) rate.

The Court held that the requirement for a single "service-connected disability rated as total" cannot be satisfied by a combination of disabilities. Multiple service-connected disabilities that combine to 70 percent or more and establish entitlement to TDIU under 38 CFR § 4.16(a) cannot be treated as a single "service-connected disability rated as total" for purposes of entitlement to SMC at the (s) rate.

New Evidentiary Standard

Based on the Court's decision in *Bradley*, entitlement to SMC at the (s) rate will now be granted for TDIU recipients if the TDIU evaluation was, or can be, predicated upon a single disability and (1) there exists additional disability or disabilities independently ratable at 60 percent or more, or (2) the veteran is permanently housebound by reason of a service-connected disability or disabilities.

For example, a veteran in receipt of TDIU based on a 70 percent evaluation for Post-traumatic stress disorder (PTSD) and other service-connected disabilities consisting of a below-the-knee amputation, rated 40 percent disabling; tinnitus, rated 10 percent disabling; and diabetes mellitus, rated 20 percent disabling, would be entitled to SMC at the (s) rate if it is determined that PTSD is the sole cause of the unemployability, as the other disabilities have a combined evaluation of 60 percent.

It is important that, for purposes of section 1114(s)(1), no disability is considered twice to ensure that the prohibition against pyramiding contained in 38 CFR § 4.14 is not violated when determining which disability results in TDIU entitlement and in determining which disability or disabilities satisfy the independent 60 percent evaluation to award SMC at the (s) rate.

However, for purposes of section 1114(s)(2), a disability may be considered in determining TDIU entitlement as well as in determining whether a veteran is permanently housebound as a result of service-connected disability or disabilities because that provision does not specify "additional service-connected disability or disabilities" as in section 1114(s)(1).

Accordingly, a determination for entitlement to SMC at the (s) rate must be made in all TDIU cases where potential entitlement to SMC (s) is reasonably raised by the evidence.

Current Status

Regulations and M21-1MR, IV.ii.2.H.46.a will be revised to comply with the Court's decision. In the interim, the Court's holding will be applied to all pending and future claims.

In applying the Court's holding, if the medical evidence is insufficient to render an adjudicative determination as to whether the veteran's TDIU entitlement solely originates from a single service-connected disability, and there is potential entitlement to SMC at the (s) rate, the veteran should be scheduled for a VA examination to include an opinion as to the cause of unemployability.

Questions

Questions concerning this fast letter and other issues related to this issue should be submitted to the VAVBAWAS/CO/21FL mailbox.

Bradley G. Mayes
Director
Compensation & Pension Service

