

**Veterans' Disability Benefits Commission**  
*Established Pursuant to Public Law 108-136*

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October 17, 2007

**WRITTEN STATEMENT TO ACCOMPANY  
TESTIMONY BEFORE THE  
SENATE COMMITTEE ON VETERANS' AFFAIRS**

The Veterans' Disability Benefits Commission is pleased to submit the enclosed written statement to accompany testimony before the Senate Committee on Veterans' Affairs oversight hearing on VA and DoD collaboration; the President's Commission on Care for America's Returning Wounded Warriors; the report of the Veterans' Disability Benefit Commission; and other related reports.

The full report of the Veterans' Disability Benefits Commission, *Honoring the Call to Duty: Veterans' Disability Benefits in the 21<sup>st</sup> Century*, is available on line at [www.vetscommission.org/reports.asp](http://www.vetscommission.org/reports.asp). Enclosed with the testimony is also a copy of the Executive Summary of the Commission's report.

Sincerely,

  
JAMES TERRY SCOTT, LTG, USA (RET)  
Chairman

Enclosures

**STATEMENT OF  
JAMES TERRY SCOTT, LTG, USA (RET)  
CHAIRMAN  
VETERANS' DISABILITY BENEFITS COMMISSION**

**BEFORE THE  
UNITED STATES SENATE  
HEARING OF THE VETERANS' AFFAIRS COMMITTEE  
ON  
OCTOBER 17, 2007**

Chairman Akaka, Ranking Member Burr, and Members of the Committee:  
It is my pleasure to appear before you today representing the Veterans' Disability Benefits Commission.

You asked that I focus directly today on areas of overlap between the recommendations of our Commission and those of the President's Commission on Care for America's Returning Wounded Warriors (the Dole/Shalala Commission), the Task Force on Returning Global War on Terror Heroes (the Nicholson Task Force), and the DoD Independent Review Group (the Marsh/West Group.) You also asked for views on how to improve VA and DoD collaboration and cooperation and to resolve the long standing issue of creating a VA/DoD electronic health record.

First, let me say that there is a tremendous amount of consistency among the findings and recommendations of the four reports. The scope of the four efforts was quite different and this resulted in variations in some areas. But we all want to see improvements in benefits and services for injured and disabled service members and veterans. Our Commission generally agrees with the advice provided by the Independent Review Group and the Task Force and more recently by the Dole/Shalala Commission, but we differ with two of the Dole/Shalala suggestions. We believe that all disabilities and injuries should be compensated based on severity of disability and not be limited to combat or combat-related injuries. Nor does our Commission believe that VA disability compensation should end and be replaced with Social Security at retirement age.

For our own purposes, we prepared a matrix comparing the findings and recommendations of the four reports which I am pleased to share with the Committee. I caution that the matrix is not intended to be exhaustive nor a verbatim listing of all findings and recommendations. Rather it is a broad overview that I found useful.

The matrix contains a description of each study group's focus and a brief summary of findings and recommendations and a summary of topics that overlap. The major topics with considerable overlap are: VA/DoD Disability Process; Case Management; Family Support; IT Compatibility; PTSD; TBI;

Ancillary Benefits; Quality of Life; and Vocational Rehabilitation. Other topics with limited overlap include: Concurrent Receipt; Hazards and Exposures; Combat/Combat Related, Social Security, and Walter Reed. Our Commission addressed all of these topics except Walter Reed, which was not within the scope of our charge.

### **VA/DoD Disability Process**

All four reports addressed the problems with the process used when service members are determined to be fit or unfit for military duty. Our Commission conducted a detailed analysis of those separated or retired as unfit for duty during the seven-year period from 2000 through 2006 and compared their ratings with ratings subsequently completed by VA. We found that the combined ratings by VA were higher, on average, than ratings by the Services. For example, individuals rated zero percent by the Services were rated an average of 30 percent by VA and those rated 30 percent by the Services were rated an average of 56 percent by VA. Among individuals rated by the Services as zero, 10, or 20 percent, VA rated them 30 percent or higher 61 percent of the time. This was largely because VA rated 2.4 to 3.3 more conditions than the Services. When comparing the ratings for individual diagnoses, VA ratings were statistically significantly higher than the Services for 10 of 13 frequent diagnoses analyzed.

We concluded that there should be a realignment of the process and this is essentially the same conclusion reached by the Dole/Shalala Commission, the Independent Review Group, and the Nicholson Task Force. We also believe that the Services should determine if the service member is fit or unfit and VA should be responsible for assigning disability ratings to all conditions found as part of a single, comprehensive examination. The Dole/Shalala Commission made the same recommendation.

In redesigning the VA/DoD disability process and specifying the benefits available for these service members, it may be appropriate to focus specifically on the severely disabled. However, we should also recognize that the overwhelming proportion of service members medically discharged as unfit do not meet the several definitions of severely disabled. During the seven-year period 2000 through 2006, there were 83,008 service members medically discharged as unfit. DoD rated 81 percent of these as 0 through 20 percent disabled and provided separation pay. Only 5,060 (6.1 percent) were rated by DoD as 50 percent through 100 percent and, of these, only 1,478 (1.8 percent) were rated 100 percent. The process and the benefits should be appropriate for all service members found unfit, not just the severely disabled.

Our Commission did not specify which department should conduct the single examination; in fact we believe that this should be determined more by the capabilities of the two departments at the local level. Our Commission extensively reviewed the examination process used by VA with the advice of the

Institute of Medicine and made recommendations relating to the use of templates, training and certification of examiners, and quality assurance. Completion of a thorough and comprehensive examination is essential for accurate ratings and these recommendations should be addressed no matter which department conducts the examinations.

### **Case Management**

All four study groups recommended developing a case management system for severely injured service members and their families to ensure the right care and support at the right time and in the right place. A single case manager should have overall responsibility. The Dole/Shalala Commission also recommended comprehensive recovery plans. Improving case management is a key topic upon which there is strong agreement.

### **Family Support**

Family support is addressed by all of the study groups except the Nicholson Task Force. The families of the severely injured are assisting in the care and rehabilitation of these wounded warriors. Some are sacrificing jobs, careers, homes, and health insurance, and facing a tremendous impact on their own health in order to support their injured family members. Our Commission recommended that VA be authorized to provide similar services as currently provided by DoD to families of the severely injured. We also recommended extending ChampVA medical care to caregivers (currently this benefit is provided only to dependents of 100 percent disabled veterans, not caregivers) and providing a caregiver allowance. We also recommended eliminating any Tricare copays and deductibles for the severely disabled because we do not believe the injured should have to pay in any way for their injuries. We feel that our recommendations would more fully meet the needs of the families and caregivers of all severely disabled. The Dole/Shalala Commission would limit Tricare coverage to only families of those unfit due to combat-related injuries.

### **PTSD and TBI**

All four reports recommend improvements in awareness, research, treatment, staffing, and diagnosis/examination of posttraumatic stress disorder (PTSD) and traumatic brain injury (TBI). Our Commission focused more on compensating and rating these conditions and recommend that a “holistic” approach to PTSD be established that couples compensation, treatment, and vocational assessment. We also believe that re-evaluation should occur every two to three years to gauge treatment effectiveness and encourage wellness. Regarding TBI, we recommend including medical criteria for this diagnosis as a priority in the revision to the VA Schedule for Rating Disabilities.

## **Ancillary Benefits**

Our Commission recommended increases to several benefits that have not kept pace with cost of living, extending eligibility in some instances to burn victims, and expanding auto and housing allowances. We also recommended eliminating the premiums for Traumatic Servicemembers' Group Life Insurance (TSGLI) as we do not believe service members should have to insure themselves for traumatic injuries. Perhaps most importantly, our Commission recommends establishing a pre-stabilization allowance of up to 50 percent of current compensation for up to 5 years to address the real out-of-pocket expenses for the severely disabled. The Dole/Shalala Commission recommended a transition pay of three months' base pay or longer-term payments if participating in rehabilitation, education, or training. This is conceptually similar to our Pre-stabilization recommendation.

## **Quality of Life**

Both our Commission and the Dole/Shalala Commission recommend a compensation payment for the impact of disability on quality of life. We believe the level of compensation should be based on the severity of disability and should make up for average impairments of earnings capacity and the impact of disability on functionality and quality of life. It should not be based on whether it occurred during combat or combat training; or the geographic location of injury, or whether the disability occurred during wartime or a time of peace. Current compensation payments do not provide payment above that required to offset earnings loss. Therefore, there is currently no compensation for the impact of disability on quality of life for most veterans. While permanent quality of life measures are developed and implemented, we recommend that compensation payments should be increased up to 25 percent with priority to the more seriously disabled.

## **Vocational Rehabilitation**

All but the Independent Review Group addressed vocational rehabilitation. Both the Dole/Shalala Commission and our Commission found that the effectiveness of the program is not currently assessed and graduates are not followed except for a very brief time period. Both commissions recommend either an incentive bonus of up to 25 percent (Dole/Shalala) or exploring incentives as a way to encourage completion. The Nicholson Task Force focused on using existing programs and opportunities.

## **Concurrent Receipt**

Regarding concurrent receipt of military retirement and VA disability payments, our Commission found these to be two different programs with entirely different missions. DoD retirement recognizes years of service and VA disability payments

compensate for impairment in earnings and should compensate for impact on quality of life.

Over time, Congress should eliminate the ban on concurrent receipt for all military retirees and for all service members who are separated from the military due to service-connected disabilities. Priority should be given to veterans who separate or retire with less than 20 years of service and a service-connected disability rating of 50 percent or greater or disability as a result of combat. Payment offset should also be eliminated for survivors of those who die in service or retirees who die of service-related causes so that the survivors can receive both VA Dependency and Indemnity Compensation (known as DIC) and DoD Survivors Benefit Plan (known as SBP.)

The Dole/Shalala Commission also recommends that DoD compensate for years of service while VA compensates for disability.

### **Hazards and Exposures**

Our Commission and the Nicholson Task Force both addressed hazards and exposures but in different ways. The Nicholson Task Force recommended creating a center of excellence and a registry for embedded shrapnel or fragments from blast injuries. Our Commission recommended a new presumption process as proposed by the Institute of Medicine. The new process includes enhanced registries of service members and veterans based on exposure, deployment, and disease histories.

### **Improving VA and DoD Collaboration**

In addition to assessing areas of overlap among the four reports, you asked my views on how to improve collaboration and cooperation between VA and DoD. Our Commission made several recommendations that we believe would enhance benefits and services for service members and veterans, both while they are transitioning from the military to civilian status and for many years in the future. We found many encouraging signs and also areas which need improvement.

The Joint Executive Council (JEC) established by statute has demonstrated how both departments can benefit from coordinated planning and increased cooperation. We applaud the results that are evident in specific initiatives. These include the integration of the North Chicago VA Medical Center and the Naval Health Clinic Great Lakes (named last week for astronaut James Lovell), in the coordinated treatment of severely injured in dedicated poly trauma centers, and in shared rehabilitation units. These are all indications of how joint efforts can benefit both departments and improve service to veterans and service members. However, we believe that the JEC planning effort can be significantly improved by including specific milestones and designating responsible officials for each. We also suggest that transition coordination and effectiveness could be

improved by including the Department of Labor and the Social Security Administration in some capacity in the JEC since these organizations have major transition roles.

Successfully transitioning service members to civilian life is crucial and ensuring that service members understand the benefits and services that are available to them is essential. Information is disseminated through the Transition Assistance Program (TAP) and the Disabled Transition Assistance Program (DTAP.) We believe that the TAP briefings should be mandatory for all separating service members, especially the Guard and Reserves and those in medical hold status. Currently, these briefings are not mandatory in all Services. In addition, we found that funding for these briefings has been static for the last decade and we recommend that adequate funding be provided. All service members should be knowledgeable about benefits prior to leaving the service.

After leaving service, many veterans find it difficult to prove that injuries and diseases that occur later in life are the result of military service. The veteran, with the assistance of VA, has to produce evidence that the condition originated in service. This is made more difficult because not all separating service members receive separation examinations; only those who intend to file a claim for VA disability benefits. We believe that all separating service members should receive a separation examination to establish a baseline for medical conditions. An entrance examination is required to enter active duty and a separation examination should be required to leave active duty.

Application for disability benefits is expedited through the Benefits Delivery at Discharge (BDD) process which is currently available at some 140 military facilities and these claims are processed at two VA locations. Two problems exist with the BDD process: (1) it is not available unless the individual has an established date of discharge and is within 180 days of that date; and (2) it is not available at all locations. Those on medical hold or on the temporary disability retired list are often precluded from participating in BDD and Guard and Reserves often separate at locations where BDD is not available. We believe that BDD should be available to virtually all separating service members, including Guard and Reserves.

One cause for delay in claims processing even in the BDD process is availability of the DD-214 discharge document. Our Commission recommends that DoD immediately provide VA with an authenticated electronic document so that processing can begin right away.

### **IT Compatibility**

All of the reports address the absolute necessity for VA and DoD to have compatible information systems. All recognize the importance of this capability but also recognize that this will not solve all problems.

Much has been said over the past several years about “seamless transition.” This is an admirable goal but it is not a current reality. Not all of DoD’s medical and personnel records are electronic and those that are electronic are not yet fully compatible between the Services, much less between VA and DoD. The AHLTA and VistA systems are not compatible. AHLTA may provide a more modern platform than VistA, but significant functions in the older VA system are not available to DoD users. For example, inpatient discharge summaries and digital images are not yet available in AHLTA. Therefore, DoD cannot easily transfer these types of information to VA upon a service member’s discharge or transfer for medical care without paper copies first being scanned. In January 2007, VA and DoD announced an agreement to create a joint inpatient electronic record that would be instantly accessible to clinicians in both departments. As far as we know, the departments have not committed to a completion date although the Nicholson Task Force identified January 31, 2008 as the date for completion of an analysis of alternatives.

Veterans Benefits Administration continues to use paper claims folders and has no long-term plan to convert them to electronic records. Both VA and DoD will have to continue to use paper records well into the future. Plans need to be made to convert existing paper records and finally be able to exclusively use electronic records at some time in the future.

Our Commission believes that development and implementation of compatible information systems should be expedited. We also agree with the Government Accountability Office that a detailed project management plan should be developed with a lead agent designated and with specific milestones and planned completion dates. We understand why the departments are reluctant to establish planned completion dates since they will be expected to achieve those goals. However, we believe that planned completion dates for specific actions are absolutely essential in order to estimate resource requirements and to monitor progress.

Compatible electronic systems will greatly enhance the ability of both departments to share information and work together. This critical interface will also improve claims processing and avoid some of the unfortunate cases that “slip through the cracks” during the transition from VA to DoD.

In conclusion, VA and DoD have much to gain by greater coordination and collaboration but service members and veterans have even more to gain by the two departments working better together. A lot of valuable work has been done by VA and DoD and they should be commended for the progress made. However, a great deal of work remains and the only way that the goal of a reasonably seamless transition will ever be realized is if the two departments are required to develop realistic, yet challenging, goals with specific milestones. Joint ventures, sharing agreements, and integrations should be the norm rather

than the exception. Congress should review the plan and oversee progress. Congress also has the responsibility to ensure that sufficient funding is provided to accomplish the goals and objectives contained in the plan.

**Veterans' Disability Benefits Commission**

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

<b>Study Group</b>	<b>Veterans' Disability Benefits Commission</b>	<b>Independent Review Group</b>	<b>GWOT Task Force</b>	<b>PCCWW</b>
<b>Topic:</b>				
<b>VA/DoD Disability Process</b>	Realign disability evaluation process – Services determine fitness for duty, VA rates disability	DoD should overhaul the DES system by implementing a single physical exam (as described by GAO 2004). The services should consistently be determining fitness for duty & VA provides disability rating. DoD should also expand the Disability Advisory Council, Conduct quality assurance reviews on previous 0-20% & EPTS cases, Evaluate loss of function due to burns similar to amputation.	Joint process whereby VA/DoD cooperate in assigning a disability evaluation, determining fitness for retention, level of disability retirement & VA compensation	Restructure disability & compensation systems - DoD/VA should create a single, comprehensive standardized medical exam that DoD administers, DoD maintains authority over fitness & pays for years of service while VA establishes rating, compensation & benefits
<b>Case Management</b>	Intensive case management with an identifiable lead agent	Create tri-Service policy & guidelines for case management services & training, Assign single primary care physician & case manager	System of case & co-management	Comprehensive Recovery Plans & Coordinators <u>with HHS as lead.</u>

<b>Topic</b>	<b>Veterans' Disability Benefits Commission</b>	<b>Independent Review Group</b>	<b>GWOT Task Force</b>	<b>PCCWW</b>
<b>Family Support</b>	Authorize VA to provide family services, Extend health care & allowance to caregivers, Eliminate SBP-DIC offset, Eliminate Tricare co-pays & deductibles for severely injured families	Provide family education on benefits, Survey families on their needs, Assign family advocates	None	Strengthen support for families through Tricare Respite Care & *Aide and Attendant Benefit, Caregiver training, Extend FMLA for 6 months, All combat-related injured families should have full Tricare coverage.
<b>IT Compatibility</b>	Expedite development & implementation of compatible information systems with a detailed plan, milestones, & lead agency, Use IT to improve claims cycle time	Streamline transition by rapidly developing a standard automated system interface for a bilateral exchange of clinical and administrative info between DoD & VA (Described in 2003 PTF)	Enhance VA computerized Patient Record System & electronic enrollment, VA needs to develop a patient tracking application compatible with DoD, Create a TBI database, Improve VA's access to military health records & create an interface with DoD, Create OIF/OEF identifiers and markers for polytrauma, Improve IT interoperability between VA & HHS Indian Health Services.	Rapidly transfer patient information, Create a <i>MyeBenefits</i> website

<b>Topic</b>	<b>Veterans' Disability Benefits Commission</b>	<b>Independent Review Group</b>	<b>GWOT Task Force</b>	<b>PCCWW</b>
<b>PTSD</b>	Holistic approach that couples treatment, rehabilitation, compensation & re-evaluation for wellness, Revise Rating Schedule for PTSD, Baseline level of benefits, PTSD exam process, Examiner & rater training & certification, research on Military Sexual Trauma	Functional/cognitive measures & screenings upon entry & post-deployment, comprehensive & universal clinical practice & coding guidelines for blast injuries and TBI with PTSD overlay to include recording of exposures to blast in patient record. VA/DoD create center of excellence for TBI and PTSD treatment, research & training	Provide Outreach & Education to Community Health Centers on VA benefits & services (to reach vets with PTSD)	VA should care for all OIF/OEF vets with PTSD & (with DoD) improve prevention, diagnosis & treatment, reduce PTSD stigma. DoD should address its mental health shortage, Disseminate clinical practice guidelines to all providers
<b>TBI</b>	Update the Rating Schedule for TBI	Functional/cognitive measures & screenings upon entry & post-deployment, comprehensive & universal clinical practice & coding guidelines for blast injuries and TBI with PTSD overlay to include recording of exposures to blast in patient record. VA/DoD create center of excellence for TBI and PTSD treatment, research & training	Screen all GWOT veterans for TBI	DoD/VA should prevent, diagnose, & treat TBI, Partner with the private sector on TBI care, Disseminate clinical practice guidelines to all providers

<b>Topic</b>	<b>Veterans' Disability Benefits Commission</b>	<b>Independent Review Group</b>	<b>GWOT Task Force</b>	<b>PCCWW</b>
<b>Ancillary Benefits</b>	Adjust & extend A&A, Extend auto & housing allowances to veterans with severe burns, Eliminate TSGLI premiums, Improve SDVI & VMLI, Increase benefits to original intention, Adjust automatically for inflation, Provide a Stabilization Allowance, Research additional ancillary benefits	DoD should partner with VA to provide treatment, education & research in prosthesis care, production & amputee therapy, Allow VA patients to use Military and private prosthetist	Expedite Adapted Housing and Special Home Adaptation Grants, Expand HUD National Housing Locator, Enhance capacity to provide Dental care through VA & private sector.	Transition (3 months of base pay or long-term) payments, Earnings-loss payments, All unfit combat-related injured should receive full Tricare coverage.
<b>Quality of Life</b>	Compensate for 3 consequences: work disability, loss of functionality & QOL, VA develop measures for QOL loss, but in the meantime create up to 25% QOL payment, Research health-related QOL & need for additional ancillary benefits, Increase SMC to address impact on QOL,	Survey patients on their needs.	None	Determine appropriate QOL payments

<b>Topic</b>	<b>Veterans' Disability Benefits Commission</b>	<b>Independent Review Group</b>	<b>GWOT Task Force</b>	<b>PCCWW</b>
<b>Vocational Rehabilitation &amp; Employment (VR&amp;E)</b>	Test VR&E incentives, Review & revise 12-year time limit, Expand VR&E to all medically separating service members, & allow all service disabled veterans access to VR&E counseling, VR&E should screen all IU applicants, increase VR&E staffing, tracking, & resources,	None	Extend VR&E evaluation determination time limit, Expand eligibility for SBA Patriot Express Loans, Increase Career Fairs & integrate Hire Vets First Campaign, Provide Credentialing, Certification, Financial Aid Education Assistance, & Employment rights, Develop Wounded Warrior Intern & Wounded Veterans Readjustment Work Experience Programs,	VR&E effectiveness is not well established and should offer completion incentives of up to a 25% bonus
<b>Concurrent Receipt</b>	Eliminate the ban	None	None	Create a DoD Annuity payment based on rank & years of service
<b>Hazards &amp; Exposures</b>	Create a new structure for Presumption based on casual relationship using four categories	None	Create an embedded Fragment Surveillance Center and Registry	None

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

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

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

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

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

**Table 3 - Total Recommendations**

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

**Honoring the Call to Duty:  
Veterans' Disability Benefits in the 21st Century**

**Veterans' Disability Benefits Commission  
October 2007**

**EXECUTIVE SUMMARY**

## Executive Summary

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

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

The Commission received extensive analytical support from the CNA Corporation

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

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

Additionally, the Commission conducted eight field visits and held numerous public sessions.

### **Guiding Principles**

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

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

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

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

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

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

differentiate the value of sacrifice among veterans whose disabilities are of similar type and severity. Setting different rates of compensation for the same degree of severity would be both impractical and inequitable.

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

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

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

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

## **Results of the Commission's Analysis**

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

### **Ensure Horizontal and Vertical Equity**

For veterans to receive proper compensation for their service-connected disabilities,

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

### **Ensure Parity with Non-Disabled Veterans**

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

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

### **Compensate for Loss of Quality of Life**

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

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

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

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

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

### **Update the Rating Schedule**

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

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

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

### **Individual Unemployability**

The Individual Unemployability (IU) program enables a veteran rated 60 percent or more but less than 100 percent to receive benefits at the 100 percent rate if he or she is unable to work due to service-connected disabilities. IU has received considerable attention recently because the number of veterans granted IU increased by 90 percent. The Commission found this increase to be explained by the aging of the cohort of Vietnam veterans.

### **Develop PTSD-Specific Rating Criteria and Improve PTSD Treatment**

Concerning PTSD and other mental disorders, it is very clear that having one set of

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

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

### **Vocational Rehabilitation and Employment (VR&E)**

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

### **Allow Concurrent Receipt**

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

In addition, the Commission believes that those separated as medically unfit with less than 20 years of service should also be able to receive military retirement and VA compensation without offset. Currently, those receiving ratings of less than 30 percent from DoD receive separation pay, which must be paid back through deductions from VA compensation for the unfitting conditions before VA compensation is received. Those receiving DoD ratings of 30 percent or higher and a continuing disability retirement have their DoD payments offset by any VA compensation. Priority among medical discharges should be given to those separated or retired with less than 20 years of service and disability rating greater than 50 percent or disability as a result of combat.

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

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

SSDI or are being denied the insurance. Increased outreach should be made and better coordination between VA and Social Security should result in increased mutual acceptance of decisions.

### **Realign the VA-DoD Process for Rating Disabilities**

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

The Commission finds that the policies and procedures used by VA and DoD are not consistent and the resulting dual systems are not in the best interest of the injured service members nor the nation. Existing practices that allow service members to be found unfit for pre-existing conditions after up to eight years of active duty and that allow DoD to rate only the conditions that DoD finds unfitting should be re-examined. Service members being considered unfit should be given a single, comprehensive examination and all identified conditions should be rated and compensated.

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

### **Link Benefits to Cost-of-Living Increases**

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

### **Simplify and Expedite the Processing of Disability Claims and Appeals**

VA disability benefits and services are not currently provided in a timely manner. Court decisions, statutory changes, and resource limitations have all contributed to this unacceptable situation. Numerous studies over the years have assessed the processing of both claims and appeals and have made numerous recommendations for change. Still, veterans seeking disability compensation face a complex process. The population of veterans is steadily decreasing with the passing of veterans of World War II and Korea. Yet, the aging of the Vietnam Era veterans means that they are filing original and re-opened claims in large numbers. Technology offers opportunities for improvement, but is unlikely to solve all problems. The Commission believes that increased reliance on best business practices and maximum use of information technology should be coupled with a simplified and expedited process for well-documented claims to improve timeliness and reduce the backlog. The Commission is aware that a significant increase in claims processing staff has been recently approved but is also aware that the time required for training and the slow development of job experience will limit the speed with which results can realistically occur.

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

### **Improve Transition Assistance**

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

### **Improve Support for Severely Disabled Veterans and their Caregivers**

Severely disabled service members who are about to transition into civilian life need far more support and assistance than is currently provided. An effective case management program should be established with a clearly identified lead agent who has authority and responsibility to intercede on behalf of disabled individuals. The lead agent should be an advocate for service members and their families. In addition, VA should be authorized to provide family assistance similar to that provided by DoD up until discharge. Tricare deductibles and copays are costs incurred by the severely

disabled; the Commission believes that these costs should be waived. In addition, consideration should be given to expanding health care and providing an allowance for caregivers of the severely disabled. Currently, health care is only provided for the dependents of severely disabled veterans but not for parents and other family members who are caregivers.

### **Implement a New Process for Determining Presumption**

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

### **Conclusion**

The Commission made 113 recommendations. All are important and should receive attention from Congress, DoD, and VA. The Commission suggests that the following recommendations receive immediate consideration. Congress should establish an executive oversight group to ensure timely and effective implementation of the Commission recommendations.

### **Priority Recommendations**

#### **Recommendation 4.23**

#### **Chapter 4, Section I.5**

VA should immediately begin to update the current Rating Schedule, beginning with those body systems addressing the evaluation and rating of posttraumatic stress disorder and other mental disorders and of traumatic brain injury. Then proceed through the other body systems until the Rating Schedule has been comprehensively revised. The revision process should be completed within 5 years. VA should create a

system for keeping the Rating Schedule up to date, including a published schedule for revising each body system.

**Recommendation 5.28**

**Chapter 5, Section III.3**

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

**Recommendation 5.30**

**Chapter 5, Section III.3**

VA should establish a holistic approach that couples posttraumatic stress disorder treatment, compensation, and vocational assessment. Re-evaluation should occur every 2–3 years to gauge treatment effectiveness and encourage wellness.

**Recommendation 6.14**

**Chapter 6, Section IV.2**

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

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

**Recommendation 7.5**

**Chapter 7, Section II.3**

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

**Recommendation 7.6**

**Chapter 7, Section II.3**

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

**Recommendation 7.7**

**Chapter 7, Section III.2**

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

**Recommendation 7.9**

**Chapter 7, Section III.2**

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

**Recommendation 7.10**

**Chapter 7, Section III.2**

Congress should enact legislation that would bring the ancillary and special purpose benefits to the levels originally intended considering cost of living and provide for automatic annual adjustments to keep pace with cost of living.

**Recommendation 7.14**

**Chapter 7, Section III.3**

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

**Recommendation 8.2**

**Chapter 8, Section III.1.B**

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

**Recommendation 9.1**

**Chapter 9, Section II.5.A.b**

Improve claims cycle time by:

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

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

**Recommendation 10.11**

**Chapter 10, Section VII**

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

**Recommendation 11.1**

**Chapter 11**

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

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

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

Also available on the Commission's website are:

- [Bios](#) of the Commissioners
- [Commission Charter](#)
- [Commission Charter](#) (renewed, 2-21-2007)
- [Public Law 108-136](#) establishing the Commission
- [Extension](#) of the Commission's Charter in Public Law 109-163
- [Legislative History](#) of VA Disability Compensation Program, Economic Systems Inc., Dec 2004
- [Appendices](#) to the Legislative History (Dec 2004)
- [Literature Review](#) of VA Disability Compensation Program, Economic Systems Inc., Dec 2004
- [Appendices](#) to the Literature Review (Dec 2004)
- Commission's [Approved Research Questions](#), October 14, 2005
- Institute of Medicine ([IOM](#)) [Summary of the PTSD Review](#) contracted by the Veterans Health Administration, Mar 2006
- [A History and Analysis of Presumptions of Service Connection \(1921-1993\)](#)
- An Updated Legal Analysis of Presumptions of Service Connection ([1993-2006](#))
- Center for Naval Analyses ([CNA](#)) [Literature Review](#) (Final), May 2006
- [Appendix](#) to the CNA Literature Review (Final), May 2006
- [Veterans' Claims Adjudication Commission \(VCAC\)](#), also known as the Melidosian Commission Report (1996)
- [Blue Ribbon Panel on Claims Processing: Proposals to Improve Disability Claims Processing in the Veterans Benefits Administration](#), November 1993
- [Bradley Commission Report](#) 1956
- IOM Report to VA on [Posttraumatic Stress Disorder: Diagnosis and Assessment](#), 2006
- [Testimony of Chairman Scott](#) at a Joint Hearing of the Senate Armed Services & Veterans' Affairs Committees, April 12, 2007
- CNA Report: [Findings from Raters and VSOs Surveys](#), May 2007
- IOM Report to VA on [PTSD Compensation and Military Service](#), 2007
- [A 21st Century System for Evaluating Veterans for Disability Benefits](#), IOM Final Report, June 2007
- [Improving the Presumptive Disability Decision-Making Process for Veterans](#), IOM Final Report, and [Executive Summary](#) August 2007
- CNA Final Report: [Final Report for the Veterans' Disability Benefits Commission: Compensation, Survey Results and Selected Topics](#), August 2007