JOHN L. WILSON, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS

STATEMENT OF
JOHN L. WILSON
ASSISTANT NATIONAL LEGISLATIVE DIRECTOR
OF THE
DISABLED AMERICAN VETERANS
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE
SEPTEMBER 17, 2009

Mr. Chairman, Ranking Member and Members of the Committee.

I am pleased to have this opportunity to appear before you on behalf of the Disabled American Veterans (DAV), to address the report to the Secretary of the Department of Veterans Affairs (VA) by the Advisory Committee on Disability Compensation.

The Advisory Committee focused on the necessity and methodology of updating the VA's Schedule of Rating Disabilities or VASRD; transition compensation adequacy and sequencing for service members moving to veterans' status; and quality of life compensation.

The importance of a systematic review and update of the VASRD, in our view, is a priority, as it is the source of all disability compensation ratings. It is a rating scheme that addresses illnesses and conditions that run into the hundreds, and as such, should reflect the most recent medical findings in each and every case. DAV agrees with the Advisory Committees' assessment that a systematic process is lacking and that one is a necessity. The Committee offered the following recommendations, with all of which we agree:

(1) The Deputy Secretary of the VA should be tasked with providing oversight of the VASRD process, and of ensuring that the Veterans Health Administration (VHA) and Office of the General Counsel (OGC) are fully integrated in the Veterans Benefits Administration's (VBA's) process;

(2) Immediately increase staff at the VBA to 9 full-time employees (FTE) for the purpose of continuously reviewing and updating the VASRD. The staff should include a coordinating administrative person and two sub-teams comprised of one medical expert, two legal specialists, and one administrative support staff each. This staff should be assigned to the Compensation and Pension Service (C&P) for administrative purposes; and

(3) As part of its new role as full partner in the VASRD review process, VHA must establish a permanent administrative staff to participate in VASRD review. The VHA administrative staff should include at least one permanent party medical expert. This staff member should have the authority to liaise with VBA, assign medical staff from VHA to participate in VBA body system reviews, and to coordinate with other medical experts as appropriate.

Staffing within the VHA and VBA must be allocated towards this task. It is a positive step to include the medical expertise from the VHA into this process. Although previous sources of expertise such as the Institute of Medicine contributed to this body of work, the experiential expertise that VHA professionals will bring to the discussion, with a decades-long role in providing medical care to veterans, should prove invaluable to this endeavor and well worth the additional staffing.

The various stakeholders must also have a voice in this process. Such a collaborative effort by all parties helps to dispel any misperceptions and missteps.

Additionally, VA's leadership must ensure oversight and successful implementation of this important recommendation. It was anticipated that VA's commitment to the systematic updating of the VASRD would have carried forward and been reflected in its strategic plan. Is not the VASRD the key source of all disability ratings? However, a search of VA's fiscal year (FY) 2006-2011 Strategic Plan finds no mention of the VASRD. The need for an update of the VASRD is instead referenced in the FY 2008 Performance and Accountability Report, as a result of a U.S. Government Accountability Office (GAO) update to its High-Risk Series (GAO-07-310), GAO High-Risk Area #1: Modernizing Federal Disability Program. The VA would be well served to add the very language of this section of the Advisory Committee's report to its Strategic Plan as its map for the systematic updating of the VASRD.

As noted earlier, while we agree that a rewrite of sections of the VASRD is appropriate, DAV would oppose an approach that required a complete revamping of the 1945 rating schedule. Generally, the VASRD has served America's disabled veterans quite adequately. It incorporates a policy of "average impairment," and that policy has treated all veterans with like disabilities equally and fairly, in spite of age, education or work experience. It also encourages disabled veterans to seek vocational rehabilitation training in order to become a more productive wage earner without penalty for doing so. Understandably, the VASRD has been modified and upgraded many times when advances in medical science dictates a change in a particular disability rating might be necessary, or additions to the Schedule have been incorporated to cover injuries, infirmities and illnesses unique to some theatre of operations. We agree with the Advisory Committee that the VASRD be updated in a systematic fashion, based on sound medical principles, provided there are no wholesale changes and, when change is necessary, it is based on the above principles.

We also agree with the body system prioritization the Committee offers, beginning with mental health disorders. It is essential that different criteria be formulated to evaluate the various mental disorders under the appropriate psychiatric disorder. Criteria for evaluating mental disorder under title 38, Code of Federal Regulations, Section 4.130, are very ambiguous. For example, schizophrenia and other psychotic disorders, delirium, dementia, and amnestic and other cognitive disorders, anxiety disorders, dissociative disorders, somatoform disorders, mood disorders, and chronic adjustment disorders, are all evaluated using the same general rating formula for mental disorders. The Diagnostic and Statistical Manual for Mental Disorders (DSM IV) specifically lists different symptoms for posttraumatic stress disorder, schizophrenia, and other psychiatric disorders. One veteran service connected for schizophrenia and another veteran service connected for another psychiatric disorder should not be evaluated using the same

general formula. Therefore, the DAV supports amendment of title 38, Code of Federal Regulations, section 4.130, to formulate different criteria to evaluate the various mental disorders under the appropriate psychiatric disorder and is pleased to see the Advisory Committee place mental disorders as the first to be considered in this systematic review.

The next area the Advisory Committee addressed was Quality of Life (QOL). While the VASRD focuses its ratings and subsequent compensation as a result of loss of income when compared to civilian contemporaries, QOL is a separate but related category. The Advisory Committee's recommended definition of "An overall sense of well-being based on physical and psychological health, social relationships, and economic factors," is acceptable. Given an acceptable definition, the next question is should a loss of QOL be compensated? We believe the answer is yes. A veteran's quality of life generally decreases as the severity of their disabilities increases. The Advisory Committee reasons that the VA's providing additional monetary assistance through Special Monthly Compensation (SMC) is, at a minimum, an inferred QOL compensation program.

SMC is a rate paid in addition to disability compensation (i.e., SMC (K)). And this compensation can be viewed as an inferred payment for a decrease in quality of life. To qualify, a veteran must be disabled beyond a combined degree percentage or due to special circumstances such as the loss or loss of use of specific organs or extremities. SMCs are referred to by the letters (K) through (R.2). These alphabetic designations follow the paragraph numbering system in title 38, United States Code § 1114 .

While following the Advisory Committee's recommendation to change the reference from "Quality of Life" to "non-economic loss," clarifying the definition may prove helpful, DAV agrees that additional benefits/compensation should be provided to veterans. Eligibility criteria for non-economic loss should be clear, precise, and objective in order to reduce uncertainty about the benefit's purpose, inconsistent application of eligibility criteria and perceptions of unfairness. We look forward to working with VA and Congress to create legislation and a framework for controlled growth of this program.

The Advisory Committee has also recommended the use of International Classification of Diseases (ICD) codes being added to the VASRD where there is a direct correlation between an ICD code and a VASRD diagnostic code. The DAV has no resolution on this issue.

The next area for future study has to do with reporting on the inadequacies of the Vocational Rehabilitation and Employment Program. According to a January 2009 GAO report, the "program [has] not fulfilled its primary purpose, which is to ensure that veterans obtain suitable employment."

The GAO Report summary noted:

"In 2004, the Veterans Affairs' Vocational Rehabilitation and Employment (VR&E) program was reviewed by a VR&E Task Force. It recommended numerous changes, in particular focusing on employment through a new Five-Track service delivery model and increasing program

capacity. Since then, VR&E has worked to implement these recommendations. To help Congress understand whether VR&E is now better prepared to meet the needs of veterans with disabilities, GAO was asked to determine (1) how the implementation of the Five-Track Employment Process has affected VR&E's focus on employment, (2) the extent to which VR&E has taken steps to improve its capacity, and (3) how program outcomes are reported. GAO interviewed officials from VR&E, the 2004 Task Force, and veteran organizations; visited four VR&E offices; surveyed all VR&E officers; and analyzed agency data and reports."

"By launching the Five-Track Employment Process, VR&E has strengthened its focus on employment, but program incentives have not been updated to reflect this emphasis. VR&E has delineated its services into five tracks to accommodate the different needs of veterans, such as those who need immediate employment as opposed to those who need training to meet their career goal. However, program incentives remain directed toward education and training. Veterans who receive those services collect an allowance, but those who opt exclusively for employment services do not. While VR&E officials said they believed it would be helpful to better align incentives with the employment mission, they have not yet taken steps to address this issue. VR&E has improved its capacity to provide services by increasing its collaboration with other organizations and by hiring more staff, but it lacks a strategic approach to workforce planning. Although there have been staff increases, many of VR&E's regional offices still reported staff and skill shortages. The program is not addressing these workforce problems with strategic planning practices that GAO's prior work has identified as essential. For example, VR&E officials have not fully determined the correct number of staff and the skills they need to serve current and future veterans. VA does not adequately report program outcomes, which could limit understanding of the program's performance. Specifically, it reports one overall rehabilitation rate for veterans pursuing employment and those trying to live independently. Computing each group's success rate for fiscal year 2008, GAO found a lower rate of success for the majority seeking employment and a higher rate of success for the minority seeking independent living than the overall rate. GAO also found that VR&E changed the way it calculates the rehabilitation rate in fiscal year 2006, without acknowledgments in key agency reports. VA noted the change in its fiscal year 2006 performance report, but did not do so for its fiscal year 2007 and 2008 reports, or for its fiscal year 2008 and 2009 budget submissions. Such omissions could lead to misinterpretation of program performance over time."

While VA has contracted a study with Econ Systems to review the VRE program and plans to complete a study workforce planning study in FY 2010, DAV and others have commented previously that the VR&E subsistence allowance is insufficient, which causes veterans to avoid entering the program or exiting it prematurely.

DAV supports legislation that offers limited dual entitlement to vocational rehabilitation and employment chapter 31, and the post-9/11 education assistance program under chapter 33 in order to ensure that disabled veterans are not forced to choose the lesser of two benefits. Our nation established veterans' programs to repay or reward veterans for their extraordinary service and sacrifices on behalf of their fellow citizens, especially those veterans disabled as a result of military service. These programs include the VR&E program for service-connected disabled veterans with employment handicaps as well as the post-9/11 GI Bill under title 38, United States Code, chapter 33 (GI Bill). The GI Bill currently provides a more financially lucrative

subsistence allowance than does the current VR&E Chapter 31 program. Such a disparity will ultimately force service-connected disabled veterans with employment handicaps to either utilize a program less financially supportive to them and their families than their non-disabled counterparts, or opt out of vocational rehabilitation for the more financially beneficial post 9/11 GI Bill.

Subsistence allowances must be comparable, regardless of program, to ensure maximum participation and maximum benefit, whether it is assisting veterans in finding employment, participation in vocational rehabilitation or other services. The basis of that decision must never be based on its financial incentives when compared to various VA programs.

The issue of the transition from active duty status to veteran status is also a subject of future study and we look forward to participating in these discussions as well. DAV notes that there are existing programs that prove invaluable during this transition period, but are in need of additional funding. An area where Congress could act now is by providing increased funding for the Transition Assistance Program (TAP) and the Disabled Transition Assistance Program (DTAP). The transition from military service to civilian life is very difficult for most veterans, who must overcome many obstacles to successful employment. TAP and DTAP were created with the goal of furnishing separating service members with vocational guidance to aid them in obtaining meaningful civilian careers and their continuation is essential to easing some of the problems associated with transition. Unfortunately, the level of funding and staffing is inadequate to support the routine discharges per year from all branches of the Armed Forces.

Additionally, Congress could enact legislation supporting licensure and certification of active duty personnel. The Department of Defense (DOD) provides some of the best vocational training in the nation for its military personnel. DOD establishes, measures, and evaluates performance standards for every occupation within the Armed Forces. There are many occupational career fields in the Armed Forces that can easily translate to a civilian occupation but there are many occupations in the civilian workforce that require a license or certification. The Armed Forces occupational standards meet or exceed the civilian license or certification criteria yet many former military personnel, certified as proficient in their military occupational career, are not licensed or certified to perform a comparable job in the civilian workforce. This situation creates an artificial barrier to employment upon separation from military service. A study by the Congressional Commission on Service-members' and Veterans' Transition Assistance identified several military professions in which civilian credentialing is required for employment in the private sector. Congress could enact legislation to eliminate employment barriers that impede the transfer of military job skills to the civilian labor market by requiring the DOD to take appropriate steps to ensure that servicemembers be trained, tested, evaluated, and issued any licensure or certification that may be required in the civilian workforce. Simultaneously, Congress could amend legislation and make GI Bill eligibility available to pay for all necessary civilian license and certification examination requirements, including necessary preparatory courses to increase the civilian labor market's acceptance of the occupational training provided by the military.

Another area for Congressional action could come with modification of the Omnibus Budget Reconciliation Act of 1982 (Public Law 97-253, now title 38, United States Code 511), which

currently prohibits disability compensation payments until the first day of the second month after the VA grants a disability rating. A rewrite would allow the newest veterans to receive disability compensation at the end of the first month after discharge.

In reference to family care-giver support, the Advisory Committee noted the Veterans Disability Benefits Commission (VDBC) cited gaps in services when service members leave active duty and transfer to VA under title 38, United States Code. The VDBC recommended that Congress should authorize and fund VA to establish and provide support services for the families of severely injured veterans similar to those provided by DOD. In a separate but related issue, under the issue heading Services as a Disability Benefit, it noted that VA could directly provide respite services for family members of severely disabled veterans who provide daily aid and attendance and indirectly provide services such as seed or grant money to encourage individuals, groups, and/or non-profit organizations to develop and implement programs for veterans and their families. Additionally, VA could establish a clearinghouse for identification, referral, and support of existing and newly emerging programs.

DAV supports legislation to create a comprehensive program through which family members of severely wounded veterans can receive VA training, certification, counseling, respite, a family allowance and health coverage under CHAMP VA. The Advisory Committee is focusing on two aspects of disability compensation as it pertains to family care-giving. These are the impact on families when the service member transfers from DOD to VA, and the long-term roles and needs of family caregivers.

DAV has testified before the House Veterans' Affairs Subcommittee on Health on June 4, 2009 and on February 28, 2008 regarding the issue of family caregivers. Informal caregivers play a critical role in facilitating recovery and maintaining the veteran's independence and quality of life while residing in their community, and are an important component in the delivery of health care by the VA. These family members, relatives, or friends are motivated by empathy and love, but the very touchstones that have defined their lives – careers, love relationships, friendships, and their own personal goals and dreams – have been sacrificed, and they face a daunting lifelong duty as caregivers. Research has found that all too often the role of informal caregiver exacts a tremendous toll on that caregiver's health and well-being.

Family caregiving has been associated with increased levels of isolation, depression and anxiety, higher use of prescription medications, compromised immune function, poorer self-reported physical health, and increased mortality. Research also suggests that caregiver support services can help to reduce adverse health outcomes arising from caregiving responsibilities and can improve overall health status.

Despite these documented physical and psychological hardships and knowledge of effective interventions against caregiver burden, family caregivers of disabled veterans receive little support from VA, compromising their ability to provide care to their loved one. Accordingly, the delegates to our most recent National Convention, held in Denver, Colorado, August 22-25, 2009, approved a resolution calling for legislation that would provide comprehensive supportive services, including but not limited to financial support, health and homemaker services, respite, education and training and other necessary relief, to immediate family member caregivers of veterans severely injured, wounded or ill from military service.

The last area to be addressed has to do with the relationship between level of Individual Unemployability (IU) and VR&E. Modern concepts of disability largely preclude the concept of "unemployable" except in the case of the most catastrophically disabled. For that reason, the Committee is considering whether a finding of IU should occur only after or in conjunction with some level of the VR&E services. DAV's position is that determinations of IU are the province of medical professionals familiar with their patients' history. VR&E personnel, although skilled in their areas of expertise, do not have the medical perspective essential to the proper determination as to whether a veteran should be diagnosed as unemployable.

CONCLUSION

DAV looks forward to a continuing dialogue on the issues of the necessity and methodology of updating the VASRD, transition compensation adequacy and sequencing for service members moving to veteran status and QOL compensation that were the focus of the Advisory Committee. As we move forward it is a necessity that a transparent process be set in place to address each of these sensitive issues. We should not have to offer reminders this late in the game about the important perspective that veterans service organizations bring to discussions on topics such as these. Talking openly and discussing potential changes will help resolve the understandable angst about these complex and important questions. The time to act is now—our nation's veterans deserve no less than our best effort.

Thank you, Mr. Chairman and Members of the Committee for allowing DAV to share our views on this critical topic.