Joyce McMahon, PhD, Managing Director, Center for Health Research and Policy, CNA Corporation Accompanied by: Eric Christensen, PhD, Senior Project Director, Center for Health Research and Policy, CNA Corporation

Testimony for the Senate Committee on Veterans' Affairs on the Findings and Recommendations of the Veterans' Disability Benefits Commission

Chairman Akaka, Senator Burr, distinguished members, I appreciate the opportunity to testify before the Senate Committee on Veterans' Affairs today on the subject of the findings and recommendations of the Veterans' Disability Benefits Commission (VDBC). This testimony is based on the findings reported in Final Report for the Veterans' Disability Benefits Commission: Compensation, Survey Results, and Selected Topics, by Eric Christensen, Joyce McMahon, Elizabeth Schaefer, Ted Jaditz, and Dan Harris, of the CNA Corporation (CNA). Details on the specific findings discussed here can be found in the report, which is available at http://www.cna.org/domestic/healthcare/.

The Commission asked CNA to help assess the appropriateness of the benefits that the Department of Veterans Affairs (VA) provides to veterans and their survivors for disabilities and deaths attributable to military service. Our overall focus was to provide analyses regarding the appropriateness of the current benefits program for compensating for loss of average earnings and degradation of quality of life resulting from service-connected disabilities for veterans. We also evaluated the impact of VA compensation for the economic well-being of survivors and assessed their quality of life.

In addition, the Commission asked us to address additional topics, including:

- Disincentives for disabled veterans to work or to receive recommended treatment.
- Surveys of raters and Veterans Service Officers with regard to how they perceive the processes of rating claims and assisting applicants.
- Comparing the VA disability compensation program to other disability programs
- Evaluating offering a lump sum option to some service-disabled veterans.
- Individual unemployability (IU), mortality, and Social Security Disability Income
- Comparing DOD disability determinations to those conducted by the VA.

Earnings comparisons for service-disabled veterans

Our primary task was to answer the question of how well the VA compensation benefits serve to replace the average loss in earnings capacity for service-disabled veterans. Our approach identified target populations of service-disabled veterans and peer or comparison groups (non-service-disabled veterans) and obtained data to measure earned income for each group. We also investigated how various factors such as disability rating, type of disability, and age impact earned income. Finally, we compared lifetime earned income losses for service-disabled veterans to their lifetime VA compensation, adjusting for expected mortality and discounting to present value terms, to see how well VA compensation replaces lost earning capacity.

Congressional language indicates that the intent of VA compensation is to provide a replacement for the average impairment in earning capacity. VA compensation is not an individual means-tested program, although there are minor exceptions to this. Therefore, we focused on average

losses for all service-disabled veterans and for subgroups. We defined the subgroups of disabled veterans, through consultation with the Commission, on the body system of the primary disability (16 in all) and on the total combined disability rating (10 percent, 20-40 percent, 50-90 percent, and 100 percent disabled). In addition, we further split the 50-90-percent disabled group into those with and without individual unemployability status (IU). After meeting certain disability criteria as well as providing evidence that they are unable to engage in substantial gainful employment, IU disabled veterans receive compensation at the 100-percent disabled level.

To make earnings comparisons over a lifetime, it is necessary to have a starting point. In other words, a young service-disabled veteran will have a long period of lost earnings capacity during prime wage-earning years, while a veteran who enters into the VA disability compensation system at an older age will face reduced earnings capacity for a smaller number of years. If a veteran first becomes eligible for VA compensation at age 65 or older, the average expectation of lost earnings is very low, because a large share of individuals are retired or planning to retire soon by this age. The data show that the average age of entry into the VA compensation system is about 55 years, although many enter at a younger or older age. Also, the average age of entry varies somewhat across the body systems of the primary disability and combined degree of disability.

We looked at average VA compensation for all male service-disabled veterans, and found that they are about at parity with respect to lost earnings capacity at the average age of entry (55). We compared the discounted present value of their lifetime expected earnings to the earnings of their peer group (i.e., veterans who were not service disabled). To calculate expected earnings parity, we took the ratio of service-disabled earned income plus VA compensation divided by the present value of total expected earnings for the peer group. This figure is 0.97, which is near parity. A ratio of exactly 1 would be perfect parity, indicating that the earnings of disabled veterans, plus their VA compensation, give them the same lifetime earnings as their peers. A ratio of less than one would mean that the service-disabled veterans receive less than their peers on average, while a ratio of greater than one would mean that they receive more than their peers.

We also evaluated the parity of earned income and VA compensation for service-disabled veterans compared to the peer group by disability rating group and age at first entry into the VA compensation system. Our findings indicate that it is important to distinguish whether the primary disability is a physical or a mental condition. We found that there is not much difference in the results among physical body systems (e.g., musculoskeletal, cardiovascular), and for mental disabilities, it does not matter much whether the disability is for PTSD or some other mental disability.

Examining veterans with a physical primary disability, our findings indicate that service-disabled veterans are generally at parity at the average age of first entry into VA compensation system (50 to 55 years of age). However, we observed earnings ratios substantially below parity for service-disabled veterans who were IU, and slightly below parity for those who were 100-percent disabled, who entered at a young age. Those who first entered at age 65 or older were generally above parity.

For veterans with a mental primary disability, we found that their earnings ratios were generally below parity at the average age of entry, except for the severely disabled (IU and 100-percent disabled). We found that the severely disabled who enter at a young age are substantially below parity. Those who entered at age 65 or older generally were above parity, except for the 10-percent disabled group, which was still slightly below parity.

To summarize the earnings ratio findings for male veterans, there is general parity overall. However, when we explored various subgroups, we found that some were above parity, while others were below parity. The most important distinguishing characteristic is whether the primary disability is physical or mental. In general, those with a primary mental disability have lower earnings ratios than those with a primary physical disability, and many of the rating subgroups for those with a primary mental disability had earnings rates below parity. In addition, entry at a young age is associated with below parity earnings ratios, especially for severely disabled subgroups.

Veterans' quality-of-life survey results

The second principal tasking from the Commission was to assess whether the current benefits program compensates not just for loss of average earnings, but also for veterans' quality-of-life degradation resulting from service-connected disability. Addressing this issue required collecting data from a representative sample of service-disabled veterans, which would allow us to estimate their average quality of life. To do this, we constructed, in consultation with the Commission, a survey to evaluate the self-reported physical and mental health of veterans and other related issues. CNAC's subcontractor, ORC Macro, conducted the survey and collected the data. As with the earned income analysis, we designed the survey to collect data by the major subgroup. We defined subgroups by the body system of the primary disability and combined disability rating, and three SMC categories. We were also able to characterize the survey results by IU status within the 50- to 90-percent disabled subgroup.

The survey utilized 20 health-related questions taken from a standardized bank of questions that are widely used to examine heath status in the overall population. These questions allowed us to calculate a physical health summary score (physical component summary, or PCS) and a mental health summary score (mental component summary, or MCS). This approach is widely used to measure health status in a variety of national surveys, and it allowed us to compare the results for the service-disabled veterans to widely published population norms. We also calculated five additional health subscales that also have widely published population norms.

For evaluating the survey, we analyzed the results by subgroup similar to the strategy we used for comparing earnings ratios. We looked at those with a primary physical disability and those with a primary mental disability separately. We also examined the PCS and MCS scores for additional subgroups within those categories. For the population norms, the PCS average is set at 50 points, and the norms decrease slightly with age. For the MSC scores, the population norm is quite flat at an average of 50, and decreases only for the oldest age categories.

For service-disabled veterans with a primary physical disability, we found that their PCS measures were below population norms for all disability levels, and that the scores were in general lower as the disability level increased. In addition, having a primary physical disability was not generally associated with reduced mental health as measured by MCS. Mental health

scores for those with a primary physical disability were close to population norms, although those who were severely disabled had slightly lower mental scores.

For service-disabled veterans with a primary mental disability, we found that both the physical and mental component summary scores were well below population norms. This was true for each of the rating groups. This was a distinction from those with a primary physical condition, who (except for the severely disabled) did not have MCS scores below population norms.

To summarize our overall findings, as the degree of disability increased, generally overall health declined. There were differences between those with physical and mental primary disabilities in terms of physical and mental health. Physical disability did not lead to lowered mental health in general. However, mental disability did appear to lead to lowered physical health in general. For those with a primary mental disability, physical scores were well below the population norms for all rating groups, and those with PTSD had the lowest PCS values.

We also used the Veterans Survey to investigate other issues that the Commission raised. First, we investigated whether service-disabled veterans tended to not follow recommended medical treatments because they felt it might impact their disability benefits. We used a series of indirect questions to ascertain this information. We found that this does not appear to be an issue.

In addition, the Commission asked us to investigate whether VA benefits created a disincentive to work for service-disabled veterans. Again, we used a series of indirect questions to ascertain this information. For example, a disincentive to work might be seen through working part-time instead of full-time, or retiring early. We did not find this to be a major issue, as only 12 percent of the service-disabled veterans indicated that they might work, or work more, if it were not for their VA benefits. However, it could be that these individuals felt that they would have no choice but to work more, if they had no VA benefits, and that it might be quite difficult for them to actually work more.

Combining earnings and quality-of-life findings for service-disabled veterans

The quality-of-life measures allow us to examine earnings ratio parity measures in the context of quality-of-life issues. In essence, the earnings parity measures allow an estimate of whether the VA compensation benefits provide an implicit quality-of-life payment. If a subgroup of service-disabled veterans has an earnings ratio above parity, they are receiving an implicit quality-of-life payment. At parity, there is no quality-of-life payment, and those with a ratio less than parity are effectively receiving a negative quality-of-life payment. We turned next to considering the implicit quality-of-life payment in the context of the veterans' self-reported health status.

With regard to self-reported quality of life, we had multiple measures to consider, such as the PCS and MCS measures, and a survey question on overall life satisfaction. In addition, there is no intrinsic valuation of a PCS score of 42 compared to a score of 45. We know that a score of 45 reflects a higher degree of health than a score of 42 does, but we have no precise way to categorize the magnitude of the difference. To simplify the analysis, we combined the information from the PCS and MCS into an overall health score, with a population norm of 100 points (each scale had a norm of 50 points separately). Then we calculated the population percentile that would be attributed to the combined score. For example, for a score of 77 points, we know that 94 percent of individuals in the age range 45 to 54 would score above 77. This gave us a way to calibrate our results, in terms of how the overall physical and mental health of

the service-disabled veterans compares to population norms. By construction, the 50th percentile is the population norm of this measure.

The results of this analysis confirmed our earlier finding that there are more significant health deficits for those with a primary mental disability than a primary physical disability. We found that overall health for those with a mental primary disability is generally below the 5th percentile in the typical working years for those who are 20 percent or more disabled (this would represent a combined score of 77). Even for the 10-percent group, the overall health score is generally below the 20th percentile (a combined score of 83).

This approach allows us to consider the implicit quality-of-life payment, based on the parity of the earnings ratio, compared to the overall health percentile and the overall life satisfaction measure (the percentage of respondents who say that they are generally satisfied with their overall life). We investigated this by rating groups and average age at first entry, separately for those with a physical primary disability compared to a mental primary disability. We discuss our findings separately for those with a physical primary disability and for those with a mental primary disability, considering the implicit quality-of-life payment, the overall health percentile and the overall life satisfaction.

For those with a physical primary disability, the average age at first entry varied from 45 to 55, rising with the combined degree of disability. For 10-percent and 20- to 40-percent disability, there was a negative quality-of-life payment, although their overall health percentile ranged from 28 to 15 percent. For these groups, the overall life satisfaction ranged from 78 to 73 percent. For higher level of disability groups, there was a modest positive quality-of-life payment, ranging as high as $2,921 annually for the 100-percent disabled group. For the 100-percent disabled group, the overall health percentile was 4, meaning that 96 percent of the population would have a higher health score than the average score for this subgroup, and the overall life satisfaction was only 60 percent.

For service-disabled veterans with a mental primary disability, we found that there was an implicit negative quality-of-life payment for veterans of all disability levels except for those designated as IU. Also, for these subgroups, the overall health percentile was at the 13th percentile for 10-percent disabled and at the 6th percentile for 20- to 40-percent disabled. In fact, for the higher disability groups, the overall health score was at or below one percent, meaning that 99 percent of the population would have a higher overall health score. Overall life satisfaction, even for the 10-percent disability level, was only 61 percent. For disability levels 50- to 90-percent, IU, and 100-percent disabled, the overall life satisfaction measure hovered around 30 percent.

With regard to implicit quality-of-life payments, we found positive quality-of-life payments for those with a physical primary disability at a combined rating of 50 to 90 percent or higher (except for IU). For those with a mental primary disability, we found a positive quality-of-life payment only for the IU subgroup. In comparing overall health percentiles and life satisfaction, however, we found that for all rating groups, those with a mental primary disability had lower overall health percentiles, and substantially lower overall life satisfaction, than those with a physical primary disability. Those with a mental primary disability had lower health and life

satisfaction compared to those with a physical primary disability, but received less in implicit quality-of-life payments.

To summarize, we found that VA compensation is about right overall relative to earnings losses based on comparison groups for those at the average age at first entry. But the earnings ratios are below parity for severely disabled veterans who enter the system at a young age and more generally below parity among subgroups for those with a mental primary disability. Earnings ratios tend to be above parity for those who enter the VA system at age 65 or older. On average, VA compensation does not provide a positive implicit quality-of-life payment. Finally, the loss of quality of life appears to be greatest for those with a mental primary disability.

Earnings and quality-of-life findings for survivors

We computed earnings profiles for survivors using a methodology analogous to that used for service-disabled veterans. We calculated earnings income by age group and compared these earnings levels to the earnings of surviving spouses in the general population. Segmenting by age group is critical as 69 percent of survivors are 65 or more years old.

We also constructed and conducted a survey for survivors to assess how their self-reported health compared to population norms. We focused our comparisons on female survivors and their peers from the Current Population Survey (CPS). We were asked to explore how well Dependency and Indemnity Compensation (DIC) provided a partial replacement for lost earnings attributed to the loss of a service member or veteran.

The earnings comparisons show that on average survivors generally have lower earnings than their civilian peer groups, but that the combination of earned income plus VA compensation is as high as, or higher than, the average earned income of their peer groups at every age. In addition, based on our survey results, 90 percent of the respondents said that they were satisfied with DIC. We concluded that DIC appears to provide an adequate replacement for lost earnings for survivors.

The health differences among survivors and their peers are not as dramatic as the health differences were for service-disabled veterans and their peers, but there are some departures from population norms. The PCS for survivors is below population norms for age 55 and over, and the MCS is below population norms for ages 35 to 64. Those survivors who provided substantive care to a disabled veteran (4 or more hours per day, 5 days a week, for 2 or more years) appeared to suffer some negative effects on physical health and participation in social activities.

Raters and VSOs survey results

The Commission asked us to survey VBA rating officials and accredited veterans service officers (VSOs) of National Veterans Service Organizations (NVSOs) to gather insights from those who work most closely with the benefits determination and claims rating process. Through consultation with the Commission, we constructed separate (but largely parallel) surveys for raters and VSOs. The surveys focused on the challenges in implementing the benefits determination and claims rating process and perspectives on how the process works. Training, proficiency on the job, and resource availability and usage were among the issues examined.

The overall assessment indicated that the benefits determination process is viewed as difficult to use. Many VSOs find it difficult to assist in the benefits determination process. In addition, VSOs report that most veterans and survivors find it difficult to understand the determination process

and difficult to navigate through the required steps and provide the required evidence. Most raters and VSOs agreed that veterans have unrealistic expectations of the claims process and benefits.

Raters and VSOs noted that additional clinical input would be useful, especially from physicians and mental health professionals. Raters felt that the complexity of claims was rising over time, and that additional resources and time to process claims would help. Some raters felt that they were not adequately trained or that they lacked enough experience. They viewed mental claims, especially PTSD, as requiring more judgment and subjectivity and as being more difficult and time-consuming compared to physical claims. Many raters indicated that the criteria for IU are too broad and that more specific decision criteria or evidence would help in deciding IU claims.

VA disability compensation program compared to other disability programs

The Commission was interested in operational aspects of the veterans' disability compensation program and asked us to compare VA's program with other federal disability compensation programs to determine whether there are any useful practices that VA could adopt to improve its own operations. Our first task was to identify the major criticisms of operations in the VA disability program. We reviewed a variety of sources that discussed problems with VA performance, including reports from the Government Accountability Office (GAO), reports from the VA Office of the Inspector General (OIG), congressional testimony, and the results of the Commission's site visits.

After identifying the major criticisms of VA, we spoke with the relevant VA staff to get additional information on the areas being criticized. We interviewed individuals who worked in VBA's Compensation and Pension Service, VBA's Office of Employee Development and Training, the Board of Veterans' Appeals, and the Office of the General Counsel. We discussed specific aspects of VA operations that were identified as problematic and the approaches that the other disability programs take in those areas.

Except for the very important issue of timeliness, VA does not appear to be under-performing in comparison with other disability programs. Recent training improvements seem promising for improving VA timeliness in the long term, but effects will not be seen for a while. Some of VA's problems with timeliness could be the result of a complex program design, with multiple disabilities per claim, the need to determine service connection (sometimes many years after separation), and the need to assign a disability rating to each disability.

Option for a lump sum alternative

The Commission asked us to explore options for replacing the current annuity benefits stream for some service-disabled veterans with a lump sum alternative. We looked at this from the perspective of the potential benefits and costs both to the VA and to service-disabled veterans, and with respect to potential implementation barriers. We also investigated how other countries use a lump sum alternative for their service-disabled veterans. We focused on exploring possible options for those at the lowest disability levels (10 to 20 percent). In addition, we determined that this would be most feasible for body systems where rating changes were infrequent, as re-rating might generate the need to recalculate lump sum payments or provide an annuity.

For the VA, the anticipated benefits of a lump sum derive primarily from the potential for reduced administrative interactions (which might lead to speedier claims processing) and savings

in compensation and administrative costs. If the lump sum were optional, this would increase the choices open to service-disabled veterans. Finally, there are a number of concerns about how the lump sum amounts would be determined, what would happen if a veteran's condition worsened after he/she had taken a lump sum, and whether veterans would use a lump sum "wisely" or not.

We looked at Australia's, Canada's, and the United Kingdom's disability compensation systems for their service-disabled veterans, all of which utilize some version of a lump sum alternative. These countries generally use an annuity system to compensate for "economic" losses, and reserve the lump sum for compensating for "non-economic" or quality-of-life losses. Canada and the UK use lump sums to compensate for lost quality of life, while Australia offers the veteran a choice between an annuity and a lump sum.

We made a number of simplifying assumptions and selected a small number of examples to simulate how a lump sum program might be implemented. We found that the VA could obtain net savings, but a lump sum option would be costly up front, taking between 17 and 25 years for the VA to achieve net savings. In addition, we identified a number of institutional issues that would pose execution challenges.

IU and mortality

The Commission asked us to conduct an analysis of those receiving the individually unemployable (IU) designation. This designation is for those who do not have a 100-percent combined rating but whom VA determines to be unemployable. The designation enables them to receive disability compensation at the 100-percent level.

Overall 8 percent of those receiving VA disability compensation have IU, but 31 percent of those with PTSD as their primary diagnosis have IU status. Ideally, if the rating schedule works well, the need for IU will be minimal because those who need 100-percent disability compensation will get it from the ratings schedule. The fact that 31 percent of those with PTSD as their primary condition have IU may be an indication that the ratings schedule does not work well for PTSD.

Another concern is the rapid growth in the number of veterans designated as IU-from 117,000 in 2000 to 223,000 in 2005. This represents a 90-percent increase, an increase that occurred while the number of disabled veterans increased 15 percent and the total number of veterans declined by 8 percent. The issue is whether disabled veterans were taking advantage of the system, using IU status to increase their disability compensation. The data suggest that this was not the case. While there has been some increase in the prevalence of getting IU status for certain rating-and-age combinations, the vast majority of the increase in the IU population is explained by demographic changes (specifically the aging of the Vietnam cohort) in the veteran population.

We also used mortality rates to determine whether IU recipients were taking advantage of the system. If those with IU had higher mortality rates than those without IU, it would appear to identify clinical differences between those with and without IU. Our findings confirm that those with IU status have higher mortality rates than those rated 50-90 percent without IU, although IU mortality rates are less than for the 100-percent disabled.

Comparison of DOD/VA disability ratings

Due to concern with consistency of DOD and VA disability ratings, the Commission asked CNAC to study the issue. We first looked to see how much overlap there was between the two

systems. We found that roughly four-fifths of those who receive a DOD disability rating end up in the VA compensation system in less than 2 years.

Next we explored whether DOD and VA gave approximately the same combined disability rating. On average, we found that service-disabled veterans received substantially higher ratings from VA than from DOD. The question is why? First, VA rates more conditions than DOD does: on average VA rates about three more conditions per person than DOD does. Second, we found that even at the individual diagnosis level, VA gives higher ratings than DOD does on average. For some codes, the average rating from DOD is slightly higher than from VA. But for others, such as mental diagnostic codes, the average rating from VA is substantially higher than the rating from DOD.

Note that while we found differences in combined and individual ratings given by DOD and VA, we make no judgment as to the correctness of the ratings in either system. We have neither the data nor the clinical expertise to make such judgments. What we have done is point out aspects of the VA and DOD disability systems that differ.

Overall options and recommendations

One issue that emerges from the data concerns service-disabled veterans with a mental primary disability. Their overall health percentiles and overall life satisfaction percentiles are far below those with physical primary disabilities at the same rating level. Their earnings in general are well below those with physical primary disabilities. The data clearly indicate that their life experience is less satisfying than that of their counterparts. It is important to consider how veterans' programs could be made more effective at benefiting this group of veterans. However, there is no current metric to translate the quality-of-life losses documented in the Veterans Survey into dollars.

There are several options for addressing the lack of earnings parity where it exists and for compensation for lost quality of life. Earnings parity of those with mental conditions could be improved through higher ratings for mental conditions or special monthly compensation similar to that currently paid for other conditions. However, using higher ratings would require re-rating all of those with a mental disability. Earnings parity for the severely disabled who enter the system at "young" ages could be improved by making disability compensation levels a function of age at first entry into the disability system or through a special monthly compensation.

Another issue is the IU designation that many veterans receive because they are unemployable. If the purpose of this designation truly relates to employment, there could be a maximum eligibility age reflecting typical retirement patterns. If the purpose is to correct for rating schedule deficiencies, an option is to correct the ratings schedule so that fewer need to be artificially rated 100-percent through IU.