

**THE U.S. DEPARTMENT OF VETERANS AFFAIRS SCHEDULE FOR RATING
DISABILITIES**

HEARING
BEFORE THE
SUBCOMMITTEE ON DISABILITY ASSISTANCE AND MEMORIAL AFFAIRS
OF THE
COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES
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**THE U.S. DEPARTMENT OF VETERANS AFFAIRS SCHEDULE FOR RATING
DISABILITIES**

Tuesday, February 26, 2008
U. S. House of Representatives,
Subcommittee on Disability Assistance and Memorial Affairs,
Committee on Veterans' Affairs,
Washington, DC.

The Subcommittee met, pursuant to notice, at 2:02 p.m., in Room 334, Cannon House Office Building, Hon. John J. Hall [Chairman of the Subcommittee] presiding.

Present: Representatives Hall, Rodriguez, Lamborn, and Bilirakis.

OPENING STATEMENT OF CHAIRMAN HALL

Mr. HALL. Good afternoon. The Committee on Veterans' Affairs, Subcommittee Disability Assistance and Memorial Affairs, hearing on the U.S. Department of Veterans Affairs (VA) Schedule for Rating Disabilities will come to order.

Before I begin my opening statement, I would like to call attention to the fact that the American Medical Association (AMA) has asked to submit a written statement for the hearing record. If there is no objection, I ask for unanimous consent that this statement be entered for the record. Hearing no objection, so entered.

[The statement of the [American Medical Association](#) appears in the Appendix.]

Mr. HALL. Could we all please rise for the Pledge of Allegiance. Flags are at both ends of the room.

[Pledge of Allegiance.]

Thank you and thank you for being here. We will be expecting Congressman Bilirakis at some point to be joining us. Minority Counsel is here and we are going to proceed with his agreement to go ahead and hope to get through as much of this hearing as possible without putting it on autopilot.

This is the third hearing of the Subcommittee regarding the VA's claims processing system. As we have discussed before, this system has not lived up to expectations and has left many disabled veterans without proper and timely compensation and other benefits.

At the heart of this system is the VA Schedule for Rating Disabilities or VASRD. The rating schedule as we know it today is divided into 14 body systems, which incorporate approximately 700 codes that describe illness or injury symptoms and levels of severity. Ratings range from zero to 100 percent and are in increments of ten. This schedule was uniquely developed for use by the VA, but the U.S. Department of Defense (DoD) has also mandated its use when the service branches conduct evaluation boards on servicemembers who are unfit for duty. Otherwise, it is not used by any other governmental agencies or private-sector disability plans.

In its study, the Veterans' Disability Benefits Commission (VDBC) concluded that the VA rating schedule had not been comprehensively updated since 1945. Although sections of it have been modified, no overall review has been satisfactorily conducted, leaving some parts of the schedule out of date, relying on arcane medical practices, and not in sync with modern disability concepts.

The notion of a rating schedule was first crafted in 1917, so that returning World War I veterans would be cared for when they could no longer function in their pre-war occupations.

At the same time, the American economy was primarily agricultural based and labor intensive. Today's economy is different and the effects of disability are understood to be greater than the average loss of earning capacity.

Many disability specialists agree that quality of life, functionality, and social adaptation are just as important.

Our Nation's disabled veterans deserve to have a system that is based on the most available and relevant medical knowledge.

There are several issues pertaining to the rating schedule I hope to have us discuss today. First would be the need to remove out-of-date and archaic criteria that are still part of the schedule for some conditions and replace them with current medical and psychiatric evaluation instruments for determining and understanding disabilities.

The medical community relies on codes from the International Classification of Disease (ICD) and the Diagnostic and Statistical Manual of Mental Disorders (DSM). Should the Veterans Benefit Administration (VBA) be relying on these and other AMA Guides as well?

Individual Unemployability, IU, as a rating gives VA an alternative means by which to compensate veterans who cannot sustain gainful occupation, but might not otherwise be rated 100 percent.

The U.S. Government Accountability Office (GAO) found that the use of IU was ineffective and inefficient since it relies on old data, outdated criteria, and lacks guidance.

[See ["VA Benefits: Fundamental Changes to VA's Disability Criteria Need Careful Consideration," GAO-03-1172T](#), Testimony Before the Senate Committee on Veterans' Affairs, September 23, 2003, Statement of Cynthia A. Bascetta, Director, Education, Workforce, and Income Security Issues, U.S. General Accounting Office, which appears in the Appendix.]

The VDBC, Institute of Medicine (IOM), and the Center for Naval Analyses (CNA) Corporation, also studied IU and expressed their concerns over how it is utilized instead of scheduled ratings. I look forward to hearing from them today.

The criteria for psychiatric disabilities, especially for post traumatic stress disorder or PTSD, are in dire need of expansion. The current rating schedule has only one schedule for all of mental health which is based on the Global Assessment of Functioning scale, or GAF.

The IOM noted that one of the many problems with GAF is that it was developed for schizophrenia, and therefore, not as accurate for other disorders, and recommended that VA replace it as a diagnostic tool. I am especially concerned about this issue and how it pertains to PTSD and other mental disorders.

The VDBC also recommended that traumatic brain injury or TBI, in case you have not had enough initials yet, be a priority area of concentration, and for VA to improve the neurological criteria for TBI, which has become one of the signature injuries of this war.

I know there has been much discussion on how to compensate veterans for their quality of life losses. Both the VDBC and Dole-Shalala reports recommended that this be a new category added to the rating schedule in some fashion, but they did not necessarily agree or provide clear guidance on how to do this or whether the current system does so implicitly. So next steps are still needed.

Presumptions have had a major impact on VA compensation over the last few decades for conditions related to ionizing radiation, Agent Orange, and the Gulf War. The IOM, therefore, engaged in a lengthy study for the VDBC on presumptions and recommended that there be evidence-based criteria which could impact the rating schedule.

I commend Secretary Peake for changing the regulation on PTSD, but we might also want to add a presumption that combat-zone service is a stressor when evaluating PTSD.

I look forward to the testimony today on these complex rating schedule issues. I know there is a lot to be done to improve the VA claims processing system. But with the rating schedule at the core of the process, it seems that the centerpiece is in need of immediate comprehensive repair, which we intend to advocate.

I look forward to working with Ranking Member Lamborn and the Members of the Subcommittee in providing oversight for the VA's schedule for rating disabilities. The VA needs the right tools to do the right thing so our Nation's disabled veterans get the right assistance.

[The statement of [Chairman Hall](#) appears in the Appendix.]

Mr. Lamborn, our Ranking Member, was unable to be here. Will he have a statement for the record?

Mr. LAWRENCE. Yes.

[The statement of [Congressman Lamborn](#) appears in the Appendix.]

Mr. HALL. It will be made a part of the record. Whenever Mr. Bilirakis arrives, then he will be afforded the chance to make an opening statement and also to ask questions.

I would like to first of all welcome our panels, all of our panelists today, and to remind you that your complete written statements have been made part of the hearing record.

Please limit your remarks so that we can have sufficient time to follow-up with questions once everyone has had the opportunity to provide their testimony.

Joining us on our first panel is Vice Admiral Dennis Vincent McGinn, member of the Veterans' Disability Benefits Commission.

Admiral McGinn, I first want to express my deepest sympathies to you, the rest of the Commission, and its staff on the passing of Commissioner Butch Joeckel. Butch was a true American hero, a great Marine, and a veterans' advocate to the end, who understood all too well why we are here today trying to improve the quality of life for our disabled veterans.

I understand that Butch was known for saying, "You just have to do the right thing." And I think it is apropos that we keep that spirit in mind as we move forward on improving the VA claims processing system.

We also welcome Dr. Lonnie Bristow, Chair of the Committee on Medical Evaluation of Veterans for Disability Benefits for the Institute of Medicine; Dr. Dean Kilpatrick, Member of the Committee on Veterans' Compensation for Posttraumatic Stress Disorder for the Institute of Medicine; Dr. Jonathan Samet—is that the correct pronunciation?

Dr. SAMET. Samet.

Mr. HALL. Samet. Thank you. Dr. Jonathan Samet, Chair of the Committee on Evaluation of Presumptive Disability, Decision-Making Process for Veterans for the Institute of Medicine; and Dr. Joyce McMahon from the Center for Health Research and Policy of the CNA Corporation. Thank you all for joining us.

And, Admiral McGinn, you are now recognized for five minutes.

STATEMENTS OF VICE ADMIRAL DENNIS VINCENT MCGINN, USN (RET.), MEMBER, VETERANS' DISABILITY BENEFITS COMMISSION, ON BEHALF OF LIEUTENANT GENERAL JAMES TERRY SCOTT, CHAIRMAN; LONNIE BRISTOW, M.D., CHAIR, COMMITTEE ON MEDICAL EVALUATION OF VETERANS FOR DISABILITY BENEFITS, BOARD ON MILITARY AND VETERANS HEALTH, INSTITUTE OF MEDICINE, THE NATIONAL ACADEMIES; DEAN G. KILPATRICK, PH.D., MEMBER, COMMITTEE ON VETERANS' COMPENSATION FOR POSTTRAUMATIC STRESS DISORDER, INSTITUTE OF MEDICINE, THE NATIONAL ACADEMIES, AND DISTINGUISHED UNIVERSITY PROFESSOR AND

DIRECTOR, NATIONAL CRIME VICTIMS RESEARCH AND TREATMENT CENTER, MEDICAL UNIVERSITY OF SOUTH CAROLINA, CHARLESTON, SC; JONATHAN M. SAMET, M.D., M.S., CHAIRMAN, COMMITTEE ON EVALUATION OF THE PRESUMPTIVE DISABILITY, DECISION-MAKING PROCESS FOR VETERANS, BOARD ON MILITARY AND VETERANS AFFAIRS, INSTITUTE OF MEDICINE, THE NATIONAL ACADEMIES, AND, PROFESSOR AND CHAIRMAN, DEPARTMENT OF EPIDEMIOLOGY, JOHNS HOPKINS BLOOMBERG SCHOOL OF PUBLIC HEALTH, JOHNS HOPKINS UNIVERSITY, BALTIMORE, MD; AND JOYCE MCMAHON, PH.D., MANAGING DIRECTOR, CENTER FOR HEALTH RESEARCH AND POLICY, CENTER FOR NAVAL ANALYSES (CNA) CORPORATION, ALEXANDRIA, VA

STATEMENT OF VICE ADMIRAL DENNIS VINCENT MCGINN, USN (RET.)

Admiral MCGINN. Thank you, Mr. Chairman and Members of the Committee. I am pleased to appear before you today on behalf of the Chairman of the Veterans' Disability Benefits Commission, General Terry Scott, to discuss the findings, conclusions, and recommendations of the Commission related to revising the VA rating schedule.

The Commission was tasked to examine and make recommendations concerning the appropriateness of benefits, the appropriateness of the level of benefits, and appropriate standards for determining whether a disability or death of a veteran should be compensated. We completed our work and submitted our report on the 3rd of October 2007.

Mr. Chairman, I appreciate your comments concerning Commissioner Joeckel. You may note that we dedicated our report to him and he was the conscience of our Commission and a continuous reminder of the tremendous debt our Nation owes to disabled veterans.

For almost two and a half years, the Commission conducted an extensive and comprehensive examination of issues related to veterans' disability benefits. This was the first time that the subject had been studied in depth by an independent body since the Bradley Commission in 1956.

We identified 31 key issues for study and made every effort to ensure that our analysis was evidence based and data driven. And we engaged two well-known organizations to provide medical expertise and analysis. First the Institute of Medicine of the National Academies and the CNA Corporation. Both of those organizations are represented today in this panel.

Of the many issues the Commission examined, one of the most important was determining the effectiveness of the VA rating schedule.

You will be hearing from four panels today, including to my left Drs. Bristow, Kilpatrick, Samet representing their IOM Committees, and Dr. McMahon from CNA, independent experts, Veteran Service Organizations, and later Admiral Dan Cooper and Mr. Mayes representing the Department of Veterans Affairs.

I will keep my remarks brief and focus on the conclusions and recommendations of our Commission related to the rating schedule.

Our Commission is most appreciative of the outstanding work of the IOM Committees and CNA. We believe that their efforts were exceptionally complementary of each other and that the results were remarkably consistent.

The Commission's report summarizes the analysis and recommendations of CNA and the IOM Committees in some detail. However, the reports to the Commission are rich in detail with extensive analysis and each should be carefully reviewed by the Committee.

I would like to highlight a few of their key findings that our Commission found especially helpful. For example, Dr. Bristow's Committee emphasized that the rating schedule should achieve horizontal and vertical equity.

Vertical equity means that the VA ratings of severity of disability assigned in ten percent increments from zero to 100 percent should be accurately assigned so that those assigned more severe ratings should be those veterans whose disabilities impact their earnings more than those assigned less severe ratings.

CNA's comparison of the earnings of veterans who are not service disabled with service-disabled veterans demonstrated that disability causes lower earnings in employment at all levels of severity and types of disabilities and that the earnings loss of the disabled veteran increases as the percent rating increases. Thus, VA ratings using the rating schedule are generally achieving vertical equity.

Horizontal equity means that assigning ratings of severity should reflect average loss of earnings among the nearly 800 diagnostic codes and across the 16 body systems. CNA's analysis generally confirmed horizontal equity as well. Overall, their analysis confirmed that the VA rating schedule and VA's assignment of ratings using the rating schedule results in compensation paid to veterans that is generally adequate to offset average impairment of earnings.

Taken as a whole, the rating schedule is doing its job reasonably well. The detailed and comprehensive analysis demonstrated that even veterans with less severe ratings do, in fact, have loss of earnings.

However, the key word in the aforementioned paragraph is generally. The CNA analysis also identified very pronounced disparities for some veteran cohorts in which vertical and horizontal equity are not being achieved.

The amount of compensation is not sufficient to offset loss of earnings for three specific groups of veterans, those whose primary disability is post traumatic stress disorder, PTSD, or other mental disorders, those who are severely disabled at a young age, and those who are granted maximum benefits because their disabilities make them unemployable.

For these veteran groups, horizontal and vertical equity is not being achieved. Those severely disabled at a young age have greater loss of earning, especially over their remaining lives since they did not have established civilian careers or transferable job skills and have more of the normal working years ahead of them.

The analysis also clearly demonstrates that veterans with PTSD and other mental disorders experience much greater loss of employment and earnings than those with physical disabilities, particularly those more severely disabled.

These disparities should be addressed by a careful but prompt revision to the rating schedule leading to a more equitable level of payment to disabled veterans in the severely disabled category.

Concerning PTSD and mental disorders, the reasons for insufficient compensation may lie partly in the criteria in the rating schedule itself and partly in how the VA raters interpret or apply the criteria.

The rating schedule was revised a few years ago to eliminate separate criteria for diagnoses such as PTSD and in order to have a single set of criteria for all 67 diagnoses contained in the body system known as mental disorders.

The Commission asked the IOM to provide advice as to whether a single set of criteria is effective. IOM recommended that separate criteria should be established for PTSD and CNA's survey of VA raters and VSO service officers found agreement with that advice.

Concerning the interpretation of the criteria by raters, the Commission learned that almost one-half of 223,000 veterans granted individual unemployability or IU as being unable to work due to their service-connected disabilities had a primary diagnosis of PTSD, that would constitute 31 percent, or other mental disorders, 16 percent.

To be granted IU, the veteran must be rated at 60 to 90 percent disabled and also be found unable to work due to the service-connected disability.

Mr. HALL. Excuse me, Admiral.

Admiral MCGINN. Yes.

Mr. HALL. I am sorry. Could you summarize, please?

Admiral MCGINN. I certainly will. Yes, sir.

Our Commission concluded that there has been an implied but unstated congressional intent to compensate disabled veterans for impairment to quality to life due to their service-connected disabilities. And this is a key area that the Committee can make a real difference.

I would also like to point out before I make my concluding remarks that since the reports of the IOM that indicated the need to update the rating schedule, there has been very, very limited progress by the VA. And this should be looked at both in terms of what is the sense of urgency and other adequate resources available to do this rating schedule update as a matter of priority.

As I reflected in my written statement and partially in the oral statement I have just made, only by keeping the rating schedule current with the best up-to-date medical knowledge and by adjusting the payment levels to offset both loss of earnings and quality of life can we be assured that disabled veterans and their families are adequately compensated.

This was the clear consensus of our Commission. The specific recommendations in our report should be used to guide needed legislative actions by Congress as well as the policy and resource allocations by the departments and agencies needed to update and improve disabled veterans' benefits.

Mr. Chairman, I would be glad to answer any questions the Committee may have.

[The statement of [Admiral McGinn](#) appears in the Appendix.]

Mr. HALL. Thank you, Admiral.

And next, Dr. Bristow, you are recognized for five minutes.

STATEMENT OF LONNIE BRISTOW, M.D.

Dr. BRISTOW. Thank you. Good afternoon, Chairman Hall and Ranking Member Lamborn and Members of the Committee.

My name is Lonnie Bristow. I am a physician and I have served as the President of the American Medical Association. And I am joined this day on this panel by Drs. Dean Kilpatrick and Jonathan Samet who will introduce themselves shortly.

But on their behalf, we want to thank you for the opportunity to testify about the work of our Institute of Medicine Committees, our three Committees from the IOM.

My task today is to present to you the recommendations of the IOM Committee, which I chair, which was asked to evaluate the VA's schedule for rating disabilities and related matters.

Dr. Kilpatrick will follow me to speak about his Committee's work which focused on post traumatic stress disorder, a particular challenge for the VA to evaluate. And Dr. Samet will conclude our panel's presentation from the IOM by briefing you on the findings of his Committee which was asked to offer its perspective on the scientific considerations underlying the question of whether a health outcome should be presumed to be connected to military service.

We submitted testimony, written testimony for the record and we will summarize our presentations here. I only have a few minutes, so let me quickly list our key findings and recommendations concerning the VA rating schedule. And I will be glad to go into more detail about any of them during the question period.

Our Committee found that the statutory purpose of disability compensation which is to compensate for an average loss of earning capacity is, in fact, an unduly restrictive rationale for the program and it is inconsistent with the current modern models of disability.

The Committee recommends that the VA compensate for three consequences of service-connected injuries and diseases. First, for work disability which it currently does. And, second, however, for loss of ability to engage in usual life activities other than work, what disability experts today call functional limitations. And, third, for loss in quality of life.

Concerning the rating schedule, the Committee found that the schedule is not as current medically as it could be or should be. The relationship of the rating levels to average loss of earning capacity is not known at the time of our evaluation. The schedule does not evaluate impact on a veteran's ability to function in every-day life and the schedule does not evaluate for loss in quality of life.

The Committee, therefore, recommends that VA immediately update the current rating schedule medically beginning with those body systems that have gone the longest without a comprehensive update and adopt a system for keeping that schedule up to date medically.

Second, establish an external Disability Advisory Committee to provide advice during the updating process.

And, third, as a part of updating the schedule, we recommend moving to the ICD and DSM diagnostic classification systems.

Fourth, we recommend investigating the relationship between the ratings and actual earnings to see the extent to which the rating schedule is compensating for loss of earnings on average and make adjustments in the rating criteria to reduce any disparities that are found.

Fifth, compensate for functional limitations on usual life activities to the extent that the rating schedule does not.

And, sixth, develop a method of measuring loss of quality of life and where the schedule does not adequately compensate for it, VA should adopt a method for doing so.

The Committee also reviewed individual unemployability or IU and our main finding concerning IU is that it is not something that can be determined on medical grounds alone. Therefore, the Committee recommends that the VA conduct vocational assessments as well as medical evaluations whenever they are determining IU eligibility.

This concludes my remarks. And I want to thank you again for the opportunity to testify, and I will be happy to address any questions you might have about our report.

[The statement of [Dr. Bristow](#) appears in the Appendix.]

Mr. HALL. Thank you, Doctor.

And as you heard, the bell buzzer was sounding indicating that votes have been called. So I am going to have to ask you to be patient once again, and this Subcommittee will be in recess until this stack of votes are over.

[Recess.]

Mr. HALL. The Subcommittee is called back to order. And we apologize for the delay. You will be happy to know our legislative business is over for this afternoon, so we will be able to continue uninterrupted.

Dr. Kilpatrick, your written statement is in the record. You are now recognized for five minutes, please.

STATEMENT OF DEAN G. KILPATRICK, PH.D.

Dr. KILPATRICK. Thank you very much, and I appreciate the opportunity to testify on behalf of the Committee on Veterans' Compensation for PTSD.

Last June, our Committee completed its report entitled "PTSD Compensation and Military Service," which addresses several potential revisions to the schedule for rating disabilities in the context of a larger review of how the VA administers its PTSD compensation program. Our Committee's review of the scientific literature led it to draw the following conclusions:

First, there are two primary steps in the VA's disability compensation process. The first of these is a compensation and pension or C&P exam.

Testimony presented to our Committee indicated that clinicians often feel pressured to limit the time they devote to conducting a PTSD C&P exam, sometimes to as little as 20 minutes, even though the protocol suggested in a best practice manual developed by the VA National Center for PTSD can take three hours or more to complete.

Our Committee felt very strongly that the key to a proper administration of the VA's PTSD compensation program is a thorough C&P clinical examination conducted by experienced mental health professionals. Many of the issues that arise could be dealt with nicely if the resources needed for a thorough examination were provided.

The Committee also recommended that a system-wide training program be implemented for the clinicians who conduct these exams in order to promote uniformity and consistent evaluations.

The second step in the VA compensation process is rating the level of disability associated with service-connected disorders. This rating is performed by a VA employee using information gathered in the C&P exam and the criteria set forth in the schedule for rating disabilities.

Currently the same set of criteria are used for rating all mental disorders and they primarily focus on symptoms from schizophrenia, mood and anxiety disorders.

The Committee found that these criteria are, at very best, a crude and it is an overly-general instrument for the assessment of PTSD disability. We recommend that the new criteria be developed and applied that specifically address PTSD symptoms and that are firmly grounded in the standards set out in the DSM used by mental health professionals.

A third point is that our Committee suggested that the VA take a broader and more comprehensive view of what constitutes disability for PTSD. There is a special emphasis and some might say a total emphasis on occupational impairment in the current criteria that unduly penalizes veterans who may be capable of working but who are significantly symptomatic or impaired in other dimensions and, thus, the current system may serve as a disincentive to both work and recovery.

Under this framework, the psychosocial and occupational aspects of functional impairment would be separately evaluated and the claimant would be rated on the dimension upon which he or she is more affected.

In order to promote more accurate, consistent, and uniform PTSD disability ratings, the Committee recommended that the VA establish a specific certification program for raters who deal with PTSD claims and to have training along with that as well.

Finally, at the VA's request, the Committee addressed whether it would be advisable to establish a set schedule for reexamining veterans receiving compensation for PTSD. The Committee concluded that this was not appropriate to require across-the-board, periodic reexaminations and instead recommended that it be done on a case-by-case basis when there is some reason to believe that maybe the disability status had changed.

Our reasoning for that was that the resources that the VA has are finite and they would be better spent focusing on doing a really first-class and timely initial evaluation than diverting the resources to do periodic rereviews.

The second point about that is that if only PTSD is singled out, it says to the veteran that there is something suspect about this so that we have to reexamine you over and over again. And we did not find any data that suggests that there was a need for that.

I realize that there has been some differences of opinion between various committees about the extent to which reexamination should happen and I think honest people could disagree on that. And we would just urge that, you know, the Congress as well as that the VA, consider carefully the merits of each of those approaches.

And, finally, I really would say, and this is my opinion, but I think it is consistent with what our Committee thought, that if we are going to do periodic PTSD reexaminations and we are going to implement that, we should not do so until there are adequate resources to ensure that every veteran gets a first-rate initial C&P exam that is done in a timely fashion.

We have several other recommendations in our report. I understand that each of you have that, and so I would be happy to answer any questions when the time comes.

[The statement of [Dr. Kilpatrick](#) appears in the Appendix.]

Mr. HALL. Thank you, Doctor.

Dr. Samet, you are now recognized for five minutes.

STATEMENT OF JONATHAN M. SAMET, M.D., M.S.

Dr. SAMET. Thank you. Good afternoon. I am pleased to speak with you today on behalf of our 16-member Committee about the report, improving the presumptive disability, decision-making process for veterans. You have the report and we have also made the executive summary available.

We were charged with describing the current process for how presumptive decisions are made for veterans and with proposing the scientific framework for making such presumptive decisions in the future.

As you know, presumptions are made in order to reach decisions in the face of unavailable or incomplete information. And presumptions have been made since 1921 around matters of exposure and causation.

To address our charge, we met with the full range of involved stakeholders. We completed a series of ten in-depth case studies to look at lessons learned from past presumptions. We also looked at how information is obtained on the health of the veterans and how exposures during military service are evaluated and potentially linkable to health events in the future. We also looked at how scientists synthesize information to judge what is known about association and causation.

To the first part of our charge, the present approach to presumptive disability, decision making largely flows from the "Agent Orange Act of 1991." In that law, Congress asked the VA to contract with an independent organization to review scientific evidence for Agent Orange, that organization being the Institute of Medicine.

The Institute of Medicine provides its reports to the VA which then acts with its own internal decision-making process to determine if a presumption is to be made.

Our case studies pointed to a number of difficulties in this current approach that need to be addressed in any future approach, lack of information on exposures received by military

personnel, insufficient surveillance of veterans for service-related illness, gaps in information because of secrecy, varying approaches to bringing information together, and variation in classification of evidence in different presumptions sometimes around association and sometimes around causation, and a general lack of transparency of aspects of the process.

We proposed a new approach that we feel will address these deficiencies when implemented. We call for an approach that is outlined in the figure attached to my testimony. Elements of this approach include an open process for nominating exposures and health conditions for review involving all stakeholders who are interested in the outcome of the presumptive disability, decision-making process.

We recommend a revised process for evaluating scientific information on whether a given exposure causes a health condition in veterans. We offer a new set of categories to assess the strength of evidence for causation and propose that in a second step of the scientific evaluation of the evidence, an estimate be made of the numbers of exposed veterans who are at risk from the exposure.

We call for a consistent and transparent decision-making process by the VA and a system for tracking the exposures of military personnel and for monitoring health conditions while in service and after separation and an organizational structure to support this process.

Two elements of the organizational process include creating two panels. One we called the Advisory Committee would be advisory to the VA. This Committee would monitor information as it comes in on the exposures and health of veterans. It would assess nominations made for consideration for presumptions and give recommendations to the VA.

The second panel would be a Science Review Board, an independent body that would evaluate the evidence, the strength of the evidence, and do the quantitative estimations if appropriate. The recommendations of this group would go to the VA as well.

We propose a set of principles, including stakeholder inclusiveness, evidence-based decisions, a transparent process, flexibility and consistency, and, finally, use of causation and not just association as the target for decision making.

We offer a set of categories around how certain the evidence is for causation and suggest that for the purpose of causation that the benefit always goes to the veterans and that the evidence should be at least 50 percent or more pointing towards causation for making presumptive decision making.

This implementation of this approach will call for action by Congress. Legislation would be needed to create the two panels and the resources would be needed to create and sustain exposure and health tracking for service personnel and veterans.

Elements of this system we recommend could be implemented at present even as steps are taken to move the DoD and VA towards implementing the full model.

Thank you.

[The statement of [Dr. Samet](#) appears in the Appendix.]

Mr. HALL. Thank you, Doctor.

Dr. McMahon, you are now recognized.

STATEMENT OF JOYCE MCMAHON, PH.D.

Dr. MCMAHON. Thank you. Chairman Hall, Representative Lamborn, and distinguished Members, I appreciate the opportunity to testify before the House Subcommittee on Disability Assistance and Memorial Affairs of the House Committee on Veterans' Affairs today on the subject of revising the VA schedule for rating disabilities.

This testimony is based on the findings reported in the CNA final report for the Veterans' Disability Benefits Commission.

We were asked to provide analysis to the Commission 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.

Pertinent to today's topic is that we were asked to examine the evidence regarding the individual unemployability rating, to evaluate the quality of life findings for disabled veterans, and to conduct surveys of raters and Veterans Service Officers with regard to how they perceive the process of rating claims and assisting applicants.

Our primary task was to focus on how well the VA compensation benefits served to replace the average loss in earnings capacity for service-disabled veterans. We defined subgroups of disabled veterans by body system of the primary disability and on the total combined disability rating in four groups, 10 percent, 20 to 40 percent, 50 to 90 percent, and 100 percent disabled.

Within this, we further stratified the 50- to 90-percent disabled group into those with and without individual unemployability status.

Our overall finding is that for male veterans, there is general parity overall at the average age of entry. When we looked at various subgroups, we found some differences as has been mentioned before. In particular, 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 with severe disability is associated with below parity earnings ratios.

We were asked to look at veterans' quality of life degradation, and we did this by conducting a survey using health-related questions taken from a standardized bank of questions used to survey the general population. This allowed us to compare results for service-disabled veterans to widely-used population norms.

We found that as the degree of disability increased, generally overall health declined, and that there were differences between those with physical and mental primary disabilities. Physical disability led to lower physical health, but in general did not lead to lowered mental health except for the most severely disabled.

On the other hand, mental disability led not only to lower mental health scores but was also associated with lower physical health in general. For those with a primary mental disability, physical scores were well below the population norms for all rating groups and lowest for those with PTSD.

In general, we did not find that there were any implicit quality of life payments being made to the disabled veteran population since most veterans were at parity with the exception of the subgroups we have mentioned. Overall, there is no quality of life payment implicitly being provided by the current compensation schedule.

There are groups that are below parity and these would include those entering as severely-disabled veterans at a young age and, in particular, those with a mental primary disability. Since these people are below parity, that implies a negative implicit quality of life payment for these groups. However, it is worth noting that in general the loss of quality of life appears to be the greatest for those with a mental primary disability.

Turning to the survey of raters and Veterans Service Officers that we conducted, I will make a few points quickly. Many raters indicated that the criteria for IU are too broad and that more specific decision criteria or evidence regarding IU would be helpful in deciding IU claims.

They reported that claims are becoming more complex, that mental claims are harder to evaluate than physical claims, and that they would appreciate more specific criteria to help them resolve mental health issues, especially PTSD.

Turning to IU, we were asked specifically to look at this in the context of the system and how it works. We have a figure that eight percent of those receiving VA disability compensation have IU, but 31 percent of those with PTSD as their primary diagnosis have IU status. This may indicate that the rating schedule does not work well for PTSD.

We were asked to comment on the rapid growth in the number of disabled veterans categorized as IU from 2000 to 2005. The data suggests that the vast majority of the increase in the IU population is explained by demographic changes, specifically the aging of the Vietnam cohort.

We also looked at mortality rates to determine if there were clinical differences for those with IU, and we found that those with IU status have higher mortality rates than those who were rated 50 to 90 percent disabled without IU. IU mortality rates were, however, less than was observed for those who are 100 percent disabled.

Finally, we would make a couple of comments about rating system implications. If the purpose of the IU designation is primarily related to employment, there could be a maximum eligibility age reflecting typical retirement patterns. But if it is to correct for rating schedule deficiencies,

an option might be to simply correct the rating schedule so that fewer disabled veterans would need to be classified as IU.

In particular, I do not think you will ever find that you can get away from the rating system using an IU designation completely, but you might well be able to limit the number of veterans who receive this designation each year by changing the schedule or considering other options such as a greater use of retraining programs.

Thank you.

[The statement of [Dr. McMahan](#) appears in the Appendix.]

Mr. HALL. Thank you, Doctor.

Thank you to all of our panelists.

At this time, I want to acknowledge Congressman Rodriguez and Congressman Bilirakis who have joined us.

I will ask a few questions first. Admiral McGinn, as a member of the Commission and participant in its deliberations, what is your sense of the priority of revising the rating schedule from the perspective of the veteran? In other words, what do veterans need most?

Admiral MCGINN. I think the comments by some of my colleagues at the panel here reflected the priority that should be placed on PTSD, TBI or traumatic brain injury, and other mental conditions as areas in which the VA should start their review of the rating schedule. Those are all very, very compelling in terms of numbers and the effects it has on veterans and their families. And from a veteran's perspective, that is a good place to start.

That said, the entire rating schedule should be approached, and updated with a much greater sense of urgency. And if that requires more resources, those should be applied.

Thank you, sir.

Mr. HALL. In your testimony, you called for VA's response to be urgent and expedient, but then pointed out that this has never been the case with the VA's reaction to recommendations such as those made by Omar Bradley's Commission in 1956.

So if we want this done now, what is the best way for Congress to ensure your call to action?

Admiral MCGINN. I know we made a recommendation in our report on establishing an oversight group comprised of DoD and the VA to track the progress of the various recommendations that we made.

I will say that given the fact that we are at war, we are seeing terribly injured veterans come back and into the system, tremendous effect on their families, and various spotlights have been put on how we treat those veterans.

The VA and DoD, for example, have made tremendous progress, more in the past couple of months, six months say, than in the previous ten years on addressing the so-called seamless transition from uniform member to disabled veteran.

I think that same type of focus needs to be applied in updating the rating schedule and we will see the results that we need.

Mr. HALL. And would you consider the 25-percent quality of life payment as recommended by the Commission sufficient to correct the horizontal and vertical equity issues described by CNA? Should the maximum payment of 25 percent only pertain to the most severely disabled or for the three groups you described as below parity?

Admiral MCGINN. I think that horizontal and vertical equity issues should be dealt with separately than quality of life. And quality of life should be applied as we are developing standards for measuring quality of life or decrement to quality of life and what appropriate compensation should be.

I think that immediately those veterans who are most severely disabled should benefit first from a quality of life increase.

Mr. HALL. Thank you.

Dr. Bristow, could the rating schedule be simplified and still be an effective tool for VA to use in compensating veterans?

Dr. BRISTOW. That is a very difficult question, Mr. Chairman. I believe the rating system needs to be clarified. I am not sure if simplified is the term that I would use. But I think it certainly needs to be clarified so that it has logic.

It currently fails to have the sort of logic, at least from the point of view or from the perspective of medicine or science, that it should have and can have. It has a lack of logic because it has not progressed during the last five decades at the rate that it should have.

In some areas, it has been abysmally behind the times. Others, there have been fitful starts in an effort to become more modernized. But its problem is a lack of being up to date rather than being too complex.

Mr. HALL. Do you agree with the Commission's recommendation to begin with mental health, specifically PTSD and TBI?

Dr. BRISTOW. Yes, sir, although my Committee recommended that the updating take place approaching those particular systems that have had the longest lag of inattention.

This actually dovetails with the Commission's recommendation, particularly if you look at traumatic brain injury, which is a part of the neurological system, which would be one of the first systems that needs to be upgraded.

The addition of PTSD that the Commission is recommending for early and urgent attention, I think, is based on pragmatism and it makes eminently good sense. And I am quite certain that no one on my Committee would disagree or dispute or find fault with that.

Mr. HALL. Thank you.

In a hearing last month, Dr. Randy Miller from Vanderbilt University testified that the rating schedule was too vague and ambiguous. He suggested that if it had better definitions and clear-cut key words, it could be automated.

What is your opinion on these observations and would you advocate for the automating of the rating schedule using software, artificial intelligence, et cetera?

Dr. BRISTOW. I think it is key that the rating system begin to use as rapidly as can be accomplished DSM and ICD codes. The reason is because that would bring the greatest clarity to what the medical condition or surgical condition is of a particular individual. And clarity is essential if you are going to do any sort of epidemiologic approach to a given population.

The rating system currently has been using only 700 plus codes and whenever a condition does not fit a particular code, the raters are encouraged or advised that they should use an analogous code. That is a matter of administrative convenience. But when one attempts to look back and decide what is going on with a given population of diseases or injuries, there is a mishmash that has been created in that fashion.

And so it is important that although the ICD codes are far more numerous, parenthetically, we are talking about an alternative with the potential use, the use of potentially anywhere from 14 to 17,000 different codes as opposed to 700 plus, they would bring a great deal more clarity and make the information that the VA is collecting much more useful in terms of how to allocate resources, in terms of how to develop programs, and provide the sort of the services that the entire Nation wishes our veterans to have.

Mr. HALL. Thank you.

And my seven minutes have just gone flying by.

Congressman Rodriguez?

Mr. BILIRAKIS. I have one question.

Mr. HALL. Mr. Bilirakis?

Mr. BILIRAKIS. One question. Thank you.

Dr. McMahon, how might the VA adjust the rating schedule so that it more accurately reflects the consequences of PTSD?

Dr. MCMAHON. Well, I am not a clinical expert. We approach this at CNA from a point of analysis of what the rating schedule showed. I would say that the information with regard to individual unemployability suggested that there was an inability to rate the person in terms of the fullness of the disability. In other words, many people were unable to work and were granted individual unemployability who did have PTSD.

One way to address that would be to rate them at a higher rating for PTSD instead of at their current rating level. So part of it may be a systematic rating that does not properly assess the degree of disability associated with PTSD. But that gets into some more clinical issues which I do not really feel I should address. The IOM is more appropriate for that.

We certainly could see, however, that, overall, the earnings capability of those people who had a primary disability of mental disability or PTSD was much lower than for someone who had a physical disability. There was a sharp discrepancy between physical disability and mental disability in terms of how people fared.

This was true with regard to earnings and it was also true with quality of life. Those with mental primary disabilities tended to earn less than people with a physical disability at the same rating level, and they tended to have a lower quality of life when you compared both their mental and physical quality of life in the scales that we calculated.

The story becomes consistent that they do not earn as much and they have a lower quality of life. I think that could be reflected in terms of how the schedules are applied. But the actual clinical way in which that could be done, I am not prepared to answer.

Mr. BILIRAKIS. Thank you.

Mr. HALL. Mr. Rodriguez?

Mr. RODRIGUEZ. Yes. Thank you very much.

Dr. Kilpatrick or maybe anyone else that might know, what are your thoughts on the possibility of delayed onset of PTSD and how would the Department of Veteran Affairs detect where we have missed that.

I am referring to as they arrive, the importance of picking up on them as quickly as possible, but then—and this is an additional question, how do we distinguish between those veterans that have been out there maybe from Vietnam and the duration of PTSD and the onset? Have we been able to come to grips with that?

Dr. KILPATRICK. Yes. In fact, our Committee report addresses that at some length. And a CliffsNotes version of what we found was that basically there is ample evidence that you can get delayed responses of PTSD.

And that can occur for a number of reasons, one of which is it may be that people are symptomatic and they have been symptomatic for a long period of time and all of a sudden, it gets to a threshold where they recognize that there is a problem or more commonly a family member or a co-worker or somebody like that recognizes that they have a problem, brings them to the attention of mental health professionals and whatnot, and then they get diagnosed.

The other aspect of what you are saying is that there is a strong belief on the part of many servicemembers when they get out that they will be fine when they go back home. In other words: "I have been in a dangerous war zone situation. All I need is to get back to my family and to my civilian life and I will be fine."

In many cases, it turns out that not to be the case, so that it takes a while for them to understand that this is not going away. It is here and maybe I need to do something about it.

For mental health, PTSD specifically, but also with a lot of mental disorders, there are ample epidemiological data suggesting that probably the majority of people who have PTSD or mental health problems do not seek treatment out for some of these reasons. There is still a lot of stigma.

In fact, you know, my previous testimony about why we did not want to have a reexam mandated was that if it is just for PTSD and not for anything else, it is telling people with PTSD that you have a suspect condition here and we are concerned that might, in fact, deter people from being willing to come forward for treatment.

Mr. RODRIGUEZ. Do we know a little bit in terms of the condition because I know and I have given the example of schizophrenia where the worse the person acts as the prognosis, they are better for prognosis because they are reacting to their illness? Do we have any indication that post traumatic stress works in the same way, that those where the onset is very slow, their prognosis may be less? Or are we still researching that? Where their prognosis is more evident initially, do we have any information in that?

Dr. KILPATRICK. Well, I think that is a complicated question and so I will give you a somewhat complicated answer, not too complicated, I hope.

But the thing is is that some people if they are just totally unable to function, in other words, if they are, you know, very, very, very disturbed very soon afterwards and it comes to other people's attention, they are more likely to have a severe case perhaps.

But the number of people who basically may have subthreshold PTSD or who may actually meet all the diagnostic criteria, but they keep it to themselves, I would suggest the Ken Burns movie that came out on PBS fairly recently in which one of the most moving things to me was seeing these World War II veterans, many of whom had functioned incredibly well for 50 or 60 years and who now are tearing up.

And, you know, military people do not tear up very much. That is not what they are supposed to do. And these people had functioned very well throughout life, but it had taken a toll to the point that they still had a great deal of difficulty talking about things.

So that I think there are two groups that we are talking about. One group is people that you can see what is going on and it is obvious that they are very disturbed. There is another group that may through their force of will and their character and everything else be striving to work and striving to have relationships, but who are still, it has taken a toll on them and, you know, it takes a while for it to become obvious to everybody else.

Mr. RODRIGUEZ. And I know, if I can follow-up with another question, I know psychiatrists that will tell you that there is a clear distinction. But have we been able to get a clear distinction between the people that have been diagnosed with personality disorders versus having post traumatic stress disorders?

Dr. KILPATRICK. There are people who have PTSD who can have personality changes, but I would argue that someone who is a competent mental health professional who knows something about PTSD would not make the mistake of diagnosing somebody as having a personality disorder when, in fact, it is an outcome of PTSD.

For example, one of the symptoms of PTSD is, you know, maybe angry outbursts and things like that. So if you are still in the military and you are telling, you know, your superior officers to do something or you are getting in fights and maybe you are drinking a lot to try to cope maladaptively with some of the PTSD symptoms, that may look a little like a personality disorder. But anybody who knows something about PTSD and knows how to assess people should not make the mistake of saying this is primarily a personality disorder versus this is PTSD.

Mr. RODRIGUEZ. Yes. I was bringing that up because I know, I think it was DoD that had identified some 20,000 soldiers with personality disorders. And that makes a big difference in terms of benefits for one when it comes to the VA.

If on the personality disorders, if they are picked up and allowed to participate in the military with a personality disorder, you would think that that trait would come up pretty quickly. At what point do you think that personality disorder reveals itself as such and not as PTSD?

Dr. KILPATRICK. Well, I would say that most people think that most personality disorders might, in fact, predate, I mean just in terms of time of onset, would predate, you know, entry into service. Now, most of us get worse under stress and so if you had a personality disorder, maybe that would be get worse under stress too.

But the key is that if you can look at military trauma, sexual trauma, other kinds of trauma, you can look at things that happened during the military and then you look at that to see how that relates to the specific PTSD symptoms.

Mr. RODRIGUEZ. Okay. I am out of time. Thank you.

Mr. HALL. Thank you.

I would like to ask a couple more questions, if I may.

Dr. Kilpatrick, the rating schedule for mental health is very much based on the Global Assessment of Functioning or GAF scale, which a different IOM Committee found to be ineffective and recommended that it should be replaced.

What do you think that says about the rating schedule itself and should the same conclusion apply?

Dr. KILPATRICK. Well, I believe our Committee did, in fact, reach that conclusion. The problem with it is that it was not designed to capture the specific types of disabilities that go along with and difficulties in functioning that go along with PTSD. And so the items and the anchors in it do not really fit PTSD very well. So there are better measures there.

And if anybody wants chapter and verse on that, there is a long discussion of it in, you know, our report. But the Committee really felt like that there were better ways to capture that than a rating system that is based on the GAF.

Mr. HALL. You mentioned that the current rating schedule serves as a disincentive for both recovery and work for those with PTSD who might also be able to work.

Should VA allow veterans with mental disabilities to be rated 100 percent and for them to be employable just like with physical disabilities?

Dr. KILPATRICK. Well, I think if you were interested in parity, that would be something that would appear to be attractive. Again, this is my personal opinion.

But I think the Committee also felt that encouraging people to work and not setting up a system that provides a disincentive to do that is probably not what you would want to do if you were wanting to encourage people to, you know, get vocational services and other kinds of things that would enable them to be productive.

There are clearly people who are 100-percent disabled for a physical disability, but who if they go to work, they do not have to give up the disability. And it seems to me that parity would suggest that, you know, that you try to do the same thing for people with PTSD specifically, but also for other mental disorders.

Mr. HALL. Thank you.

Dr. Samet, it sounds like the causal effect level of evidence that your Committee proposes is very stringent and would make it even more difficult for veterans to achieve service connection on a presumptive basis.

Is that really the intention and does that really serve our veterans best?

Dr. SAMET. Several comments. The four-level categorization of evidence has a point of balance between 50 percent certainty that there might be a causal association or less. And we suggest that, in fact, the 50 percent and above level of certainty be used for compensation.

I do not know that this is necessarily more stringent than the current approach. We also call for a more holistic approach to evidence evaluation, making certain that the latest understanding of how exposures received in the military might cause disease or incorporate it into the decision making.

We also suggest that when the evidence does not meet that balance point, action still might be taken. For one, research might be developed to fill the gaps that are there so that the level of certainty can be higher.

I think this is a point for an important discussion because, as I pointed out, our case studies show that, in fact, sometimes judgments have been made on the standard of association and sometimes on causation. We think that this should be uniform. It should be clear. It should be transparent.

And as the decision is made about what is the right approach, there should be a weighing of how many potential presumptions might be made when the evidence is not there yet, a false positive, and then also how often an association, a causal association might be missed, a false negative.

We want a system that assures that we do not miss those conditions that are actually linked to exposures in the military and at the same time does not let some through where there is no association. It is a difficult balancing and we propose a system that we hope will do the right job.

Mr. HALL. Thank you.

The Committee recommended the creation of a VA Presumption Advisory Committee and a Scientific Review Board to consider and review scientific evidence. But developing this level of evidence as described in your report could take years.

What should we do about getting veterans their benefits in the meantime?

Dr. SAMET. You know, I think embedded in your question is an important point. Scientific evidence will always be accumulating and first we call for the accumulation of the best stream of evidence possible on the health of veterans.

I mean, going back to the question about PTSD, if we did have the right public health surveillance approaches in place, some of the questions that were posed would be answerable.

So we think that while evidence is accumulating, judgments have to be made. The evidence needs to be looked at serially. When there are gaps, they need to be targeted. If there are questions about delayed onset of PTSD, there should be a focused investigation. And I think the VA needs the capacity to do that.

An Advisory Committee would have the role of providing guidance on what evidence is needed and how it might be obtained. And, again, if perhaps evidence is unobtainable, then it is best to know that and to make a decision with acknowledgment of the uncertainty.

Mr. HALL. Thank you.

Dr. McMahon, the data you have presented is compelling and it seems that the groups who suffer the most from service disabling injuries and illnesses are those who are younger, more severely injured, those with mental health issues, and those who are unemployable.

If VA were able to augment those whose disabilities were more impairing with a quality of life loss schedule, do you think that would improve the financial parity for those veterans or is there a need to change the rates of compensation or the levels of severity?

Dr. MCMAHON. Well, I would think that you would want to address these issues separately. I would have to say that while I can identify the quality of life degradation pretty sharply by some of the criteria that you mentioned, I am not able to put a dollar figure on exactly how much would be appropriate for a quality of life adjustment.

We did look in some of our analysis at some of the steps that other countries took with regard to quality of life adjustments. Some of those countries dealt with it with a lump sum payment, for example. I am not suggesting that that is the way we would want to go.

I do think that these are separable issues. One of them is a matter of compensation and whether a person is unable to work in the accustomed area or maybe has not been able to be retrained into another line of work. That is a matter of fairness. You have lost something compared to what you started with. You have not been able to keep up with your peer group.

The issue of a loss of quality of life is something different and I think that needs to be dealt with separately rather than merged together in a single payment because that gives you a cleaner way of dealing with the situation.

Mr. HALL. Thank you.

I want to thank you all for your testimony.

We were talking before about the various resources that are available that are more up to date than the VA's rating schedule. This DSM manual from the American Psychiatric Association, which has a section on post traumatic stress disorder in it, it is copyrighted in 1994 and updated through 1997 with new codes and so on.

I am hopeful that all of us together with the testimony that you have provided us and with what the other panels will be providing us, we can help VA move from the 1950s or 1960s or wherever they last were into the present and future in terms of clarifying this and making this a more logical system and one that serves our veterans better.

Thank you all so much for your patience and for testifying before the Subcommittee today, and the first panel is now excused.

And we will ask our second panel, Mark Hyman, M.D., American Academy of Disability Evaluating Physicians (AADEP); Sidney Weissman, M.D., member of the American Psychiatric Association; Ronald Abrams, Joint Executive Director of the National Veterans Legal Services Program (NVLSP), to join us please.

Thank you also for your patience. As usual, your full written statement will be entered in the record and you will each be recognized for five minutes. So feel free to summarize or deviate from it in whichever way you choose.

Dr. Hyman, you are now recognized for five minutes.

STATEMENTS OF MARK H. HYMAN, M.D., FAADEP, PRESENTER, AMERICAN ACADEMY OF DISABILITY EVALUATING PHYSICIANS, AND MARK H. HYMAN, M.D., INC., F.A.C.P., F.A.A.D.E.P., LOS ANGELES, LA; SIDNEY WEISSMAN, M.D., MEMBER, COMMITTEE ON MENTAL HEALTHCARE FOR VETERANS AND MILITARY PERSONNEL AND THEIR FAMILIES, AMERICAN PSYCHIATRIC ASSOCIATION; AND RONALD B. ABRAMS, JOINT EXECUTIVE DIRECTOR, NATIONAL VETERANS LEGAL SERVICES PROGRAM

STATEMENT OF MARK H. HYMAN, M.D.

Dr. HYMAN. Thank you very much, Mr. Hall, Members, and staff.

I read the Institute of Medicine report and do wish to align my recommendations from the private sector experience.

In the community, if we have an injured person, they file a claim within a recognized jurisdiction, usually at the State level. This triggers a claims handling by either a private insurance entity or a State mandated agency. Records are obtained and the patient is then referred to a physician for evaluation.

A report is prepared in the format required by the jurisdiction and the findings of the evaluation are then translated into an impairment rating which then triggers subsequent administrative actions.

Implementation of the recommendations in the report would bring our veterans system in a closer approximation to what I have just described. In particular, I must strongly underscore the need for a common language and the process which emanates from already existing national standards, including the AMA Guides, the ICD, and the DSM.

These resources are the products of multiple leaders throughout the world. The AMA Guides began in 1958 in response to the developing field of disability evaluation. The mission has always been to bring the soundest possible reasoning to the impairment process. The Guides

have become the community standard in the majority of the States within our country. In essence, the Guides are the tools and the rules of the disability trade.

We have just produced the sixth edition of this seminal work and there are many companion books that go with this. These have been provided to your staff and I have copies of them here. Together these books represent the efforts of experts around the country who regularly work in the disability field.

There is also a mechanism of updating this information through an Advisory Board that we have and we also do major revisions when it is warranted.

Through this mechanism that is used in the private sector, we can thoroughly describe and categorize the range of human injury. We are able to develop a fair, equitable, consistent rating on an individual's impairment, small or large.

Further, the Guides are aligned with the World Health Organization's (WHO's) standards of disablement which are called the International Classification of Functioning, Disability, and Health.

As with all jurisdictions, once an impairment rating process has occurred, then, like all other jurisdictions, specific unique coding or administrative concerns can then be added to the process.

Indeed, in many jurisdictions, the evaluators may not even fully know all of the subsequent claims processing that their impairment rating triggers.

In the current VA example, raters could take this report from the medical evaluation and cohesively apply a disability rating with good reproducibility. They can add whatever modifiers they feel are necessary or unique to the VA system.

The use of these resources will allow for a transition to an electronic health record which is currently the standard for the veterans health system on the medical side. Tracking of the data then becomes much easier.

To accomplish this process, all shareholders from the VA system must have a seat at round-table discussions and have input into recommendations from the Advisory Committee. The Advisory Committee must be charged and funded to meet at least once yearly with quarterly telephonic meetings in order to ensure implementation, assess outcomes, and ensure proper education.

I cannot underscore enough the importance of education as this field is one that is not covered heavily or extensively in standard medical training and has many unique aspects.

By using the resources which I have identified as central to this process, the common language of impairment and disability will be broadened to all personnel involved in the process. I personally, as a citizen of this country and our organization that I am representing today, AADEP, offer assistance to you in furthering this project.

Finally, based on briefly some comments I heard today, I want you to know that there is data that works for the vast majority of people and these resources cover the vast majority of concerns.

In looking at your reporting from the Institute of Medicine, the three most common difficulties, orthopedic, hearing, psychiatric, are all covered in the AMA Guides. The best way to get this done is through the AMA Guides. The research already exists. You do not have to reinvent the wheel. The resources are already regularly examined and updated. These resources cover matters of concern to you.

There is no perfect book. There will never be a perfect book to describe the entire human condition. But the AMA Guides is the closest we have to equanimity and I strongly recommend it.

Thank you for allowing me to help our country, but, in particular, for giving me a chance to help those men and women who have provided for our security that we can meet here today and try to repay their effort. May God bless you in your deliberations.

[The statement of [Dr. Hyman](#) appears in the Appendix.]

Mr. HALL. Thank you, Dr. Hyman.

Dr. Weissman, now you are recognized for five minutes.

STATEMENT OF SIDNEY WEISSMAN, M.D.

Dr. WEISSMAN. Thank you, Mr. Chairman.

I am Sidney Weissman and I am here to represent the American Psychiatric Association which is the publisher of the DSM which has been spoken about this afternoon.

The American Psychiatric Association published the current DSM in 1994 and you noted some of the revisions.

As publisher, we have a vital interest in the work of the Subcommittee and particularly in the interest of expanding the criteria for psychiatric disability, especially for veterans suffering from post traumatic stress disorder.

I would like to say I share the Chairman's concern that we have instruments for assessing the disability of our members who have served us so well, but I would also, though, disagree that the GAF as has been reported and commented on by a number of people does not do that job.

The GAF or the global assessment of functioning of the DSM is designed to look at all mental health disorders. And what I think has been confusing to some people is that as it describes varying levels of functioning, it has references or it will say EG, for example. What is confusing is that the for examples frequently refer to schizophrenia or depressive disorders, but in point of fact, the broad categories themselves can be used to apply for all mental health disorders and

could as readily be designed to respond to post traumatic stress disorder. We at the APA or myself would be glad to work on some models of that.

I should also note that I would like to agree with the Institute of Medicine for the need for the establishment of broad criteria and the training of Veterans Administration's physicians and evaluators to a standardization of the criteria and the terms in which all mental health diagnoses are made.

Four years ago, I had the opportunity as a psychiatrist working for Veterans Integrated Services Network (VISN) 12 to review how PTSD was diagnosed and treated in the Veterans Administration hospitals in the Great Lakes. To my amazement, there was no universal agreement. The treatment you got or the diagnosis you received depended totally on which hospital you attended. There was no comparability. One hospitalized everybody for a month. One treated everybody in a day treatment center and one treated everybody as an outpatient. This will not do.

It's not surprising that categorization of assessment tools do not work if the people filling them out and completing them have no standardization.

I should note that all mental disorders ranging from mild depression to schizophrenia to PTSD vary in the degree of disability associated with them. The questions of disability not only affect veterans and active-duty military personnel, but they affect civilians in Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI).

We believe it is important that clinical research, insurance claims management, and government use of mental disorders diagnosis all have a common frame of reference and a common diagnostic set of tools.

The DSM is that common reference point and it is used throughout the world to accomplish this, not just in the United States, but in all sectors of the world. It has been used and worked on by World Health Organization. And on the basis of that work, for the past 26 years, we have been working then to reassess and revise and reexamine and reformulate the DSM.

I should note that the DSM is used by all mental health practitioners, psychologists, social workers, counselors, mental health administrators. And the need for a common language has been noted by some of my colleagues. In the absence of a common language and standards, epidemiological surveys and studies of mental health practice patterns cannot be made. Practice guidelines for clinicians to improve and standardize patient care could not be made.

Our concern is that we not fragment our system of assessment by introducing new forms which could be idiosyncratic, but that we use a standardized form. We can work to modify the forms used for the global assessment functioning be changed to respond to PTSD and refer specifically to PTSD.

We should also note in closing that all forms of the United States Government from TRICARE to Champus to Medicaid and Social Security all use the DSM.

In closing, I should also note that we are in the process of developing a new DSM or DSM-V. The Chair of the work group to develop the DSM-V apropos of PTSD is Dr. Matthew Freedman. He is a psychiatrist and Executive Director of the U.S. Department of Veterans National Center for Posttraumatic Stress, so he brings a critical perspective to the review of the DSM. And a particular focus of this DSM-V work group will be the reevaluation of the relationship between mental disorder and disability.

And I close as did my colleague of our need to ensure the adequate and responsible acknowledgment of the needs of the men and women who have served our country so well.

Thank you.

[The statement of [Dr. Weissman](#) appears in the Appendix.]

Mr. HALL. Thank you, Doctor.

I should have acknowledged our Ranking Member, Congressman Lamborn, who obviously you noticed his presence, but I am acknowledging it officially and thanking him for being here.

And now we will turn to Mr. Abrams who is recognized for five minutes.

STATEMENT OF RONALD B. ABRAMS

Mr. ABRAMS. Thank you, Mr. Chairman and Members. I am pleased to have the opportunity to submit this testimony on behalf of NVLSP.

I would like to point out that many parts of the rating schedule have been updated, amended, and changed. Some have been helpful. Some of the changes have been helpful. Some have been harmful. If you want to look at a bad one, go look at the way they changed the back condition evaluations.

As someone with a severe back condition, I can tell you that the current rules on evaluating back conditions where you have to be in bed for so many weeks really hurts people with those conditions and they ought to do something about that and fix that.

Of course, NVLSP would want the rating schedule updated, modernized, and otherwise improved. However, we want to caution that improving the rating schedule is not a cure all. In our opinion, there is no amount of money that would adequately compensate any veteran for the loss or loss of use of a body part, permanent cognitive impairment, or the loss of a creative organ. We should be asking not how much is the disability worth, but how much can this Nation afford to pay.

I want to stress that our priority is the evaluation of mental conditions and we believe that for a long time, the VA has tended to under-evaluate mental disabilities. This has occurred at the same time that our society has evolved from one dominated by manual labor to a work environment that emphasizing intellectual endeavors.

We really cannot compare the impact of a mental condition today to the impact of a mental condition in 1947 where we had more of a farm economy than we do today.

I also want to stress that veterans with mental conditions are handicapped. While vets with heart conditions, lung conditions, and other conditions can get 100-percent schedule or evaluation, a veteran with a severe mental condition who is lucky enough to find some kind of minimal work cannot work and get the 100-percent evaluation. We do not think that is fair.

Also, we would like to stress that we agree with the current VA rating policy on individual unemployability or IU. We reject any recommendation that would require the VA to implement a periodic evaluation or review of veterans in receipt of IU benefits. They tried this in the 1980s. I worked for the VA at that time. And we ended up being pushed as employees to cut off as many veterans as we could.

At one time, the rolls went from, I believe, 180,000 vets getting IU to under 80,000. I do not think you want to go there. That is not the way to go.

This long-standing policy about paying people unable to perform substantial gainful employment because of their service-connected conditions without considering nonservice-connected conditions, without considering age should not be changed.

We have already talked about at other hearings our views on traumatic brain injury, so I will leave that for you to talk about later.

And we also want to stress that the current association standard regarding presumptive service-connected conditions should not be changed. The causal effect would be almost impossible for vets who come back from Vietnam after being exposed to Agent Orange to win benefits unless science can determine what is a causal effect.

Do not go there. This is not working. We are getting benefits for people when statistically we can see an association between being in a terrible place in the world where we send our troops and then later getting hypertension and other terrible conditions, lung cancers.

Thank you very much.

[The statement of [Mr. Abrams](#) appears in the Appendix.]

Mr. HALL. Thank you, Mr. Abrams.

It is true I was noticing reading the pages in the part of the DSM on post traumatic stress and anxiety disorder that a substantial number of our former panelists said numbers of the population at large, civilians, exhibit these symptoms depending on exposure to robberies or muggings or volcanic events, I am sure there are quite a few residents of the New Orleans area who were exhibiting symptoms because of Hurricanes Katrina and Rita and so on.

Now we are hearing from Iraq and Afghanistan that our Diplomat Corps and their families are reporting symptoms that would probably qualify as PTSD.

I wanted to ask Dr. Hyman, based on your testimony, it seems you are advocating for the use of the current WHO standard as encompassed in the AMA Guides.

Can you give us an example so we can better understand the difference between disability and impairment?

Dr. HYMAN. Yes, Mr. Hall.

Let me give you an example from my own private practice. I take care of a conductor for the Philharmonic in my city. And he called me one day and said, you know, Mark, there is something wrong with my ear and I cannot hear very well.

Now, hearing loss, which is one of the three most common conditions that are in the claims for the veterans, would be evaluated with specific hearing tests. And one would generate an impairment rating. In other words, how impaired, how much loss of use of that hearing has somebody obtained.

But that loss of hearing for my conductor patient could translate into 100-percent disability because he is not able to work as a conductor because hearing is so critical to his work, whereas for another worker where that level of hearing acuity is not necessary to perform their essential job functions would have a lower disability.

Another example might be in that same type of field a concert violinist. If somebody injures their finger and they happen to be performing janitorial services and it happens to be their fourth digit and it is a partial amputation, they could probably fulfill all the job requirements of their janitorial duties. And in that respect, they would have no disability from their job. But a concert violinist is now 100-percent disabled.

They both have the same injury. They both have the same impairment. They are both evaluated in the same manner and are given a very fair, appropriate, understandable impairment rating, which is then translated by the impairment rating process and the disability process into their ultimate effects.

Mr. HALL. Dr. Weissman, the issues with mental health and PTSD have been complex. Could we have your opinion on these as well? For instance, what is your reaction to the IOM study on PTSD and compensation?

Dr. WEISSMAN. It is interesting because I think they are not unlike my colleague's comments vis-à-vis what your tasks are and what your jobs are. I think that we have probably underestimated for varying reasons the significance of PTSD and its disabling effect on people.

I think that as is the case in all mental disorders, it can be so totaling disabling and marginally disabling. I think that the need for a thorough diagnostic assessment of someone with PTSD is

the aid and the assistance in making that determination, but I believe that we have probably underestimated the significance of it because, as you noted, we frequently think in terms of mental disorders of schizophrenia and, again, a global notion of it.

So I would agree with the Institute of Medicine report. It is understated. It is more complex and we need to do a much better job in assessing veterans who suffer from it.

Mr. HALL. What do you think of the VA's reliance on the GAF and should that be changed, especially as the basis of the rating schedule?

Dr. WEISSMAN. If one went to the GAF, I have got my DSM also, and where it says EG, it will say every ten points, there is a statement and then it is EG. If I started on the top at 90, I suspect any number of people here are at 100, but we will not quibble about our scores, not myself, but I believe you could take the GAF, use as the EGS, which means for example, elements of the symptomatology and behaviors observed in PTSD and as you would go down the GAF scores, the EGS, would describe more intensive intrusion into functioning. One could make the GAF an extremely effective agent for assessing PTSD as you could for any number of other mental disorders as it is used, by the way, around the world.

Mr. HALL. Would this fall into your comment about common language and standards? Is that specific enough and simple enough to be part of a rating system which could be automated, which could be computerized?

Dr. WEISSMAN. I would not want to computerize the diagnostic assessment of the man or woman who has served our country.

Mr. HALL. I am not saying computerize the assessment. I am saying that once a psychiatrist has diagnosed a particular level on the scale and that it could be entered in assuming—both the Ranking Member and I have an interest in moving toward, as much as we can, toward artificial intelligence for the purpose of rating and processing claims.

Dr. WEISSMAN. Assuming we went through the DSM and the GAF down the line and used as our example now, for our for example, PTSD and the varying elements of it, then I believe you could do just what you said. So, I have seen the patient with an extensive diagnostic interview and I have given him a rating of 55 and that scale should fit.

But I would also want to make sure that we have then done what the IOM also reported or asked for, which is a training schedule so that you certify people and that there is some inter-rater reliability because if there is no inter-rater reliability, then the number doesn't mean anything.

Mr. HALL. Mr. Abrams, would you be so kind as to give us in writing, at your earliest convenience, specifically how we should change the evaluation for back conditions.

Mr. ABRAMS. I would be happy to.

Mr. HALL. Thank you. I am personally interested in that as well.

Mr. ABRAMS. As someone who suffers from severe spinal stenosis, I would not get much if I could apply for my back condition. And I can tell you that I am lucky to have a job that I can do where I can sit, not stand, where I do not have to walk. And I truly believe that if I applied for Social Security, I would get it if I was not working. But in VA, I might get ten percent.

I do want to add something to what Dr. Weissman said. The GAF score would be a wonderful tool if the VA followed it and all they have to do is say—in fact, they are obligated to do it now. We take many cases to the Court of Appeals for Veterans Claims where the GAF is not consistent with the symptomatology and the VA under-evaluates the veteran's mental condition.

We feel that if the VA was encouraged to either accept the GAF score, I mean, we have seen people with 40 GAF scores get a 30 percent evaluation. That is just nuts. If they do not think the GAF score is right, the VA should send it back to the examiner and ask them to explain why such a score was assigned. And we win those cases on a routine basis at the court.

And so you do have a common language there if you can just get the VA to buy into that and do it, but we see that as a consistent error. In fact, if you look at our American Legion quality checks, you will see that is many of the errors that we found in the Regional Offices.

Mr. HALL. Thank you.

Mr. Lamborn, you are recognized for five minutes.

Mr. LAMBORN. Thank you, Mr. Chairman.

Dr. Weissman, will you briefly summarize for us the findings of the planning conference on PTSD from June of 2005? For example, what were the specific recommendations for research and will these be included in the DSM revision due in 2011?

Dr. WEISSMAN. Well, in one of my other roles, I happen to be a trustee of the American Psychiatric Association. We are in the very early form of developing a number of task forces to look at the totality of the psychiatric diagnostic system.

So I cannot tell you explicitly what that conference was other than to say that that was to form the framework of beginning to put together people from around the world to create the new DSM-V, which will not be published until 2011 and 2012. So this is the formative period. It will use all of this data.

I would hope that as my friend here, I will sound like one of the candidates, I believe that if we work on the common language, use it effectively, understand language from as follows, that will then be able to inform not just for veterans, men and women who have experienced combat. But, as Mr. Hall says, PTSD is not simply a disorder of the military. It is a disorder for all of us. All of us have family members who have experienced traumatic situations. And I dare say all of us could find members of our families who have some degree of PTSD.

But that is the formative period for the task force and the work groups to establish the DSM-V and one element that one of the task force works on these issues.

Mr. LAMBORN. Thank you.

Mr. HALL. Thank you, Mr. Lamborn. And—

Dr. HYMAN. Mr. Chairman.

Mr. HALL. Yes.

Dr. HYMAN. One brief comment. In reflecting on some of the comments here, I do hear an understandable concern as the mechanisms of bringing the science to the patient. And I think these resources have that process built into them. And I said, there will never be a perfect scale for many of these conditions, but this is the state of where we are at and we will always get better.

What I think is very important is to have the mechanisms in place of using these standard references. And as an example, I want you to know that in California where I am now at, we have the country's largest workers' compensation system and we passed a law to put into place the AMA Guides. And that process took eight months.

This is not something that, requires a long period of start-up and evaluation in order to accomplish what is doable. And that could be something for your deliberations as far as putting something in place that can begin to bear on the benefits for these veterans that are needed and over time, work on the associated issues.

Mr. HALL. Thank you.

Dr. Weissman, I wanted to ask you, would you say that if a veteran is diagnosed with PTSD, it would be safe to assume that the stressor occurred in a combat zone even if the veteran did not have a combat action ribbon or some other combat related award?

Dr. WEISSMAN. One could serve in the military and experience a traumatic situation, which is not in the combat zone. A woman, and we know this is the case, could be sexually abused and assaulted and experience PTSD that is not combat related. One could be in an accident.

So the existence of PTSD in a veteran or an active-duty soldier does not in and of itself tell me that that was obtained in a combat zone.

Mr. HALL. Your comment that each VA hospital that you studied handled PTSD differently, diagnosed it differently, treated it differently is disturbing to me and not surprising based on some of the other testimony that this Subcommittee has heard.

Other than the common language and common standards, can you get more specific than that in terms of how you would suggest that we approach this?

Dr. WEISSMAN. I would take and work using the GAF, for example, work it through to each of those points where it says EG, develop a model that fits PTSD. I would then view the cases or interviews of men and women with PTSD and I would have a number of people observe those interviews, assess that data so that I could get a standardization.

And then after I have obtained a standardization and inter-rater reliability from my people developing the standardization—we have wonderful ways now of communicating that instantly around the country. With the web, I would then develop a training program to be taken by all VA psychiatrists or mental health workers who would assess someone for a mental disorder, for PTSD so that there would then be an agreement that if I was evaluated in Milwaukee or at Hines VA or Jesse Brown or in Tomah, Wisconsin, these are some of the places we looked at it, I would have the same rating.

However, I could warn you that when you do this, the inter-rater reliability fails after a time. The three of us could take the training and agree and very quickly, he goes to California and I go to Chicago, my friend, I am not sure where you are going, you have to make sure that the training is repeated, that we redo the training. This is a constant process. The VA is not always effective at constant processes.

It is not one where you get your transfer punched and it is good for the lifetime. You have to do this repeatedly. And I am convinced if we did that, we could develop a scale that works and I could ensure you, Mr. Chairman, and the American people that a vet evaluated in Milwaukee or Chicago or Los Angeles or Washington would get a comparable evaluation and be treated fairly. And he would not or she would not have to go somewhere else.

Mr. HALL. Thank you, Doctor.

Dr. Weissman, Dr. Hyman, Mr. Abrams, thank you all for your testimony and you have been very helpful to us. And thank you again for your patience. This panel is excused. Have a lovely evening.

Would our third panel please come to the table, Dean Stoline, the Assistant Director of the National Legislative Commission, the American Legion; Kerry Baker, Associate National Legislative Director of Disabled American Veterans (DAV); and Gerald T. Manar, Deputy Director, National Veterans Service of the Veterans of Foreign Wars (VFW) of the United States.

Gentlemen, thank you. Your full written statements have been entered as is customary into the record, so your oral testimony may be as brief or lengthy as you would like it to be. Hopefully not more than five minutes.

Mr. Stoline, you are recognized now.

STATEMENTS OF DEAN F. STOLINE, ASSISTANT DIRECTOR, NATIONAL LEGISLATIVE COMMISSION, AMERICAN LEGION; KERRY BAKER, ASSOCIATE NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS; AND

**GERALD T. MANAR, DEPUTY DIRECTOR, NATIONAL VETERANS SERVICE,
VETERANS OF FOREIGN WARS OF THE UNITED STATES**

STATEMENT OF DEAN F. STOLINE

Mr. STOLINE. Thank you, Mr. Chairman, Mr. Lamborn, and Members of the Subcommittee. My name is Dean Stoline. I am Assistant Director for the National Legislative Commission of the American Legion.

Thank you for this opportunity to present the American Legion's views on revising the Department of Veterans Affairs schedule for rating disabilities.

My statement includes the American Legion's views on this subject and also our views on recommendations contained in the Veterans' Disability Benefits Commission.

The VA should update the current rating schedule and begin with body systems that evaluate post traumatic stress disorder and other mental disorders such as traumatic brain injury. This revision process should be completed within five years and a published system of keeping the rating schedule up-to-date should be devised.

The American Legion cautions that revision of the rating schedule should be put into its proper perspective as the Committee conducts its work.

While we agree with the need for a new schedule, the problem for veterans is getting service connection on their claims. The rating schedule is a downstream issue a veteran contends with after the award of service connection.

In addition, the rating schedule is not the major cause of problems in the VA process. While updating disabilities that have not been properly reviewed is a good idea, the real problems veterans face are the inadequate staffing, the inadequate funding, the ineffective quality assurance, the premature adjudications, and the inadequate training that plague the VA, especially in the Regional Offices.

For example, what good is a new rating schedule if the veteran who files a claim waits for years going through a series of VA denials, remands, appeals, requests for submission of new evidence, and hearings before finally receiving the service connection award?

Only after service connection is the rating schedule relevant. And in the rating schedule, if the disability is lower than it should be, the veteran must appeal that decision through the same process all over again.

What good is a new rating schedule to Reservists and National Guardsmen who submit claims only to have them denied because the VA decides the disability did not occur or have its onset when they were serving on active duty? As with the prior example, the Reservist must appeal and face many years of fighting and waiting before a service connection is awarded. Only then will the rating schedule be relevant.

The Committee should note VA's lack of proper review of Reserve component servicemembers' claims will become more exacerbated as this Nation continues with the Global War on Terrorism.

Recent VA figures indicate that while the conflicts in Afghanistan and Iraq may be an active-duty war, they are also a citizen-soldier fight. Only 48 percent of the veterans from Afghanistan and Iraq have been active-duty servicemembers. Fifty-two percent are Reserve and National Guard members.

Clearly VA and DoD must be held accountable to properly ensure Reserve component servicemembers are getting the proper documentation while in active service for review of potential disability claims.

And the Committee must ask how a seamless transition for Reserve component servicemembers from DoD to VA can ever be made if the citizen-soldiers are not given an end-of-service medical examination. This DoD examination would be the one piece of medical evidence Reserve component servicemembers would need most for a VA claim to succeed.

Clearly these problems will not be resolved by a new rating schedule. The American Legion emphasizes the solution of those problems must be a major focus to reform the adjudication process.

Getting back to improving the schedule, the American Legion first stresses that we are a Nation at war. Therefore, no injury or disability to any current servicemember should receive less compensation because of an update to the rating schedule.

The American Legion believes evaluations for some disabilities, for example, amputations, loss of use of limb, loss of use of creative organ, are under-compensated because they fail to consider the impact of those disabilities on a veteran's quality of life and other disabilities such as mental conditions fail to adjust to changing American work environments over time. The American Legion welcomes changes to the rating schedule to take care of these inequities.

I will skip the PTSD and IU subjects because they were adequately covered in prior testimony by NVLSP.

I will move on to the periodic evaluation of IU eligible veterans. VA should authorize only a gradual reduction of their compensation for those returning to substantial gainful employment rather than abruptly terminating payments to them at an arbitrary level of earnings.

The American Legion opposes part of the Commission's recommendation that would be interpreted as requiring consideration of age in determining eligibility. It is inherently unfair to punish an older veteran who would not be able to work at any age because of a service-connected condition and award the benefit to a similarly disabled younger veteran.

The schedule is based on the average impairment in earning capacity. If the veteran cannot work because of service-connected disabilities, then IU should be awarded.

With regard to TBI, VA proposes a regulation to amend the current criteria. The American Legion commends the VA for recognizing the situation and for making an effort to revise the current criteria.

Lastly, the proposed regulation does not discuss consideration of the history of the disability on TBI. TBI symptoms wax and wane for some veterans. Therefore, some veterans may be under-evaluated if the history of their symptomatology is not considered.

With regard to the evaluation of cognitive impairment, we believe that “moderately impaired” and “severely impaired” should also be defined in the regulation.

With regard to applicability date, the VA contends the proposed rule should be applicable to claims received on or after the effective date. The American Legion disagrees. It does not make sense to apply the old rating criteria to a claim that has not been initially adjudicated or is pending readjudication due to an appeal simply because the claim was received prior to the effective date of the new rule.

With regard to presumptions, the Commission made recommendations regarding the replacement of the current association standard with its causal effect standard in the presumptive disability, decision-making process. The American Legion does not support those recommendations because the association standard currently used in the presumption determination process is consistent with a nonadversarial and liberal nature of the VA disability process.

For example, for 1991 Gulf War veterans, specific or reliable exposure data is not available due to improper record keeping. So for Operations Desert Storm and Desert Shield veterans, there is insufficient information to properly determine their exposure to the numerous environmental and other hazards found in that conflict. This lack of data clearly diminishes the value and reliability of a causation standard. It should be noted that despite its recommendation, the Commission did state that it was concerned that causation rather than association may be too stringent and encourage further study of the matter.

In closing, I thank you again, Mr. Chairman, for allowing the American Legion to present its comments on these important matters. As always, the American Legion welcomes the opportunity to work closely with you and your colleagues. I stand ready for any questions you may have of me.

[The statement of [Mr. Stoline](#) appears in the Appendix.]

Mr. HALL. Thank you, sir, and we appreciate your testimony. We will have questions in a minute.

But, first, Mr. Baker is recognized.

STATEMENT OF KERRY BAKER

Mr. BAKER. Mr. Chairman and Members of the Subcommittee, on behalf of the DAV, I am pleased to offer my testimony to address the VA disability rating schedule.

The present rating schedule was developed in 1945. By 1961, there had been no less than 15 revisions. In fact, since the beginning of 1990, there have been no less than 28 sections of the rating schedule updated to some degree.

I am providing this information in response to most of the rhetoric that VA must completely revise its entire compensation system. The majority of support for such rhetoric stems from speechless proposals that VA's compensation system is over 60 years. It is not. VA's disability system in 1945 was but a shell of today's system.

In no previous war was there a need to recreate VA's disability system nor does such a need currently exist. However, the DAV agrees that portions of the rating schedule must be updated such as but not limited to traumatic brain injury or TBI and residuals and the mental health rating criteria.

The problem with the mental health criteria is the weak nexus between severity of symptoms and degree of disability. Another problem is the proclivity for VA decision makers to deny increased rating claims based on failure to demonstrate symptoms required for a higher rating and the lack of such symptoms is not at all associated with a condition. Therefore, any update to the mental health disorders rating schedule should be condition specific rather than a one-size-fits-all criteria.

Essentially the DAV supports the Veterans' Disability Benefits Commission or VDBC recommendation that VA update the rating schedule, keep it up-to-date, and establish an Advisory Committee to assist in the updating process.

With respect to ratings for individual unemployability or IU, the VDBC asked the CNA Corporation to conduct an analysis of veterans receiving IU. The central focus of their work was to determine whether the increase in IU was due to veterans manipulating the system.

The CNA Corporation discovered that the growth in the IU population is a function of demographics and that disabilities are worsening as veterans age. The CNA Corporation concluded that the increase in IU is not due to veteran manipulation.

We realize the need to help unemployed veterans return to work when feasible. Most desire to lead productive lives rather than attempt to survive only on VA compensation. Nonetheless the slightest misinterpretation by VA employees of a change in law regarding entitlement to benefits under this program will result in a large number of veterans receiving an unlawful denial of benefits or worse a revocation of benefits.

We ask that you realize that no single disability will ever affect two veterans in the same manner. What may render one unemployable may simply not be the other.

With respect to quality of life, the VDBC recommended that Congress increase compensation rates up to 25 percent for loss of quality of life. The DAV fully supports this recommendation.

Through comprehensive research, the Commission determined that compensation at most helps some groups of disabled veterans achieve parity with their nondisabled counterparts, but only with respect to loss of earnings due to disability. However, other groups were found to be below parity when compared to nondisabled veterans.

These findings show that VA compensation replaces only the average in lost earnings for many veterans, but much less for others. In no event are veterans being overcompensated. The question then arises of how, not if, VA should develop a way to compensate for each. I believe that question is simply yet to be answered.

In conclusion, we know that society has laws that are evolutionary. The founders took great care in assuring that change does not come easy, but still provided for its evolution. Some ignore this by acting hastily, attempting to push legislative agendas aimed at more conserving the bottom line than conserving the benefits that disabled veterans spent the last hundred years fighting for.

Some of these agendas would pit veterans against veterans or worse pit veterans against their government. We simply urge caution. We support a vast majority of the VDBC's recommendations because they are well-researched, carefully-planned suggestions with the potential of improving what is already a good system.

Once again, however, we urge Congress to resist hastily-laid plans designed to do more undoing than doing or else the next battle we will fight will be the one against unintended consequences.

Mr. Chairman, thank you for inviting the DAV to testify today. I will be happy to answer any of your questions.

[The statement of [Mr. Baker](#) appears in the Appendix.]

Mr. HALL. Thank you, Mr. Baker.

Mr. Manar, you are now recognized.

STATEMENT OF GERALD T. MANAR

Mr. MANAR. Thank you. Chairman Hall, thank you for this opportunity to present the views of the 2.3 million veterans and auxiliaries of the Veterans of Foreign Wars of the United States on the state of the VA's schedule for rating disabilities.

Today I am going to talk about the rating schedule, individual unemployability, and presumptions. We address other topics in our testimony, and we hope that you have an opportunity to review it.

We have heard today about the history of the development of the rating schedule. I think it was you yourself who mentioned that there was a rating schedule that was created in 1917. Certainly there was one in 1921, 1925, 1933, and 1945.

The interesting thing about the 1925 rating schedule is that it attempted to do what one of your earlier witnesses advocates and that is to tailor individual evaluations based on the profession or the occupation of the individual veteran.

While it is a laudable goal, it is in our view, unworkable. Certainly the VA found that it was, in fact, unworkable and they reverted to an earlier scheme in 1933.

The VA has, as my colleague here from the DAV has said, continuously updated bits and pieces of the rating schedule since 1945. They have not ignored it.

The problem is that as time has passed, they have been able to, in our view, devote fewer and fewer resources to it. And as a consequence, the changes have flowed less frequently.

And, in fact, as they have made changes, they have incorporated some problems into the rating schedule that might have been avoided had they been able to devote more resources and more experts to the process.

Now, the Institute of Medicine, the Dole-Shalala Commission and the Veterans' Disability Benefits Commission all found that the rating schedule is filled with terminology that is archaic, had criteria for evaluating disabilities that needs to be refined. Medical knowledge has advanced to the point where much of the rating schedule needs to be rearranged and reformed.

Everybody has an alternative approach to doing this. Under Dole-Shalala, they would simply throw it out and start fresh. In our view, their proposals would have a new rating schedule in a very short period of time, formulated in a back room of a bureaucracy, reviewed and modified by the Office of Management and Budget, and then presented to the world for their consideration.

If left alone, the VA also will continue reviewing and fixing bits and pieces of the rating schedule. But they are doing so with the resources that they have at hand. So we will get what we have already got in that respect.

The Veterans' Disability Benefits Commission, on the other hand, has made recommendations that build on those from the Institute of Medicine. It is the only plan to create a process for the logical, methodical, measured review in updating of the rating schedule.

We do not agree with everything the Institute of Medicine recommended, but we do support their structured approach. They have presented a blueprint for change. They advocate the creation of an Advisory Committee, which would be staffed with experts in medical care, disability evaluation, functional and vocational assessment and rehabilitation, representatives from health, health policy, disability law, and from the veterans community.

Our view of its function is somewhat different from what the Veterans' Disability Benefits Commission and the Institute of Medicine have recommended. We think this Committee should perhaps look at, as an example, the Defense Health Board and see how that has worked for the Defense Department.

We think that this Advisory Committee needs to be separately funded and not directly under the Compensation and Pension Service. We expect that it would meet several times a year and work in the open. We view this as very important. And it would provide guidance and direction to the VA. We expect that it would make changes based on data and research.

In our view, individual unemployability is not broken. You have heard testimony earlier today from the Center for Naval Analysis that the increase in the grants of individual unemployability over the last ten years is almost certainly related to defects or problems with the rating schedule rather than any other single individual cause.

Understanding why there is something like individual unemployability is very important. The rating schedule is very mechanical. If you can only raise your arm to your shoulder level, you get a certain evaluation. If you can only raise it to your waist level, you get a higher evaluation. It is very uniform.

The regulations allowing the grant of individual unemployability allows the VA in this one instance to exercise flexibility to address the inequities in the rating schedule and differences among individuals. It allows the rating specialists to look at education, vocational skills, job history, and experiences of the individual.

If the VA grants individual unemployability for certain conditions more than others, it may be an indication that the rating criteria is not appropriate and should be changed.

[The statement of [Mr. Manar](#) appears in the Appendix.]

Mr. HALL. Thank you, Mr. Manar.

Mr. MANAR. Thank you.

Mr. HALL. Thank you all.

Mr. Stoline, your comment that 48 percent of Operation Iraqi Freedom/Operation Enduring Freedom soldiers are active duty and the remainder Guard and Reserve is a striking one.

One of our earlier hearings, we had a witness testify that we should approach this—well, he was specifically talking about educational benefits, but I believe he would say the same for disabilities or for medical benefits. Same service, same battlefield, same benefits.

And in this case, it is just a reminder to me that we are using our Guard and Reserve today in a way that perhaps they have historically not been used.

And also your comment about, I was not sure if you said it was turning into a system soldier fight or if we want—

Mr. STOLINE. Citizen soldiers fight because the Reserve—

Mr. HALL. Citizen. Excuse me. I heard you wrong. Citizen soldiers fight, right.

Mr. STOLINE. I think the Nation looks upon what they see on the news as the active duty of the President's force. But when you look at the statistics, which are VA statistics, not American Legion, you rapidly see it is the folks who are the part-time soldiers who are paying the price and not the price just on the battlefield but the price after the war because when they get back to the VA, the VA is not able to understand. Even though the health problems are the same, they do not think because it is a Reservist they suffered it under active-duty conditions and it is just a real struggle.

And that is why in my testimony I said it is a DoD as well as a VA problem. They have to have the proper documentation, especially that end-of-service documentation. Otherwise, citizen-soldiers just lose out with the VA. And a rating schedule, no matter how good, will not change that.

Mr. HALL. Okay. All right. Thank you for clearing that up for me.

Timeliness issues seem to be a priority concern with the veterans I have spoken with, especially older veterans who have waited years for decisions and younger veterans who are just now leaving the military and do not have months of financial reserves to fall back on while waiting for VA to rate a claim.

Would it not be better to get these veterans paid in 45 days as opposed to months or years later?

Mr. STOLINE. Is that to me?

Mr. HALL. Yes.

Mr. STOLINE. Yes. I would think it would be. We understand the nature that VA has to protect the public, but the law is quite clear that it is to be liberally applied and the veteran should get the benefit of the doubt.

And I think there is ample opportunity for the VA to relook back at the record after they have made a decision because it is in the law that they can rectify a decision that was erred too much to the side of the veteran. But as you see, most of the time, it errs too much to the side of the government.

Mr. HALL. As CNA studied and found, but most of us believe to be true, that the veterans are not massively trying to rip off the government. And I think that most people would expect that to be the case.

What I hear from my constituents and people I meet around the country and especially in these hearing rooms is that we should be presuming more on the side of the veteran and not asking them to clear a high bar or jump through hoops.

You have expressed concern in your testimony over the presumption standard proposed by the IOM and the VDBC. After hearing your testimony today that explains the need to create a model to develop better scientific and medical data, do you not think it would be in the best interest of veterans to know more about the environmental and occupational hazards that they are exposed to during military service and could that not also mean better treatment and recovery? And I would also like to hear DAV and VFW's thoughts on this subject.

Mr. STOLINE. Well, mine, of course, we talked about and used the Gulf War as an example is that the military does not keep proper records. How are you ever going to be able to scientifically study what the exposures were? And I think that speaks for itself.

Mr. BAKER. I can probably add a little bit to what Mr. Stoline said. I mean, I cannot speak to the military's record-keeping process as far as the Gulf War is concerned. I am sure it could have been better. But they do have records of what they know was there.

I was there extensively. They know the things in the atmosphere as far as oils and some of the chemicals and some of the biological agents. But they still have not been able to point a finger of any of those things to any particular symptom from any of the veterans that have been sick after they returned from the Gulf War.

And that is why I think if you try to structure the presumptions around some of the ways that the IOM suggested, you are never going to get to that answer. The same thing applies to Vietnam veterans with dioxin exposure. A statistical relationship is all that has ever been shown.

I believe one of the gentlemen mentioned you would give the presumption at least when it is 50 percent or more that a specific condition is related to a specific exposure, whatever it may be. But if you cannot prove one way or the other, I do not see how you get past that 50 percent. If it is inconclusive results, it is inconclusive results.

But if you know that 80 percent of the veteran population that were exposed as opposed to 80 percent that were unexposed are getting sick, well, then I think you have to rely on that statistical information if you have no other route to go down.

Mr. HALL. Mr. Manar?

Mr. MANAR. Both my colleagues have pointed out first the real difficulty is in gathering data on a battlefield or in every-day occupations. You can imagine somebody at an airfield being exposed to gasoline fumes, toxic chemicals of all kinds and perhaps not even know it.

It would probably be an overwhelming task for the military to accumulate data on every possible exposure. So knowing that it is impossible, I think the law has to take into account that we have

to know that there are some things we are not going to know fully or we might not know for many years to come.

So that is why, of course, there are presumptions and that is why we oppose any proposal that would raise the bar, whether it is legal or scientific, to ensure that veterans receive healthcare and compensation.

We believe that the current standard of association is appropriately high enough and to make veterans wait years, perhaps even die while they are waiting for science to catch up with and make a decision as to whether there is a causation between something that occurred in service and a current disability is too high.

Mr. HALL. Thank you.

Mr. Manar, in your testimony, you stated that Compensation and Pension Service has fewer than 140 people. However, VA reports that its C&P direct labor full-time equivalent (FTE) for 2008 is about 10,304.

Are you suggesting that more of the FTE be directed to the Central Office rather than in the field?

Mr. MANAR. You direct more people in the Central Office, fewer claims get rated or processed. But at the same time, this is a \$30 billion plus program or set of programs and VA needs to dedicate adequate resources to administer it.

As I mentioned earlier, the rating schedule has slowly eroded or fallen into disrepair because not enough resources were allocated to keeping it up to date and keeping it current. Had the VA done so, many of the problems that veterans face today would not exist.

So I think that, yes, there should be more people in Central Office. As difficult as it is to recruit and find qualified people to come to Washington, a high-cost area, they need to make the effort because this is too important to let go on as it has in the past.

Mr. HALL. Thank you.

And just one more question to Mr. Baker. I understand that DAV is cautious in changing the way VA does business since there are components of the process that do work. I thank you for your extensive review of rating schedule revisions.

But as staunch veterans' advocates, you must see that the system the way it is needs serious repair and cannot continue to rely on antiquated medical concepts, outdated tools, and ineffective business practices.

Has the DAV explored how to improve the system beyond resources and training which we have heard? What else would you suggest to make this a better rating system for disabled veterans?

Mr. BAKER. We only give the impression that we are against updating the rating schedule. We are certainly not. Anything that is outdated, we support 100-percent updating that.

What we are opposed to is recreating the system. The system that VA works within is very good. And over the years, if you look at the 1945 schedule and the 1945 system and compared it to today, you would find a lot of holes that veterans can fall through in the 1945 system that have been accounted for now. And if you recreate that, you are going to recreate those holes and I think you are going to recreate some problems.

We all in DAV have some ideas about some large policy changes, maybe some small policy changes that we think could make some very good improvements in the system. I would suggest looking at all aspects from the top down or bottom up, however you wanted to start, looking at practices of the Court of Appeals for Veterans Claims. There are issues there that could be very cost effective, that could be changed, that would support the court more, the veteran more, and help the VA more.

The same thing with the Board of Veterans Appeals. Same thing with developmental procedures at the Regional Offices.

Everybody is looking at IT technology. I think it is important to focus that IT technology in the right place. What is taking the longest in developing these claims? Well, the development is. It is not the rating decision. So focus the IT technology to the development process. That is currently taking the longest time. It is about 90 percent of the whole time frame to decide a case.

Once a case is ready to rate, it is not taking that long. You can develop an automated system for rating once you focus on the larger problem.

There are other smaller things, changes in small regulations or maybe statutes that, you know, I would be happy to submit for the record in writing so I can give you a little bit more detailed answer without getting into the weeds too much here.

But we are certainly not opposed, you know, to updating anything. We want to see the updates. We just do not want to recreate the system that has served veterans pretty good for a very long time.

Mr. HALL. Thank you very much, sir.

Thank you all for your service to our country and to our veterans. Thank you for your patience. Thank you for your testimony this afternoon, and you are now excused.

And changing of the guard, we will ask our fourth panel to join us, Brad Mayes, the Director for Compensation and Pension Service of the Veterans Benefits Administration, U.S. Department of Veterans Affairs; accompanied by Tom Pamprin, Deputy Director for Policy, Compensation and Pension Service, Veterans Benefits Administration; Steven H. Brown, M.D., M.S., Director for Compensation and Pension Exam Program, the Veterans Health Administration; Patrick Joyce,

M.D., Chief Occupational Health Clinic, Veterans Health Administration; Richard Hipolit, Assistant General Counsel for Department of Veterans Affairs; Joseph Kelley, M.D., Deputy Assistant Secretary of Defense for Clinical and Program Policy, U.S. Department of Defense; and Horace Carson, M.D., Senior Medical Advisor, Air Force Review Boards Agency, Department of Defense. Thank you all for being with us. Thank you for your patience also. This has been a long afternoon. Somehow it always turns out that way.

And, Director Mayes, your statement is in the record, as you submitted it, and you are given five minutes to address us however you choose.

STATEMENTS BRADLEY G. MAYES, DIRECTOR, COMPENSATION AND PENSION SERVICE, VETERANS BENEFITS ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY TOM PAMPRIN, DEPUTY DIRECTOR FOR POLICY, COMPENSATION AND PENSION SERVICE, VETERANS BENEFITS ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; STEVEN H. BROWN, M.D., M.S., DIRECTOR, COMPENSATION AND PENSION EXAMINATION PROGRAM, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; PATRICK JOYCE, M.D., CHIEF, OCCUPATIONAL HEALTH CLINIC, AND CHIEF PHYSICIAN, COMPENSATION AND PENSION PROGRAM, WASHINGTON, DC, VETERANS AFFAIRS MEDICAL CENTER, VETERANS HEALTH ADMINISTRATION U.S. DEPARTMENT OF VETERANS AFFAIRS; RICHARD HIPOLIT, ASSISTANT GENERAL COUNSEL, OFFICE OF GENERAL COUNSEL, U.S. DEPARTMENT OF VETERANS AFFAIRS; AND MAJOR GENERAL JOSEPH E. KELLEY, M.D., USAF (RET.), DEPUTY ASSISTANT SECRETARY OF DEFENSE FOR CLINICAL AND PROGRAM POLICY (HEALTH AFFAIRS), U.S. DEPARTMENT OF DEFENSE; ACCOMPANIED BY HORACE CARSON, M.D., SENIOR MEDICAL ADVISOR, AIR FORCE REVIEW BOARDS AGENCY, U.S. DEPARTMENT OF DEFENSE

STATEMENT OF BRADLEY G. MAYES

Mr. MAYES. Thank you. Mr. Chairman, Mr. Rodriguez, I am pleased to appear before you today to speak on the subject of revising the Department of Veterans Affairs VA schedule for rating disabilities.

As you noted, I am accompanied by Dr. Patrick Joyce, Chief of the Occupational Health Clinic and Chief Physician, Compensation and Pension Program at the Washington, DC, VA Medical Center; Dr. Steven Brown, Director of the Compensation and Pension Examination Program Office, Veterans Health Administration; Mr. Tom Pamperin, Deputy Director for Policy, Compensation and Pension Service; and Mr. Richard Hipoli, VA Office of General Counsel.

I would like to briefly highlight some points made in my written statement, which was submitted for the record. Before I begin, however, Mr. Chairman, I want to apologize for getting the statement to the Committee so late.

We spent a great deal of time preparing for this hearing, to include my statement, because we know this subject is of such great importance. I regret, however, that you may not have had sufficient time to review what was submitted for the record and I hope that you have an opportunity to do so. I described, in some detail, the history of VA's rating schedule and how we got where we are today, much of which we have heard from the previous panels.

With that, let me say that the VA rating schedule has truly evolved over time and continues to evolve. It has served literally millions of veterans throughout much of this Nation's great history.

There are some fundamental underpinnings to VA's disability compensation program that bear mentioning. First, it is a system designed to compensate disabled veterans for lost earnings capacity.

The system is modeled after workmen's compensation programs developed at the turn of the 20th century and still in use by society today.

The system is based on the "average man" concept so that individuals are not penalized because they may be able to overcome their disability.

And, finally, the system generally relies on degree of anatomic loss and functional loss to approximate those lost earnings, with the exception of mental disorders where there is consideration of social and economic impacts.

Fundamentally, I believe we need to ask two questions. Does the VA rating schedule meet Congress' mandate to compensate veterans for reductions in earning capacity from specific injuries or combinations of injuries and should that mandate be expanded to include compensation for loss in quality of life due to injury or disease in service?

The second part of the question is a broader public policy question that requires study and that is exactly what this Administration initiated in recent proposed legislation sent to Congress this past October.

Title 2 of the President's draft bill, "America's Wounded Warriors Act," would require VA to complete a study regarding creation of a schedule for rating disabilities based upon current concepts of medicine and disability, taking into account loss of quality of life and loss of earnings resulting from specific injuries.

VA entered into a contract on January 25th of this year for a study to analyze the nature of specific injuries and diseases for which disability compensation is payable under various disability programs of Federal and State governments, including VA's own program, and those of other countries.

The study will examine specific approaches and the usefulness of currently available instruments for measuring disabilities' effects on an individual's psychological state, loss of physical

integrity, and social inadaptability to include the impact on quality of life. We expect that study will be completed by August of 2008.

Finally, in my written statement, I outline a five-point plan to update the schedule and address various suggestions made by recent commissions and studies. The elements of the plan include the above-mentioned contract for a study, aggressive staff development and possible utilization of further contractor support, continued revisions to the schedule that are already underway, (we recently published a new regulation for evaluation of traumatic brain injury and we are reviewing the mental disorders portion of the rating schedule currently) development of a periodic review process to ascertain the effectiveness of the schedule, and, finally, evaluation of a possible quality of life component to VA's disability compensation scheme.

Mr. Chairman, this concludes my prepared remarks. I and others on the panel would be pleased to answer any questions you and Members of the Subcommittee might have.

[The statement of [Mr. Mayes](#) appears in the Appendix.]

Mr. HALL. Thank you.

Dr. Kelley, you are recognized for five minutes.

STATEMENT OF MAJOR GENERAL JOSEPH E. KELLEY, M.D., USAF (RET.)

Dr. KELLEY. Thank you, Mr. Chairman.

Due to the time constraints, I have submitted a statement and I will summarize the major points of that. And hopefully we will have more time for questions then.

The Administration has made significant efforts to improve the treatment of active-duty servicemembers and veterans. And they have commissioned independent review groups, task forces, Presidential Commissions, and this has culminated in the formation of a Senior Oversight Committee (SOC) chaired by the Deputy Secretary of Defense and the Deputy Secretary of the Department of Veterans Affairs. This has resulted in significant progress in DoD and VA cooperation.

When DoD looks at the issues for the goals for a disability system, they would like to have a fair, consistent, timely, and accurate adjudication of the disabilities which maximizes or incentivizes rehabilitation.

And the components of those that I think we have heard discussed is that it be scientifically based or evidence based, up to date and rapidly modifiable to meet new developments, new types of injuries, illnesses, medical treatments, consistent nomenclature, and that the DoD would have the ability to input when changes are needed in that system.

Recently, there has been great success in that as we have looked at the newly-formed and revised standards for traumatic brain injury and burns, which were published in the *Federal Register* in

January of this year. We would like to see that process formalized or institutionalized so that DoD would be involved in the revision of any of those standards as they went forward.

And I would like to also mention the pilot program in the National Capital region where there is an effort to have a single discharge disability evaluation where the DoD is concentrating on determining fitness for duty and all disability ratings are being done by the VA so there is not an inconsistency between the departments.

And that so far has gone well, but we do not have any conclusions from that study which is in progress right now. And we look forward to that and potentially promulgating that throughout the entire system.

Sir, thank you for the opportunity to make a statement and appreciate your comments.

[The statement of [Dr. Kelley](#) appears in the Appendix.]

Mr. HALL. Thank you, Dr. Kelley.

This is a little bit off topic, but since I have both Dr. Kelley and Mr. Mayes here, I wanted to ask you if you are consistent with nomenclature and the electronic transition or transfer of records that we all want to see happen.

I heard in Landstuhl from the Commander of the hospital there in October that he thought it was going to start happening in December, where the onion, as he described it of electronic information coming back with each wounded service man or woman from the field of battle, which would have added to it a layer in Balad, and again in the plane on the way to Germany, and again in Germany and the Landstuhl Medical Center, and then, every step of the way, there would be the medication, the treatment, the surgeries, whatever, starting with the diagnosis and any continued additions or changes in the diagnosis or diagnoses and then again on the plane back to the States to Walter Reed or Bethesda or whichever DoD facility they were in and the entire onion would then be able to be handed off to the VA.

And when Deputy Under Secretary Walcoff was with us last week, I asked him if he knew how close we were to that happening and he was not able to say, but I wondered if you could give us any update, based on your knowledge as to how close we are. We are not talking about a rating schedule here as much as we are IT, but the compatibility of technology between the two departments. How close are we?

Dr. KELLEY. Sir, if I could make a comment, I would like to take that and give you a more detailed answer later.

But just a summary statement is that we do have what we call the Joint Patient Tracking Application which goes through the system. It captures that data that you were talking about from the far forward front, bringing it back in the system. And it is not visible at all VA facilities at this time, but it is visible at the VA facilities where there are major treatment centers. And we

plan to expand that broader to encompass the entire system so that those who have the need to know have that.

So it is partially in place, what you describe, but it is not completely available. And that goes along with increasing cooperation. We are developing a common methodology for our next generation of electronic medical records.

Mr. HALL. Just do not call it Next Gen, okay? We will get confused.

Dr. KELLEY. And so we are making progress and it is going on and it is becoming present at more and more facilities as we go on.

Mr. HALL. That is good to hear. Thank you.

And please update us as it progresses because it is something the Subcommittee and the full Committee are very interested in, and concerned with.

Director Mayes, you said that the revision of the rating schedule has actually been underway since the 1990s, which seems like a long time to get this done. Realizing, of course, that as the battle changes and the weapons change and the circumstances change that, maybe it will never be done, but it seems you are still working on recommendations, some recommendations anyway, from 1956 and ones that never materialized in 1971.

Have you been doing one code at a time or why does it appear this way? Would it not be better accomplished by an established editorial panel that constantly updates the codes?

Mr. MAYES. Mr. Chairman, I think you are right on point. We agree with the Institute of Medicine and with the Disability Benefits Commission, there has to be an ongoing systematic approach to revising the schedule. You really are never going to finish because medical science advances.

We have gone through 12 of the 15 body systems. We take it a body system at a time. That has been our approach. We begin looking at that body system which will have multiple diagnostic codes and we begin reviewing the criteria looking for obsolete codes or obsolete evaluation criteria, engaging our partners in the Veterans Health Administration, and then we propose changes similar to what we did recently with the traumatic brain injury revisions to the schedule. They are published for notice and comment so that our stakeholders have an opportunity to weigh in. And we got lots of comments on the proposed TBI regs and we are in the process of assimilating those comments.

So, I agree. One of the elements of my five-point plan is to put in place this regular schedule so that it is continuous. And we are building the capacity to be able to do that.

Mr. HALL. That is very encouraging and I commend you for that.

It seems that the private sector relies on some codes and guides that work well for them that are simpler than the VA's rating schedule. I am just curious if you had the observation and if you considered adopting what is already in existence in terms of disability ratings in the private schedule as opposed to going through this process of what some would call reinventing the wheel.

Would it take a shorter time to revise the rating schedule if we did that?

Mr. MAYES. A couple of comments on that. I guess one could argue the VA has been revising that schedule since 1917, you know, in reality. I would say that we are interested in hearing what the American Medical Association has to say, as well as the World Health Organization.

As a matter of fact, next week, we are meeting with Dr. Rondinelli to discuss their compensation scheme. We are open to considering other alternatives.

I would say, though, I was struck by Dr. Bristow's comment regarding the International Classification of Disease system. I think he mentioned 14,000 to 17,000 codes. The VA rating schedule right now has in excess of 700 codes.

Mr. HALL. They should adopt your schedule then.

Mr. MAYES. Yes, sir. I do not know that we want to get more complex. What we want to do is make sure that we have a system that accurately compensates veterans for earnings loss and quality of life if that becomes the mandate.

And I believe that there is the possibility to cross walk that system with the International Classification of Disease system which, as I understand it, was primarily set up for identifying diseases and for billing purposes.

We are trying to come up with a system and particular codes that will provide for evaluation criteria to compensate veterans. I think that makes it a little bit different than the ICD scheme.

Mr. HALL. Right. I would also assume that the World Health Organization and other organizations have to consider some genetic syndromes and diseases that, may not be something that would be service related. They could be if you happened to be serving in an area where a rare pathogen was at work, but that some of them could be ruled out.

I wanted to ask you, does VHA already evaluate veterans for their quality of life? Is that not what the SF36 scale is designed to indicate?

Mr. MAYES. I am aware of that standard form and I do believe that they administer that, but I personally am not familiar with how frequently or who they administer that instrument to.

Mr. HALL. Can you explain why according to the VDBC report so many veterans with PTSD are rated with IU instead of a 100-percent schedule rating?

Mr. MAYES. I cannot unequivocally explain that, although I would take the opportunity to echo what some of the previous panel members from the Veteran Service Organizations said.

The IU benefit was created in 1934, and it was set up to provide VA with the ability to compensate a veteran for an unusual disability picture that the schedule may not have been able to deal with when that disability precluded employment. And that was the purpose of the IU benefit.

I would agree with some of the previous panel members. It may be that we have got a higher percentage of PTSD recipients who are having difficulty securing and maintaining gainful employment. Therefore, we have exercised that discretion and granted the IU benefit. And that is precisely why we are beginning to tackle the mental disabilities portion of the rating schedule.

Mr. HALL. In 2006, VA agreed with the GAO recommendation to establish procedures for rating specialists to request Vocational Rehabilitation and Employment to conduct vocational assessments of IU claimants "as appropriate." But VA has never acted on its concurrence.

Why is this?

Mr. MAYES. The purposes of the vocational rehabilitation program is to assimilate veterans back into the workforce. The vocational rehabilitation assessment was designed to assist our voc rehab employees with developing a rehabilitation plan. And the whole construct for that program was to evaluate and to try to transition those servicemembers or veterans back into the workforce.

I do not have a short answer for you. I think that we talked about it. I do not believe we were resourced. I do not want to say that we were not resourced. But our distribution of resources would have been challenging because we had never done that for IU. The decision was made to continue on that path.

Tom, do you want to add to that? I know you were here during those discussions.

Mr. PAMPERIN. Yes, sir. We looked at it extensively. And I think there is value in looking at the potential for rehabilitation when considering individual unemployability.

There are, however, a couple of immediate barriers that have to be confronted. This would require a vocational assessment for everyone who claimed individual unemployability or whose disability picture was such that it reasonably raised IU as an issue.

And when we were looking at the numbers, this is in excess of 80,000 people a year who would have to be assessed through vocational rehabilitation. And whether or not we are positioned to deal with that level of workload and still deliver rehabilitation services to people who want them is a real challenge.

There is also the question as to whether or not legally that could be done without legislation.

Mr. HALL. Thank you.

Mr. Mayes, you were asked to discuss presumption in your testimony today, but you only mentioned it as it was applied in 1921 for tuberculosis.

Is there a further VA response to the recent IOM report on presumptive disability decision making?

Mr. MAYES. We are still evaluating the IOM study. I do not have a formal position regarding their recommendations at this point, although I would say that it seems that the causation standard would be a high standard.

Mr. HALL. Maybe you could send us a message when you come to a further conclusion.

I keep hearing that there are three simple things needed to establish service connection, the diagnosis, eligible military service, and a nexus between the two.

Can you explain the overwhelming need for evidence? How much evidence is enough and why does VA require so much documentation from a veteran?

Mr. MAYES. Ultimately I believe that we want to make sure that we collect all of the evidence that is available so that we render an accurate decision and a decision that favors the veteran to the extent possible.

Further, we do have certain statutory requirements, a duty to assist, a duty to notify. Those requirements are very specific that we must attempt to obtain any and all evidence that is referenced by the claimant.

Those records that are in our constructive custody, we must obtain those unless the custodian of those records tell us that they do not exist. That truly is a statutory requirement, and we want to help the veteran.

Mr. HALL. Thank you.

Dr. Kelley, you mentioned that since National Defense Authorization Act of 2008 (NDAA) and the creation of the Senior Oversight Committee (SOC), many of the issues between the two departments on the application and revisions of the VASRD are now being worked in a collaborative and productive manner, unquote.

Can you tell me what those applications and revisions are and how did you communicate your input on the VASRD prior to the SOC?

Dr. KELLEY. Let me let Dr. Carson answer that first.

Mr. HALL. Sure.

Dr. CARSON. Mr. Chairman, thank you for the opportunity.

My current role as an appellate review physician at our Air Force Review Boards Agency, I am prefacing my remarks with this statement so that you will understand a bit about how we communicate with our sister services and the VA.

We have established communication that is via the Disability Advisory Council, which is a Department of Defense Committee, where there is cross talk, communication, discussion on issues. It is also attended by a Department of Veterans Affairs representative. So that forum has been and will be a principal entity for the type of communication that you are referring to.

I will say that as recent as this past Friday, the Department of Veterans Affairs and the Air Force Personnel Center at Randolph Air Force Base initiated an initial conference call to discuss variances in methodologies in ratings.

Also, the Department of Veterans Affairs has offered training as soon as March of this year and April of this year designed to train our adjudicators on VA methodologies.

Additionally, the NDAA 2008 has been reviewed top to bottom and all disability-related matters have been looked at carefully. And we are in the process as of the execution date of that Act in looking at applications and our current policy under Department of Defense instruction 1332.39, which is our principal document that we use along with the VASRD in rating disabilities.

And we are identifying those areas that we are now prohibited from utilizing in rating disabilities that may result in a reduction or a deduction or a rating less than the VA absent the existence of this policy.

This is ongoing. And as of even yesterday, we received at our agency an initial inventory of records that have recently been adjudicated so that immediate disability rating corrections, or adjustments, may be made as necessary, in the context of current law; specifically, the NDAA that become effective on January 28, 2008.

[The following information was subsequently received:]

The specific implementation methods for services to review ALL cases previously rated at "less than 30 percent dating to "9/11," is still in the planning phase. This item will be followed-up to assure it is addressed at the next Disability Advisory Council meeting.

Dr. CARSON. I will pause at this point and allow Dr. Kelley to speak.

Dr. KELLEY. Yes, sir. So I think Dr. Carson mentioned that we are having the combined training. Each of the services will have their senior physician that does the disability processes going to that training in April. And there are some on the personnel side that are also going to that training in April.

Dr. Carson mentioned the Disability Advisory Council. There is also a review in the H-E-C, which we call the HEC, which is the Health Executive Council. That is chaired by the Assistant

Secretaries for Health on both sides, as well as the JEC, which is the Joint Executive Council, which reviews both the health and the personnel issues. And that is at the Under Secretary that is chaired.

And then the example that I cited in my summary where we have had a working group that worked extensively with the VA on the TBI and the burn revisions that were just published. And so that is moving forward.

Mr. HALL. Well, that is encouraging. If you guys keep working together like that, we might not have anything to do.

Mr. PAMPERIN. Sir, could I add something?

Mr. HALL. Yes.

Mr. PAMPERIN. Because I, like Dr. Carson, am on the Disability Advisory Council. Based upon the conversations we had at the last session, DoD did submit to us concerns or issues or recommendations on about four items in the rating schedule that we took under advisement and provided them with a response to. I believe it was last week.

Mr. HALL. Thank you.

And if you could keep the Committee in the loop or the Subcommittee because you are a little bit of a moving target. We are trying to figure out what to do or what we might need to do or what would be helpful for us to do legislatively.

And I am happy to hear that these working groups and conversations and cross talk is going on because we all think that it is essential certainly to the accuracy and the timeliness of the ratings and the provision of benefits to the veterans who deserve them.

And, Dr. Kelley, the Veterans' Disability Benefits Commission found in their study that there were variances in the way DoD rates disabilities and compares them to the way VA does them. As you probably know, VA has also had its own issues with variances between raters and Regional Offices.

What steps beside the training that you mentioned would you recommend to gain more consistency in rating disabled veterans regardless of where or who did the rating?

Dr. KELLEY. Well, I think that the training is important as a first step. I think that there needs to be a greater understanding of the exact nature of why those differences occur which we need to discuss and adjust so that we understand so that there are some—we have heard several other panel members talk about how a specific illness or injury could affect different people depending on their occupation differently.

And the DoD when they do a fitness for duty, they determine a fitness to work in the particular job. It is not a general fitness for duty. And so because of that and the VA is doing a general and total evaluation, there are some differences.

I think that we need to have the common nomenclature so that we are all talking the same way, and that, again, has been mentioned earlier, so that we can interpret the rating systems in the same way on both sides.

Mr. HALL. You mentioned that in your oral testimony, "consistent nomenclature." I think that would be a helpful step among other things in terms of getting closer to a system that could do a substantial number of ratings electronically with artificial intelligence.

You mentioned the Disability Advisory Committee. When did that group start interacting with the VA and do they or are you discussing the rating schedule as part of those discussions? What would make the rating schedule a better tool from DoD's standpoint besides consistent nomenclature?

Dr. KELLEY. I will get back to you on when the VA actually started working in the Disability Advisory Committee.

Mr. HALL. Dr. Carson.

Dr. CARSON. I can assure you that since my entry into the system in 1998, I know you have got a decade of it at least, and I am sure it is many, many years before that.

Mr. HALL. Good.

From your statement, Dr. Kelley, it sounds as if DoD is already preparing to implement the findings of the disability evaluation system pilot that is ongoing with VA.

What steps are being taken to prepare for this transition to a single system for evaluating disabilities?

Dr. KELLEY. We are looking forward to doing that and we are not prepared to do that right now. So we do not have a complete strategic plan of how we will do that because we are waiting for some of the results or the results of the lessons learned from that pilot.

We are working with the VA. We have issues to work out on the resources that are going to be required, who is going to do the exams. There are certain locations. For example, having the VA do the exams would work, but there are no VA facilities overseas.

And so we have to work out those details of the specific cases. Some places we have bases and there is only clinics that do not have the VA capability of providing many services. Other places the VA has much better facilities than the military does.

And so we think that it is probably going to require a mapping process for each specific site and then when we bring in the Reserves and the Guards, that is going to make that a much more difficult conclusion or solution for that. And so we have to work those out, but are looking for the lessons learned as we go along so that we can apply that.

Mr. HALL. Difficulty aside or taken into account, do you have a time frame in mind that you think this can be done in?

Dr. KELLEY. I do not, sir. I will get back to you if we have one.

Mr. HALL. Somewhere between two and ten years?

Dr. KELLEY. Sir, we are looking in terms of short term rather than long term.

[Follow-up information from Dr. Kelly was supplied in the [post-hearing questions and responses for the record](#), which appear in the Appendix.]

Mr. HALL. We will all be grateful for that.

Lastly, I have a question from Ranking Member Lamborn to Mr. Mayes. Your testimony suggests that the revision of the rating schedule has been underway since the 1990s.

I recently became aware of a case of a veteran who is completely deaf in one ear, yet he only receives the minimum level of compensation. I was unable to explain to him why the rates for hearing loss are at such a seemingly paltry level.

I understand that *The Independent Budget* has a long-standing resolution calling for a compensable rating for anyone with a hearing aid. It seems reasonable to me that the required use of a prosthetic device would easily warrant compensation, especially when one considers the high noise environment inherent to military service.

Has any consideration been given to revising the rates for hearing loss?

Mr. MAYES. Specifically, consideration has been given to compensation for veterans who are in need of a hearing aid. We have had those discussions in our policy shop and have contemplated moving forward with that.

As far as changing the diagnostic criteria for hearing loss, there is nothing currently in the works to change that diagnostic criteria.

Mr. HALL. What about for other prosthetic devices?

Mr. MAYES. For other prosthetic devices?

Mr. HALL. Right. The question was specifically about hearing aids, but I would also ask the question about—

Mr. MAYES. Typically a veteran in need of prosthetic devices is going to have an amputation. There is already a compensation scheme in place for amputation. It is very detailed and lays out the criteria, whether it be, for example, a below-knee amputation, above-knee amputation, below the elbow, above the elbow, etc.

I am not sure that there is the difficulty or maybe the perception that I am hearing about the hearing loss—

Mr. HALL. It is more concrete and easily identified than hearing loss?

Mr. MAYES. Exactly. We hear this because veterans are service-connected because there is some impairment, but it is not at a level sufficient for us to pay disability compensation based on the evaluation criteria. VHA will issue them a hearing aid. We understand that and we have had discussions regarding that.

Mr. HALL. Thank you.

I want to thank you all very much for your testimony, for your dedication to our Nation's veterans, for your patience this afternoon waiting to be the fourth but greatest panel.

And we thank everyone for their interesting and informative statements this afternoon. We look forward to working with you on this very important topic and improving the VA claims process system.

This hearing now stands adjourned.

[Whereupon, at 6:20 p.m., the Subcommittee was adjourned.]

APPENDIX

Prepared Opening Statements:

Prepared statement of [Hon. John J. Hall](#), Chairman, and a Representative in Congress from the State of New York

Prepared statement of [Hon. Doug Lamborn](#), Ranking Republican Member, and a Representative in Congress from the State of Colorado

Prepared Witness statements:

Prepared statement of [Vice Admiral Dennis Vincent McGinn](#), USN (Ret.), Member, Veterans' Disability Benefits Commission, on behalf of Lieutenant General James Terry Scott, Chairman

Prepared statement of [Lonnie Bristow](#), M.D., Chair, Committee on Medical Evaluation of

Veterans for Disability Benefits, Board on Military and Veterans Health, Institute of Medicine, The National Academies

Prepared statement of [Dean G. Kilpatrick](#), Ph.D., Member, Committee on Veterans' Compensation for Posttraumatic Stress Disorder, Institute of Medicine, The National Academies, and Distinguished University Professor and Director, National Crime Victims Research and Treatment Center, Medical University of South Carolina, Charleston, SC

Prepared statement of [Jonathan M. Samet](#), M.D., M.S., Chairman, Committee on Evaluation of the Presumptive Disability, Decision-Making Process for Veterans, Board on Military and Veterans Affairs, Institute of Medicine, The National Academies, and, Professor and Chairman,, Department of Epidemiology, Johns Hopkins Bloomberg School of Public Health, Johns Hopkins University, Baltimore, MD

Prepared statement of [Joyce McMahan](#), Ph.D., Managing Director, Center for Health Research and Policy, Center for Naval Analyses (CNA) Corporation, Alexandria, VA

Prepared statement of [Mark H. Hyman](#), M.D., FAADEP, Presenter, American Academy of Disability Evaluating Physicians , and Mark H. Hyman, M.D., Inc., F.A.C.P., F.A.A.D.E.P., Los Angeles, LA,

Prepared statement of [Sidney Weissman](#), M.D., Member, Committee on Mental Healthcare for Veterans and Military Personnel and Their Families, American Psychiatric Association

Prepared statement of [Ronald B. Abrams](#), Joint Executive Director, National Veterans Legal Services Program

Prepared statement of [Dean F. Stoline](#), Assistant Director, National Legislative Commission, American Legion

Prepared statement of [Kerry Baker](#), Associate National Legislative Director, Disabled American Veterans

Prepared statement of [Gerald T. Manar](#), Deputy Director, National Veterans Service, Veterans of Foreign Wars of the United States

Prepared statement of [Bradley G. Mayes](#), Director, Compensation and Pension Service, Veterans Benefits Administration, U.S. Department of Veterans Affairs

Prepared statement of [Major General Joseph E. Kelley](#), M.D., USAF (Ret.), Deputy Assistant Secretary of Defense for Clinical and Program Policy (Health Affairs), U.S. Department of Defense

Submissions for the Record:

Prepared statement of [American Medical Association](#)

Material Submitted for the Record:

Reports:

["VA Benefits: Fundamental Changes to VA's Disability Criteria Need Careful Consideration," GAO-03-1172T, Testimony Before the Senate Committee on Veterans' Affairs, September 23,](#)

[2003, Statement of Cynthia A. Bascetta, Director, Education, Workforce, and Income Security Issues, U.S. General Accounting Office](#)

Post-Hearing Questions and Responses for the Record:

[Hon. John J. Hall, Chairman, Subcommittee on Disability Assistance and Memorial Affairs, Committee on Veterans' Affairs, to Vice Admiral Dennis Vincent McGinn, USN \(Ret.\), Member, Veterans' Disability Benefits Commission, letter dated February 29, 2008, and Admiral McGinn's response letter dated March 31, 2008](#)

[Hon. John J. Hall, Chairman, Subcommittee on Disability Assistance and Memorial Affairs, Committee on Veterans' Affairs, to Lonnie Bristow, M.D., Chair, Committee on Medical Evaluation of Veterans for Disability Benefits, Institute of Medicine, letter dated February 29, 2008, and Dr. Bristow's responses](#)

[Hon. John J. Hall, Chairman, Subcommittee on Disability Assistance and Memorial Affairs, Committee on Veterans' Affairs, to Dean Kilpatrick, Ph.D., Committee on Veterans' Compensation For Posttraumatic Stress Disorder, Institute of Medicine, letter dated February 29, 2008, and Dr. Kilpatrick's responses](#)

[Hon. John J. Hall, Chairman, Subcommittee on Disability Assistance and Memorial Affairs, Committee on Veterans' Affairs, to Jonathan Samet, M.D., Chair, Committee on Evaluation of the Presumptive Disability Decision-Making Process for Veterans, Institute of Medicine, letter dated February 29, 2008, and response letter dated March 18, 2008](#)

[Hon. John J. Hall, Chairman, Subcommittee on Disability Assistance and Memorial Affairs, Committee on Veterans' Affairs, to Joyce McMahon, Ph.D., Managing Director, Center for Health Research and Policy, Center for Naval Analysis Corporation, letter dated February 29, 2008, and Dr. McMahon's responses](#)

[Hon. John J. Hall, Chairman, Subcommittee on Disability Assistance and Memorial Affairs, Committee on Veterans' Affairs, to Mark Hyman, M.D., American Academy of Disability Evaluating Physicians, letter dated February 29, 2008, and Dr. Hyman's responses](#)

[Hon. John J. Hall, Chairman, Subcommittee on Disability Assistance and Memorial Affairs, Committee on Veterans' Affairs, to Sidney Weissman, M.D., Committee on Mental Healthcare for Veterans and Military Personnel, American Psychiatric Association, letter dated February 29, 2008, and response letter dated April 4, 2008](#)

[Hon. John J. Hall, Chairman, Subcommittee on Disability Assistance and Memorial Affairs, Committee on Veterans' Affairs, to Ronald Abrams, Joint Executive Director, National Veterans Legal Services Program, letter dated February 29, 2008, and response letter dated March 24, 2008](#)

[Hon. John J. Hall, Chairman, Subcommittee on Disability Assistance and Memorial Affairs, Committee on Veterans' Affairs, to Dean Stoline, Assistant Director, National Legislative](#)

[Commission, American Legion, letter dated February 29, 2008, and response letter dated March 20, 2008](#)

[Hon. John J. Hall, Chairman, Subcommittee on Disability Assistance and Memorial Affairs, Committee on Veterans' Affairs, to Bradley Mayes, Director, Compensation and Pension Service, Veterans Benefits Administration, U.S. Department of Veterans Affairs, letter dated February 29, 2008, and VA responses](#)

[Hon. John J. Hall, Chairman, Subcommittee on Disability Assistance and Memorial Affairs, Committee on Veterans' Affairs, to Joseph Kelley, M.D., Deputy Assistant Secretary of Defense for Clinical and Program Policy, U.S. Department of Defense, letter dated February 29, 2008, and DoD responses](#)
