# 7

# Appropriateness of the Level of Benefits

In this chapter, the Commission analyzes the appropriateness of the level of benefits available to veterans for disabilities and deaths attributable to military service. The benefits themselves and their appropriateness were described in chapter 6.

## I Impairments of Earning Capacity

The Department of Veterans Affairs (VA) Schedule for Rating Disabilities (VASRD) is intended to compensate for average impairment of earning capacity as required by statute.[1] That is to say that impairment is not specifically linked to an individual veteran, his or her skill set, and the ways a particular injury or disease affects that individual's ability to maintain gainful employment. For instance, the Rating Schedule does not take into account the difference between a lawyer losing a leg and a carpenter suffering the same loss; the two individuals are rated equally, even though an argument could be made that the amputation of a leg compromises a carpenter's ability to earn a livelihood more than a lawyer's ability to do so.

The Rating Schedule should not only be up to date medically, in terms of diagnostic classifications, terminology, and types of required tests and examinations, but should also be effective in fulfilling the purposes of the VA Disability Compensation Program. The stated statutory purpose is to compensate for average impairments of earning capacity. Another, unstated purpose of at least some aspects of the disability compensation program is to compensate for loss of quality of life. This Commission asked the Institute of Medicine (IOM) Committee on Medical Evaluation of Veterans for Disability Compensation to assess the ability of the Rating Schedule to compensate for impairment of earning capacity, loss of quality of life, or both. The Commission also asked the CNA Corporation (CNAC) to analyze average earnings of beneficiaries by rating percentage in each of the body systems and in cases of posttraumatic stress disorder (PTSD) specifically, and to survey veterans about

[1] President's Commission, *Administration of Veterans' Benefits*, 33.

their quality of life. This section of the report reviews the work of IOM and CNAC and presents the Commission's findings on the effectiveness of the Rating Schedule in compensating for average impairments of earning capacity and loss of quality of life.

## I.1 Compensating for Impairments of Earning Capacity

Because average impairments of earning capacity are the basis of the VA Rating Schedule, it is important to understand the concept in the context of the VA Disability Compensation Program. According to the report of the IOM Committee on Medical Evaluation of Veterans for Disability Compensation, impairment of earning capacity "is more a legal or economic than medical concept":

> It is used in the legal system as a basis for determining damages in personal injury cases. It was carried over into workers' compensation programs, which were established in the early 20th century to replace the tort system in dealing with accidents at work. When disability benefits for veterans were established by an amendment of the War Risk Insurance Program in 1917, the concept of a rating schedule to compensate for diminished earning capacity was borrowed from state workers' compensation programs.[2]

## I.2 Impairments of Earning Capacity in Court Cases

In most courts, earning capacity is the standard for assessing economic damages due to loss of wages or salary caused by injury or death rather than a standard of actual or expected earnings.[3] According to a recent treatise on the law of damages, the law typically defines earning capacity as "the ability to earn money" and impairment of earning capacity as "the diminution or loss of the ability to earn money."[4] A recent manual on determining earning capacity has the following definition: "Earning capacity measures a person's past, present, and future ability to earn employment income with respect to their maximum ability."[5]

The concept of impairment of earning capacity was developed because it was commonly recognized that actual earnings before a person is injured are not an adequate measure of the impact of a person's disability. One example of a situation in which pre-injury earnings would not reflect a person's maximum ability to earn is when someone is too young to have an earnings record or, if they have one, it would not accurately reflect the ramp up of experience and

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[2] Institute of Medicine (IOM), *21st Century System*, 64.
[3] Horner and Slesnick, "Valuation of Earning Capacity Definition," 13-32, at 13.
[4] Minzer et al., *Damages in Tort Actions,* 31.
[5] Shahnasarian, *Assessment of Earning Capacity.*

skills—and therefore the increase in earning potential—of someone in the early- and midcareer phases of their working life. This situation is especially pertinent to veterans' compensation because, for many service members, the military is their first real job.

Although the courts recognize the concept of impairment of earning capacity, they have fairly strict evidentiary requirements that require plaintiffs to have more than a speculative basis for the damages suffered in earning capacity that they are claiming. Generally, a plaintiff's estimate of impaired earning capacity must be based on reasonable certainty, although courts do not usually require absolute precision. As a result, the plaintiff's history of earnings, or forecast of expected earnings based on past earnings, often has a large influence on court decisions:

> Often, the most reliable evidence will be past earnings, which is also the most common basis for estimating expected earnings. In other words, the legal standard of loss in personal injury cases is usually earning capacity, but the evidentiary requirements of the legal process often lead to an estimation of earning capacity that is identical to an estimation of expected earnings.[6]

The assessment of earning capacity considers the person's medical situation in conjunction with vocational factors:

> Assessing earning capacity involves a complex, systematic process to determine the maximum amount of employment income an individual is capable of generating, given her or his vocational profile, workplace conditions, specified industry or locale, and other relevant factors. The process may involve reviewing records to determine demonstrated and potential capabilities, interviewing the claimant, administering standardized tests to the claimant, and conducting labor market research.[7]

Typically, a vocational expert analyzes variables including age, education, work history, and local labor market conditions, as well as income at the time of injury.[8] The expert looks at the physical and mental limitations reported by the physician; psychological issues affecting career development; education and training; work history, experience, and skills; age; vocational handicaps; and capacity for retraining. This usually involves a clinical interview and appropriate tests. The expert next determines a vocational category or categories that would maximize the individual's earnings both before and after the injury. Finally, the vocational expert conducts a labor market analysis to further understand the demand and

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[6] Horner and Slesnick, "Valuation of Earning Capacity Definition," 13-32, at 13.
[7] Shahnasarian, *Assessment of Earning Capacity.*
[8] Field, *Strategies for the Rehabilitation Consultant.*

prevailing wages for the individual's vocational category and to determine the likely loss of earnings.[9]

## I.3 Impairments of Earning Capacity in Workers' Compensation Program

Beginning in 1911, when state workers' compensation programs were being established, the concept of impairment of earning capacity was included, sometimes expressed as loss of ability to compete in the labor market, although at first most used actual wage loss as the basis for compensation.[10] New Jersey, one of the first 10 states to establish a workers' compensation program in 1911, included a schedule to determine compensation, which was an innovation. According to the schedule, the injured worker was paid half his or her wages for a fixed number of weeks, depending on the injury and its extent, even though the statutory basis for compensation in New Jersey was impairment of earning capacity. For example, if a New Jersey citizen lost a hand at work, he or she was paid 50 percent of his or her wages for 150 weeks. This was criticized at the time as opposed to the principle of compensation for permanent partial disability (i.e., it should be paid in proportion to the reduction in earning capacity as long as the disability lasts), but almost every state soon adopted schedules as more administratively convenient and more predictable in terms of benefit costs. It saved a program from having to evaluate the individual earning capacity of injured workers, which depended on the type and severity of their injury but also on their age, education, work experience, and local labor market conditions. This simplified the process by assigning a fixed amount or number of weeks to a given loss or functional limitation of a body part or system, without regard to actual loss of earnings.

Another problem facing the early workers' compensation programs and the veterans' disability compensation program was lack of knowledge of the effect of injury on employability or earnings.

> The introduction of workmen's compensation into this country was too hasty and precipitate to permit of the immediate preparation of the necessary statistical material on which to base economically sound schedules of awards.…The consequence has been a very great and unscientific diversity among the provisions of our state laws.[11]

Currently, state workers' compensation programs use one or a combination of the following approaches:[12]

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[9] Shahnasarian, *Assessment of Earning Capacity*.
[10] Larson and Larson, *Larson's Workers' Compensation,* § 80.05[3].
[11] Van Doren, *Workmen's Compensation and Insurance*, 109.
[12] National Academy of Social Insurance, *Adequacy of Earnings Replacement*, 13.

1. Compensation for degree of impairment: "The level of impairment, often expressed as a percentage of full functionality or 'whole body,' is sometimes translated into a percentage of total disability. This percentage is then used to determine the benefit amount."
2. Compensation for impairment of earning capacity: "Some states modify the impairment rating to try and account for impairment of earning capacity by adjusting for vocational factors, such as the worker's education, job experience, and age."
3. Compensation for actual lost wages: "Other states employ a system that attempts to compensate workers for actual lost wages."

Most state workers' compensation programs, even those with a statutory mandate to compensate for impairment of earning capacity, use a rating schedule based mostly, if not completely, on degree of impairment.

## I.4 Impairments of Earning Capacity in Veterans' Disability Compensation

The War Risk Insurance Act of 1917, which authorized disability compensation for veterans, was drafted by social insurance experts involved in designing state workers' compensation programs. The idea of compensating for the percentage of impairment of earning capacity and using a rating schedule to determine the percentage was taken from the recently established state workers' compensation programs, but the VA Rating Schedule differed from the state programs in important ways. As a result, in many ways it was truer to the underlying principles of workers' compensation than most of the state programs. These underlying principles include

- monthly payments compensating for the degree of impairment of earning capacity as long as the disability lasts (rather than paying a flat rate, usually two-thirds of wages, for a fixed number of weeks),
- compensating for diseases, including mental disorders, as well as physical injuries (rather than just compensating for physical injuries),
- compensating for all disabling conditions (rather than a delimited schedule of specific conditions),
- making everyone eligible for the benefit (rather than excluding certain employment groups), and
- adjusting the payments for family size (rather than paying the same amount regardless of the number of dependents).

The veterans' compensation program also diverged from underlying principles in several ways, for example, by:

- paying benefits for life (rather than just during time the individual is expected to work),
- paying the same amount to all veterans (rather than adjusting for individual differences in wages,
- not paying for injuries resulting from a veteran's "willful misconduct" (rather than being fully no-fault, though in practice, most state workers' compensation programs also bar compensation for injuries caused by willful misconduct), and
- paying the full extent of impairment earning capacity (rather than paying a fraction of wages; state programs paid a fraction to provide an incentive for workers to return to work.

Section 300 of the act provided compensation for death or disability resulting from personal injury suffered or disease contracted in the line of duty by active-duty service members and Army and Navy nurses. It specified that compensation for total disability would be between $30 a month (for a single veteran) to $75 a month (for a veteran with a wife and three or more children). Compensation for partial disability was set as a percentage of the compensation amount for total disability, "equal to the degree of the reduction in earning capacity resulting from the disability."

To implement the scheme for rating partial disabilities, section 302(2) of the act directed the Bureau of War Risk Insurance to adopt a "schedule of ratings of reductions in earning capacity from specific injuries or combinations of injuries of a permanent nature," with ratings up to 100 percent.

> The ratings shall be based, as far as practicable, upon the average impairments of earning capacity resulting from such injuries in civil occupations and not upon the impairment in earning capacity in each individual case, so that there shall be no reduction in the rate of compensation for individual success in overcoming the handicap of a permanent injury.

Before the first Rating Schedule was completed, the law was amended by adding a sentence to the paragraph just quoted:

> The Bureau in adopting the schedule of ratings of reduction in earning capacity shall consider the impairment in ability to secure employment which results from such injuries (Ch. 104, part 10, 40 Stat. 609, 611[1919]).

The federal program had the same problem in assigning percentages of impairment of earning capacity to a particular injury or disease or severity of injury or disease as the state workers' compensation programs did, namely, lack of relevant data. The Bureau of War Risk Insurance proceeded nevertheless by establishing an advisory board of three members "skilled in the practice of insurance against death or disability," who consulted with other experts and drew on the experience of other programs, including state workers' compensation programs and foreign veterans' compensation programs, to construct the first schedule for rating disabilities (Pub. L. No. 65-90, Art. I, § 14, [1917]).[13] Without statistics on disability (i.e., the economic effects of various impairments), the preparers of the first Rating Schedule had to rely on expert judgment informed by the practices of existing programs to assign rating percentages representing the impairment of earning capacity of the average person in civil occupations.

The 1921 schedule was under development for several years, including several provisional versions, before it was formally adopted in 1921. According to the introduction of the first part of the 1921 schedule, which covered neuropsychiatric conditions, the schedule took into account "opinions of leading neuropsychiatrists of the United States; the rating schedules of France, Canada, England, and Belgium; and the accumulated experience of this Bureau." Similarly, other parts of the schedule—for example, surgical disabilities; amputations, fractures, and their sequelae; and general medicine—were based on the opinions of leading surgeons, orthopedic surgeons, and internists, respectively, as well as on the rating schedules of other countries.

The 1921 schedule dealt with the problem of lack of knowledge about the impact of impairment and functional limitation on disability in several ways. These included using degree of impairment as the measure of impairment of earning capacity although this approach ignored vocational factors, and gave discretion to raters to determine the rating percentage rather than specifying criteria for different rating percentages. In most parts of the schedule, the ratings were pegged to a loss, or loss of use of, a body part or system, rather than to the extent to which the person is unable to function in a work setting. The exceptions were psychoses and psychoneuroses in the neuropsychiatric section. Disability from psychoses and psychoneuroses was to be determined by degree of "social inadaptability," defined as "the degree to which the claimant is able to adjust himself to his social and industrial environment."[14] These conditions could be

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[13] President's Commission, *Veterans' Administration Disability Rating Schedule*, 34. According to the Bradley Commission staff report on the development of the Rating Schedule, the advisory board was formed and "compiled, with the assistance of surgeons in New York, a tentative schedule of ratings."

[14] Veterans' Bureau, *United States Veterans' Bureau*, 14, 15. The 1921 schedule also directed raters to determine average disability not by inability to resume a former occupation but by "the degree to which the claimant is incapacitated from carrying on any substantially gainful occupation."

rated at 25 percent (partial social inadaptability but not requiring supervision), 50 percent (partial social inadaptability but requiring supervision), and 100 percent (complete social inadaptability).

For some disabilities, the extent of disability was left to the rater to determine, with either no criteria or general criteria stated in the schedule. In these cases, the schedule gave the rating as a range of percentages. For example, rheumatoid arthritis could be rated from temporary partial 25 percent to permanent 100 percent "dependent upon the number of joints involved, degree of involvement, and loss of function." In other cases, a range was given without evaluation criteria. For example, impairment of the sciatic nerve affecting the upper half of the thigh could be rated from 40 to 60 percent, if it affected the lower third of the thigh, the ratings could be from 30 to 50 percent, but no guidance on determining which percentage should be assigned was given. Most of the ratings were very specific, however, in assigning a specific rating percentage to the impairment or degree of impairment.

The VA Rating Schedule was most like the one used by the California workers' compensation program. It was comprehensive rather than limited in the number of injuries and diseases included, and it compensated for permanent partial disability for as long as the disability lasted rather than for a fixed time or amount. The California schedule was very different in one respect, however. It adjusted the impairment rating for occupation and age to account better for impairment of earning capacity than a strictly impairment-based rating.

When Congress revised the statute in 1924 to base compensation on the impairment of earning capacity that the service-connected injuries would cause in civil occupations by adding the phrase, "similar to the occupation of the injured man at the time of enlistment," the Veterans Administration developed a new schedule with added tables to adjust the impairment ratings by occupation. This approach proved to be very difficult to administer, in part because many veterans did not have an occupation when they enlisted, and basing compensation on part-time jobs during high school was not satisfactory.

Under the Economy Act of 1933, the Roosevelt administration tried to cut veterans' benefits, for example, by reducing the compensation levels. The administration planned to reduce the rolls another way, by switching from 10 to 4 rating levels—25, 50, 75, and 100 percent. The main effect would have been to eliminate compensation for veterans rated 10 or 20 percent and reduce it for those rated 30 and 40 percent (to 25 percent), 60 and 70 percent (to 50 percent), and 80 and 90 percent (to 75 percent). This schedule was withdrawn before it took effect, and a new 1933 schedule was developed with the 10 rating levels from 10 to 100 percent, but without the occupational adjustments in the 1925

schedule. The basis for compensation reverted to the one in the original 1917 act: "The ratings shall be based, as far as practicable, upon the average impairments of earning capacity resulting from such injuries in civil occupations." Congress set the schedule of benefits on the basis of the average entry-level earnings of an unskilled adult male working as a common laborer (Pub. L. No. 76-257)

Although the 1945 Rating Schedule was a comprehensive revision of the 1933 schedule, in the absence of empirical data on the average earnings of service-disabled veterans at the different rating levels, it was still based on professional judgment or, as the head of the VA rating schedule board put it in 1952, "the consensus of informed opinion of experienced rating personnel, for the most part physicians."[15] These were members of a Disability Policy Board. They estimated "the relative effects of different levels of severity of a condition…on the average veteran's ability to compete for employment in the job market," based on a detailed description of the etiology and manifestations of each of the conditions in the schedule.[16] As a result, adjustments were made in some rating percentages, but many were continued from the 1933 schedule. Amputation of the arm at the shoulder, for example, has been rated 90 percent since 1933 (in the 1921 schedule, it was 94 for the dominant arm, 85 for the non-dominant arm). Complete paralysis of the middle radicular nerve group has been rated 70 percent (dominant) or 60 percent (non-dominant) since 1921.

In summary, most of the rating percentages in the VA Rating Schedule are based on degree of impairment, meaning the extent of anatomical loss or functional limitation of a body part or system. With the exception of ratings for mental disorders and the epilepsies, they are not based on direct measures of the capacity of a person to function in everyday life or in the workplace. Instead of looking at the net impact of impairments on an individual's capacity to function, it uses a formula to combine the ratings of multiple impairments that is less than additive, based on the "whole person" concept, although some injury or illness combinations may be multiplicative in their impact on overall function.

## I.5 Relationship of Rating Levels to Average Earnings

Impairment of earning capacity is not the same as loss of actual or expected earnings. As explained earlier, the concept was developed in recognition that pre-injury wages are not necessarily a fair measure of impairment of earning capacity in every case. The VA Disability Compensation Program modified the concept somewhat by introducing the notion of "average" impairments of earning capacity, sometimes expressed as the impact that given impairments would have

[15] President's Commission. 1956a:33.
[16] General Accounting Office (GAO), *VA Disability Compensation.*

on an average person. This was done intentionally "to give the injured man every inducement to rehabilitate himself. His compensation, since it is based on the 'average impairments of earning capacity,' is not decreased if he succeeds in raising himself to his former earning capacity."[17]

The VA Disability Compensation Program adopted an impairment-based rating schedule, which was the most common basis for compensation in use in 1917 by state workers' compensation programs and private accident and disability insurance companies. The original drafters of the 1917 act were aware of the limited state of knowledge about the impact of injuries and diseases on earnings and included the following directive after the sentence about basing compensation on the average impairments of earning capacity:

> The bureau shall from time to time readjust this schedule of ratings in accordance with actual experience (Pub. L. No. 90, Art. III, § 302[2] [1917]).

As shown in section I.3.B of this report, the Rating Schedule has gone through several comprehensive iterations, most recently in 1945. Most, but not all, of the body systems have been revised comprehensively one or more times since 1945, usually to update medical terms and criteria for determining severity rather than change the rating percentages assigned to each level of severity. The most recent round of reviews, for example, which resulted in the revision of 11 of the 14 body systems, focused explicitly on medical updating rather than on increasing or decreasing ratings in response to advances in medical care and assistive technology or to changes in the workplace (Schedule for Rating Disabilities; The Genitourinary System, 54 Fed. Reg. 34531, August 21, 1989).[18]

Although average impairment of earning capacity is not the same as the average loss of actual earnings, the latter can be a useful check on how effective the Rating Schedule is generally in predicting average impairment of earning capacity, that is, as the ratings go up, earnings tend to go down. Determining the average loss of actual earnings is also useful in assessing how well the amount of compensation for each rating level equalizes the earnings of veterans with and without disabilities, that is, the adequacy of compensation. This was the reason that the Commission asked CNAC to compare the average earned income losses of veterans with service-connected disabilities with VA compensation amounts to see if the compensation replaces the losses, on average. Before

[17] Douglas, "War Risk Insurance Act," 461–483, at 474.

[18] The 1989 Advanced Notice of Proposed Rulemaking (ANPRM) announcing VA's intention to revise each of the 14 body systems comprehensively, beginning with the genitourinary system, noted that VA's "primary concern in this ANPRM is the medical criteria used to evaluate genitourinary disabilities and not the percentage evaluations presently assigned to each level of severity." (The same language was included in the ANPRMs issued for each body system in the 1989-1991 period, which resulted in the review and revision of 11 of the 14 systems.)

turning to the results of the CNAC study, however, it is informative to review the two earlier efforts to determine average actual earnings losses of veterans with service-connected disabilities and the adequacy of compensation, one by the President's Commission on Veterans' Pensions (known as the Bradley Commission) in 1956 and one by VA (known as the Economic Validation of the Rating Schedule) in 1971. Some of the findings of the CNAC analysis are consistent with these earlier analyses.

## I.5.A Bradley Commission—1956

The Bradley Commission surveyed veterans with and without service-connected disabilities asking respondents to self-report their earnings and total income. The median total income of veterans with disabilities, including compensation, was about three percent less than the median income of all veterans.[19] The Bradley Commission concluded that incomes were about equal, because veterans with disabilities did not have to pay income tax on their compensation.

When median incomes by rating level were compared with those of all veterans, however, some differences emerged. While those rated 10 through 80 percent had average incomes a few percent higher or lower than all veterans, those rated 90 percent had incomes 25 percent higher and those rated 100 percent, or totally disabled, had incomes 30 percent lower on average than all veterans. The Bradley Commission was concerned that, since no study of actual impairment of earning capacity had been made previously and since the standard was predominantly based on physical disabilities affecting manual laborers, compensation might not be adequate and equitable. On the basis of the data it collected the Commission concluded that:

> While there are some important exceptions, it appears that—despite the inadequacies discussed above—on the whole veterans' compensation tends to work out in such a way that the average wage loss of those who are disabled is made up through compensation.[20]

The Bradley Commission recommended, however, that the practice of equal increments between compensation amounts be changed to one in which the increase in amount of compensation be greater as the rating percentage increased, because of the finding that the incomes (including compensation) of those rated 100 percent were substantially less than those of nondisabled veterans.[21] In response, in 1957 Congress began to increase the compensation

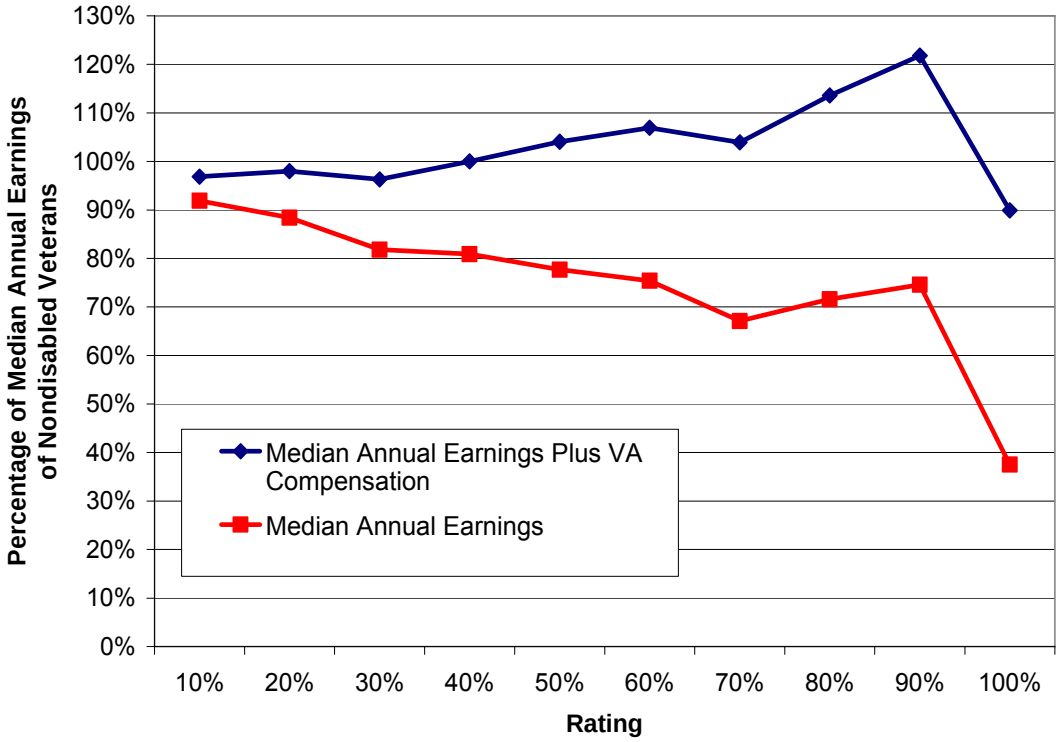
[19] President's Commission, *Finding and Recommendations*, 160. The difference was calculated from the data in Chart II.
[20] President's Commission, *Finding and Recommendations*, 165–166.
[21] Ibid., 174–175.

for veterans rated 100 percent relative to the other rating levels. Since 1957, the percentage jump in compensation from the 90 to 100 percent rating levels has increased steadily, and the increments have also increased at lower levels so that the straight line relationship between the rating and compensation has become more of a curve.[22]

When the Bradley Commission looked at earnings rather than total income by level of disability, it found that while compensation generally made up for loss in earnings, those rated 100 percent still had about 10 percent less than the earnings of nondisabled veterans (Figure 7.1). The commission did not make comparisons by body system, but it did compare total median income (including compensation) of veterans having general medical or surgical disorders with veterans having psychiatric or neurological disorders, relative to nondisabled veterans. The comparison found that veterans with psychiatric or neurological disorders had median total incomes lower than veterans with general medical or surgical disorders at 9 of the 10 rating levels, and substantially less at the 30, 50, 70, and 100 percent levels (Figure 7.2).

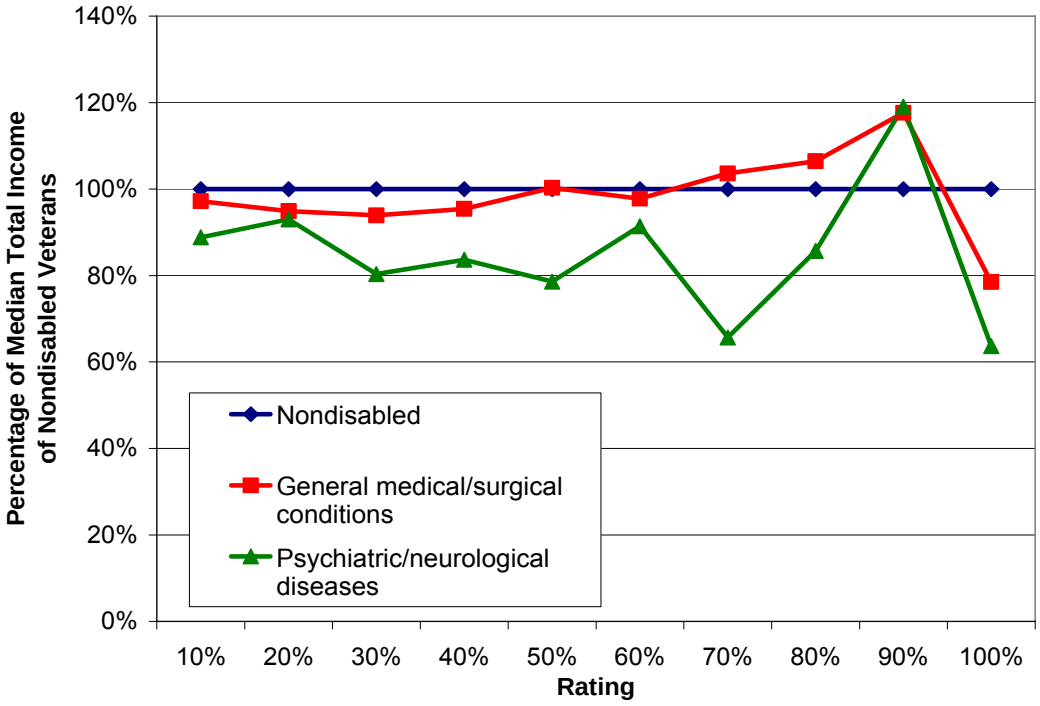
[22] Economics Systems, *VA Disability Compensation Program*, 18.

**Figure 7.1 Median annual earnings compared with earnings plus annual compensation of disabled veterans, as percentage of median annual earnings of non-disabled veterans, by combined rating level: 1954–1955.**




SOURCE: President's Commission on Veterans' Pensions. 1956. *Survey of disabled veterans: Analysis of statistical data on income, employment, and other characteristics*. Staff Report Number VIII, Part C, of the Bradley Commission Report. House Committee Print No. 286, Committee on Veterans' Affairs, 84th Congress, 2nd Session, August 10, 1956, Table 33.

**Figure 7.2 Median annual total income of disabled veterans as percentage of median annual total income of non-disabled veterans, by combined rating degree: 1954-1955**




SOURCE: President's Commission on Veterans' Pensions. 1956. *Survey of disabled veterans: Analysis of statistical data on income, employment, and other characteristics*. Staff Report Number VIII, Part C, of the Bradley Commission Report. House Committee Print No. 286, Committee on Veterans' Affairs, 84th Congress, 2nd Session, August 10, 1956, Table 22.

## I.5.B Economic Validation of the Rating Schedule (ECVARS)—1971

In 1971, VA conducted a detailed evaluation of the average (median) earnings associated with one or more rating levels for about 530 of the 700 diagnostic codes (in some cases, closely related codes in terms of disease process or injury type and rating criteria were grouped). The number of rating levels analyzed per diagnostic code varied from 1 to 10, for a total of 1,004 possible comparisons with the average earnings of nondisabled veterans. This effort was called the Economic Validation of the Rating Schedule (ECVARS).

To recap the results of ECVARS, the average percentage loss of earnings of service-connected veterans was less than their rating percentage in 82 percent of the comparisons (820 of 1,004), more than the rating percentage in 11 percent of the comparisons (110 of 1,004), and about the same in 7 percent of the

comparisons (74 of 1,004).[23] Nearly three-quarters of the cases (81 of 110) in which the average earning loss percentage was greater than the rating percentage were in the digestive, neurological and convulsive, and mental disorders systems, three body systems that had not been comprehensively updated since 1945.[24]

When the value of compensation was added, the total on average (earnings plus compensation) for service-connected veterans was at least 95 percent of the average earnings of nondisabled veterans in 57 percent of the comparisons (577 of 1,004). Service-connected veterans made between 75 and 95 percent of what comparable nondisabled veterans earned on average in 29 percent of the comparisons, but they made less than 75 percent of what nondisabled veterans earned in 14 percent of the comparisons. Most (84 of 139) of the comparisons in which service-connected veterans made less than 75 percent of nondisabled veterans were in the neurological and mental disorders body systems.

## I.6 CNA Corporation (CNAC) Study—2007

CNAC was asked to analyze 2004 data on veterans with service-connected disabilities in different body systems and at different rating levels and compare their earned income (earnings plus benefits) with the earned income of a demographically similar group of nonservice-disabled veterans ("comparison-group veterans"). The purpose of the analysis was to help answer the question posed by this Commission, "How well do benefits provided to [service-disabled] veterans meet the congressional intent of replacing average impairment in earning capacity?" The statistics on earnings by rating percentage and by body system are also useful for evaluating the effectiveness of the Rating Schedule in predicting actual earnings, which was recommended by the IOM Committee on Medical Evaluation of Veterans for Disability Compensation.[25]

The earnings data were obtained by matching veteran records with Social Security earning records. The assumptions are that, for comparison purposes, the average earnings of comparison-group veterans are about the same as what service-connected veterans would be making on average if they had not been

[23] "About the same" means earnings between 90 and 110 percent of the rating percentages of nondisabled veterans.
[24] The mental disorders section of the Rating Schedule was comprehensively revised in 1996.
[25] IOM, *21st Century System*, 101.

disabled in service and are a reasonable although not exact measure of average impairments of earning capacity.[26]

CNAC, in consultation with the Commission, stratified the service-connected veterans into four rating percentage groups: 10 percent, 20 through 40 percent, 50 through 90 percent, and 100 percent. Also in consultation with the Commission, CNAC grouped the service-connected veterans by the body system of their primary (i.e., highest-rated) disability and also looked at PTSD separately from the rest of the mental disorders. Veterans receiving special monthly compensation were looked at separately, as were veterans who have Individual Unemployability (IU) status. CNAC stratified service-connected veterans by age group: 18–29, 30–39, 40–49, 50–60, 61–64, 65–69, 70–74, and 75 and older. Finally, CNAC developed a comparison group of veterans not receiving disability compensation from VA or DoD who are demographically equivalent in age, race, gender, and education at time of entry into military service. The detailed results of the CNAC analysis of veterans' earnings are in Chapter 2 of their report to the Commission.[27]

## I.6.A Average Earned Income—Overall

At the most aggregate level, as might be expected, service-connected veterans on average earned less than the comparison group (Figure 7.3).[28] For example, in the 30–39 and 40–49 age groups, service-connected veterans averaged about $43,000 a year, compared with the $48,000 averaged by comparison-group veterans. Moreover, the average earnings of service-connected veterans began to drop after age 49 while those of comparison-group veterans stayed about level until after age 60. Part of the reason for this is that service-connected veterans at all ages are less likely to be employed, especially those in their 50s and 60s, than their non-service-connected peers.[29]

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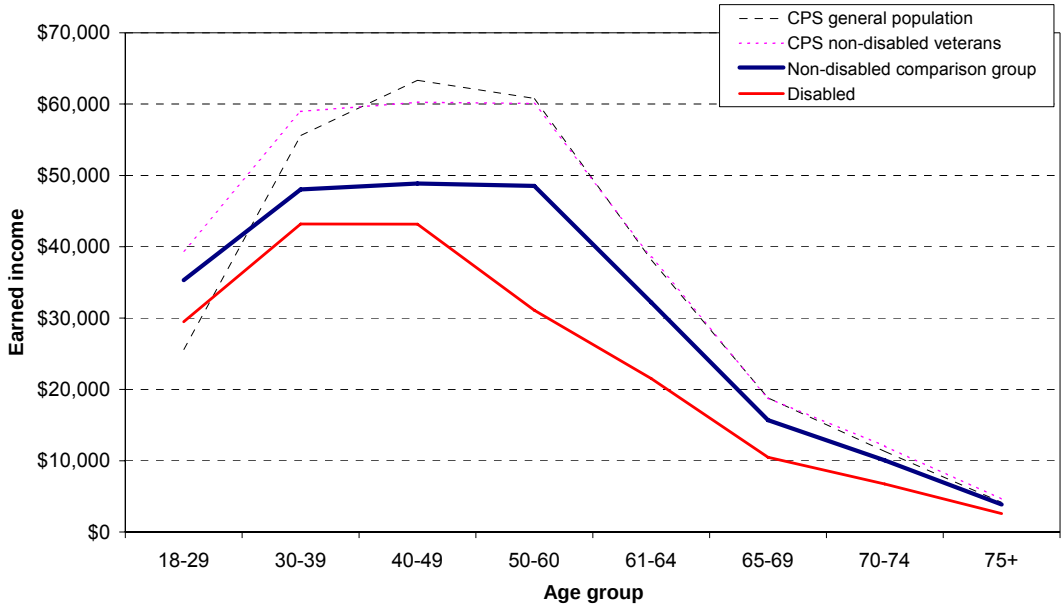
[26] Not exact to the extent that some service-connected veterans are not working to their maximum ability. Also, it should be noted that some of the members of the comparison group are likely to have disabilities that are not service connected.

[27] CNAC, *Final Report for the Veterans' Disability Benefits Commission*, Ch. 2.

[28] CNAC, *Final Report,* Figure 5. Unless otherwise indicated, the data cited in this report are for men, because there are too few service-connected women for statistical robustness. CNAC's final report has tables for women in an appendix (Appendix A).

[29] The wage gap is $17,000 a year for veterans in their 50s, after which the gap steadily closes to about $1,000 a year for those age 75 and older. The employment rate gap is about 5 percentage points for veterans in their 20s and 30s, increases to 24 percentage points in the 50s, and decreases after age 60 (Figure 4 in CNAC report).

**Figure 7.3 Average Earned Income of Service-Connected and Nonservice-Connected Veterans (men): 2004**

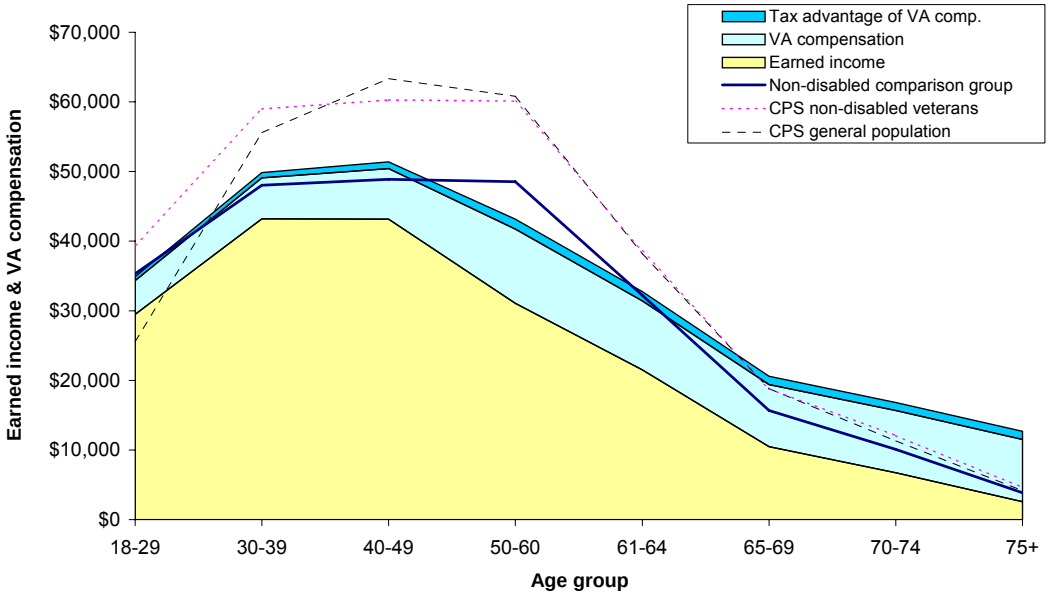



SOURCE: CNAC, *Final Report*, Page 33.

## I.6.B Average Earned Income Plus Compensation—Overall

When CNAC compared the average earned income plus compensation of service-connected veterans with the earned income of comparison-group veterans, it found that service-connected veterans received more dollars than the comparison group in some age brackets (e.g., 30–49, 61 and older) and less in other age brackets (18–29, 50–60) (Figure 7.4).[30] "Hence, on average," the authors of the CNAC report concluded, "VA compensation does a pretty good job of replacing lost earning capacity."[31]

**Figure 7.4 Average Earned Income and the Taxable Equivalent of VA Compensation of Service-Disabled Veterans (men)**




SOURCE: CNAC, *Final Report*, Page 34.

## I.6.C Average Earned Income—By Rating Group

CNAC found that average earned income differed by rating group, with those rated 10 percent earning less than comparison-group veterans, those rated 20–40 percent earning less than those rated 10 percent, and so on, with those rated 100 percent earning less on average than those at lower rating levels (Figure 7.5).[32] The differences are evident for every age group, and they are greatest for the 50–60 year old age group (Table 7.1).

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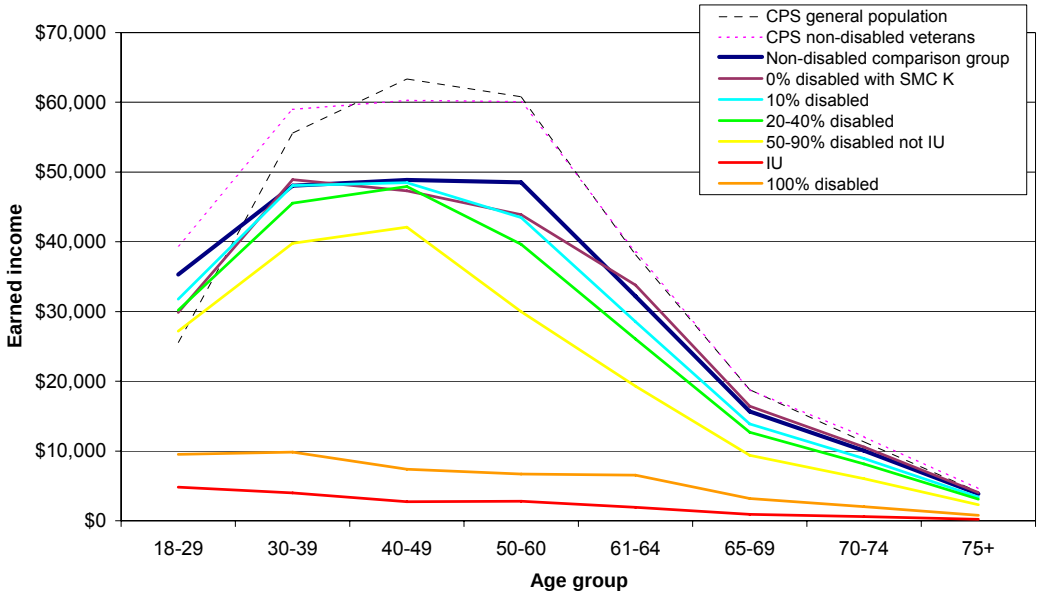
[30] In this and similar comparisons involving compensation, the compensation has been adjusted (i.e., increased) to account for the fact it is not taxed).

[31] CNAC, *Final Report*, 34.

[32] Veterans rated 50–90 percent who have Individual Unemployability (IU) status have even less earned income on average than veterans rated 100 percent according to the schedule, but this finding is affected by the requirement that IU veterans not have substantial earnings.

**Figure 7.5 Average Earned Income of Service-Connected Veterans by Rating Group and Nonservice-Connected Comparison Group (men): 2004**




SOURCE: CNAC, *Final Report*, Page 36.

**Table 7.1 Average Earned Income of Service-Connected Veterans Ages 50–60 by Rating Degree, as a Percentage of Earned Income of Comparison-Group Veterans: 2004**

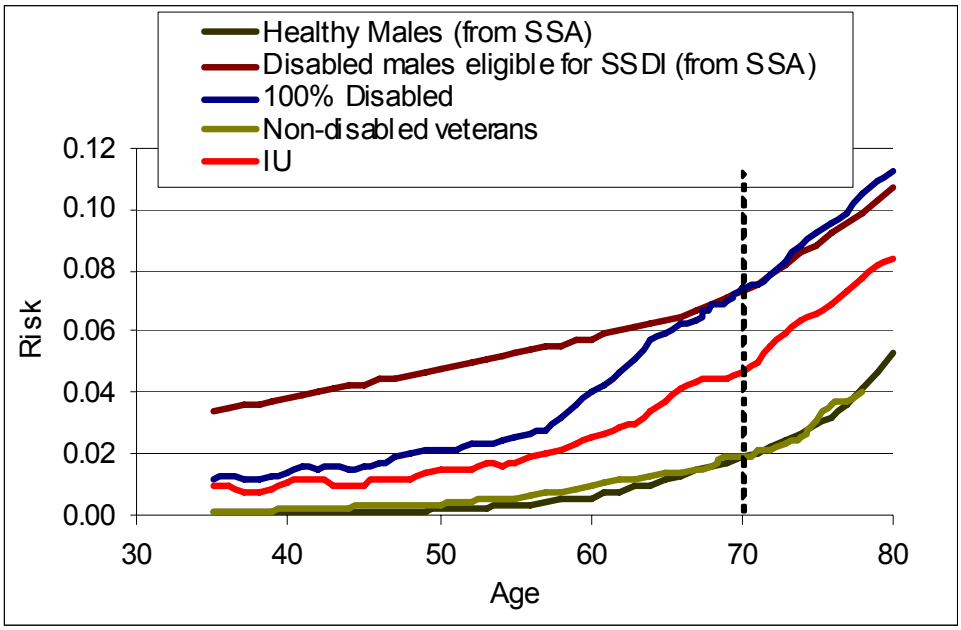
| DISABILITY STATUS | AVERAGE EARNED INCOME | |
|---|---|---|
| | Dollars | Percent of comparison-group average earned income |
| Non-service connected | $48,500 | 100% |
| 10% | $44,000 | 91% |
| 20-40% | $40,000 | 82% |
| 50-90% | $30,000 | 62% |
| 100% | $6,500 | 13% |

SOURCE: CNAC, adapted from *Final Report*, Page 36.

CNAC determined mortality rates by rating level as well as earnings. Although mortality rates are different than rates of earning, finding that the average mortality rate increases with rating percentage gives additional support to a finding that the Rating Schedule is effective at identifying how healthy veterans

are, which is related to earning capacity. CNAC found that mortality rates do increase monotonically with each increase in the rating percentage, even at the lowest rating levels (Figure 7.6).

**Figure 7.6 Comparison of Mortality Rates of Healthy Males and Male Service-Connected Veterans, by Rating Percentage Group**



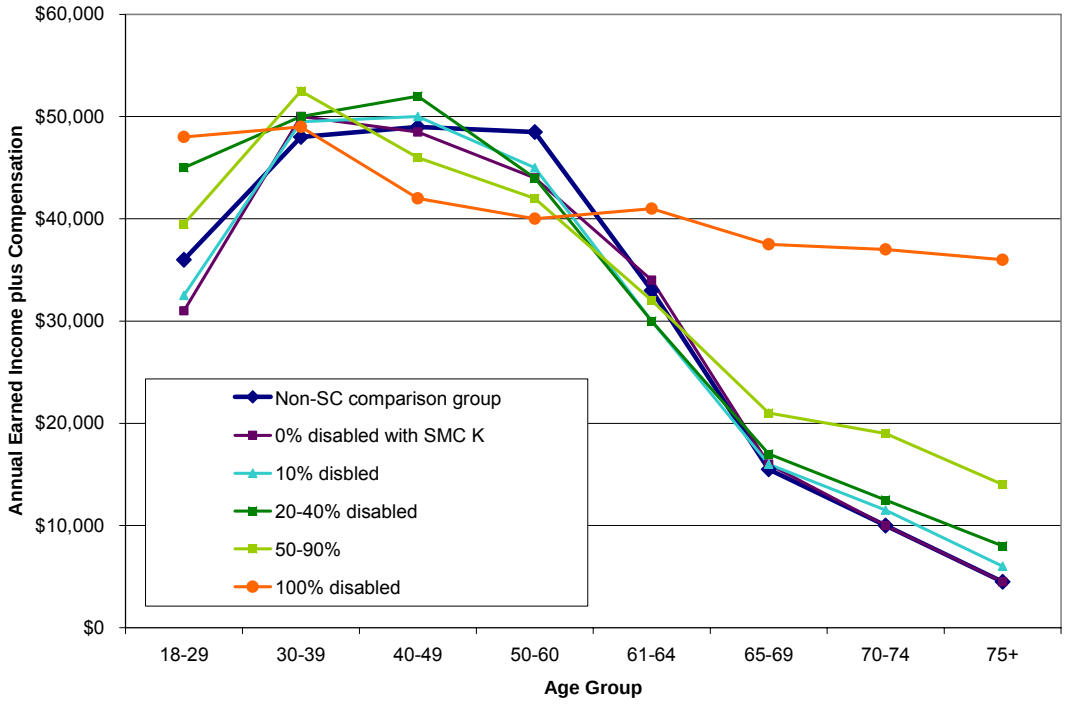

SOURCE: CNAC, *Final Report*, Page 171.

## I.6.D Average Earned Income Plus Compensation—By Rating Level

Generally, service-connected veterans rated 10 percent or 20–40 percent receive compensation that, when added to average earnings, is between 90 percent and 110 percent of the average earnings of comparison-group veterans when they are ages 18–69. Beginning with the 70–74 year old group, the total of earnings and compensation begins to be significantly more than the earnings of the comparison-group veterans (Figure 7.7). This result is consistent with the intent of the compensation program established in 1917: that benefits would be paid for life, rather than just during the time the individual is expected to work.

Veterans rated 50–90 percent or 100 percent tend to have more dollars from earnings and compensation when younger (39 and under), less from age 40–60 (because their earnings, already low, fall off rapidly), and significantly more after age 60 (when the earnings of the comparison-group veterans fall off rapidly to very low levels as they leave the work force) (Figure 7.7).

**Figure 7.7 Average Annual Earnings Plus Compensation of Veterans by Rating Percentage Group and Earnings of Comparison-Group Veterans (men): 2004**

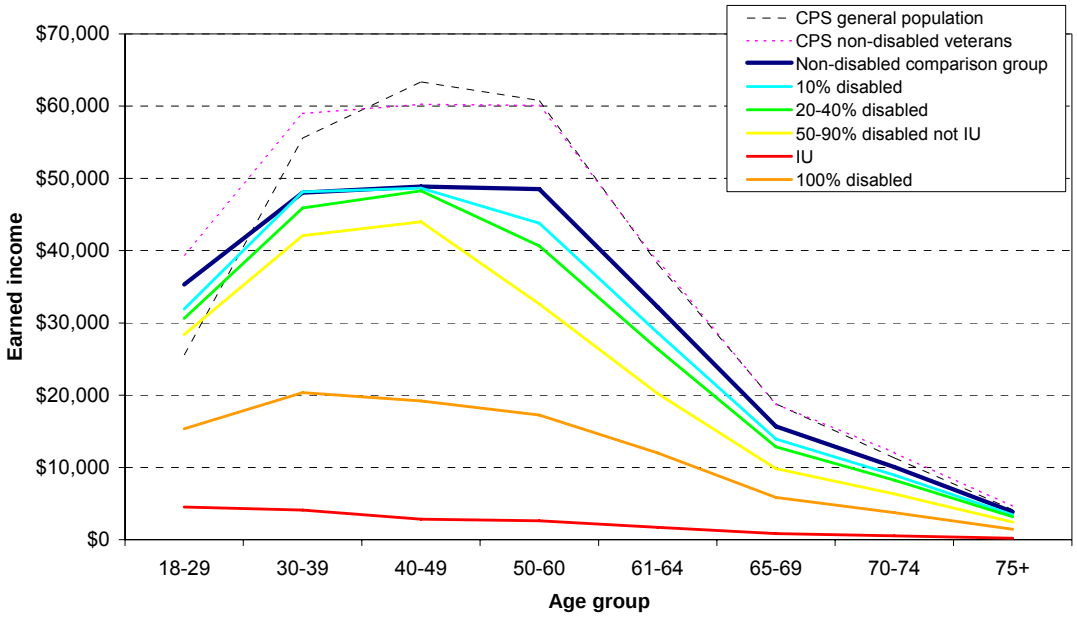



SOURCE: CNAC, adapted from *Final Report*, Pages 37-42.

## I.6.E Average Earned Income—By Body System of Primary Disability

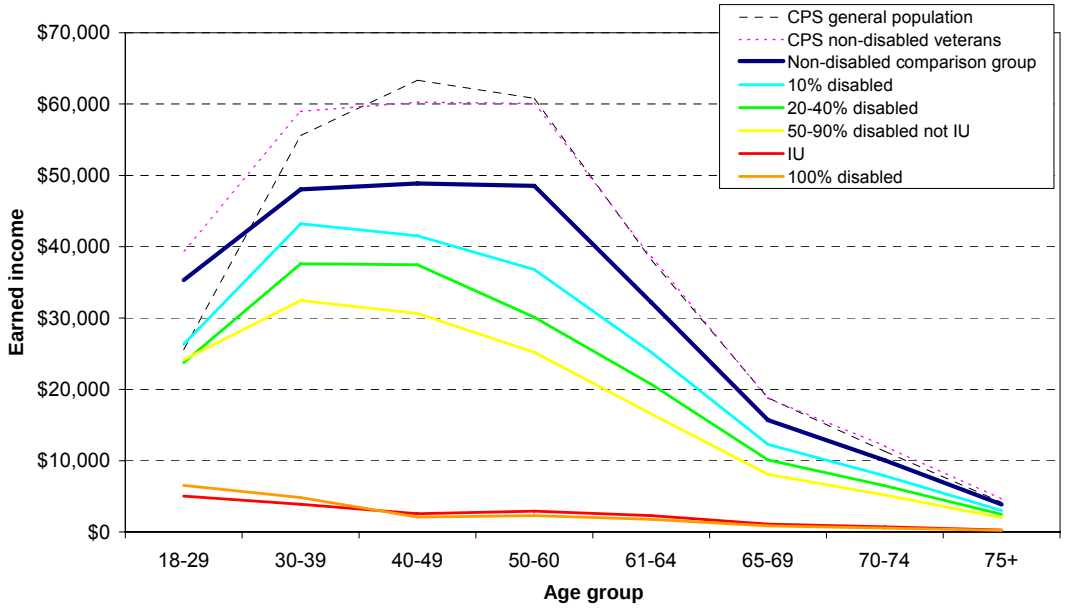
CNAC analyzed average earned income and employment rates by body system and rating percentage to see if there were significant differences. CNAC's final report contains figures for each body system, separately for men and women. The analysis found that the patterns for the physical disabilities (e.g., musculoskeletal, hearing, vision, digestive, skin, endocrine, and other nonmental body systems) were very similar. The patterns for PTSD and mental disorders other than PTSD were also very similar, but very different from those for the physical disabilities. It is possible, therefore, to capture the essence of this analysis with two figures, one of average annual earnings of veterans with *physical* disabilities as their primary diagnosis and the other of average annual earnings of veterans with *mental* disabilities as their primary diagnosis (Figures 7-8 and 7-9).

**Figure 7.8 Average Annual Earning of Service-Connected Veterans with a Physical Primary Disability, by Rating Group, and Nonservice-Connected Comparison Group (men): 2004**




SOURCE: CNAC, *Final Report*, Page 49.

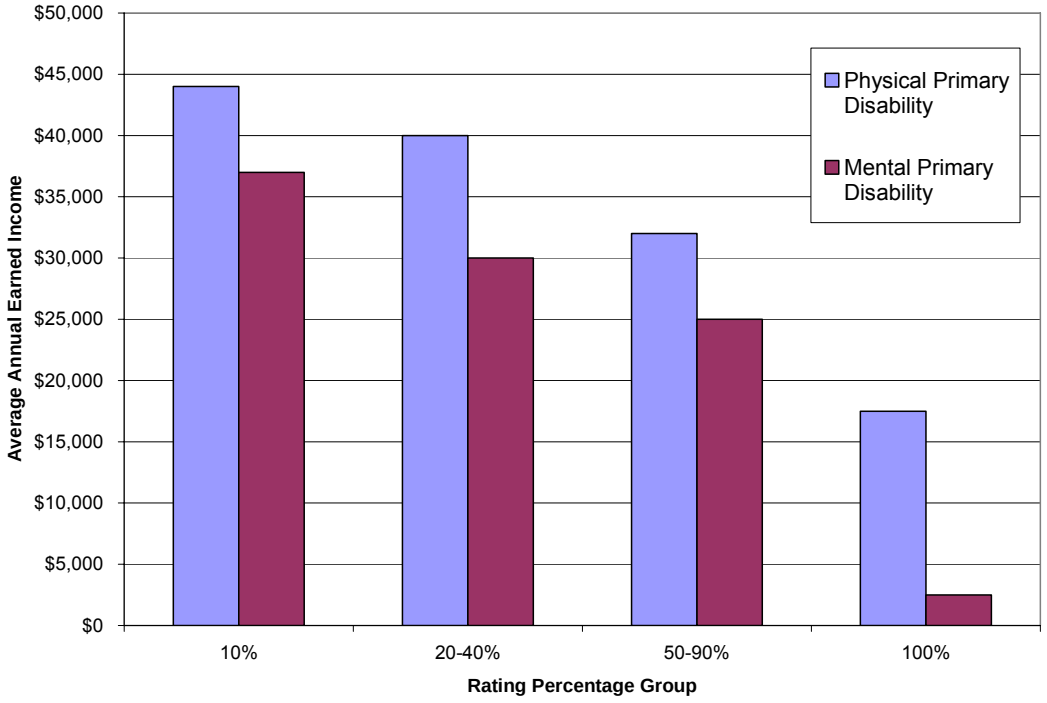
**Figure 7.9 Average Annual Earnings of Service-Connected Veterans with a Mental Primary Disability, by Rating Group and Nonservice-Connected Comparison Group (men): 2004**




SOURCE: CNAC, *Final Report*, Page 49.

For every age group and rating percentage group, the average earned income of service-connected veterans with mental primary disabilities is less—substantially less at higher rating percentages—than the average earned income of service-connected veterans with physical primary disabilities. For example, in the peak earning years—ages 50–60—veterans rated 10 percent for mental primary disabilities earn 86 percent of what veterans rated 10 percent for physical primary disabilities earn. Those rated 20–40 percent for mental primary disabilities earn 77 percent as much, those rated 50–90 percent earn 69 percent as much, and those rated 100 percent earn only 11 percent as much, on average, as those with the same rating percentage but with primary physical disabilities (Figure 7.10).

**Figure 7.10 Comparison of Average Earnings of Service-Connected Veterans Ages 50-60 with Primary Physical Disabilities and with Primary Mental Disabilities (men): 2004**




SOURCE: CNAC, adapted from *Final Report*, Page 49.

## I.6.F Average Earned Income Plus Compensation—By Body System of Primary Disability

For this part of the analysis, CNAC compared the present value of the average lifetime earned income (earnings plus benefits plus compensation) of service-connected veterans with the present value of the average lifetime earned income

(earnings plus benefits) of comparison-group veterans.[33] This approach makes it possible to take into account significant differences in average age of first entry into the compensation system across rating percentage groups and body systems of primary disability. It also takes into account the higher average mortality rate of service-connected veterans compared with the comparison-group veterans.[34]

First, CNAC calculated the present average value of the lifetime earned income of service-connected men at age 55, the average age of first entry into the compensation system, and calculated the same value for comparison-group veterans. The results were $250,769 and $402,268, respectively. When $148,053, the average lifetime present value of compensation, was added to the earnings of service-connected veterans, the total of $398,822 was 99 percent of the expected earnings of the comparison group ($398,822 divided by $402,268), or close to parity. This "earnings ratio"—0.99—indicates that the amount of compensation is about the same as the amount of lost earnings for the typical service-connected veteran.

When the same calculation is made for different ages of first entry, the picture changes. Veterans entering at older ages than 55 tend to receive compensation greater than their expected earnings losses (Table 7.2).

**Table 7.2 Earnings Ratio at Age of First Entry**

| AGE AT FIRST ENTRY | MEN | WOMEN |
|---|---|---|
| 25 | 1.05 | 1.05 |
| 35 | 1.02 | 1.03 |
| 45 | 0.96 | 1.00 |
| 55 | 0.97 | 1.00 |
| 65 | 1.51 | 1.63 |
| 75 | 2.62 | 3.59 |

NOTE: Average age at first entry is 55 for men and women.

SOURCE: CNAC, *Final Report*, Page 55.

[33] CNAC, *Final Report*, § 2.3, 51–62; Shahnasarian, *Assessment of Earning Capacity.* The present value of lifetime earned income is the same as the dollar value of an annuity which, if invested, would yield an income stream that compensates for the loss of earning capacity. This is also the methodology used in damage suits to determine compensation for loss of earning capacity. .

[34] CNAC, *Final Report*, 51–53; a more detailed technical description of the methodology for determining present value of lifetime earned income is in Appendix C of the CNAC report.

The picture becomes more complicated if the rating percentage groups are looked at separately by age of first entry (Table 7.3). The earnings ratio shows that compensation achieves between 93 and 111 percent of parity for the average ages of first entry by rating percentage group. It is also near parity for veterans rated 10 percent regardless of age of first entry, and for those rated 20–40 percent or 50–90 percent at ages up to and including average age of first entry but not for those who enter at age 65 or older. In the higher age and rating groups, the present average value of the lifetime earned income begins to exceed the amount of lost earning capacity. At the highest rating percentage—100 percent—veterans entering at younger ages have relatively low average earnings ratios (i.e., they are receiving less in compensation than their expected loss of earnings) but those entering at older ages have relatively high earnings ratios (.i.e., they are receiving more in compensation than their average impairment of earning capacity). As the authors of the CNAC report wrote,

> Why the difference? For those who become severely service disabled at younger ages, most of their working life is ahead of them. Hence, they incur substantial lost earning capacity for longer periods so it requires more disability compensation to replace lost earning capacity. In contrast, for those who become service disabled at older ages, much of their working years are behind them, so their disability compensation is replacing only the earned income that occurs after they become service disabled.[35]

**Table 7.3 Earnings Ratio by Age of First Entry and Rating Percentages Group (men)**

| AGE AT FIRST ENTRY | 10% | 20–40% | 50–90% | 100% |
|---|---|---|---|---|
| 25 | 0.99 | 1.01 | 1.05 | 0.87 |
| 35 | 0.99 | 1.01 | 1.03 | 0.80 |
| 45 | **0.96** | **0.97** | **0.98** | 0.83 |
| 55 | **0.93** | **0.95** | **1.00** | **1.04** |
| 65 | 0.97 | 1.16 | 1.66 | 2.50 |
| 75 | 1.03 | 1.58 | 3.08 | 5.60 |

NOTE: Average age at first entry is bolded. IU recipients are excluded from the 50–90 percent rating group.

SOURCE: CNAC, *Final Report*, Page 56.

[35] CNAC, *Final Report*, 56.

CNAC calculated the earnings ratio by rating group and average age at first entry for each body system.[36] It found that the results for physical disabilities were very similar and those for mental disorders were also very similar, but they differed markedly between physical and mental disorders (Table 7.4).[37] At entry age 25, for example, veterans with a primary physical disability have earnings ratios between 0.95 and 1.10, indicating that they are near parity (i.e., their expected lifetime earnings plus compensation are about the same as the lifetime expected earnings of comparison-group veterans). Veterans with the same age of first entry but with a primary mental disability have lower earnings rations, between 0.75 and 0.89, indicating lack of parity (i.e., their expected compensation is not making up for lost earnings).

**Table 7.4 Earnings Ratio by Age of First Entry and Rating Percentages Group for Veterans with Primary Physical Disabilities (men)**

| | Physical Primary Disabilities | | | | | Mental Primary Disabilities | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Age at First Entry | 10% | 20-40% | 50-90% (not IU) | IU | 100% | 10% | 20-40% | 50-90% (not IU) | IU | 100% |
| 25 | 0.99 | 1.02 | 1.10 | 0.75 | 0.94 | 0.86 | 0.83 | 0.88 | 0.77 | 0.75 |
| 35 | 0.99 | 1.02 | 1.08 | 0.71 | 0.89 | 0.85 | 0.82 | 0.84 | 0.74 | 0.69 |
| 45 | **0.96** | **0.99** | **1.04** | 0.76 | 0.91 | **0.81** | **0.78** | **0.82** | 0.80 | 0.73 |
| 55 | **0.93** | **0.97** | **1.06** | **0.99** | **1.08** | **0.79** | **0.77** | **0.88** | **1.07** | **0.95** |
| 65 | 0.98 | 1.17 | 1.71 | 2.56 | 2.37 | 0.86 | 1.04 | 1.50 | 2.80 | 2.40 |
| 75 | 1.04 | 1.58 | 3.13 | 6.08 | 5.30 | 0.93 | 1.57 | 2.84 | 6.81 | 5.61 |

NOTE: The earnings ratios for average age at first entry are bolded.

SOURCE: CNAC, *Final Report*, Page 59.

As the authors of the CNAC report wrote,

> To summarize the earnings ratio findings for male veterans, there is general parity overall. However, when we explored various subgroups, we found that some were above parity, while others were below parity. The most important distinguishing characteristic is whether the primary disability is physical or mental. In general, those with a primary mental disability have lower earnings ratios

[36] CNAC, *Final Report*. The tables for veterans with primary musculoskeletal and primary PTSD disabilities are on page 61 of the CNAC report and the rest of the tables are in Appendix D.
[37] Ibid., 61. Within the body systems for physical primary disabilities, the earnings ratios are a little smaller for auditory and endocrine, and a little larger for genitourinary and cardiovascular, systems compared with the overall average.

than those with a primary physical disability, and many of the rating subgroups for those with a primary mental disability had earnings ratios below parity. In addition, entry at a young age is associated with below parity earnings ratios, especially for severely disabled subgroups.[38]

## I.6.G IOM Study of the Ability of the Rating Schedule to Compensate for Impairment of Earning Capacity

The report of the IOM Committee on Medical Evaluation of Veterans for Disability Compensation recommended regular analyses of the ability of the Rating Schedule to compensate for average earning losses. The IOM committee also recommended that adjustments be made whenever it is found that step increases in rating percentages do not correlate with decreases in actual average earnings, either by revising the criteria for evaluating severity of disability or changing the amount of compensation paid at each rating percentage level, or both.

> **IOM Recommendation 4-2:** VA should regularly conduct research on the ability of the Rating Schedule to predict actual loss in earnings. The accuracy of the Rating Schedule to predict such losses should be evaluated using the criteria of horizontal and vertical equity.

> **IOM Recommendation 4-3:** VA should conduct research to determine if inclusion of factors in addition to medical impairment, such as age, education, and work experience, improves the ability of the Rating Schedule to predict actual losses in earnings.

> **IOM Recommendation 4-4:** VA should regularly use the results from research on the ability of the Rating Schedule to predict actual losses in earnings to revise the rating system, either by changing the rating criteria in the Rating Schedule or by adjusting the amounts of compensation associated with each rating degree.

The Commission generally agrees with the recommendation of the IOM Committee on Medical Evaluation of Veterans for Disability Compensation that VA periodically analyze the extent to which the Rating Schedule is associated with average earnings losses in the way expected, and make adjustments in the

[38] CNAC, *Final Report*, 4-5. CNAC performed the same analysis of women to the extent that more limited data allowed and found very similar results.

criteria for evaluating severity of disability or in the amount of compensation for one or more rating percentages, if necessary. However, the Commission rejected a few of the recommendations since it finds that the VA Rating Schedule is not designed nor intended to predict actual loss of earnings. The Commission wants to ensure that it is clearly understood that the purpose of the periodic analysis is to assess the average impairments of earnings capacity, not to assess the actual earnings of individuals.

## I.6.G.a Horizontal and Vertical Equity Assessment

Horizontal and vertical equity are concepts borrowed from the workers' compensation field, where they are used to assess the accuracy of rating schedules and adequacy of benefit levels.[39] Equity refers to the provision of equal benefits to workers with the same disability and to providing benefits in proportion to disability for those with different degrees of loss.

> *Horizontal equity* is achieved when the impairment of earning capacity is the same on average for veterans with the same degree of disability. In other words, veterans with the same rating percentage should experience approximately the same impairment of earning capacity regardless of the nature or location of the impairment.

> *Vertical equity* is achieved when impairment of earning capacity increases in proportion to increases in the degree of disability. Veterans with less earning capacity because of service-connected injuries should have higher rating percentages than those with more earning capacity.

The results of the CNAC analysis of earnings of veterans indicate that the VA Rating Schedule does generally provide vertical equity, at least at the body system level (rather than the diagnostic code level) and using rating percentage groups (rather than all 10 rating percentages). For example, the data on average earned income of service-connected veterans provide 293 possible comparisons of earnings between adjacent rating groups across body systems (e.g., between the 10 percent and 20–40 percent groups, between the 20–40 percent and 50–90 percent groups, and between the 50–90 percent and 100 percent groups). The higher rating group had lower average earnings 93 percent of the time, higher average earnings 4 percent of the time, and the same average earnings 3 percent of the time. Of 120 possible comparisons of average earnings of veterans rated 10 percent with those of comparison-group veterans, those rated

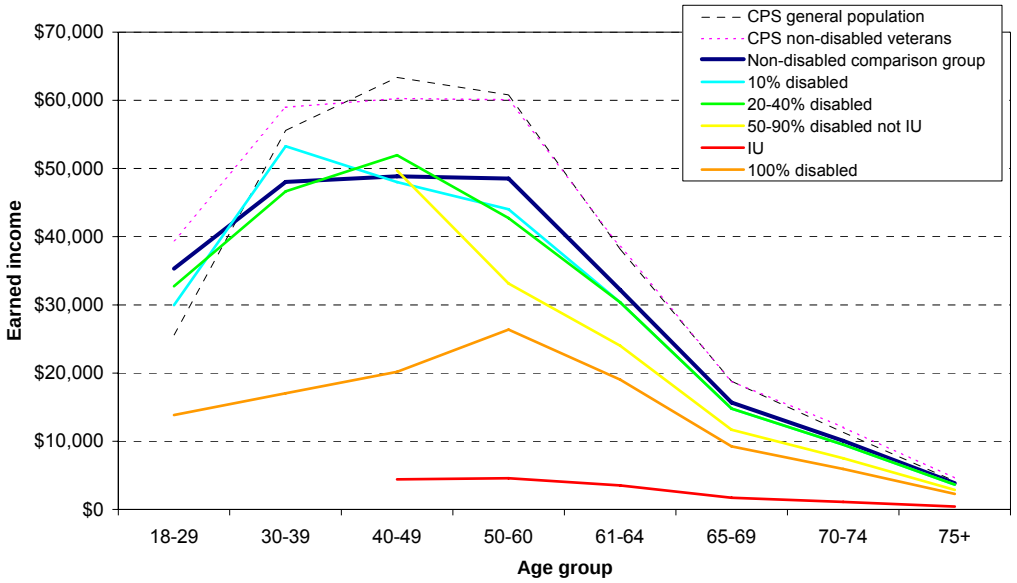
[39] See, for example, Berkowitz and Burton, *Permanent Disability Benefits.*

10 percent had lower average earnings than comparison-group veterans 90 percent of the time. In 12 instances, however, veterans rated 10 percent made more than the comparison group, in 8 instances, veterans rated 20 percent made more than the comparison group, and in 1 instance, veterans rated 50–90 percent made more than the comparison group, on average.

In some body systems, the Rating Schedule had some difficulty predicting differences in earnings among those rated 10 percent, 20–40 percent, and those not rated (i.e., comparison-group members) in the under 40 age groupings. In these systems—auditory, digestive, respiratory, endocrine, and genitourinary—the order of ratings was sometimes reversed. For genitourinary disabilities, for example, at age 30–39, the 10 percent rating group had the highest average earned income ($53,000), the comparison group had the second highest ($48,000), and the 20–40 percent group had the third highest ($47,000) (Figure 7.11). For the 40–49 age group, however, those rated 20–40 percent had the highest average earned income ($52,000), followed by those rated 50–90 percent ($50,000) and the comparison group ($49,000). Beginning with the 50–60 age group, however, higher rated veterans do not earn more than lower rated veterans in the genitourinary or any other body systems, although the differences might be narrow or they may earn the same (Figure 7.12).

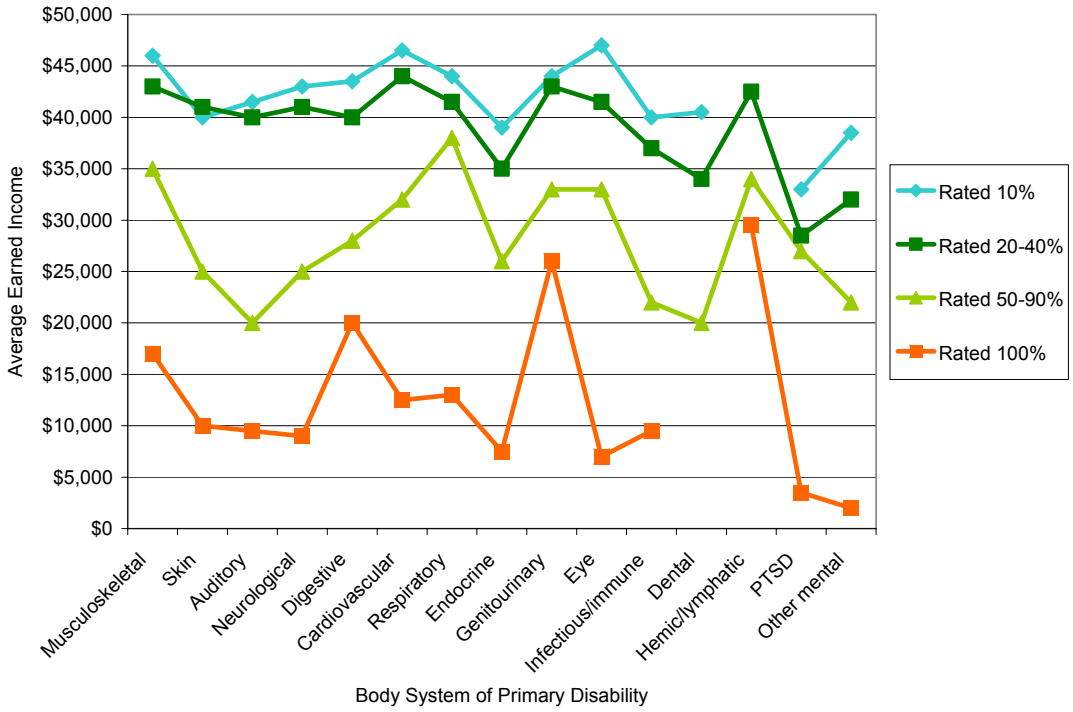
The Rating Schedule clearly lacks horizontal equity between veterans service connected for primary physical and primary mental disabilities (Figure 7.11). This was also a finding of the two previous analyses of the relationship between rating percentages and earnings losses, the Bradley Commission and ECVARS. Looking at each body system separately, horizontal equity among groups with primary physical disabilities is not perfect, although their earnings are relatively similar on average at each rating group percentage level when compared with the earnings of veterans with service-connected primary mental disabilities (Figure 7.12).

**Figure 7.11 Average Earned Income of Service-Connected Veterans with Primary Genitourinary Disabilities, by Rating Percentage and Comparison-Group Veterans (men): 2004**




SOURCE: CNAC, *Final Report*, Page 222.

**Figure 7.12 Earned income of service-connected veterans ages 50-60, by rating percentage, and comparison-group veterans (men): 2004**




NOTE: There were not enough cases of dental disabilities rated 100 percent or hemic/lymphatic disabilities rated 10 percent to determine an accurate average earned income for those rating percentage groups.

SOURCE: CNAC, adapted from *Final Report*, pages 47, 211-217.

The CNAC analysis of average earnings of service-connected veterans is a good first pass at evaluating the ability of the VA Rating Schedule to assign rating percentages equitably. Generally, the Rating Schedule meets the vertical equity test, that is, most of the time it successfully predicts the earnings of veterans by assigning higher rating percentages to those who earn less on average. It clearly does not meet the horizontal equity test for veterans with mental disabilities, that is, in each rating percentage group, veterans with primary mental disabilities make substantially less on average than veterans with primary physical disabilities.

The finding that the Rating Schedule has vertical equity is reinforced by CNAC's analysis of mortality rates, which also vary by the rating percentage in the expected direction, that is, the average mortality rate increases as the rating percentage increases. This means that lower earnings are not due solely to decisions of beneficiaries to work less because they are receiving compensation.

The CNAC analysis does not look at specific diseases or injuries within body systems, except PTSD, and it groups rating percentages. It is possible that a more detailed analysis using the same methodology would reveal equity issues with specific disabling conditions that do not appear in the more aggregate body system-level analysis. Looking at all 10 rating percentages also might reveal conditions or body systems in which those rated at a given percentage earn more than those rated at lower percentages. In various instances, analysis has been hampered by the inability to acquire data. For future analytical purposes, statutory authorization should enable VA and DoD to acquire and analyze data at the individual level.

What is expected from analyzing average earnings of service-connected veterans is that, for each step increase in rating percentage, average earnings decrease monotonically, and that at each rating percentage, average earnings of veterans with that rating percentage should be similar across body systems. If this condition is not met (and assuming that average actual earnings are a reasonable proxy for earning capacity), then some veterans may be over parity or under parity. The Commission believes that adjustments to the compensation levels should not result in reduction of benefits for any recipients.

Based on the findings of the IOM Committee on Veterans' Compensation for Posttraumatic Stress Disorder, the criteria for rating mental disabilities should be specific to the type of disorder as also discussed in Chapter 5 of that report. The IOM committee recommended that "new Schedule for Rating Disabilities rating criteria specific to PTSD and based on the DSM should be developed and implemented."[40] The recommendation is based on the IOM committee's finding that the general rating formula for mental disorders, which is used for all mental disorders except eating disorders, "lumps together heterogeneous symptoms and signs, allowing very little differentiation across specific conditions."[41] In other words, by trying to address nearly all mental disorders with a single rating formula, the schedule does not address any particular mental disorder very well. VA should decide whether to develop criteria for broad categories that form the basis for sections of the DSM, such as schizophrenia and other psychotic disorders, mood disorders, anxiety disorders, somatoform disorders, and dissociative disorders, or whether to develop criteria for specific disorders, or both. For some specific disorders, such as PTSD, the prevalence among veterans may be so high that VA should develop criteria specific to these disorders.

[40] IOM, *PTSD Compensation*, 162. The DSM is published by the American Psychiatric Association.
[41] Ibid., 156.

It is possible, based on CNAC data, that adjusting the rating criteria for mental disorders will not equalize earnings losses among these rated 100 percent for mental disabilities and those rated 100 percent for other disabilities. Even if everyone now rated 70 percent for a primary mental disability were rerated at 100 percent, average earnings of these rated 100 percent would not increase enough to be comparable to the earnings of other veterans rated 100 percent.

The Commission does not concur with the recommendation of the IOM Committee on Medical Evaluation of Veterans for Disability Compensation that VA investigate whether including factors in addition to severity of medical impairment, such as the veteran's age, education, and work experience, would improve the ability of the Rating Schedule to predict earnings losses (IOM Recommendation 4-3), because the Commission does not support a policy of considering age or other vocational factors in individual rating determinations.

**Recommendation 7.1**

**Congress should authorize VA to revise the existing payment scale based on age at date of initial claim and based on degree of severity for severely disabled veterans.**

**Recommendation 7.2**

**Congress should adjust VA compensation levels for all disabled veterans using the best available data, surveys, and analysis in order to achieve fair and equitable levels of income compared to the nondisabled veteran.**

**Recommendation 7.3**

**VA and DoD should be directed to collect and study appropriate data, with due restrictions to ensure privacy. These agencies should be granted statutory authority to obtain appropriate data from the Social Security Administration and the Office of Personnel Management only for the purpose of periodically assessing appropriate benefits delivery program outcomes.**

# II Compensating for Individual Unemployability

As part of its assessment of the appropriateness of the level of benefits, the Commission evaluated VA's use of Individual Unemployability (IU) as a compensation rating. To accomplish this, the Commission relied on studies

conducted by the Government Accountability Office (GAO) and IOM; it also requested an analysis of IU by CNAC.

## II.1 Background

The purpose of IU is to provide VA with a mechanism for compensating veterans at the 100 percent rate who are unable to work because of their service-connected disabilities and for disability ratings that do not meet the Rating Schedule's threshold for receiving the 100 percent rate. To provide a service-connected veteran with IU, VA evaluates the veteran's capacity to engage in substantial gainful occupation as the result of his or her service-connected disabilities. The definition for "substantial gainful occupation" is the inability to earn more than the federal poverty level.

In addition, IU takes into consideration the fact that the disabled veterans often have multiple disabilities. If, for example, a disabled veteran has only one disability; it must be rated 60 percent or more. However, if there are two or more disabilities, at least one disability must be rated at 40 percent or more resulting in a combined 70 percent rating. IU is not provided to veterans who receive a 100 percent rating because it is not necessary. This serves as an advantage for the veteran receiving a 100 percent schedule rating because they are allowed to work.[42] Individuals who receive an IU rating are unable to engage in gainful employment while collecting the compensation.

The service-connected disabled veteran experiences a significant financial increase with the addition of an IU award. For example, VA compensates a veteran who has a 60 percent rating (without children) $901 per month compared to $2,471 per month for someone rated 100 percent disabled.

The adjudication of IU claims by VA raters takes into account the veteran's current physical and mental condition and his or her employment status, including the nature of employment, and the reason employment was terminated.[43] Factors that are beyond the scope of inquiry, such as age, non-service-connected disabilities, injuries sustained postservice, availability of work, or voluntary withdrawal from the employment market, are identified and separated to determine the nature of the service-connected disability. Raters are specifically instructed that IU should not be granted if the veteran retired from work for reasons other than for their service-connected disability.[44]

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[42] IOM, *21st Century System*, 191.
[43] Ibid., 192.
[44] Ibid.

In recent years, IU awards have grown rapidly. The number of service-disabled veterans receiving IU has increased 103 percent from FY 2000 to FY 2005. In comparison, the overall number of veterans receiving any form of disability compensation increased by 16 percent over the same period.[45] This increase has caused concern regarding the basis for providing IU to service-connected disabled veterans, particularly for those who would likely not be looking for work due to their age and retirement eligibility.

These concerns led to a GAO report in May 2006 that addressed IU.[46] In its report, GAO found that VA's process for ensuring ongoing eligibility of IU beneficiaries is inefficient and ineffective, and relies on old data, has outdated and time-consuming manual procedures, offers insufficient guidance, and provides weak criteria.

VA has attempted to rectify issues concerning IU. For example, in October 2001, VA published a Notice of Proposed Rulemaking (NPRM).[47] This document was a draft of a rewritten set of regulations governing IU. However, after much internal and external discord, the NPRM was removed. VA removed the document because the new regulations failed to accomplish the stated purpose. In the same statement, VA announced that it would release a proposal, but has not yet done so. However, VA contends that both younger and older veterans at retirement age are encouraged to participate in vocational rehabilitation, therefore VA makes no judgments about a veteran's right to pursue a vocation.

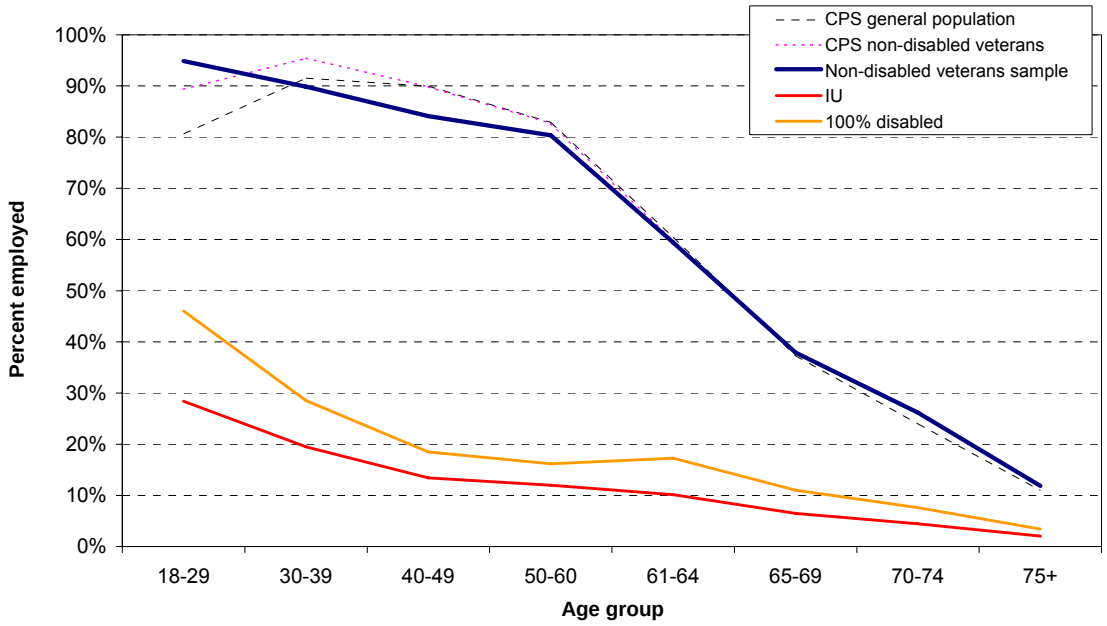
## II.2 CNAC Highlights on IU

The Commission asked CNAC to conduct an analysis of those service-connected disabled veterans who are receiving IU.[48] The central focus of CNAC's work revolved around determining whether or not the increases in IU were due to veterans' manipulation of the system to get additional compensation. To conduct their analysis, CNAC analyzed the mortality rates of those with and without IU and who concurrently receive Social Security Disability Insurance (SSDI) payments.

[45] IOM, *21st Century System*, 189.
[46] Ibid., 197.
[47] Ibid., 193.
[48] CNAC, *Final Report*, 160.

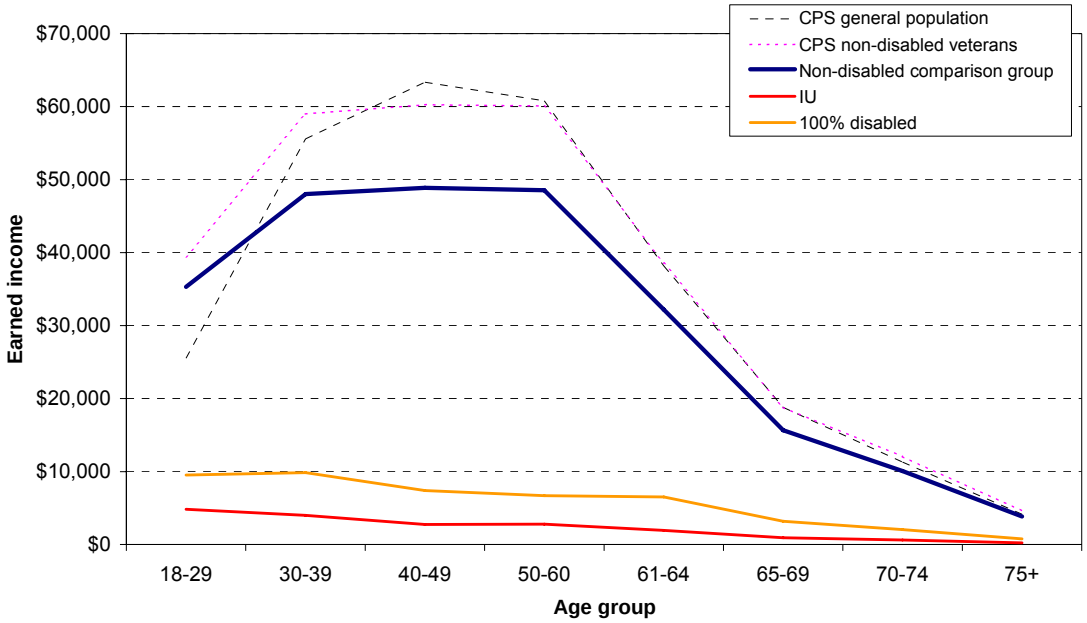
CNAC discovered that certain body systems are more likely to receive IU ratings. For example, 28 percent of those with IU have musculoskeletal disorders and 29 percent have PTSD. CNAC surmised that this may be an area of implicit failure of the Rating Schedule. Second, CNAC discovered that the growth in the IU population is mostly a function of demographic changes. These changes have come about because veterans with service-connected disabilities are facing complications with those disabilities as they age. As a result, CNAC concluded that the increase in IU is not due to veteran manipulation. CNAC also discovered that average employment rates and earned income are consistent between IU and 100-percent disabled veterans with a mental primary diagnosis. In addition, Figures 7-13 and 7-14 show how IU participants earn less and work less than individuals who are rated 100 percent and not IU.

**Figure 7.13 Average Employment Rate of IU and 100-Percent Disabled Veterans**




SOURCE: CNAC, *Final Report*, Page 167.

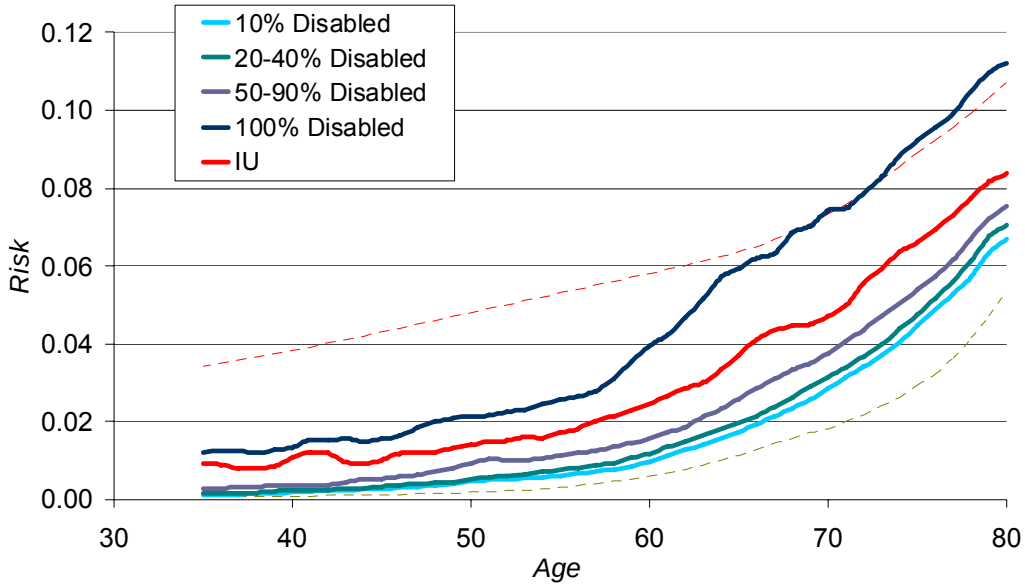
**Figure 7.14 Average Earned Income of IU and 100-Percent Disabled Veterans**




Source: CNAC, *Final Report*, Page 168.

Mortality rates show that there is an association with disability ratings, including IU. CNAC observed that there is a closely matched pattern as seen in their earnings and quality of life analyses. As shown in Figure 7.15, mortality rates increase with the level of disability rating assigned to a service-connected veteran.

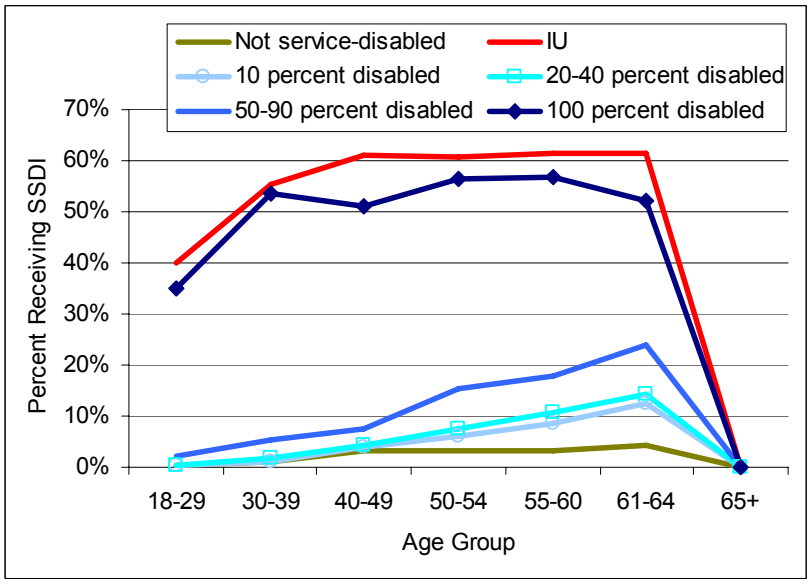
**Figure 7.15 Mortality Rates for Service-Disabled Veterans by Rating Group**




Source: CNAC, *Final Report*, Page 172.

Finally, CNAC found that SSDI is similar in its eligibility because of the emphasis on employability. As shown in Figure 7.16, 61 percent of those with IU receive SSDI payments.

**Figure 7.16 Percent with SSDI by Rating Group**

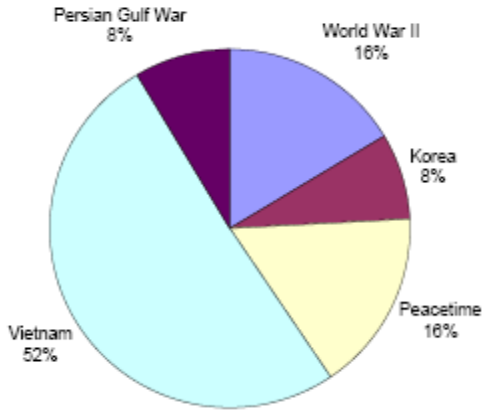



Source: CNAC, *Final Report*, Page 175.

## II.3 IOM Highlights on IU

IOM investigated the issue of IU and reported its findings in *A 21st Century System for Evaluating Veterans for Disability Benefits.* In that report, IOM recognized that IU is one of the fastest growing segments within the VA Disability Compensation Program. There were 112,400 veterans receiving IU in FY 2000, but by the end of FY 2006, that number had more than doubled to 228,500 veterans.[49] IOM reported that 35 percent of IU beneficiaries have mental health conditions as their major diagnosis.[50] Of this group, two-thirds have PTSD. Outside of the mental health realm, 29 percent of the IU population has musculoskeletal conditions, and 13 percent have cardiovascular conditions.[51] In addition, FY 2005 saw 38 percent of all IU beneficiaries at or above 65 years of age, 13 percent were between the ages of 60 and 64, and 49 percent were ages 59 and younger.[52] In addition, as the shown in Figure 7.17, a large portion of the individuals participating in IU served during the Vietnam War Era.

**Figure 7.17 IU recipients by period of service**




Source: IOM, *21st Century System*, Page 234.

Several recommendations were made by IOM concerning what needed to be done to the IU program. IOM recommended the following:

[49] IOM, *21st Century System*, 189.
[50] Ibid., 190.
[51] Ibid., 190.
[52] Ibid., 190.

- Medical evaluations should be done by medical professionals, and VA should require vocational assessment in the determination of eligibility for IU benefits.
- VA should monitor and evaluate trends in its disability program, and conduct research on employment among veterans with disabilities.
- Research should be conducted with service-connected disabled veterans who receive IU benefits past the normal age of retirement.
- IU should be based on the impacts of an individual's service-connected disabilities, in combination with education, employment history, and the medical effects of that individual's age on potential employability.
- A gradual reduction in compensation should take place when recipients are able to return to substantial gainful employment rather than abruptly terminating their disability payments at an arbitrary level of earnings.

The Commission carefully considered the findings of both IOM and CNAC and concluded that having medical evaluations performed by medical professionals trained to do them, reviewing vocational assessments by raters trained in reviewing them, updating the Schedule for Rating Disabilities to more equitably evaluate IU veterans, and a gradual reduction in compensation when the veteran is able to return to substantial work for a prolonged period of time will create an improved IU benefit reflective of the current medical, economic, and social scene.

**Recommendation 7.4**

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

**Recommendation 7.5**

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

# III Compensating for Loss of Quality of Life

The Commission asked CNAC to study the health-related quality of life of veterans with disabilities and their survivors.[53] The Commission also asked IOM to assess whether the VA Rating Schedule takes into account loss of quality of life. CNAC's finding that service-connected veterans report lower quality of life than population norms and IOM's recommendations that VA compensate for loss of ability to function in activities of daily life and, if possible, loss of quality of life, are addressed in this section of the report.

## III.1 CNAC Study of Quality of Life of Service-Connected Veterans

CNAC conducted a survey of a representative sample of service-connected veterans to collect data on their average quality of life. The survey included 20 questions from two widely used instruments for assessing health-related quality of life—12 questions from the Veterans RAND 12-Item Health Survey (VR-12) and 8 questions from the Veterans RAND 36-Item Health Survey (VR-36).[54] CNAC derived summary scores of physical health status and mental health status from the VR-12; these are the physical component summary (PCS) and mental component summary (MCS), which allowed them to compare service-connected veterans with established population norms in the published scientific literature. CNAC also calculated five additional subscales using the eight additional questions from the VR-36, which also have established population norms. The five subscales are: role physical, bodily pain, social functioning, role emotional, and mental health.

> There are standard algorithms that are used to calculate the subscales and summary scores from each individual's response to the SF-12 and SF-36. The algorithms are designed to produce scores that can be used for comparisons across groups of people. When applied to data from the general U.S. population, the algorithms produce scores with means of 50 and standard deviations of 10. Note that higher scores mean better health. This means that a group with a mean score of 45 for a particular subscale or summary score has worse health on average than the general U.S. population.[55]

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[53] Survivors are addressed in Ch. 8.

[54] CNAC, *Final Report,* 64.The SF-12 and SF-36 were developed for use in the Medical Outcomes Study conducted in 1986-1992. The SF-36 is the most used health survey in the world. The SF-12 consists of 12 questions from the SF-36 that can explain almost all the variance in the SF-36's summary scores of physical and mental quality of life. Versions of the SF-12 and SF-36 have been developed specifically for use among veterans, called the VR-12 and VR-36.

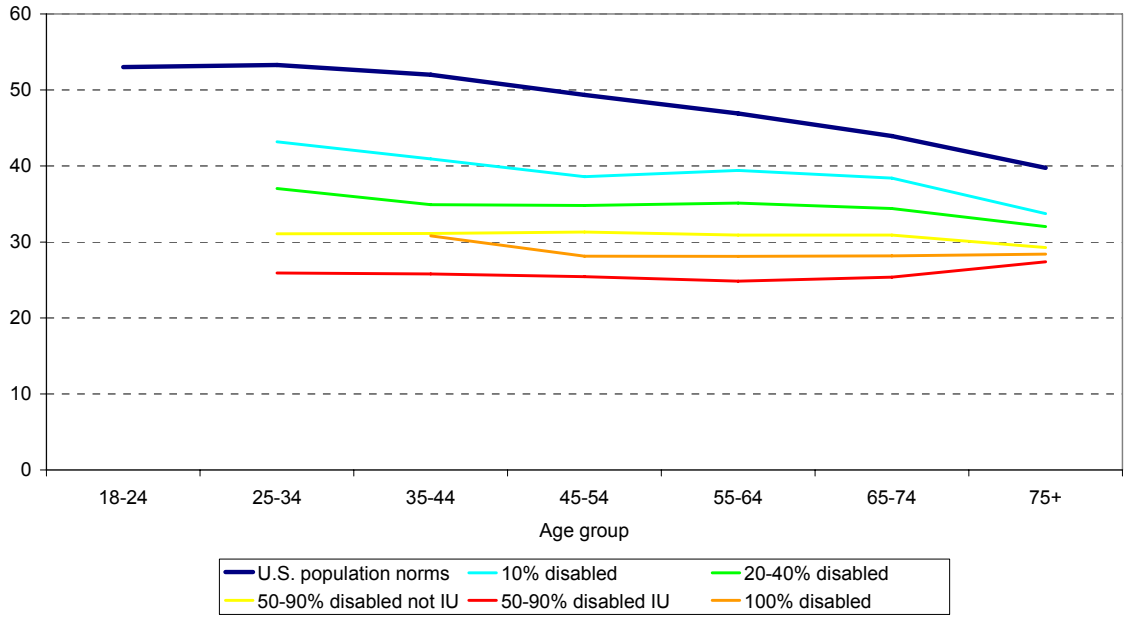
[55] CNAC, *Final Report*, 64.

The scores can be used to determine whether someone or a group, on average, has worse or better health-related quality of life compared to someone else or another group, but not how much better or worse. "Thus, if one group has an average score of 40 and another group has an average score of 42, we can say that health is better in the latter group, but we cannot say 'how much' better it is."[56]

CNAC found that service-connected veterans with primary physical disabilities have physical health status (PCS) scores below population norms at all disability levels, and that the scores generally declined as the rating percentage increased (Figure 7.18). Mental health status (MCS) scores of those with a primary physical disability were close to population norms except for veterans with the highest rating percentages, who had slightly lower mental health status scores (Figure 7.19).

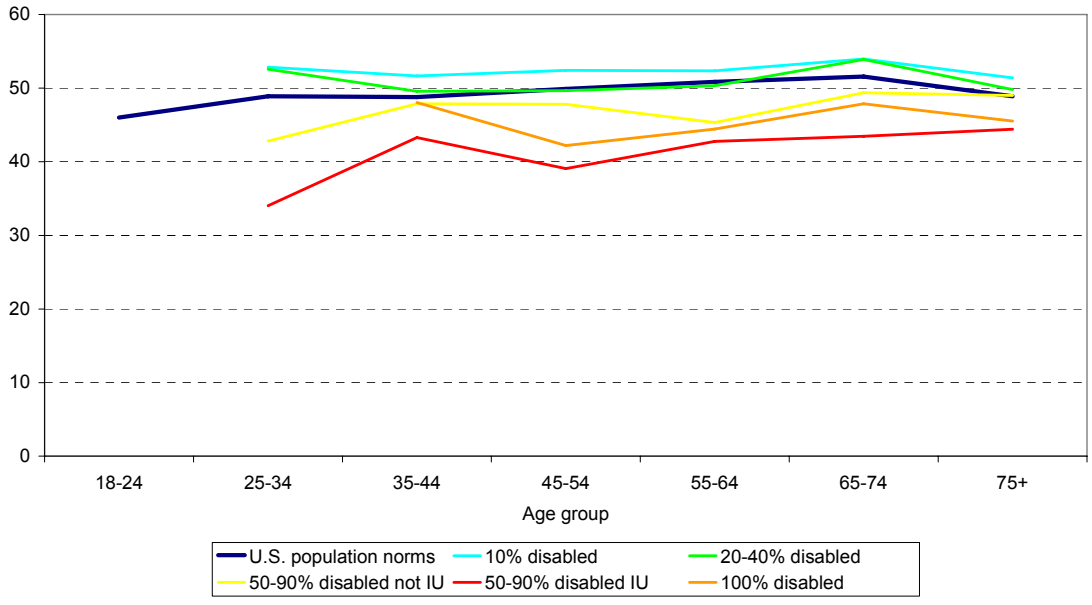
[56] Ibid.

**Figure 7.18 PCS Scores of U.S. Population and Service-Connected Veterans with Physical Primary Disabilities, by Age Group**




SOURCE: CNAC, *Final Report*, Page 68.

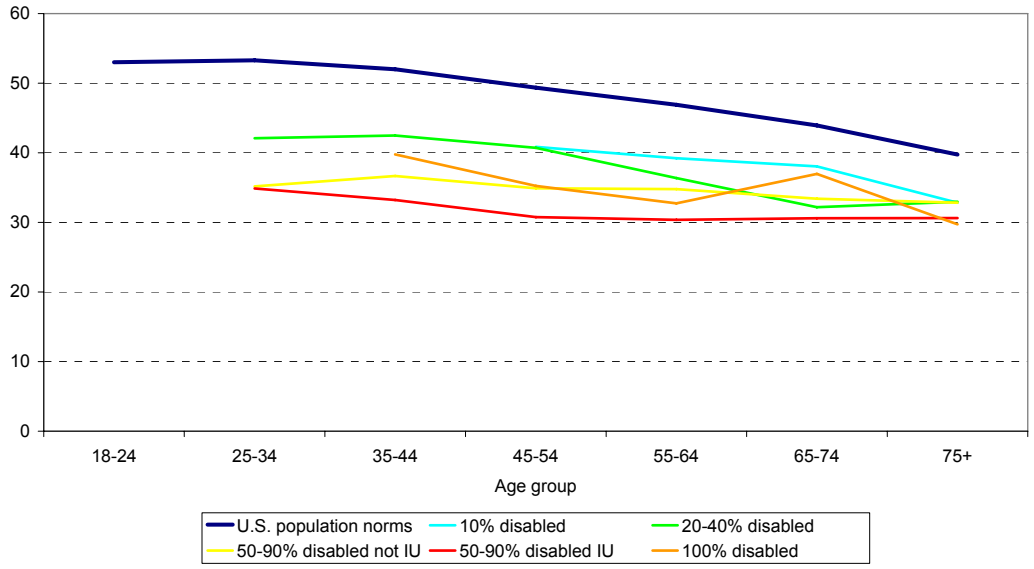
**Figure 7.19 MCS scores of U.S. population and service-connected veterans with physical primary disabilities, by age group**




SOURCE: CNAC, *Final Report*, Page 69.

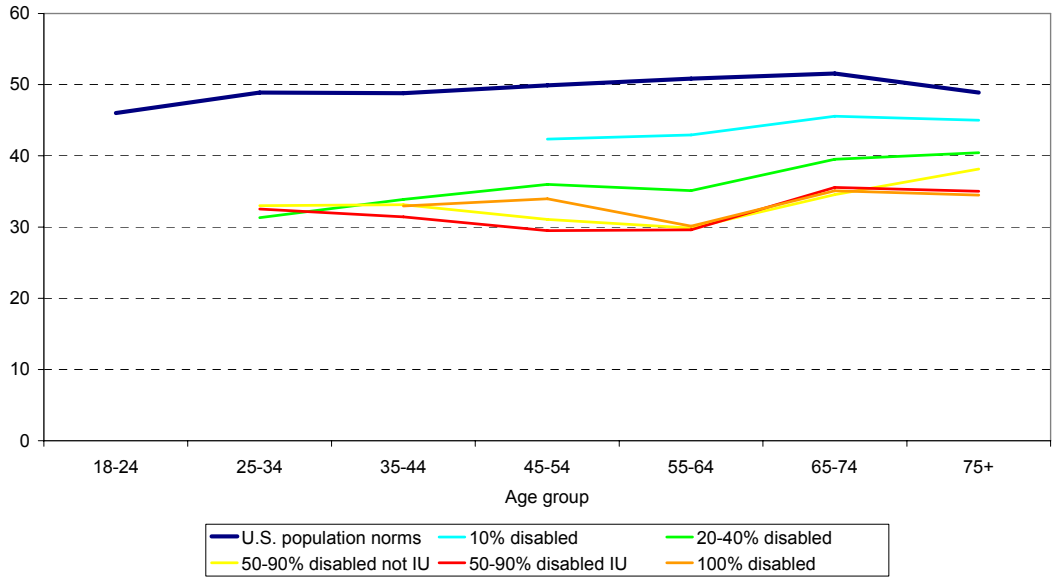
For service-connected veterans with primary mental disabilities, both physical health status and mental health status scores are well below population norms at every rating percentage (Figures 7-20 and 7-21).

**Figure 7.20 PCS scores of U.S. population and service-connected veterans with mental primary disabilities, by age group**




SOURCE: CNAC, *Final Report*, Page 70.

**Figure 7.21 MCS scores of U.S. population and service-connected veterans with mental primary disabilities, by age group**




SOURCE: CNAC, *Final Report*, Page 70.

CNAC summarized their major findings on health-related quality of life as follows:[57]

- For those with a primary physical disability, there is a statistically significant impact on physical health as measured by the physical health status score (PCS) but not a significant impact of mental health as measured by the mental health status score (MCS) except for those with the highest percentage ratings.
- For those with a primary mental disability, there is a statistically significant impact on physical health and mental health for all rating groups as measured by the physical health and mental health status scores.
- The patterns for physical and mental health are consistent across physical body systems, and they are consistent among PTSD and other mental conditions.
- The patterns in the physical health and mental health status scores observed among veterans with a physical versus mental primary disability are similar for the physical and mental health subscales.
- The overall mental health of those with a physical primary condition was about the same as U.S. population norms, but scores on the social functioning subscale were significantly less, and this held for each of the physical body systems.
- Those rated 60–90 percent with IU status have physical and mental health status scores generally lower than those observed for veterans rated 100 percent according to the Rating Schedule (the IU data are not shown here, but the finding is addressed elsewhere in the discussion of IU).

The survey also asked veterans about the satisfaction they get from life overall. The analysis found that satisfaction went down as the rating percentage went up in all age groups. Satisfaction was generally less among veterans with primary mental disabilities than among those with physical primary disabilities.[58]

CNAC's analysis of mortality rates reinforces the quality-of-life findings. They show that the Rating Schedule effectively sorts veterans by their state of health in the process of determining ratings. As the ratings increase, the mortality rate increases on average, which is consistent with the subjective assessments of service-connected veterans of their health-related quality of life. However, with respect to veterans with PTSD, mortality rates appear to be inconsistent with either quality-of-life findings or with earnings ratios. The mortality rates for veterans rated 100 percent PTSD are better than the rates for veterans rated 100

[57] CNAC, *Final Report,* 78, 79.
[58] Ibid., 79.

percent not PTSD; similarly, the mortality rates for veterans rated IU PTSD are better than the rates for veterans rated IU not PTSD. Therefore, while the mortality rates indicate that veterans with PTSD are healthier than other veterans with comparable ratings, their quality-of-life ratings and earnings ratios are lower than other veterans with comparable ratings. It is possible that this reflects difficulty for veterans with PTSD to reintegrate into civilian life to the maximum extent possible.

## III.2 IOM Study of Loss of Quality of Life

The IOM Committee on Medical Evaluation of Veterans for Disability Compensation made conceptual distinctions between *impairment*, *functional limitation*, and *work* and *nonwork disability*.[59] *Impairment* is the loss or partial loss of a physiological or anatomical structure (e.g., a lung or an arm) or loss or partial loss of a body function (e.g., limitation or loss of use of a knee or of lung capacity). *Functional limitation* refers to the extent to which a person is unable to engage in basic life activities because of impairments, such as dressing, eating, managing money, or walking across a room or up stairs. *Work* and *nonwork disability* result from the interaction of the person's functional limitations with environmental factors such as accommodations at work, availability of family support, and accessible transportation.

The IOM committee noted that the VA Rating Schedule is largely an impairment rating schedule, not a schedule for rating disability. For other than mental ratings, it does not consider the ability of the person to function in life. Other than the inclusion of some disabilities that clearly have little or no impact on ability to work, the schedule does not consider quality of life. The use of the schedule is based on the assumption that degree of impairment and its social and economic consequences (i.e., disability) are roughly related, on average. The IOM committee concluded that impairment rating does not capture the full scope of disability in many cases and recommended that VA compensate for functional limitations on usual life activities and for loss of quality of life, to the extent that the Rating Schedule does not account for them already:[60]

> **IOM Recommendation 4-5:** VA should compensate for nonwork disability, defined as functional limitations on usual life activities, to the extent that the Rating Schedule does not, either by modifying the Rating Schedule criteria to take account of the degree of functional limitation or by developing a separate mechanism.

[59] IOM, *21st Century System*, Ch. 3.
[60] IOM, *21st Century System,* 104.

> **IOM Recommendation 4-6:** VA should determine the feasibility of compensating for loss of quality of life by developing a tool for measuring quality of life validly and reliably in the veteran population, conducting research on the extent to which the Rating Schedule already accounts for loss in quality of life, and if it does not, developing a procedure for evaluating and rating loss of quality of life of veterans with disabilities.

The Commission has a broader view of the quality-of-life domain than IOM. In the scientific literature, health-related quality of life is measured with scales based on subjective self-reporting of subjects and is different from clinician assessments of an individual's ability to carry on a normal life. For compensation purposes, the Commission has interpreted quality of life to include the nonwork aspects of disability, encompassing how well someone can function in everyday life *and* how they feel about their situation. Both these aspects of disability are addressed in this section of the report.

CNAC has established that the quality of life of service-connected veterans is significantly lower than the quality of life of the general population, on average, and that average quality of life becomes less and less as rating percentages increase. IOM finds that functional limitations and loss of quality of life of individuals are aspects of disability in addition to impairment, and recommends that VA compensate for them if possible, to the extent that the medically based Rating Schedule does not do so.

> The basis for this distinction [between work and nonwork disability] is that a veteran may be working but unable to participate in other usual life activities. For example, a veteran may be employed in a good job but suffer from the symptoms of PTSD. A veteran with severe mobility restrictions might be able to use a computer linked to the Internet to earn a good living from home, especially if there are adequate social supports (e.g., friends or family to help with food shopping). There are many ways in which the lives of veterans with service-connected injuries and diseases can be changed by the effects of [those] injuries or diseases.[61]

According to IOM, one approach VA could take would be to perform functional assessments of service-connected veterans using well-established scales such as activities of daily living (ADLs) and instrumental activities of daily living (IADLs). Or VA could use condition-specific functional scales, although IOM notes that achieving parity across conditions might be a challenge. Validated

[61] IOM, *21st Century System,* 103.

functional assessment instruments have been developed for most conditions; the IOM report cites the following:

- Extended Glasgow Outcome Scale and Community Integration Questionnaire for brain injury
- National Institutes of Health Stroke Scale for stroke
- Functional Independence Measure and Spinal Cord Independence Measure for spinal cord injury
- St. George's Respiratory Questionnaire
- Guyatt's Chronic Respiratory Questionnaire
- University of California at San Diego Shortness of Breath Questionnaire for chronic obstructive pulmonary disease
- Diabetes Health Profile for diabetes

The next step would be to apply these assessments to representative groups of veterans to see if the current Rating Schedule already accounts for functional limitations to a reasonable degree. This would be the case if, in a given condition, functional limitation scores tend to increase in step with rating percentages, on average. If this is not the case, then veterans are not being compensated for the full extent of their disabilities, just for loss or loss of use of a limb or organ.

IOM recommends that, if VA finds that the Rating Schedule does not adequately account for nonwork disabilities, it should find a way to compensate for it. One way might be to incorporate functional measures in the Rating Schedule criteria, which is the direction that the American Medical Association is taking with the next edition of its *Guides to the Evaluation of Permanent Impairment*, which is widely used to measure impairment in workers' compensation and private disability insurance programs. The Listing of Impairments used by the Social Security Disability Program as its medical screening tool has been moving toward functional assessment for some time, for example, looking at the ability of someone with a musculoskeletal impairment to ambulate effectively rather than at the limitation of motion of the affected body part.

The IOM report mentioned several other methods of compensating for loss of quality of life, which are based on assessments of a veteran's ability to function:

1. The Canadian veterans' compensation program, for example, evaluates ability to participate in three functional areas: activities of independent living, participation in recreational and community activities, and initiation of and participation in personal relationships. These are graded on a scale ranging from mild limitations or reductions of ability, moderate

interference, and extreme inability to carry out each of the three functions. These are combined in a table to generate a quality-of-life rating ranging from 1 to 20 percentage points that is added to the impairment rating percentage to form the disability assessment.

2. The Australian Department of Veterans' Affairs determines an impairment rating between 5 and 100 percent using a rating schedule. Then it determines a "lifestyle rating" based on the extent an individual is limited in fulfilling roles filled by normal veterans without a service-connected injury or disease. The lifestyle rating is an average of ratings on four scales—personal relationships, mobility, recreational and community activities, and employment and domestic activities. The impairment rating and lifestyle rating are then combined using a table into the percentage used to determine the amount of compensation—the compensation factor. In Australia, the lifestyle rating can account for 15 percent of the compensation factor for impairment ratings up to 50 percent and less for higher impairment ratings. In addition, for severe conditions that leave veterans bedridden or housebound, or because of severe stroke, Parkinson's disease, heart failure, respiratory failure, liver failure, severe kidney failure, and some dementias, ADLs are evaluated using one scale and nonspecific indicators of disease such as pain, lethargy, and poor prognosis are assessed on another scale. The higher of the two scores is compared with the traditional body-system-based impairment rating, and the higher of those two ratings is used to determine the amount of compensation.[62]

There are two basic approaches to measuring subjective health-related quality of life. One is to use psychometric scales such as the VR-12 or VR-36. These are well established and widely used, and research has shown that the quality-of-life scores of participants in medical research, such as clinical trials, can be a better predictor of outcomes than clinical diagnoses. The problem with psychometric scales is that they cannot be converted into ratings. As CNAC explained in reporting on its analysis of the quality-of-life survey of veterans, the physical and mental health status or other scores based on the VR-12 and VR-36 can identify who has worse health but cannot be used to quantify how much worse.[63]

The other approach to measuring quality of life is an economic utility-based evaluation by a representative sample of a population of the percentage impact of a given condition on quality of life. Examples of these quality-of-life scales are the Quality of Well-Being Scale and EuroQol-5D, for which the utilities or preferences of the U.S. population have been determined. It would be possible to determine the preferences for a VA population. According to IOM, this approach has the promise of translating quality-of-life population norms for

[62] IOM, *21st Century System,* 68–69, 103–104.
[63] CNAC, *Final Report*, 64.

disabling conditions directly into rating percentages, but much work needs to be done to perfect the scales and develop the norms. The approach would not involve applying quality-of-life scales to each service-connected veteran; rather, norms would be set by having a relevant population, in this case, probably a representative sample or samples of military veterans or service members, decide how much quality of life they think they would lose if they suffered particular injuries, say, permanent loss of vision in an eye. Then VA could see if such studies show that the loss of quality of life is substantially more extreme than the impairment rating would indicate for some disabling conditions.

> Quality-of-life assessment is relatively new and still at a formative stage, which makes implementation of Recommendation 4-6 more long term and experimental. HRQOL [health-related quality of life] instruments are the most developed and validated. VHA already uses a psychometric HRQOL instrument, the SF-36, to assess the effectiveness of medical interventions, and it has been adapted and validated for the population of veterans receiving care in an ambulatory setting (SF-36V). Preference-based HRQOL instruments are less well developed but have the potential to be more useful in a compensation system, because the results can be quantified and located on an interval scale (the SF-36V does not, for example, provide a summary score).
>
> VA should begin a program of empirical research and development to determine the quality-of-life effects of service-connected injuries and diseases. The goal would be to see if a global HRQOL instrument could reliably and validly measure the quality of life of disabled veterans and be the basis for compensating for loss of quality of life. A preference-based HRQOL measure would also have to place values on losses that veterans and the remainder of the community agree on, so that compensation based on HRQOL losses would be acceptable to both groups. While it is not clear, based on the current status of the science, that it is possible to measure HRQOL with a significant degree of accuracy, the committee believes there is a good chance this goal can be achieved and, because of its importance, should be attempted.[64]

The Commission agrees with the IOM recommendation that VA launch a research and development effort on quality-of-life measurement tools or scales and study ways to determine the degree of loss of quality of life, on average, of disabling conditions in the Rating Schedule. If this effort is successful, VA should

[64] IOM, *21st Century System,* 108. The SF-36V has been renamed the VR-36.

analyze whether there are conditions in which the loss of quality of life is much worse than the average rating percentage and, if so, compensate for it.

The Commission recognizes that the President's Commission on Care for America's Returning Wounded Warriors (PCCARWW) also recommended a quality-of-life payment and agrees with their position.

The Commission believes that disabled veterans should not wait for extensive research to be completed; rather, an interim approach should be quickly developed to compensate veterans for the impact of their service-connected disabilities on their quality of life in the near term.

**Recommendation 7.6**

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

**Recommendation 7.7**

**Congress should create a severely disabled stabilization allowance that would allow for up to a 50 percent increase in basic monthly compensation for up to 5 years to address the real out-of-pocket costs above the compensation rate at a time of need. This would supplement to the extent appropriate any coverage under Traumatic Servicemembers' Group Life Insurance.**

**Recommendation 7.8**

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

# IV DoD Disability Evaluation System

The Disability Evaluation System (DES) is the process by which each of the military branches determines whether or not a service member is fit to perform

the duties of his or her office, grade, rank, or rating because of disease or injury.[65] The process begins with a medical evaluation board (MEB) that reviews the service member's impairment and makes a determination of fitness for duty. If the service member is not returned to duty, the process continues with a physical evaluation board (PEB). The PEB convenes with a three-member board (one or two medical officers and one or two line officers) who will decide if the service member can perform his or her military duty, and if not, determines a level of disability using the VA Schedule for Rating Disabilities (VASRD). The DES process is governed under 10 U.S.C. chapter 61 and by DoD Instruction 1332.39.[66] The Army, Navy/Marines, and Air Force each have their own directives governing the application of the DoD instruction and convene MEB and PEBs differently, based on their needs. The Commission heard criticisms regarding inconsistencies between these ratings and with VA, which led to its conducting a literature review and contracting with CNAC to find the following information.

In March 2006, the Government Accountability Office (GAO) reported on the DES and found that the Army, Navy/Marines, and Air Force's policies and procedures for disability evaluations and determinations were different. GAO attributed these dissimilarities to the lack of DoD direct implementation of its policies and guidelines. According to the GAO, "DoD has explicitly given the services the responsibility to set up their own processes for certain aspects of the Disability Evaluation System."[67] This freedom has led to the independent and somewhat different interpretation and application of the DES in each of the service branches.[68] Although DoD is providing guidance to help promote consistent, efficient, and timely disability decisions for both the active duty and reservists' disability cases, it is not monitoring compliance, accountability, effectiveness, or accuracy in the decision-making process. There is no DoD-wide database, and this prevents standardization among the branches.

GAO found that there were serious problems and inconsistencies in the electronic data. GAO attributed this disparity to the lack of systematic training and oversight by DoD, and an inadequate system for adding additional information from medical tests to the narrative summary.

This also has implications in the development of a VA/DoD medical data sharing system as it precludes the determination of accurate, useful, medical data, which would be required for expeditious and objective disability decisions. The inaccuracies of the DoD data also raises concerns over disability information

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[65] Howard, *DoD DES Exam Process.*
[66] Ibid.
[67] GAO, *Military Disability System*, 1.
[68] Ibid. See this report for a detailed description of the medical and physical evaluation boards stages of the disability process.

sharing with VA as both Departments' disability compensation evaluation systems still need significant and relevant modifications.[69]

An assessment of the disability processing time could not be conducted by GAO because the data in the Army's electronic databases were deemed unreliable.[70] GAO also found that disability ratings for reservists with comparable injuries or illness to those of the active duty were not the same, and that the level of compensation was less. The reasons why these disparities were found are not clear because of limited and unreliable information that impedes an assessment of this issue. There were several observations and recommendations that came from the March 2006 GAO report that could be further explored and implemented to improve the DES:

1. Disability Advisory Council (DAC): DoD periodically convenes DAC meetings with branch officials to review and update disability policy and discuss current issues. However, neither DoD nor the branches systematically analyze the consistency of decision making. The time and effort put forth in these meetings produces limited results because the branches are unwilling to change policies. However, if they were better aligned, a more objective analysis of the DES could be conducted. GAO indicated that, "such an analysis of data should be one key component of quality assurance."[71] GAO further noted, "DoD is not collecting available information on disability evaluation processing time from the services to determine compliance, nor are they ensuring these data are reliable."[72] Consequently, inefficiencies and errors in data collection, such as missing information and the inaccuracy of data entered, need to be corrected. Therefore, GAO concluded that increasing DAC meetings in frequency and duration would allow DoD to correct some of the limitations in the current DES. This would require having personnel from all parties involved (DoD, the branches, and VA) in the DES working as full-time members on the DAC.
2. Misinformation of functions and responsibilities: Internal communication and misunderstanding is a significant concern. GAO stated, "Despite a regulation requiring DoD's Office of Health Affairs (HA) to develop relevant training for disability staff, DoD is not exercising oversight over training for staff in the disability system."[73] HA indicated, "They were unaware that they had the responsibility to develop a training program."[74] In addition, this issue is heightened by the high turnover rate of military disability

[69] GAO, *Veteran's Disability Benefits,*
[70] GAO, *Military Disability System*, 1.
[71] Ibid, 3.
[72] Ibid.
[73] Ibid., 4.
[74] Ibid., 22.

evaluation staff, plus the branches do not have a comprehensive or well-developed plan to ensure that all staff are properly trained. A clearer delineation of responsibility and communication of duties for each DoD office is required to eliminate any confusion in these areas.

3. DoD lack of oversight and consistent guidance: There is concern with the inconsistency of the DES across the branches and lack of DoD involvement. GAO noted that in some cases the current time-processing goals were unrealistic. An assessment of a realistic timeline for processing disability cases is needed. HA needs to take charge of training by developing, implementing, and evaluating training for all of the branches.

Based on these findings, GAO made five recommendations:

1. Require branches to ensure that data to assess consistency and timeliness of military disability ratings and benefit decisions are reliable.
2. Require the branches to track and regularly report these data including comparisons of processing times, ratings, and benefit decisions for reservists and active-duty members to the Under Secretary of Personnel and Readiness and the Surgeons General.
3. Determine if ratings and benefit decisions are consistent and timely across the branches, between reservists and active-duty members, and institute improvements to address any deficiencies.
4. Evaluate the appropriateness of current timeliness goals for the disability process and take appropriate actions.
5. Assess the adequacy of training for MEB and PEB disability evaluation examiners.[75]

According to GAO, "to encourage consistent decision making, DoD requires all branches to use multiple reviews to evaluate disability cases. Furthermore, federal law requires that reviewers use a standardized disability rating system to classify the severity of the medical impairment."[76] Nevertheless, "each of the services administers its own disability evaluation system and assigns a standardized severity rating from 0 to 100 percent, to each disability condition, which along with years of service and other factors, determines compensation."[77] However, "despite this policy guidance and the presence of the disability council, DoD and the three service branches lack quality assurance mechanisms to

[75] GAO, *Military Disability System*, 27, 28
[76] Ibid., 1.
[77] Ibid.

ensure that decisions are consistent."[78] Plus, each branch has developed its own instruction on the VA Schedule for Rating Disabilities.[79]

DoD and VA need to assess the differences in the application of the Rating Schedule. The Congressional Commission documented that "the two systems apply different standards because they make determinations for different purposes."[80] The report recommended that, "a combined DoD/VA Disability Evaluation Rating Board would avoid redundancy."[81] This coordination of efforts could make sure that both military service members and veterans are receiving a consistent disability rating and compensation. At the SIMS meetings, it has been suggested that this process could include the Social Security Administration for SSDI determinations as well.

In April 2007, the Independent Review Group (IRG) on the Rehabilitative Care and Administration Processes at Walter Reed Army Medical Center and National Naval Medical Center supported the findings of several GAO studies and the President's Task Force to Improve Health Care Delivery for Our Nation's Veterans, and observed that "there are serious difficulties in administering the Physical Disability Evaluation System (PDES) due to a significant variance in policy and guidelines within the military health system. There is much disparity among the services in the application of the PDES that stems from ambiguous interpretation and implementation of a Byzantine and complex disability process."[82] The IRG concluded that titles 10 and 38 should be amended to allow "the fitness for duty determination to be adjudicated by DoD and the disability rating be adjudicated by VA,"[83] and that the Departments should implement the single physical exam process as described by GAO.[84] The IRG also recommended that the DAC be expanded.

The Task Force on Returning Global War on Terror Heroes recommended that "VA and DoD develop a joint process for disability determinations."[85] They described a similar process by which the Departments would cooperate in assigning a disability evaluation that would be used to determine fitness for retention, level of military retirement, and VA compensation, and be undertaken as an expansion of the Benefits Delivery at Discharge (BDD) Program for all MEB and PEB service members.[86]

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[78] GAO, *Military Disability System*, 19.
[79] DoD, Instruction 1332.39.
[80] Congressional Commission, *Report,* 139.
[81] Ibid.
[82] Independent Review Group, *Rebuilding the Trust*, 28.
[83] Ibid., 30.
[84] Ibid., 34
[85] Task Force on Returning Global War on Terror Heroes, *Report to the President*, 21.
[86] Ibid., 23.

# V Consistency of Disability Ratings between DoD and VA

The Commission became concerned with the consistency of disability ratings between DoD and VA because of the findings of a 2002 RAND study, a 2006 GAO report assessing the DoD Disability Evaluation System (DES), and anecdotal evidence of inconsistencies that individual members of the public presented to the Commission.

In a 2002 study, RAND "identified 43 issues regarding variability in policy application across or within the military departments…that affect the performance of the DES."[87]

Four years later, GAO released a study that found multiple flaws in DoD's methods for rating disabilities. GAO found that DoD delegates responsibility for assigning disability ratings to the services (Army, Navy, and Air Force) and does not maintain accountability for or monitor compliance with DES. The services are allowed to establish different time frames for line-of-duty determinations, medical evaluation board (MEB) referrals, MEB compositions, MEB appeals, physical evaluation board (PEB) responsibilities and compositions, and training. GAO found an absence of consistency in the training of staff who serve on MEBs and PEBs, and as counselors. GAO also found that there is no common DoD database that tracks disabled service members; moreover, each service's database for such tracking is different.[88]

Individuals testifying before the Commission alleged that VA ratings were generally much higher than DoD ratings. No analysis of actual differences in ratings could be found.

## V.1 Analysis of DoD and VA Ratings by CNAC

In response to this information, the Commission contracted with CNAC to compare DoD rating decisions with VA ratings and assess their consistency. CNAC received 83,004 records from the Army, Navy, and Air Force on all disability separations and disability retirements from 2000 through 2006, and these data were compared with data from VA on all 2.6 million veterans receiving

[87] RAND, *Methods and Actions*, 85–89.
[88] GAO, *Military Disability System*, 3, 4.

disability compensation as of December 1, 2005. Records were not requested from the services regarding those who were separated as unfit but were found to have preexisting conditions. Results of the analysis appear below.

The disability ratings shown in Table 7.5 are the combined or overall ratings assigned by DoD to those individuals who were found unfit for military duty. Those with less than 20 years of service and who are rated less than 30 percent disabled receive a severance payment based on base pay and years of service, but no continuing retirement payment. They are not eligible for Tricare coverage for themselves or their families and receive no other benefits from DoD. As can be seen, overall 19 percent of those rated by DoD are in the 30–100 percent range. The percentage rated 30 percent or higher ranges from 13 percent for the Army to 36 percent for the Navy. The individuals rated 30 percent or higher will receive continuing military disability retirement, health care coverage for themselves and their families, and many other military retirement benefits.

**Table 7.5 Veterans with DoD disability ratings (2000-2006)**

| COMBINED DISABILITY RATING | ARMY | NAVY | MARINES | AIR FORCE | TOTAL |
|---|---|---|---|---|---|
| 0-20% | 44,307 (87%) | 8,606 (64%) | 7,770 (82%) | 6,862 (73%) | 67,545 (81%) |
| 30-100% | 6,369 (13%) | 4,849 (36%) | 1,748 (18%) | 2,497 (27%) | 15,463 (19%) |
| Total | 50,676 | 13,455 | 9,518 | 9,359 | 83,008 |

SOURCE: CNAC, *Final Report*, Page 179.

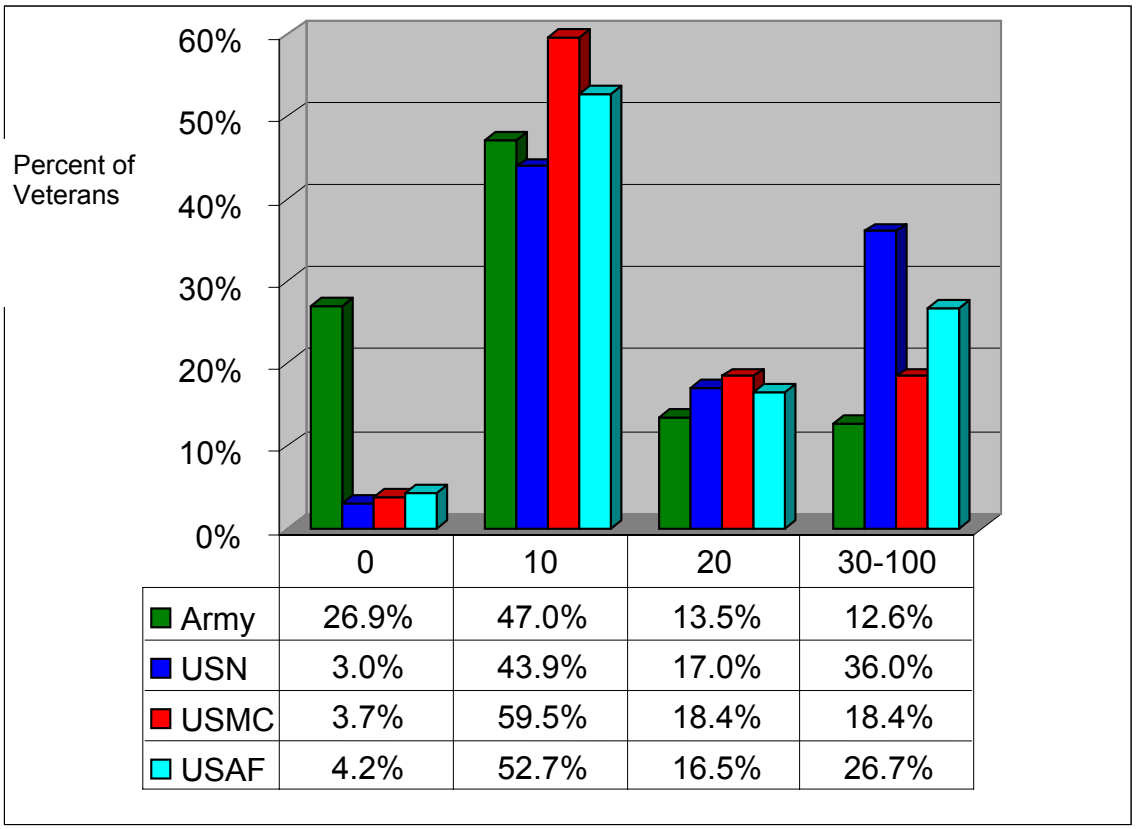
The Army data contained 13,646 records (27 percent) out of the total of 50,676 service members who were found unfit for duty yet assigned zero percent ratings. The Navy, Marine Corps, and Air Force each assigned zero percent ratings to about 400 individuals or less. The Army explained that these service members were found unfit, but with symptoms whose severity did not qualify for a compensable rating of at least 10 percent. Whether the DoD rating is zero, 10, or 20 percent, the severance payment from DoD is the same. Among the Army's zero percent ratings that matched with VA records, the average VA disability rating was 56 percent for those with 20 or more years of service and the average was 28 percent for those with less than 20 years of service and receiving severance.

It is important to note that DoD policy requires that the services only rate the condition or conditions that the services find make the individual unfit for duty.

This policy differs from that of the past. Before 1986, DoD instructions required that all service-connected conditions be rated, regardless of whether the condition(s) contributed to an unfit determination, with the exception of hysterectomies.[89] But on the basis of a DoD General Counsel opinion dated March 25, 1985, the policy changed to the present standard of rating only conditions that render service members unfit for duty.[90] Currently, when determining the disability ratings, the services are no longer required to rate a condition if that condition does not render the service member unfit for military duty. Consequently, the services rated only one condition 83 percent of the time.

The proportion of ratings in the 30–100 percent range given to Navy personnel, and, to a lesser extent, Air Force personnel is significantly greater than the proportion of ratings in the 30–100 percent range given to Marines and Army personnel (Figure 7.22). This observed difference is counterintuitive because the Army and Marines have borne the brunt of the combat in Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF). The available data were insufficient for the Commission to determine the reasons for the variance.

**Figure 7.22 Distribution of Veterans by DoD Disability Rating**




| | 0 | 10 | 20 | 30-100 |
|---|---|---|---|---|
| Army | 26.9% | 47.0% | 13.5% | 12.6% |
| USN | 3.0% | 43.9% | 17.0% | 36.0% |
| USMC | 3.7% | 59.5% | 18.4% | 18.4% |
| USAF | 4.2% | 52.7% | 16.5% | 26.7% |

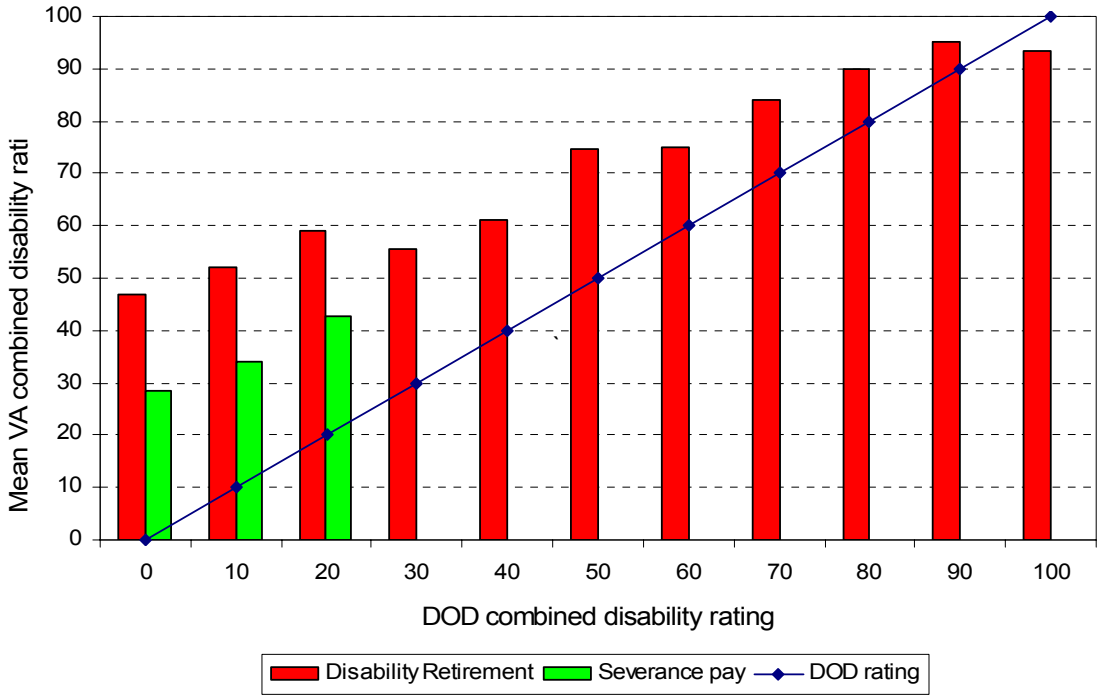
[89] DAPD-PP, 29 January 1986.
[90] DoDI 1332.18 (Enclosure 5, A2b) February 25, 1986.

Source: CNAC, *Final Report*, Page 179

Upon matching military service records with VA records, CNAC found that 79 percent of the service members rated by the military had also received disability ratings from VA.

As illustrated in Figure 7.23, the combined disability ratings made by VA are higher, on average, than the combined ratings made by the services at almost all rating levels. Individuals who received ratings of less than 30 percent and who had fewer than 20 years of service received severance pay only. Individuals assigned a zero percent rating by the services received, on average, a 30 percent rating from VA. Individuals rated 30 percent by the services were rated an average of 56 percent by VA. The difference between VA and DoD ratings is even more pronounced for those individuals rated less than 30 percent by DoD but eligible for retirement with 20 or more years of service, as represented by the first three red bars on the left of the chart.

**Figure 7.23 Comparison of Average VA Disability Ratings with DoD Disability Ratings**




NOTE: The data in this figure is based on records of 65,500 service members. The red and green bars measure the mean VA combined disability rating levels. The green bars represent service members who received VA disability ratings of less than 30 percent, had fewer than 20 years of military service, and therefore received severance pay but not disability retirement pay.

SOURCE: CNAC, *Final Report*, Page 182.

Among individuals whom the services rated as zero, 10, or 20 percent disabled, VA rated them 30 percent or higher 61 percent of the time.

The number of conditions that VA rated differs significantly from the number rated by the services (Table 7.6). Moreover, in cases where the Services rated one condition, CNAC found that VA rated an average of 3.8 conditions. In general, VA rated 2.4 to 3.3 more disabilities than did the Services. CNAC believes that this difference in the number of conditions rated accounts for the largest proportion of the difference in overall ratings by the Services compared with VA.

Because of the difference in the number of conditions rated, it is important to compare the ratings assigned by the services with the VA ratings for the same disabilities experienced by the same veterans.

CNAC analyzed the seven most frequent diagnoses among 31,473 matches of individual diagnoses that it identified. Those diagnoses are the following:

- Lumbosacral or cervical strain
- Arthritis
- Intervertebral disc syndrome
- Asthma
- Diabetes
- Knee impairment
- Posttraumatic stress disorder (PTSD)

Six other diagnoses among the 20 most frequent diagnoses were also selected:

- Traumatic brain injury
- Migraine
- Seizure disorder
- Bipolar disorder
- Major depressive disorder
- Sleep apnea

**Table 7.6 Number of VA Disabilities v. Number of DoD Disabilities**

| Number of DoD Disabilities | Number of Veterans | Average Number of VA Disabilities | VA-DoD Difference |
|---|---|---|---|
| **Army** | | | |
| 1 | 32,356 | 3.8 | 2.8 |
| 2 | 6,031 | 5.3 | 3.3 |
| 3 | 1,170 | 6.4 | 3.4 |
| 4 | 329 | 7.1 | 3.1 |
| **Navy** | | | |
| 1 | 9,182 | 3.9 | 2.9 |
| 2 | 1,337 | 5.4 | 3.4 |
| 3 | 335 | 6.3 | 3.3 |
| 4+ | 143 | 7.1 | 3.1 |
| **Marine Corps** | | | |
| 1 | 6,392 | 3.7 | 2.7 |
| 2 | 707 | 5.4 | 3.4 |
| 3 | 140 | 6.1 | 3.1 |
| 4+ | 62 | 7.1 | 3.1 |
| **Air Force** | | | |
| 1 | 5,248 | 4.3 | 3.3 |
| 2 | 1,636 | 5.0 | 3.0 |
| 3 | 433 | 5.9 | 2.9 |
| **All Services** | | | |
| 1 | 53,178 | 3.8 | 2.8 |
| 2 | 9,711 | 5.3 | 3.3 |
| 3 | 2,078 | 6.3 | 3.3 |
| 4+ | 534 | 7.1 | 3.1 |

Note: The Army data caps the number of disabilities at four and the Air Force, at three. The Air Force data contains only a single, combined percentage rating, so records with more than one disability could not be considered in the analysis of individual disabilities.

SOURCE: CNAC, *Final Report*, Page 186.

Together, these 13 diagnoses comprise 19,397, or 62 percent, of the individual diagnoses matched. Detailed information on the comparison of the 13 diagnoses can be found in Appendix G of this report.

Among those 19,397 individual diagnoses, CNAC found that 72 percent of those rated 0–20 percent by the services were also rated 0–20 percent by VA. This demonstrates general agreement between VA and the services in the rating of individual diagnoses. In some cases the VA rating was lower, but more often VA was higher.

The DoD DES provides instructions for using the VA Rating Schedule that, in effect, change the criteria for rating many conditions. For example, DoD instructions regarding sleep apnea profoundly change the criteria. CNAC found that the services rated 107 of 123 cases of sleep apnea as zero percent disabling, yet unfit. Meanwhile, VA rated all 107 cases in the 30–100 percent range, with 105 rated at 50 percent, one at 30 percent, and one at 100 percent. For some conditions such as knee impairment, DoD criteria are more specific and more measurable than VA criteria, while for other conditions such as sleep apnea, DoD criteria are less specific and less measurable.

Of the 13 individual diagnoses analyzed, the VA ratings were statistically significantly higher than the ratings of all of the services for 10 diagnoses: lumbosacral or cervical strain, intervertebral disc syndrome, asthma, sleep apnea, diabetes, migraine, seizure disorder, PTSD, bipolar disorder, and major depressive disorder (Table 7.7). The differences in ratings were significant for 12 of 13 diagnoses by the Army; the only exception being the knee. The ratings were significantly different for 11 of the 13 diagnoses by the Air Force, 10 of 13 diagnoses by the Marines, and 9 of 13 diagnoses by the Navy.

**Table 7.7 Statistical Significance of Individual Diagnoses**

| DIAGNOSIS | DIFFERENCE BETWEEN VA AND DOD IS STATISTICALLY SIGNIFICANT* | | | |
|---|---|---|---|---|
| | Army | USAF | USMC | Navy |
| Arthritis | √ | | | |
| Lumbosacral or Cervical Strain | √ | √ | √ | √ |
| Intervertebral Disc Syndrome | √ | √ | √ | √ |
| Knee Condition | | | | |
| Asthma | √ | √ | √ | √ |
| Sleep Apnea | √ | √ | | √ |
| Diabetes | √ | √ | | √ |
| Traumatic Brain Injury (TBI) | √ | √ | | |
| Migraine Headaches | √ | √ | √ | √ |
| Seizure Disorder | √ | √ | √ | √ |
| PTSD | √ | √ | √ | √ |
| Bipolar Disorder | √ | √ | √ | √ |
| Major Depressive Disorder | √ | √ | √ | √ |
| *Check marks indicate that the mean VA rating is statistically higher than DoD's rating at the 5-percent level. | | | | |

SOURCE: CNAC, *Final Report*, Page 190.

## V.2 Why are DoD and VA Ratings Different?

The difference between DoD and VA combined or overall ratings is most likely due to variance in the number of conditions rated. VA rates 2.4 to 3.3 more conditions per person than do the services. The difference in the individual diagnosis ratings also contributes to the difference in the combined ratings. VA ratings for 8 of 13 individual diagnoses were higher by a statistically significant amount than ratings by the services for the same individuals. Finally, there appears to be some incentive on the part of the services to assign ratings less than 30 percent so that only separation pay is required and continuing family health care and other retirement benefits are not provided. This incentive is reflected in the DoD policy decision in 1986 to begin rating only the condition(s) found to be unfitting.

## V.3 Findings

VA and the services face challenges to improve the quality and consistency of rating veterans and service members for disability. Service members are poorly

served by the dual processes by which both the military services and VA evaluate disabilities and award benefits. Additionally, service members find these processes to be confusing and adversarial. The President's Commission on Care for America's Returning Wounded Warriors also advocated for the complete restructuring of the DES (with VA) to eliminate parallel activities, reduce inequities, and allow injured veterans to return to living more productive lives.[91]This Commission believes that both short- and long-term changes are needed to ensure equity, effectiveness, consistency, and efficiency.

The Commission finds it unfair to discharge service members with ratings that reflect only one disability when other disabilities are present, identified, and often more severe than the disabilities that made the service member unfit according to the services. This is particularly true in cases where the Army categorized service members as unfit, but at a zero-percent rating. In addition, the current policy in which service members can be found unfit due to preexisting conditions with up to 8 years of active duty and separated with no compensation is an unreasonably long period of time, especially if the service member has served combat tours.

Fitness for duty is the most important issue to the services. Each service has unique manpower needs to meet its mission. A service member's ability to perform his or her military occupational specialty based on the service member's "office, grade, rank, or rating"[92] should continue to be evaluated for the needs of the service. Currently, the MEB determines fitness for duty. The services can find someone fit and either return him or her to full duty, or issue a "profile" that limits duty. If a service member is found unfit, a PEB assigns a disability rating.

The Commission believes that the responsibility for assigning a disability rating should be turned over to VA and that the MEB/PEB structure should be streamlined. These changes would give each service member a single, objective rating that would apply to military disability retirement pay or severance pay as well as VA disability compensation. In essence, such changes would expand the Benefits Delivery at Discharge Program that VA has implemented and would relieve the services of the burden of making rating decisions. The disability rating should be completed prior to discharge to maintain continuous financial support and health care for separating service members.

Key to this realignment would be the development and implementation of a single, comprehensive medical examination protocol that would be used by both the services and VA. This protocol would require examining all conditions that

[91] President's Commission on Care, *Report*, 5.
[92] DoD Instruction 1332.35, paragraph E.2.1.21, July 10, 2006.

were found on exam, and not be restricted to the "unfitting" conditions. Service members would not be subjected to multiple examinations. It might be appropriate for the examinations to be conducted by VA medical staff at some locations and by DoD staff at others. Training and certification of all examiners will be essential for consistent, high-quality examinations.

The Commission realizes that funding program administration and disability benefits are of concern to both DoD and VA. Budgetary considerations are very important, but neither the taxpayer nor the service member being discharged for disability cares whether the costs of disability benefits are covered by the DoD budget or the VA budget or some combination of the two. Taxpayers and service members care that people disabled in the service of our country receive prompt and appropriate compensation, health care, and other benefits.

**Short-Term Recommendations:**

**Recommendation 7.9**

**DoD should reassess the policy of allowing separation without compensation for individuals found unfit for duty who are also found to have a preexisting disability for up to 8 years of active duty.**

**Recommendation 7.10**

**VA and DoD should adopt a consistent and uniform policy for rating disabilities, using the VA Schedule for Rating Disabilities.**

**Recommendation 7.11**

**DoD should reassess the ratings of service members who were discharged as unfit but rated 0 to 30 percent disabled to determine if those ratings were equitable. (Note: Commission data only went back to 2000.)**

**Long-Term Recommendations:**

**Recommendation 7.12**

**VA and DoD should realign the disability evaluation process so that the services determine fitness for duty and service members who are found unfit are referred to VA for disability rating. All conditions that are identified as part of a single,**

**comprehensive medical examination should be rated and compensated.**

# VI Cost of Living Adjustments

Adjustments to disability compensation payments and other benefits are collectively known as the cost of living adjustments (COLA). The Commission examined the adequacy of the COLA process and questioned whether COLAs have effectively kept pace with inflation. The Commission found that, although benefit payments are not automatically indexed to inflation for most benefits, disability compensation and DIC payments are adjusted annually by acts of Congress to reflect the cost of living.

By contrast, payments for ancillary and special-purpose benefits are adjusted individually and periodically. Many ancillary and special-purpose benefits have not been adjusted for years and have not kept pace with the actual costs of goods and services or with the original intent of Congress. For example, the automobile allowance was originally intended to cover 80 percent of the average cost of a new vehicle. Yet because that allowance has not been adjusted to reflect real costs, the benefit covered only 39 percent of the average cost of a new light vehicle in 2007.[93]

Table 7.8 illustrates when the level of each of the ancillary and special-purpose benefits was last updated by Congress.

[93] Calculation based on the amount of the automobile allowance ($11,000) and the average cost of a new light vehicle in 2007 ($28,500) (E-mail from John Thomas, National Automobile Dealers Association, to Jacqueline Garrick, Commission staff, September 27, 2007).

**Table 7.8 Ancillary and Special Purpose Benefits Last Increased**

| BENEFIT | LAST INCREASED |
|---|---|
| SDVI | 1951 |
| Beneficiary Travel | 1978 |
| Home Improvement Structural Alteration | 1992 |
| VMLI | 1992 |
| Automotive & Adaptive Equipment | 2001 |
| Burial and Memorial Benefits | 2001 |
| Specially Adapted Housing (SAH) | 2002 |
| Special Housing Adaptation Grants | 2003 |
| TSGLI | 2005* |
| Birth Defects Benefits | 2005 |
| Clothing Allowance | 2006 |
| Special Monthly Compensation | 2006 |
| Vocational Rehabilitation & Employment | 2006 |
| Aid & Attendance | 2006 |
| Housebound | 2006 |
| Dependency & Indemnity Compensation | 2006 |

*Retroactive to 2001 for injuries incurred in OIF/OEF.

Another issue the Commission examined is the practice of keeping benefits and COLA increases uniform across the country rather than making adjustments for geographic variance in the cost of living. For example, the cost of adapting housing to accommodate severe disabilities varies according to local construction costs yet the benefit maximum is uniform across the country.

**Recommendation 7.13**

**Congress should enact legislation that brings ancillary and special-purpose benefits to the levels originally intended, considering the cost of living, and provides for automatic annual adjustments to keep pace with the cost of living.**

# VII State Court Spousal Support Obligations

## VII.1 Issue

Should veterans' benefits be considered by State courts in spousal support proceedings? Veterans believe that their basic disability benefits are being considered by State courts as marital property or family income earned during the marriage that is available for division in divorces. States have the primary responsibility for family issues, including determining spousal support awards. Support for spouses, and children, when the veteran does not provide it, can be

awarded by VA as an apportionment of the veteran's disability benefits. Support can also come as a garnishment of military retired pay by a court order. Congress recognizes a veteran's need for additional benefits to support their dependents and provides veterans with disability ratings between 30 and 100 percent additional benefits for a spouse and for each minor child. A veteran cannot receive additional compensation for a former spouse.

The U.S. Supreme Court decided in *Rose v. Rose* (1987) that a state court has jurisdiction to hold a disabled veteran in contempt for failing to pay child support to force compliance, even if the veteran's only means of satisfying this obligation is to utilize compensation (*Rose v. Rose,* 481 U.S. 619 [1987].) Otherwise, veterans' benefits are exempt from the claims of other creditors and are not subject to attachment by any legal or equitable process.

## VII.2 Apportionment

An apportionment is the allocation of VA benefits between a veteran and his or her dependents. When determining if and how to apportion benefits, consideration is given to the amount of benefits the veteran receives, the veteran's resources as compared to the dependent's resources, and the special needs of the veteran and his or her dependents (38 C.F.R. § 3.451 [2006]). Former spouses are not entitled to apportionments, but may receive benefits as the custodian of the veteran's children.

## VII.3 Garnishment

A garnishment is a legal procedure in which a person's earnings are required by court order to be withheld by the employer or source agency for the payment of a debt. Military retirees may waive some or all of their military retired pay in order to receive VA compensation (38 U.S.C. § 5304 [2006]). This waiver of military retirement pay allows for the garnishment of VA compensation up to the amount of military retired pay waived to pay child support and alimony (5 C.F.R. § 581.103[c][7] [2006]). The Uniformed Services Former Spouses' Protection Act (USFSPA) of 1982 gave State courts of military retirement benefits should not be impeded by congressional preemption of State law.[94]

## VII.4 Traumatic Servicemembers' Group Life Insurance

Traumatic Servicemembers' Group Life Insurance (TSGLI) provides payment to any service member who sustains a traumatic injury. The intent of the payment is to help service members and their families cope with the financial impact of

[94] Willick, *Garnishment of Benefits*.

long recuperation periods, temporary family relocation, and other unexpected expenses following a traumatic injury. If these funds are commingled with other joint funds, they become marital property.

## VII.5 Findings

Veterans view their basic disability compensation benefits as payment for the effects of their disability, and not as earnings. Therefore, their disability benefits should not be divided by garnishment. Veterans have a responsibility to support their dependents and are provided additional benefits for this purpose. While spouses claim that they should share in all benefits acquired during the course of a marriage, a veteran's basic disability benefits, and the needs of the veteran, must be considered. The trend at the state level is to award alimony to former spouses without considering that once divorced, a veteran is no longer entitled to an additional allowance for that dependent.

Except for the compensation equal to the military retired pay waived to receive compensation, the Commission believes that disability benefits, provided to disabled veterans, should be exempt from contempt citations, claims of, or attachment by State courts. Former spouses are not considered dependents by VA, and veterans cannot continue to receive any additional disability benefit, once divorced. Therefore, State courts should not consider a veteran's disability benefits in spousal support determinations.

**Recommendation 7.14**

**VA disability benefits (including Traumatic Servicemembers' Group Life Insurance), except VA compensation benefits received in lieu of military retired pay, should not be considered in state court spousal support proceedings.**

# VIII Lump Sum Payments

## VIII.1 Issue

For years a debate has simmered over the appropriateness of lump sum payments to compensate veterans for service-connected disabilities. A number of studies, including the Bradley Report, have recommended that VA investigate the viability of using lump sums, either in place of or in conjunction with monthly compensation, to compensate for decreases in quality of life. In the current system, monthly disability payments are intended to compensate for impairment of earnings capacity, though some argue that there is also an implied quality-of-life aspect to these monthly payments. Proponents of lump sum payments argue

that quality-of-life issues are better addressed through a single lump sum payment, rather than through lifetime monthly payments. In particular, these proponents argue that lump sums would be more appropriate for veterans with less severe disabilities. After deliberating the issue, however, the Commission concluded that lump sum payments are impractical and potentially detrimental to veterans, and therefore should not be made.

A number of government reports and commissions have recommended that lump sum payments be investigated as a means to better compensate veterans for their disabilities. In its 1956 report to the President, the Bradley Commission investigated the possibility of including lump sum payments as a means of compensation for less severe service-connected disabilities. The Bradley Commission found that disabled veterans rated 10 percent or 20 percent did not have a "loss of physical vitality or impairment of health."[95] Believing that monthly payments should be paid to veterans who have a loss of earnings capacity, the Bradley Commission decided that "the soundest course of action [for VA] would appear to be to find some method of discharging the obligation to such cases once and for all, and to remove them from the monthly payment files."[96]

Several decades later, in its 1996 report to Congress, the Veterans' Claims Adjudication Commission (VCAC) investigated the positive and negative aspects of lump sum payments. Focusing on veterans who are rated 10 percent disabled, the VCAC saw a lump sum payment as a means of assisting veterans with their transition to civilian life. The VCAC argued that, whereas seriously disabled veterans "can be expected to require ongoing, long-term support, those who are minimally disabled may be better served by concentrating the support at the point of transition to civilian life."[97] This conclusion was largely based on VCAC's examination of the DoD and DOL compensation schemes, which both use lump sum payments in certain circumstances to compensate for disabilities that do not "seriously impair civilian earnings capacity."[98]

More recently, in a 2005 report titled *Veterans Have Mixed Views on a Lump Sum Disability Payment Option*, GAO surveyed a group of veterans about their opinions of a "broadly defined hypothetical program that would give veterans the option of taking a one-time lump sum payment."[99] GAO's survey and focus-group questions were based on a system that compared a monthly payment with a lump sum payment in which both payments would be tax free. According to GAO's survey, 49 percent of veterans questioned said "they would definitely or probably support a lump sum option for newly compensated veterans, [and] 43

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[95] President's Commission, *Findings and Recommendations*, 176.
[96] Ibid.
[97] Veterans' Claims Adjudication Commission (VCAC), *Report to Congress*, 273.
[98] Ibid., 279, 280.
[99] GAO, *Veterans Have Mixed Views*, 4.

percent said they would definitely or probably not support it."[100] GAO's study also showed that younger veterans would be more open to receiving a lump sum payment than would older veterans.[101] That same year, the VA Office of Inspector General (OIG) released a report entitled *Review of State Variances in VA Disability Compensation Payments* that compared the disparity in veterans' benefits payments from state to state. A lump sum payment plan was recommended to improve the compensation program. When considering lump sum payments, the OIG report indicated "that [a lump sum payment] continues to be a viable option for veterans with minor disabilities."[102] The OIG report suggested that VA pay a lump sum to veterans who are rated 20 percent or less, stating that this "would result in reducing 46.9 percent or 1.17 million active case files," or approximately $1.96 billion in ongoing monthly compensation.[103]

In addition to recommending that the lump sum issue be more comprehensively examined, several of the above reports identified potential advantages and disadvantages to such a system. Advantages included the fact that a veteran with a less severe disability would be given capital that would assist him or her with transition into civilian life, and that a lump sum payment plan would reduce repeat claims, simplifying the process for veterans and reducing administrative costs for VA. The reports also identified a number of significant disadvantages to lump sum payments. Certain veterans might have to reapply for additional compensation if their disability worsened over time, for example, and poor spending habits might lead veterans to spend the money in ways that are not in their best interests for long-term investments. GAO noted a major problem for any system using lump sum payments: if a veteran's condition worsened, VA would not be able to reevaluate the disability.[104]

To finally develop a comprehensive analysis of this ongoing debate, the Commission contracted with CNAC to conduct a study of lump sum payments as a means of compensation for disabilities as an alternative to monthly payments. In the course of its investigation, CNAC identified three primary benefits that lump sum payments could provide to veterans: they could reduce interactions with VA administrators; they could prove more useful to a veteran than continued monthly payments; and, if the lump sum was optional, the veteran would be given greater control over their means of compensation.[105] In addition to these benefits to the veterans, CNAC also identified benefits for VA, particularly that VA could save money if the lump sum payment was "less than equivalent to the present value of the veteran's lifetime monthly payment."[106] VA could also reduce

[100] Ibid., 7, 8.
[101] Ibid., 10.
[102] VA Office of Inspector General, *Review of State Variances*, 39.
[103] Ibid.
[104] GAO, *Veterans Have Mixed Views*, 10.
[105] CNAC, *Lump Sum Alternatives*, 3.
[106] Ibid., 2.

the number of claims processed if it restricted a veteran's ability to have his or her disability reevaluated, which could reduce administrative costs.

In contrast to these hypothetical advantages of a lump sum payment system, CNAC identified a number of disadvantages. First, there is the concern "that the lump sum should be 'fair' in comparison with lifetime monthly compensation payments."[107] It is difficult to determine what dollar amount the veteran population would perceive as just compensation for disabilities incurred during military service, particularly given the arguments that favor lump sum payments as a means of saving money by decreasing lifetime benefits for some veterans. To achieve both a savings for VA and a fair payment for veterans, "it is important to be able to reliably estimate the personal discount rates[108] of disabled veterans. Unfortunately, there is no relevant literature specifically on that population that we can cite."[109] In a lump sum program, CNAC found that "savings would be affected by which disabilities and ratings would be eligible for a lump sum and what personal discount factor would be used when calculating the lump sums." In its estimates for selected disabilities, CNAC found "savings in lifetime compensation payments from a lump sum program ranging from about 10 to 21 percent when calculated just over the disabilities within those diagnostic codes."[110] It is important to note that CNAC focused on specific disabilities rather than overall disability ratings. When calculating the long-term budgetary effects of a lump sum payment system, CNAC reported that the savings that could result from such a system would depend on many factors. CNAC recommended that if lump sum payments were seriously considered, further study of the veteran population should be conducted to determine levels of lump sum payments.

CNAC estimated the financial impact of making lump sum payments in 2006 to veterans with ratings of 10 percent or 20 percent for those diagnoses for which the ratings increased less than 2 percent between 2000 and 2005 (Table 7.9). The estimate considered two scenarios, one in which lump sum payments would be made only for veterans with new disabilities and another for all disabilities CNAC deemed suitable for lump sums. Considering the total budget for disability compensation payments of $21.2 billion in 2006, lump sum payments would increase the budget by 31 percent if paid to all veterans meeting the above criteria. If paid only for new disabilities, the budget increase in 2006 would be 2.6 percent. In either case, the break-even point would be lengthy, 17 years for all disabilities and 25 years for new disabilities.

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[107] Ibid.
[108] In conducting this analysis CNAC looked at personal discount rates, which are based on an individual's tendency to prefer to receive a particular amount of money in the present rather than receiving an equivalent amount in the future.
[109] CNAC, *Lump Sum Alternatives*, 27, 28.
[110] Ibid., 75.

**Table 7.9 Estimates of the Effect of a Lump Sum Program on Disability Compensation Payments**

| EFFECT OF LUMP SUM PROGRAM ON TOTAL COMPENSATION PAYMENTS (B) | ALTERNATIVE PROGRAM RULES: WHICH DISABILITIES WOULD BE ELIGIBLE FOR A LUMP SUM (A) | |
|---|---|---|
| | New disabilities only | All disabilities |
| Single-year effect | | |
| 1st year (c) (d) | $545 million increase | $6,660 million increase |
| 5th year | $327 million increase | $306 million decrease |
| 10th year | $88 million increase | $462 million decrease |
| Cumulative effect | | |
| 5th year | $2.2 billion increase | $5.6 billion increase |
| 10th year | $3.1 billion increase | $3.6 billion increase |
| | | |
| Break-even point (e) | 25 years | 17 years |

SOURCE: CNAC. Lump Sum Alternatives to Current Veterans' Disability Compensation, 8–9.

Another potential problem with lump sum payments is "the treatment of cases where the disability worsens."[111] Although it may be easy to make lump sum payments for one disability rated at a specific level, difficulties will arise in cases where the disability worsens or the veteran has multiple disabilities that must be combined to calculate a monthly rate of compensation. CNAC analyzed changes in disability ratings by using "the Compensation and Pension Master Record (CPMR) data files for December 2000 and December 2005 from the Veterans Benefits Administration (VBA)."[112] It found that each diagnosis should be considered individually with respect to eligibility for a lump sum offer because each has different probabilities of worsening. In particular, disabilities such as PTSD and other mental disorders are prone to significant variations over the course of a veteran's lifetime, posing significant problems for a potential lump sum payment plan. If a veteran's disability worsens over time, but a lump sum has already been paid, then that veteran's compensation would have to be reevaluated, negating the proposed benefits of a single-evaluation lump sum system and making calculations of benefit amounts exceedingly complicated. If that veteran's compensation was not reevaluated, then he or she would not receive the fair amount of disability compensation to which he or she was due.

[111] CNAC, *Lump Sum Alternatives*, 2.
[112] Ibid., 6.

The lump sum programs used by the United Kingdom, Australia, and Canada were also reviewed by the Commission staff but information was not available on estimated savings or if the number of claims were reduced.

## VIII.2 Findings

The concept of lump sum payments for certain less severely disabled veterans has been discussed repeatedly over the years. On the surface, the concept appears to have some merit. However, from its deliberations, the Commission concluded that this concept should not be considered. Lump sum payments would require a complete change in the philosophical basis for the disability compensation program. A great amount of additional analysis would have to be conducted to determine the appropriate program design features of lump sum payments that would ensure fairness, effectiveness, and efficiency. In addition, a major policy decision would have to be made as to whether reevaluation would be possible if disabilities worsened over time. Although it may be theoretically possible to design a set of criteria that would enable reevaluation of those veterans whose conditions became catastrophically or seriously disabling, applying such criteria would be operationally difficult. In addition, the criteria would likely have to be revised over time to include less severe conditions due to court reviews and political pressure. Such revisions would defeat the goals of lump sum payments.

The complexity of lump sum payments would likely be excessive and difficult for veterans to understand and accept. The complexity would also be difficult and costly to administer. Additionally, there is serious concern about a veteran's ability to wisely manage lump sum payments. Finally, lump sum payments would have significant short-term impact on the budget of the United States and the break-even point when the up-front costs would be offset by future savings would be many years in the future, effectively negating the argument for lump sum payments as a means to decrease the VA budget. In light of all of these significant problems, the Commission concluded that lump sums should not be considered as an appropriate form of VA disability compensation.

**Recommendation 7.15**

**Lump sum payments should not be considered to compensate veterans for their disabilities.**

# IX Social Security Disability Insurance

The Commission became concerned with the eligibility of severely injured service members for Social Security Disability Insurance (SSDI) awarded by the Social

Security Administration. The purpose of the SSDI program is to partially replace earnings of individuals who are unable to work because of a disability. The program defines disability as the inability to engage in "substantial gainful activity" (SGA) due to long-term physical or mental impairment, and SGA is defined as earnings above a certain amount. Both eligibility for SSDI and SSDI compensation levels depend on an individual's earnings history.[113]

In reviewing the appropriateness of the level of benefits provided to veterans and service members, the Commission found that only 15.9 percent of service-connected veterans receive SSDI. Among veterans granted IU, only 61 percent receive SSDI, and among veterans rated 100 percent, only 54 percent receive SSDI. Only 61 percent of veterans rated 100 percent who receive special monthly compensation in the SLMN or O categories also receive SSDI, while 81 percent of veterans rated 100 percent who receive special monthly compensation in the R1 or R2 categories also receive SSDI. Given the very low earnings of those rated 100 percent and the exceptionally low earnings of the IU group, many more service-connected veterans should be receiving SSDI.

The current rates of participation in the SSDI program by service-disabled veterans strongly indicate that many of these individuals either do not know to apply for SSDI or are being denied eligibility. VA and the Social Security Administration should increase outreach to these veterans to educate them about SSDI and should improve coordination to achieve higher rates of mutual acceptance of decisions to grant SSDI to service-disabled veterans.

The Commission also felt strongly that the SSDI program should include the severely injured even if an individual does not meet the minimum credits required for SSDI eligibility. For example, a disabled person under age 24 must have six credits earned in the 3-year period ending when disability starts. Many of the service members begin their work experience in the military and may not have had the opportunity to have earned sufficient quarters to qualify for SSDI benefits.

In Chapter 10, the Commission discusses SSDI as it relates to the transition of severely injured service members and makes recommendations.

[113] CNAC, *Final Report*, 133, 134.

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