5

Policies for Determining Eligibility for Benefits

Program policies, issues, and specific disabilities are the focus of this chapter. In particular, evaluating and assessing veteran status, the standards for determining eligibility for benefits to veterans with disabilities or survivors of veterans whose deaths are attributable to military service are addressed. The distinct issues discussed are:

- Character of discharge
- Line of duty
- Reasonable doubt
- Age as a factor
- Time limit to file
- Presumptions
- Environmental and occupational hazards
  - Agent Orange and blue water veterans
  - Fort McClellan and PCB exposure risks
  - Chemical exposure at Camp Lejeune
- PTSD and other mental health disorders

Veteran status must be proven prior to any review of a claim for benefits. A discharge under other than dishonorable conditions establishes veteran status.

Assessing service connection for disabilities requires that the disability have been incurred in line of duty. If the evidence concerning the incurrence of the disability is not clear but is balanced, then the principle of reasonable doubt requires the granting of service connection. Presently, age may not be considered as a factor in evaluating service-connected disabilities, unemployability, in claims for service connection, or as a basis for total disability ratings.

To protect the veteran and minimize the time it takes to process a claim and to minimize the development burden on both the veteran and the Government,

presumptions have been established. When there is evidence that a condition was experienced by a sufficient cohort of veterans, it is reasonable to presume that all veterans in that cohort have acquired the condition as a result of military service. The Commission asked the Institute of Medicine (IOM) to review the past practices used to establish presumptions and to recommend a framework that would rely on scientific principles.

This chapter closes with a detailed review of three specific environmental and occupational hazards and an examination of the rating criteria for, diagnosis of, and compensation for PTSD and other mental health conditions.

I Program Policies and Issues

I.1 Character of Discharge

I.1.A Issue

Veterans' benefits are generally available to individuals who separate from military service with an honorable discharge, a general discharge, or a discharge under honorable conditions. Veterans' benefits are generally available also to individuals determined by the Department of Veterans Affairs (VA) to have been discharged under conditions other than dishonorable. Health care benefits may be payable, under certain conditions, to an individual who receives an other-than-honorable discharge. A discharge under honorable conditions is binding on VA as to character of discharge (38 C.F.R. 3.12[a] [2006]). Some veterans have multiple periods of service, one of which could have been dishonorable. A dishonorable discharge for one period of service does not negate rights or entitlement earned by virtue of a separate period of honorable service. The Commission considered the appropriateness of this standard.

Eligibility for VA benefits is established for a veteran whose character of discharge at separation from military service is either honorable, general, or under honorable conditions. A dishonorable discharge deprives a claimant of VA benefits for that period of service. Receipt of a dishonorable discharge is not binding on VA if it is determined that the individual was insane when committing the act(s), which resulted in the dishonorable discharge.

Because "veteran" status establishes the standard for the quality of active service that results in eligibility for VA benefits, in cases involving discharges or releases that are neither clearly honorable nor dishonorable, VA must determine the veteran status of such individual based on the facts and circumstances of service. Accordingly, the military's characterization of a discharge or release does not conclusively determine veteran status in all cases.

> The term “discharge or release” includes:
>
> (A) retirement from active military, naval, or air service, and
>
> (B) the satisfactory completion of the period of active military, naval, or air service for which a person was obligated at the time of entry into such service. Also, in the case of a person who, due to enlistment or reenlistment, was not awarded a discharge or release from such period of service at the time of such completion thereof and who, at such time, would otherwise have been eligible for the award of a discharge or release under conditions other than dishonorable.

Subsection (B), added to 38 U.S.C. 101(18) in 1977, provided new rules for determining certain veterans' eligibility for VA benefits. The legislative history of this provision discloses that Congress was attempting to correct an inequity: veterans were being denied benefits based upon an entire period of service that terminated in a discharge under dishonorable conditions, even though the individuals had successfully completed the period of service to which they had originally agreed. The intent of the change in law was to treat the honorable completion of the original period of obligated service as though it had resulted in a full discharge or release. This resulted in the individual having more than one period of service and the final discharge under dishonorable conditions no longer constituting a bar to receipt of veterans' benefits based on the prior honorable period of obligated service.[1]

A discharge found by VA to have been issued under dishonorable conditions does not, in and of itself, bar an individual from receiving VA benefits based on an earlier period of service that terminated under conditions other than dishonorable. VA long ago adopted an administrative interpretation that a discharge under dishonorable conditions from one period of service does not constitute a bar to VA benefits if there was another period of qualifying service upon which a claim could be predicated. This interpretation is currently reflected in the language of 38 C.F.R. § 3.12(a), which provides, in part, that "if the former service member did not die in service, pension, compensation, or dependency and indemnity compensation is not payable unless *the period of service on which the claim is based* was terminated by discharge or release “under conditions other than dishonorable" [emphasis added].[2]

The definition of a veteran established by the Servicemen’s Readjustment Act of 1944 (Pub. L. No. 78-346, ch 268, 58 Stat. 284, 301 [1944]) has remained essentially unchanged since its enactment. Both the language used in the definition and its legislative history clearly show congressional intent that VA

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[1] VA Office of General Counsel, *Precedent Opinion 61-91*, 3.
[2] Ibid., 2.

determine whether a discharge, on the basis of the overall conditions of service, was issued under conditions other than dishonorable in a case where the discharge or release was given for conduct that was less than honorable, but where the military did not elect to terminate service through a dishonorable discharge.

Discharges in this category include undesirable, other than honorable, and bad conduct discharges. Releases in this category include uncharacterized separations because of void enlistment or induction or being dropped from the rolls. The latter two uncharacterized separations are considered the equivalent of discharges issued under other than honorable conditions. Such discharges or releases are considered to have been issued under dishonorable conditions if they were issued because of offenses, such as acceptance of an undesirable discharge to escape trial by general court-martial, mutiny or spying, or an offense involving moral turpitude. This includes, generally, conviction of a felony.[3]

VA is authorized to provide health care and related benefits under chapter 17 of title 38, United States Code, for a disability incurred or aggravated in line of duty by a person who received an other-than-honorable discharge. These benefits are not available to a person who either received a bad conduct discharge or a discharge was issued under one of the statutory bars listed in 38 C.F.R. 3.12(c) (38 C.F.R. 3.360 [2006]).

Commissioned or warrant officers may be held to a different standard. In their case, the entire period of active duty is considered as one period of active service, and entitlement is determined by the character of the final termination of such period of active service (38 C.F.R. 3.13[b] [2006]). The exception to this rule is that a person will be considered to have been unconditionally discharged or released from active duty when the following conditions have been met:

> (1) The person served in the active military, naval, or air service for the period of time the person was obligated to serve at the time of entry into service;
>
> (2) The person was not discharged or released from such service at the time of completing that period of obligation due to an intervening enlistment or reenlistment; and
>
> (3) The person would have been eligible for a discharge or release under conditions other than dishonorable at that time except for the intervening enlistment or reenlistment (38 C.F.R. 3.13[c] [2006]).

[3] For a full listing of discharges and releases in this category, please refer to 38 C.F.R. 3.12(d).

The last types of cases to consider are those in which an individual receives an uncharacterized separation (38 C.F.R. 3.12[k] [2006]). In cases in which enlisted personnel are administratively separated from service on the basis of proceedings initiated on or after October 1, 1982, the separation may be classified as one of the following three categories of administrative separation: entry-level separation, void enlistment or induction, and dropped from the rolls. Entry-level separations are considered to have been issued under other than dishonorable conditions. Void enlistment or induction separations and dropped from the rolls separations require VA to make an administrative determination as to whether or not the separation was issued under conditions other than dishonorable.

Table 5.1 illustrates the numbers and percentages of service members who received each type of discharge between October 2000 and September 2005.

Table 5.1 Types of Discharges, October 2000–September 2005

Type	Percentage of separating service members (%)	No. of separating service members
Honorable	69.2	654,350
General discharges (under honorable conditions)	5.6	53,181
Bad conduct	0.9	8,190
Under other than honorable conditions	5.8	55,111
Dishonorable	0.0	513
Uncharacterized	12.6	118,918
Unknown/not applicable	5.9	55,333
TOTAL	100	945,596

NOTE: LtCol. Applegate further clarified the number and types of discharges. She wrote that these numbers reflected only active duty, but she cautioned that there might be a small number of cases where Guard or Reserve members were on active duty when they were discharged.

SOURCE: Applegate. *Discharge Information,* e-mail to Steve Riddle on June 20, 2007.

VA provided the following information to aid the Commission during its study of types of discharges:[4]

- 3,048,116 veterans currently receive disability compensation or non-service-connected pension. Of these:
  - 3,414 veterans are noted as having been determined by VA as having honorable discharges for VA purposes. This is a decision made by VA after discharge.
  - 4,565 veterans are noted as having been determined by VA as having dishonorable discharges for VA purposes.[5]
- 46,476,819 veterans have records in the VA Beneficiary Identification and Records Locator Subsystem (BIRLS) (almost half of these veterans are deceased.) Of these:
  - 28,459 veterans are noted as having been determined by VA as having honorable discharges for VA purposes.
  - 100,781 veterans are noted as having been determined by VA as having dishonorable discharges for VA purposes.
  - 117,283 veterans are noted as having a separation reason code of "administrative decision made."
- Note that these are unique veterans; veterans may have had multiple administrative decisions made for different periods of service.

The Bradley Commission proposed two recommendations regarding discharge requirements for veterans' benefits. The first recommendation was that an undesirable discharge for an enlisted man and a discharge under other than honorable conditions for an officer should render a claimant ineligible for benefits based upon the period of service from which he or she was so discharged, also stating, however, that health care should be provided by VA if the claimant suffered a service-connected disability unrelated to the reason for discharge. Secondly, the Bradley Commission recommended that anyone receiving a bad conduct discharge, whether imposed by a general or special court-martial, should be rendered ineligible for VA benefits based upon the period of service from which so discharged.[6]

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[4] Office of Performance Analysis & Integrity (OPA&I), data request 06-176.
VA has clarified that it was during a previous period of honorable service that these veterans incurred an injury or contracted an illness that caused their disability.
President's Commission, Findings and Recommendations, 393–397.

[5] VA has clarified that it was during a previous period of honorable service that these veterans incurred an injury or contracted an illness that caused their disability.

[6] President's Commission, *Findings and Recommendations*, 393–397.

I.1.B Findings

Basic eligibility for most benefits administered by VA is contingent on an individual being characterized as a veteran. The definition of "veteran" is a person who served in the active military service and who was discharged "under conditions other than dishonorable."

Congress adopted this statutory definition in 1944 to establish a comprehensive standard governing basic eligibility for veterans' benefits based upon the character of an individual's discharge or release from active military service. On the basis of the legislative history of that definition, it is clear that Congress intended to liberalize the then existing requirement of a discharge under honorable conditions and correct what Congress viewed as an overly strict standard that unjustly prevented many who served faithfully, but were separated for relatively minor offenses, from receiving veterans' benefits. At the same time, Congress recognized that a dishonorable discharge could only be given pursuant to a general court-martial and that some individuals were released without the formality of such a proceeding. In such cases, Congress was adamant that veterans' benefits should not be available.

Congress adopted the phrase "under conditions other than dishonorable" to accomplish its goals of liberalizing the standard for establishing basic eligibility for veterans' benefits and, at the same time, barring benefits to individuals separated for serious offenses. By adopting this phrase, Congress authorized VA to accept characterization of a discharge or release by one of the uniformed services to the extent that the discharge or release is issued under clearly honorable or dishonorable conditions. The phrase also gave VA the authority and discretion to make its own character-of-discharge determinations for VA benefit purposes in cases where the discharge or release was neither specifically honorable nor dishonorable.

The present law, as amended in 1977, allows individuals who were discharged under dishonorable conditions, or conditions otherwise precluding veteran status, to receive VA benefits based upon a separate period of service. The Commission does not agree with this policy.

The Commission believes that service members who receive bad conduct or dishonorable discharges should be barred from receiving VA benefits. These types of discharges are the result of conduct that is abhorred by the United States military, and often times includes criminal acts. From 2000 to 2005 only approximately 1 percent of all military discharges came under these two headings as shown above in Table 5.1. Therefore the Commission recommends the following:

Recommendation 5.1

Congress should change the character-of-discharge standard to require that when an individual is discharged from his or her last period of active service with a bad conduct or dishonorable discharge, it bars all benefits.

I.2 Line of Duty

I.2.A Issue

"Line of duty" is a fundamental principle in veterans' disability benefits because, by law, a causal relationship between military service and death or disability is established only when the disability or death is incurred or aggravated *in the line of duty* (38 CFR 3.301 [2006]). The definition of "line of duty" for the U.S. military has been a source of debate for years. Interpretations of the meaning can be traced at least as far back as the late 18th century, when the debate focused on what constituted a service member's duty status. Currently, a service member is considered to be in the line of duty all day every day, including when on leave. The foundation for this definition is our nation's sense of moral obligation to citizens when they are called to serve their country. This definition entitles service members to VA benefits and services for disabilities resulting from injuries incurred or diseases contracted while in active military service, whether on active duty or authorized leave, unless the injury or disease arose from the individual's willful misconduct or abuse of alcohol or drugs. Critics argue, however, that military personnel should be compensated for injuries or diseases that occur only as a direct result of the performance of military duties, implying that the line of duty definition should not extend to all times and places.

The General Accounting Office (GAO)[7] suggested in 1989 that Congress might wish to reconsider limiting compensation to injuries or diseases that occur while performing actual military duties. The report concluded that, in 1986, 19 percent of veterans had diseases unrelated to service and were compensated approximately $1.7 billion as a result.[8] GAO suggested that VA should grant service-connection compensation only for injuries and diseases directly attributable to military service.

In March 2003, the Congressional Budget Office (CBO) reported that 290,000 veterans received approximately $970 million for the disabilities that GAO found in 1989 were not caused as a direct result of military service.[9] CBO found potential savings of approximately $1 billion by restricting the criteria for granting

[7] Prior to July 7, 2004 the Government Accountability Office was the General Accounting Office.
[8] Government Accountability Office (GAO), *Disabilities Unrelated to Military Service*, 28.
[9] Congressional Budget Office, *Budget Options March 2003*.

service connection to compensate veterans. “Opponents of this option,” CBO observed, “could hold the view that veterans' compensation benefits are payments that the Federal Government owes to veterans who became disabled in any way during their service in the armed forces.”[10]

The United Kingdom, Australia, and Canada have narrower definitions of “line of duty” than does the United States. Those other governments offer compensation to veterans for illnesses or injuries that occurred at any time in a war zone, but offer compensation only in connection with activities that are directly related to military service when troops are not engaged in war or are performing military training exercises. However, those countries offer other benefits to all citizens, such as universal health care, that are not available in the United States.

Likewise, the benefit plans of civilian public safety officers (PSOs), including law enforcement officers and firefighters, have narrower definitions of “line of duty” than the U.S. military has. Usually the injury or illness must occur during working hours when the PSO is performing assigned duties or engaging in an activity that is reasonably associated with employment.[11]

The Commission also reviewed VA disability compensation practices during the period of 1933 to 1972, when veterans who served during peacetime were paid disability compensation at rates lower than those of veterans who served during wartime. From 1933 to 1939, the peacetime rate was 50 percent of the wartime rate. From 1939 to 1948, the peacetime rate was 75 percent of the wartime rate. And from 1948 to 1972, the peacetime rate was 80 percent of the wartime rate. VA notified Congress by letter in 1965 that it believed veterans suffered the same loss of earnings for identical disabilities and that it could no longer justify continuing to pay disability compensation at different rates depending on whether the illness or injury occurred during peacetime or wartime.

It is also relevant to consider whether the line of duty should encompass the same period as when service members must follow the Uniform Code of Military Justice (UCMJ), the comprehensive set of principles that underpin U.S. military law. According to 47 U.S.C. § 802 (2)(c), all service members are “subject to this chapter until such person’s active service has been terminated in accordance with law or regulations promulgated by the Secretary concerned.” Not only are all military personnel held to this code, but according to 47 U.S.C. § 805 (5), they are subject to the UCMJ “in all places.” In other words, the U.S. military is held to the requirements of the UCMJ at all times and in all locations, including while on leave. A question that then arises is whether any illness or injury that occurs

[10] Ibid.
[11] GAO, *Disability Benefits*, 11.

while the service member is subject to UCMJ—that is, at all times and in all places—should be viewed as connected to service. If so, then the line of duty includes all times and places that the service member is on active duty or authorized leave.

Finally, the Commission noted that it is standard practice in American industry to provide health insurance for employees. If periods other than direct duty were excluded from the line of duty, then DoD would need to offer service members a heath insurance program that provides coverage for the excluded periods.

I.2.B Findings

The Commission agrees with the arguments made in favor of the current definition of "line of duty." Since the 18th century, the United States has supported its citizens who have answered the call to defend their country. As clearly stated in the UCMJ, active duty is considered to be 24 hours a day, 7 days a week. Around the clock, service members are on call to perform high-risk tasks that may cause traumatic injuries and are subjected to dangerous stressors and exposures. Injuries incurred and diseases contracted while a service member is in active military, naval, or air service, whether on active duty or authorized leave, are considered to be in the line of duty unless they are due to the service member's willful misconduct or abuse of alcohol or drugs. Under this definition, VA services and benefits, including compensation, hospital care, and medical services, are available for a disability resulting from injury suffered or disease contracted in the line of duty in the active military, naval, or air service, whether on active duty or authorized leave, and not due to their own willful misconduct or abuse of alcohol or drugs. Therefore, the Commission recommends the following:

Recommendation 5.2

Maintain the present definition of line of duty: that service members are on duty 24 hours a day, 7 days a week.

Previous attempts to award benefits at different rates or not at all unless disabilities were incurred during wartime periods or in combat theaters or operations have been found to be unjustified and unfair.

Recommendation 5.3

Benefits should be awarded at the same level according to the severity of the disability, regardless of whether the injury was incurred or disease was contracted during combat or training, wartime or peacetime.

I.3 Reasonable Doubt

I.3.A Issue

Regardless of whether it is called the "reasonable doubt" standard or the "benefit of the doubt" standard, the standard of proof a VA claimant is required to meet to establish entitlement to veterans' benefits is among the most liberal used in any adjudicatory proceeding. In *Gilbert v. Derwinski*, the Court of Veterans Appeals wrote:

> This unique standard of proof is in keeping with the high esteem in which our Nation holds those who have served in the armed services. It is in recognition of our debt to our veterans that society has through legislation taken upon itself the risk of error when, in determining whether a veteran is entitled to benefits, there is an "approximate balance of positive and negative evidence." By tradition and by statute, the benefit of the doubt belongs to the veteran (*Gilbert v. Derwinski,* 1 Vet. App. 49, 54 [U.S. Court of Veterans' Appeals 1990]).

Discussions about the reasonable doubt standard occurred as early as 1855, when Attorney General Cushing argued, in an opinion concerning the definition of "line of duty," that "it would be reasonable to presume in favor of the veteran" in cases where a reasonable doubt existed (7 Op. Att'y Gen. 149, 165-166 [1855]). The first rating tables and schedules were promulgated after World War I, and one of the earliest of these tables specified that cases in which "a question of doubt" arose should be resolved in the veteran's favor. Subsequent rating tables and schedules continued to refine and promulgate the reasonable doubt standard. Then, in 1933, Congress enacted the Economy Act, which included the first legislative requirement of the reasonable doubt standard (Pub. L. No. 73-2, 48 § 8 [1933]).

In 1941, Congress promulgated a law similar to the current standard of reasonable doubt, directing VA to "resolve every reasonable doubt in favor of [the] veteran" (Pub. L. No. 77-361, ch. 603, 55 § 847 [1941]). The reasonable doubt standard remained unchanged until 1985, when Congress clarified the language of the law by defining reasonable doubt as "[doubt] which exists because of an approximate balance between positive and negative evidence" (38 U.S.C. 1154 [2006]). Congress last revised the reasonable doubt standard in 2000, when it passed the Veterans Claims Assistance Act. That act edited some wording in the reasonable doubt section in the U.S. Code, but those edits "had no substantive impact" on the standard (38 C.F.R. 3.102 [2006]).

The reasonable doubt standard is meant to ensure that decisions on claims result in the fairest possible outcome for the veteran. In cases where the

evidence does not clearly prove or disprove service connection, the reasonable doubt standard is applied and the case is decided in favor of the claimant.

To date, there has been little debate over the use of the reasonable doubt standard.

I.3.B Findings

The reasonable doubt standard has been a consistent fixture of the VA claims process since the 1850s. There has been little criticism of the standard.

Recommendation 5.4

Maintain the current reasonable doubt standard.

I.4 Age as a Factor

I.4.A Issue

Currently, age is not a factor in evaluating service connection, and there is no statutory history on age as a factor. If a disability is deemed to have been caused by service, all subsequent manifestations that develop are also service connected. As provided by 38 C.F.R. 3.303(b) [2006], "subsequent manifestations of the same chronic disease at any later date, however remote, are service connected, unless clearly attributable to intercurrent causes." The worsening of a disability over time, as opposed to acceleration by postservice injuries or superimposed diseases, is not an intercurrent cause. Since service-connected disabilities, like other degenerative and progressive diseases, worsen as part of the natural aging process, the Commission asked if the age of the veteran should be a factor when he or she is applying for compensation. For example, should a 45-year-old military retiree who gradually develops arthritis over many years be compensated for that disease, and should such a case differ from that of a 22-year-old veteran who claims arthritis due to a traumatic injury? The Commission also investigated whether a veteran should be compensated more for a condition that impairs the individual more severely because of his or her age.

Among the 2.7 million veterans who received VA compensation for a service-connected disability in fiscal year 2006, 162,805 veterans were receiving that compensation for the first time.[12] Tables 5.2 and 5.3 illustrate the age distribution of those two groups of veterans.

[12] Cohen, Email message to Commission staff.

Table 5.2 Initial Disability Awardees Distribution by Age for 2006

Age Group	Percentage (%)	Actual Numbers
< 35 years	20.4	40,989
36–55 years	34.1	54,187
56– -75 years	36.6	55,039
75+ years	9.0	12,590
Total	100	162,805

SOURCE: Cohen, E-mail message to Commission staff.

Table 5.3 All Veterans Receiving Compensation by Age for 2006

Age Group	Percentage (%)	Actual Numbers
< 35 years	7.8	213,566
36–55 years	30.6	833,346
56–75 years	42.4	1,156,703
75+ years	19.2	522,209
Total	100	2,725,824

SOURCE::Cohen, E-mail message to Commission staff.

Some 61.6 percent of the total population of service-connected veterans in 2006 was 56 years of age and older, but only 41.5 percent of those first receiving compensation were that age. By contrast, only 7.8 percent of all service-connected veterans in 2006 were 35 years of age or younger, but 25.2 percent of those first receiving compensation in 2006 were that age.

In its July 1984 report *Caring for the Older Veteran*, VA studied how it would face the challenges associated with an increasingly older population of veterans. VA reported that aging "increases the susceptibility to certain conditions, particularly those that result from degenerative changes in the body's tissue and organ systems."[13] For example, the elderly are more at risk for "cardiovascular diseases, diseases of the bones and joints, and sensory impairment."[14] Furthermore, there are diseases that may be common to other age cohorts that

[13] VA, *Caring for the Older Veteran,* 3.
[14] Ibid.

"act differently when they occur in an older person" or "may occur silently in older persons."[15]

In today's world, increasingly more elderly individuals pursue independent, active lifestyles. VA contended that "older individuals prefer to retain their independence to the maximum extent possible, and maintenance of such independence is widely accepted as the primary goal of programs and services for the elderly."[16] VA has appreciated the need to give elderly veterans levels of care and benefits that help maximize their ability to function and attain life goals.

Although there was a steady decline in labor force participation by Americans (including veterans)[17] ages 65 and older from the 1960s to the 1980s, that trend reversed in the 1990s.[18] By 2003, 33 percent of men and 23 percent of women ages 65 and older were working.[19] In addition, the rates of chronic disability among the elderly declined by 5 percent since 1987.[20] According to the Federal Interagency Forum on Aging-Related Statistics, "functioning in later years may be diminished if illness, chronic disease, or injury limits physical and/or mental abilities. Changes in disability rates have important implications for work and retirement policies, health and long-term care needs and the social well-being of the older population."[21]

According to VA, trends among veterans ages 65 and older have generally been consistent with those of the general population.[22] This cohort of veterans generally suffers from the same conditions as its peers and experiences about the same rate of unemployment. However, older veterans are more likely to have health insurance than their peers in the general population.[23]

Veterans' disability percentage ratings, when viewed by age, do not vary significantly for individuals above and below 66 years of age. The most frequent evaluation is at the 10 percent level.[24] Regardless of age, veterans may need to access VA benefits and programs created to enhance their quality of life and help them maintain their independence and productivity.

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[15] Ibid.
[16] Ibid., 3.
[17] Ibid., 74, 109.
[18] Forum on Aging-Related Statistics, *Older Americans 2004,* 18–19.
[19] Ibid.
[20] Ibid., 28.
[21] Ibid., 28.
[22] Dunne, *Older Veterans Update.*
[23] Ibid.
[24] Ibid.

Rather than allowing age to be a factor in disability ratings, the 1956 Bradley Commission decided that it was more important to focus "on helping those who need assistance most, and helping them more adequately."[25] The Bradley Commission's reasoning regarding age as a factor for non-service-connected veterans' pensions is applicable to this Commission's investigation of age as a factor for service-connected disability compensation. The Bradley Commission determined that age is an inadequate surrogate for measuring ability. The commission also noted that 65 is a somewhat arbitrary age for retirement. The concept of "age 65 as retirement age goes back to the mid-1930s, when depressed labor market conditions made it desirable to encourage people to retire early."[26] A recent study showed that 65-year-olds are able to successfully gain employment.[27] The Bradley Commission determined that despite the common belief that 65 is retirement age, individuals who are fit to work should still be able to do so.

Under the "new wars" legislation investigated by the Bradley Commission, a veteran could qualify for a pension if his or her level of disability was determined to be permanent and total. However, as a veteran aged, the level of disability required to qualify for the same pension was reduced. For example:

> A combined disability evaluation of 70 percent or even 60 percent, if arising from one single cause, is considered sufficient at any age to meet this definition. For veterans aged 55 to 59 and 60 to 64, the 70 percent is reduced to 60 and 50 percent, respectively, from any or all causes. At age 65, and thereafter, a 10 percent impairment from disability is deemed sufficient.[28]

In other words, as a veteran aged, it became easier for him or her to receive a pension because the minimum requirements were lower.

The Bradley Commission found that "undue reduction of the disability requirement by reason of age alone tends to undermine the system by opening it to those whose needs are less urgent."[29] Therefore, the Bradley Commission suggested that "a minimum requirement of more substantial disability at the higher ages will assure that veterans of any age, who are genuinely unemployable because of disablement, can continue to rely on the pension program in case of need."[30]

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[25] President's Commission, *Findings and Recommendations*, 387.
[26] Ibid., 386.
[27] Forum on Aging-Related Statistics, *Older Americans 2004*, 18–19.
[28] President's Commission, *Findings and Recommendations*, 386.
[29] Ibid., 387.
[30] Ibid., 387.

The Bradley Commission reached this conclusion because having a minimum disability requirement for unemployability will "preclude the gradual transformation of this program into one providing pensions to practically all veterans attaining age 65."[31] In the views of the Bradley Commission, it was more important to devote resources to veterans with the greatest needs than to veterans of a certain age. A veteran should not be prevented from receiving needed pension, nor should that veteran receive pension based on age alone.

In 1989, GAO reported on the *Law Allows Compensation for Disabilities Unrelated to Military Service* and found that "there are 71 diagnoses that their [GAO's] physicians concluded were neither caused nor aggravated by military service."[32] The most common of these diseases were diabetes, chronic obstructive pulmonary disease, appendicitis, osteoarthritis, cerebral vascular accidents (stroke), arteriosclerotic heart disease, multiple sclerosis, Hodgkin's disease, hemorrhoids, benign prostatic hypertrophy, uterine fibroids, Crohn's disease, and schizophrenia.[33] GAO physicians did not conclude that these conditions never would be caused or aggravated by military service, but in the cases reviewed, they did not find a direct correlation.[34] For some of these diseases, GAO concluded that the onset is age related and that the disease can be chronic and progressive.

In March 2003, the Congressional Budget Office (CBO), relying on the diseases identified in the 1989 GAO study, reported that about 290,000 veterans received approximately $970 million in 2002 for disabilities that were generally neither caused nor aggravated by military service. The diseases listed by CBO were osteoarthritis, chronic obstructive pulmonary disease, arteriosclerotic heart disease, Crohn's disease, hemorrhoids, uterine fibroids, and multiple sclerosis. (This excluded diabetes because VA had subsequently granted service connection on a presumptive basis due to Agent Orange exposure.) Ending "new compensation benefits for veterans with only those seven diseases would save…$449 million over the 2004–2008 period."[35] Furthermore, CBO stated that the elimination of compensation "for veterans whose compensable disabilities are also unrelated to military service would create significantly larger savings."[36]

Although CBO found potential savings by restricting the criteria for granting service connection to compensate veterans, it observed that "opponents of this option could hold the view that veterans' compensation benefits are payments that the Federal Government owes to veterans who became disabled in any way

[31] Ibid.
[32] GAO, *Law Allows Compensation.*
[33] Ibid.
[34] Ibid.
[35] Congressional Budget Office, *Budget Options*.
[36] Ibid.

during their service in the Armed Forces."[37] Because an individual served in the military, CBO suggested that he or she should be compensated for an injury, a disease, or both, regardless of how it happened, regardless of direct connection to military combat. This type of reasoning is applicable when determining if age should be a factor for service-connected compensation as well.

Although it may be appropriate to consider age as a factor when determining a VA pension or Social Security benefits, some argue that it would be inappropriate to consider age when determining entitlement to veterans' compensation for two reasons: first, the purpose of such compensation is to relieve aging veterans of distress from disability or destitution; and second, the purpose of compensation is to make up for the effects of service-connected disability and thus should not be tied to factors extraneous to the character of the disability, such as age. [38]

I.4.B Findings

Limited information is available to address the issue of age as a factor in evaluating a claim for disability. GAO, CBO, and VA's *Caring for the Older Veteran Report* have noted that some diseases are more likely than not to arise from normal life experiences and aging, but can reoccur during or be aggravated by military service. Some of these conditions may have a delayed or gradual onset and therefore may be diagnosed years after discharge from military service. In such cases, veterans may first apply for benefits years or even decades after military service. Currently, each application for benefits by any veteran is adjudicated on its own merit using available medical evidence.

When a veteran has established that a disability was either incurred during or aggravated by military service, and service connection has been granted for that disability, the next decision is to assign a level of severity in accordance with the VA *Schedule for Rating Disabilities*. Age, by VA regulation, is currently not considered in evaluating service-connected disability.

Although studies by GAO and CBO have recognized the cost factors associated with disabilities not thought to be caused by military service, neither organization has recommended changes to the current regulations. During its discussions, the Commission supported the current practice that age should not be a factor in entitlement to service-connected compensation. Additionally, there should be no difference in entitlement to compensation regardless of the age of the veteran or when the veteran decided to first file a claim.

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[37] Ibid.
[38] Disabled American Veterans, testimony.

In an earnings analysis directed by the Commission, the CNA Corporation (CNAC) found that those who enter the system at younger ages do not achieve parity with their non-service-connected peers, while those entering at older ages achieve greater than parity because of few working years remaining. The Commission decided to address age at entry into the system separately from the use of age as a factor in evaluating entitlement to service connection or evaluation of the degree of severity of a service-connected disability. Therefore, the Commission recommends the following:

Recommendation 5.5

Age should not be a factor for rating service connection or severity of disability, but may be a consideration in setting compensation rates.

I.5 Time Limit to File

I.5.A Issue

Currently, there is no time limit for filing an original claim for service connection. The War Risk Insurance Act of 1917, which replaced the General Pension Act of 1862, provided service-connected benefits to veterans and survivors and eliminated rank as a factor in determining the rate of compensation. There were two provisions of this act that were significant for the time limit in which to file claims for service connection. The first limitation, found in section 306 of the act, stated that the disability or death had to have occurred prior to or within 1 year after discharge or resignation from service. The second limitation, in section 309 of the act, placed a 5-year time limit upon filing compensation claims. Therefore, no compensation was available for disabilities that occurred more than 1 year after separation from duty, unless it could be demonstrated that the disability existed within that time period. Furthermore, the initial claim for compensation had to be submitted within 5 years of separation from duty. These two limitations were liberalized to some degree over the years, but remained in effect until their repeal in the World War Veterans' Act of 1930 (Pub. L. No. 71-522, 46 Stat. 991, 1000 [1930]).

The Veterans' Claims Adjudication Commission (VCAC), in their 1996 *Report to Congress*, suggested that establishing a time limit for filing claims for disability compensation warranted consideration. VCAC studied frequency of claims for disability compensation received during FY 1995, and, of the 299 claims reviewed in the study, 63 percent of original claims for disability compensation were filed within 1 year of separation. However, a significant number, almost 22 percent, were filed more than 20 years after separation.[39] Thus, while it

[39] Veterans' Claims Adjudication Commission (VCAC), *Report*, 70.

appears that most current claims would fall within a likely time limit, it is probable that a sizable number of veterans would indeed be excluded from compensation by such a limit.

VCAC recognized that traditionally, veterans have had an unlimited period of time in which to file a claim, but noted that:

> This generous filing privilege may be regarded as an advantage by veterans, but it also has certain disadvantages for them, [because] veterans' needs change over time and it is possible that the advantage of an open-ended filing period has changed with time as well.[40]

VCAC therefore went on to outline the most common arguments on both sides of the debate over imposing a time limit on filing claims, beginning with the arguments in favor of such a limit:

> A time limit for filing an initial disability compensation claim would encourage veterans to file relatively early—at the very time when they are most likely to be able to establish entitlement. Documentation is most readily available during the first few years following service. Service "buddies" are easier to contact for supporting evidence or testimony. Intervening medical problems, which make it more difficult to meet the legal requirements for entitlement, are less likely to occur. Postponing filing only increases the chances that evidence will be lost, destroyed, or otherwise degraded.[41]

Thus, it is argued that imposing a limited period in which to file a claim, and appropriately informing veterans of its existence and significance, could raise awareness that the legal requirements for receiving disability compensation are easier to fulfill the sooner the claim is filed. This increased awareness could influence veterans to improve the quality of their benefit claims beyond the extent to which simply submitting claims in a timely manner would improve them. Furthermore, an environment of timely filed claims would lead to less time-consuming claims processing, because VA would not have to expend scarce resources in unproductive efforts to locate or reproduce decades-old or lost evidence. Resources could be concentrated on processing timely filed claims, because *all* claims would be filed in a reasonably timely manner. It may be for this reason that most other governmental and private disability compensation systems impose a time limit on filing initial claims. Many also point out that "a

[40] Ibid., 347.
[41] VCAC, *Report*, 347.

time limit on initial claims would *not* prohibit or inhibit claims for increased evaluation."[42]

Some also argue that there should be no reason to maintain a lifelong filing period:

> Comprehensive services currently available *prior* to separation suggest any need for lifelong opportunity to claim disability compensation is decreased. Although unquantified, the transition services provided to 1.4 million separating service members worldwide by VA, DoD, and DOL from FY 1992 through FY 1995, increased the percentage of dischargees who file claims for benefits. In addition, VA/Army's separation examination tests are evaluating several methods for conducting examinations for separating and retiring service members who intend to file a disability claim with VA. Carrying this concept to its logical extreme, VA and DoD could cooperatively track veterans' health on *entry* into service. This could lead to a paperless benefits delivery system in which veterans would not need to apply for benefits. On discharge, VA would have all information needed to pay appropriate benefits without any action on the veteran's part.[43]

It should be noted that current law does require a veteran to submit a specific claim in order for compensation to be paid.[44] In addition, comprehensive services are not universally available at this time. For example, the Benefits Delivery at Discharge program is limited to approximately 140 separation sites.[45] Service persons at remote and small sites, and those separated while at sea, do not have as much access to these services.[46]

Concerning the time limit issue, the Under Secretary for Benefits for the Department of Veterans Affairs wrote to this Commission in support of examining the arguments in favor of a time limit:

> Today, there is no time limit for a veteran to submit an initial claim for disability compensation. He or she can be 18 or 85, have been on active duty for 6 months or 50 years, and can submit the claim immediately upon leaving the service or decades later…In today's VA, with strong emphasis in veterans' outreach, it should not be unreasonable to have a limit, at least for the time frame allowed for the initial filing of a claim. Further, the availability, to an extent not

[42] Ibid., 348.
[43] Ibid.
[44] Memo from Acting VA General Counsel, January 12, 2007.
[45] *VA Fiscal Year 2007 Budget Request*, Statement of Daniel L. Cooper.
[46] VA Compensation and Pension Service, Technical Comments.

> present earlier, of the Benefits Delivery at Discharge (BDD) Program might be a consideration for some delimiting time for an original claim.[47]

Against this support of a time limit, there are a number of arguments in favor of the current system. The first concern for those who oppose a time limit is that some veterans may not become aware that they must file an initial disability compensation claim within a certain period of time. While there could be exceptions for allowing veterans who were physically or mentally unable to file, it would be difficult to provide exceptions on the basis of unawareness. Between the lack of information and knowledge regarding eligibility, and the "red tape" associated with filing a claim, even with the current unlimited filing period, it is already possible for veterans to "fall through the cracks" of the current VA system. These obstacles may then become even greater if a time limit is imposed. If veterans today are sometimes unaware of the compensation and benefits available to them, it is likely that such veterans would also be unaware of any time limits associated with those veterans, causing them to lose the opportunity to avail themselves of the compensation due to them.

Furthermore, in spite of best efforts to inform veterans, it is possible that some veterans may not realize that a condition, which is not bothersome or disabling, should be evaluated anyway. Veterans may, believing themselves not entitled to compensation payments, choose not to apply within the time limit. If the condition then worsened after the time limit had expired, the veteran would have inadvertently forfeited his entitlement to compensation.[48]

Based on these arguments, many claim that an unlimited time to file is a right that protects veterans' vital interests. Veterans should have an open process for claiming compensation, and they should not be pressured into filing claims under what amounts to a "use it or lose it" ultimatum. And, because VCAC found no evidence of large numbers of claims filed late to justify any delimiting periods, there seems to be no imminent administrative need to impose a time limit. Without such a need, and considering the negative effects a time limit could impose on the compensation system, it would be inappropriate to impose a time limit to file an initial claim for compensation.[49]

In testimony before the House Veterans' Affairs Committee in May 1997 on the report of the Veterans' Claims Adjudication Commission, the DAV opposed the imposition of a time limit for filing compensation claims. In supporting the

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[47] Cooper, Daniel L., Under Secretary for Benefits for the Department of Veterans Affairs, before the Veterans' Disability Benefits Commission, Washington, D.C., July 22, 2005.
[48] VCAC, *Report*, 348.
[49] Ibid., 376.

unlimited time limit in which to file an original claim for service connection, DAV noted:

> The disadvantages of time limits for filing claims far outweigh any advantages. Currently, conditions such as posttraumatic stress disorder (PTSD), asbestosis, and radiogenic diseases can be service connected without regard to how long after service they are first shown. This is because of their characteristically delayed clinical manifestations or latency periods…Sometimes evidence first discovered years after service can support a claim for service connection. In other instances, proof is unavailable for years because of government secrecy…The law provides that some conditions, such as those of former prisoners of war, will be presumed service connected no matter how long after service they first manifest. The system is designed to avoid defeating meritorious claims by mere technicalities and artificial constraints.[50]

I.5.B Findings

There is no time limit for veterans and their dependents to file a claim for service-connected disability and death benefits, and this standard has remained unchanged for over 75 years. Although the Commission found that the arguments in favor of imposing a time limit were unconvincing, the issue did raise important concerns regarding the degree to which veterans are educated about the benefits available to them. To date, there have been significant outreach efforts by VA and DoD to educate veterans as to their benefit entitlements, along with significant improvements in recordkeeping and documentation of medical records by VA and DoD. In keeping with these developments, the Commission discussed the merits of mandating that a benefits briefing be provided to all separating military personnel. Therefore the Commission recommends the following:

Recommendation 5.6

Maintain the current standard of an unlimited time limit for filing an original claim for service connection.

Recommendation 5.7

DoD should require a mandatory benefits briefing to all separating military personnel, including Reserve and National Guard components, prior to discharge from service.

[50] Surratt, testimony before House Veterans' Affairs Committee.

II Presumption Decisions

II.1 Overview

This section discusses issues regarding presumptive service connection. An increasing proportion of benefits is paid through a presumptive decision-making process. Therefore, this Commission sought the expert advice of the Institute of Medicine (IOM) regarding the process by which presumptions of service connection are established.

As the VA stated in its "Analysis of Presumptions of Service Connection" (Dec. 1993, submitted to Senate Veterans Affairs Committee):

> Generally, a legal presumption is a procedural device that shifts the burden of proof by attaching certain consequences to the establishment of certain basic evidentiary facts. When the party invoking a presumption establishes the basic facts(s) giving rise to the presumption, the burden of proof shifts to the other party to prove nonexistence of the presumed fact. A presumption, as used in the law of evidence, is a direction that if fact A (e.g., manifestation within the specified period of a disease for which a presumption of service connection is available) is established, then fact B (service connection) may be taken as established, even where there is no specific evidence proving fact B (i.e., no medical evidence of a connection between the veteran's disease and the veteran's military service).[51]

Since the early part of the 20th century, the Congress and VA have used the concept of presumptions to facilitate the decision process for VA disability compensation. The first legislation explicitly providing a presumption of service connection to mitigate the difficulty of proving a connection between military service and development of a disability was the Act of August 9, 1921 (42 Stat. 147, ch. 57). This act established the Veterans' Bureau and, in section 300 of the War Risk Insurance Act, presumptions of service connection for active pulmonary tuberculosis and neuropsychiatric disease were added. This bill provided that the specified diseases developing to a degree of disability of more than 10 percent within 2 years following separation from active military service would be considered to have had their origin in service or to have been aggravated by service.[52]

[51] VA, "Analysis of Presumptions."
[52] Ibid., 7, 8.

This initial presumptive legislation was intended to overcome difficulties being observed in fixing a time of onset for these diseases. The belief of the author, Senator Walsh, was that "the great number of ex-servicemembers afflicted with tuberculosis and nervous disorders…could not be expected to be so afflicted naturally."

After the first legislation on presumptions, there were periodic additions and changes enacted through the 1950s. Legislation in the 1970s through the 1990s greatly expanded the impact of presumptions. This era saw increasing concerns—and resulting legislation—about disabilities related to ex-prisoners of war, exposure to ionizing radiation, and service in Vietnam. Because of the volume of veterans affected by these phenomena, the impact of presumption decisions increased dramatically.

An extreme example of the impact of presumptions is shown by a brief look at diabetes and the endocrine body system. In 2001, the VA Disability Compensation Program was paying 68,040 veterans for disabilities in the endocrine system, including diabetes. In 2001, the VA established presumptive service connection for type 2 diabetes based on herbicide exposure in Vietnam veterans. By 2005, the total disability cases in the endocrine system had grown to 247,324, and 86 percent of that total was Vietnam era veterans.[53]

Today, with the ongoing conflict in Iraq and the Persian Gulf, presumptions continue to be an issue. As the IOM report on presumptions states:

> Three major legislative actions by Congress have influenced the recent presumptive decisions—the Radiation-Exposed Veterans Compensation Act of 1988, the Agent Orange Act of 1991, and the Persian Gulf War Public Laws of 1995 and 1998. The concept of "at least as likely as not" in regard to exposure potential was introduced for radiation exposures and its use has since been extended. The Agent Orange Act grew out of the events following the Vietnam War and expresses substantial and significant elements of the presumptive story. The presumptions put in place by Congress for Gulf War illnesses represent the first time that Congress produced a list of health outcomes that it defined as "undiagnosed illnesses."[54]

Clearly, the history of presumptions shows that an expert review of the presumptive decision-making process was needed. This Commission therefore tasked IOM to evaluate the VA's presumptive disability decision-making process

[53] Veterans Benefits Administration, *Annual Reports*, 2004, 2005.
[54] Institute of Medicine (IOM), *Presumptive Disability Decision-Making*, Summary, 9.

and, if needed, recommend a more rigorous scientific model to underpin the decision process. Specifically, IOM was asked to

> Describe and evaluate the current model used to recognize diseases that are subject to service connection on a presumptive basis. If appropriate, propose a scientific framework that would justify recognizing or not recognizing conditions as presumptive.[55]

In the Commission's statement to the IOM Committee on the Presumptive Disability Decision-Making (PDDM) Process, the committee was requested to pursue several underlying questions:

- Assess the processes used in the past and at the current time to make decisions on presumptions.
- Provide substantive advice concerning how to ensure that this situation (inability to document exposure to biological, chemical, radiological, or other environmental agents) is not repeated in the future.
- Consider if a different methodology should be used in determining causal relationships other than the environmental aspect used for the current method.
- Provide advice, from an epidemiological and statistical standpoint, on what strength of evidence would be the appropriate requirement when the Secretary of VA considers whether to establish a presumption.

The IOM convened the Committee on the Presumptive Disability Decision-Making (PDDM) Process in May 2006. The committee consisted of 14 members and a small number of consultants and staff. After deliberating for about 16 months, holding three public meetings, and conducting 10 case studies, the committee made 19 recommendations. The Commission supports these findings and endorses the committee's recommendations, with a few caveats. First, the Commission suggests consideration of combining this advisory committee with the other advisory committee also recommended by IOM regarding the Rating Schedule in order to streamline the process, which is further discussed in Chapter 4 of the IOM PDDM report. Secondly, the Commission is concerned over the use of causal effect rather than association as the criteria for decision and encourages further exploration. Finally, during its deliberations, the Commission discussed the possibility of paying benefits on a proportional basis, but concluded that implementing such a payment scheme would not be practical. With these caveats in mind, the IOM committee's recommendations, as adopted by the Commission, are the following:

Recommendation 5.8

[55] Ibid., 2

Congress should create a formal advisory committee (Advisory Committee) to the VA to consider and advise the Secretary of VA on disability-related questions requiring scientific research and review to assist in the consideration of possible presumptions. [IOM Rec. 1]

Recommendation 5.9

Congress should authorize a permanent independent review body (Science Review Board) operating with a well-defined process that will use evaluation criteria as outlined in this committee's recommendations to evaluate scientific evidence for VA's use in considering future service-connected presumptions. [IOM Rec. 2]

Recommendation 5.10

VA should develop and publish a formal process for consideration of disability presumptions that is uniform and transparent and that clearly sets forth all evidence considered and the reasons for decisions reached. [IOM Rec. 3]

Recommendation 5.11

The goal of the presumptive disability decision-making process should be to ensure compensation for veterans whose diseases are caused by military service and this goal must serve as the foundation for the work of the Science Review Board. The committee recommends that the Science Review Board implement its proposed two-step process. [IOM Rec. 4]

Recommendation 5.12

The Science Review Board should use the proposed four-level classification scheme, as follows, in the first step of its evaluation. A standard should be adopted for "causal effect" such that if there is at least as much evidence in favor of the exposure having a causal effect on the severity or frequency of disease as there is evidence against, then a service-connected presumption will be considered. [IOM Rec. 5]

- **Sufficient: The evidence is sufficient to conclude that a causal relationship exists.**
- **Equipoise and Above: The evidence is sufficient to conclude that a causal relationship is at least as likely as**

not, but not sufficient to conclude that a causal relationship exists.

- **Below Equipoise: The evidence is not sufficient to conclude that a causal relationship is at least as likely as not, or is not sufficient to make a scientifically informed judgment.**
- **Against: The evidence suggests the lack of a causal relationship.**

Recommendation 5.13

A broad spectrum of evidence, including epidemiologic, animal, and mechanistic data, should be considered when evaluating causation. [IOM Rec. 6]

Recommendation 5.14

When the causal evidence is at Equipoise and Above, an estimate also should be made of the size of the causal effect among those exposed. [IOM Rec. 7]

Recommendation 5.15

The relative risk and exposure prevalence should be used to estimate an attributable fraction for the disease in the military setting (i.e., service-attributable fraction). [IOM Rec. 8]

Recommendation 5.16

Inventory research related to the health of veterans, including research funded by DoD and VA and research funded by the National Institutes of Health and other organizations. [IOM Rec. 9]

Recommendation 5.17

Develop a strategic plan for research on the health of veterans, particularly those returning from conflicts in the gulf and Afghanistan. [IOM Rec. 10]

Recommendation 5.18

Develop a plan for augmenting research capability within DoD and VA to more systematically generate evidence on the health of veterans. [IOM Rec. 11]

Recommendation 5.19

Assess the potential for enhancing research through record linkage using the DOD and VA administrative and health record databases. [IOM Rec. 12]

Recommendation 5.20

Conduct a critical evaluation of gulf war troop tracking and environmental exposure monitoring data so that improvements can be made in this key DoD strategy for characterizing exposures during deployment. [IOM Rec. 13]

Recommendation 5.21

Establish registries of service members and veterans based on exposure, deployment, and disease histories. [IOM Rec. 14]

Recommendation 5.22

Develop a plan for an overall integrated surveillance strategy for the health of service members and veterans. [IOM Rec. 15]

Recommendation 5.23

Improve the data linkage between the electronic health record data systems used by DoD and VA—including capabilities for handling individual soldier exposure information that is included as part of the individual's health record. [IOM Rec. 16]

Recommendation 5.24

Ensure implementation of the DoD strategy for improved exposure assessment and exposure data collection. [IOM Rec. 17]

Recommendation 5.25

Develop a data interface that allows VA to access the electronic exposure data systems used by DoD. [IOM Rec. 18]

Recommendation 5.26

DoD and VA should establish and implement mechanisms to identify, monitor, track, and medically treat individuals involved in research and other activities that have been classified and are secret. [IOM Rec. 19]

A discussion of the IOM report recommendations is provided below.

II.2 A New Framework for Presumptions

The case studies illustrated to the IOM committee that review approaches have shifted over time, that the target of review panels has vacillated between causation and association, and procedures precluded reexamination of presumptive decisions, even in the face of dynamic evidence. These findings "point to multiple points in the process of establishing presumptions that, in the committee's view, should be modified by its participants." The report goes on to state "the committee has concluded that there is a basis for making changes to the present approach. Building on the conceptual foundation developed in these earlier chapters, the committee addresses the second part of its charge in this chapter and recommends a framework for establishing presumptions in the future."[56]

Their recommended framework

> has multiple new elements: a process for proposing exposures and illnesses for review; a systematic evidence review process incorporating a new evidence classification scheme and quantification of the extent of disease attributable to an exposure; a transparent decision-making process by VA; and an organizational structure to support the process.[57]

The foundation of this new, proposed framework rests in the recommended establishment of two new panels: an Advisory Committee and a Science Review Board. These new panels would ensure a consistent approach to considering exposure reviews, making recommendations to the Secretary of VA, providing an independent expert review of evidence for causation, and estimating the service-attributable fraction of disease. This would be conducted in an open, public forum. The IOM committee offers substantial detail about the structure and the roles of the two proposed panels.

Under the IOM committee recommendation, the Advisory Committee would be chartered by Congress. It would be a permanent committee. It would be composed of veterans' representatives and recognized and credible experts in relevant medical and scientific fields. The committee would receive support from VA and other federal staff.

[56] Ibid., 12-1.
[57] Ibid.

The primary role of the Advisory Committee would be to identify potential exposures during military service and related disabilities that might be caused by these exposures; then to refer these topics, as appropriate, for comprehensive review by the Science Review Board.

Under the IOM committee's construct, the Advisory Committee would review the initial assessment and make recommendations on further review to the Secretary of VA. The Secretary of VA would have the authority to select conditions and agents for full review by the Science Review Board.

The Advisory Committee would accept proposals from any source on behalf of affected veterans. It is anticipated that proposals would be accompanied by supporting information. The Advisory Committee would establish a standard procedure for screening proposals, obtaining additional input, and completing their assessment.

The IOM committee places the VA and the Secretary of VA firmly in the center of the proposed assessment process. VA would support the Advisory Committee; VA would receive Advisory Committee recommendations and consider them. The IOM committee specifies that VA would "consider the nature and extent of evidence, number of veterans potentially affected, severity of the conditions, public comment, and potentially other factors to decide the topics that would proceed to the Science Review Board."[58]

The IOM committee further specifies that the Secretary of VA would be required to respond formally to the Advisory Committee's recommendations with an annual copy forwarded to Congress. The Secretary of VA would forward those topics deemed appropriate for further review to the Science Review Board. Ultimately, the Secretary of VA would receive the comprehensive scientific evaluations completed by the Science Review Board and decide on presumptions.

The IOM committee states strongly that the current presumptive review process has been flawed by not being open enough. The IOM committee found that "VA (1) has no formal published rules governing this process, (2) does not thoroughly disclose and discuss what "other" medical and scientific information it considered, and (3) publishes abbreviated and insufficiently informative explanations of why a presumption was or was not granted."[59]

[58] Ibid., 12-10.
[59] Ibid., 13-3.

The committee repeatedly makes the point that "VA must establish a uniform and transparent process for making decisions with regard to presumptions."[60] This mandate for a public process includes a public protocol for the internal review of reports received from the Science Review Board. It also includes publication of review notices and requests for pertinent information in the *Federal Register*, and possibly on the VA Web site.

Like the Advisory Committee, the IOM report envisions the Science Review Board being chartered by Congress and funded by VA. The Science Review Board would be an independent body made up of experts in key disciplines. The group would be supported by a staff of professionals with expertise in relevant disciplines. The Science Review Board would develop standard operating procedures for its evidence reviews and categorizations. As with the other elements in the new proposed framework, the efforts of the Science Review Board would be "transparent."

The IOM committee makes the point that evaluations conducted under the new proposed framework would routinely be subject to rereview and updating. The committee suggests that these rereviews could follow a fixed cycle, or be triggered by new compelling scientific information.[61]

This Commission strongly agrees with the need for a new framework for presumptive decision making. The Commission also endorses the fundamental elements proposed by the IOM committee. Establishment of an Advisory Committee and an independent Science Review Board will add much needed expertise and standardization to the presumptive review process. The openness of the new process and the regular involvement of stakeholders will be key to its success.

This Commission will make specific recommendations to Congress regarding the establishment of the Advisory Committee and the Science Review Board. The Commission urges that these committees be authorized quickly and that standard operating procedures reflecting the IOM committee recommendations be promulgated by VA and the Science Review Board as soon as practicable.

II.3 Causation as Basis for Presumptions

The IOM committee stated clearly that one of the most critical matters under its review was clarifying the basis for presumptive decision making. Their report

[60] Ibid., 12-10.
[61] Ibid., 12-9 to 12-13.

discusses this issue exhaustively and makes a compelling case that association is inadequate as the presumptive decision basis. The IOM committee's discussion makes it clear, as summarized below, that evidence for association can sometimes be misleading, even if the association appears to be strong.

Chapter 4 of IOM's report on presumptive disability decision making (PDDM) discusses the legislative background on presumptions. This discussion makes it clear that the standard for establishing presumptions has evolved, and from time to time, it has been confusing.

The Veterans' Dioxin and Radiation Exposure Compensation Standards Act (Pub. L. No. 98-542, Stat. 2725) was passed in 1984. Among other things, this legislation required the Secretary of VA to promulgate guidelines and standards for determining whether claims based on exposure to Agent Orange were service connected. When the VA did issue final regulations, they reflected the need for a cause-and-effect relationship to establish a presumption.

Later, in the case of *Nehmer vs. United States* (1989, U.S. District Court for the Northern District of California, Case Number 86-6160: pp. 7–9) the court concluded "that Congress did not intend VA to use a causal relationship," but suggested that "service connection…be granted on the basis of 'an increased risk of incidence,' or a 'significant correlation' between dioxin and various diseases."[62]

When Congress passed the Agent Orange Act of 1991 it stated that VA should "prescribe regulations providing for a presumption whenever the Secretary determines, on the basis of sound medical and scientific evidence, that a positive association exists…." However, in mandating a contract with the National Academy of Sciences, Congress also charged them to determine "whether there exists a plausible biological mechanism or other evidence of a causal relationship between herbicide exposure and disease."[63]

The basis for establishing presumptions became less clear when the first IOM Agent Orange committee placed its data findings into the following four categories: sufficient evidence of an association; limited/suggestive evidence of an association; inadequate/insufficient evidence to determine whether an association exists; limited/suggestive evidence of no association. These categories did not provide a clear dividing line for establishing or denying a presumption. Initially, VA did not establish presumptions for cancer categorized

[62] Ibid., 4-6.
[63] Ibid., 4-6, 4-7.

in the "limited/suggestive" category. However, upon analysis of the second IOM review (1996), VA did decide to grant presumptive service connection for prostate cancer, which was categorized as "limited/suggestive."

This winding historical path demonstrates that the basis for presumptions has been unstable and not clearly understood. From this point the IOM committee makes the case for a new, clear standard.

The IOM's PDDM report states:

> Provision of compensation to a veteran, or to any other individual who has been injured, on a presumptive basis requires a *general* decision as to whether the agent or exposure of concern has the potential to *cause* the condition or disease for which compensation is to be provided in at least some individuals, and a *specific* decision as to whether the agent or exposure has caused the condition or disease in the particular individual or group of individuals. The determination of causation for veterans is based on review and evaluation of all relevant evidence including: (1) measurements and estimates of exposures of military personnel during their service, if available, (2) direct evidence on risks for disease in relation to exposure from epidemiologic studies of military personnel, (3) other relevant evidence, including findings from epidemiologic studies of nonmilitary populations who have had exposure to the agent of interest or to similar agents, and (4) findings relevant to plausibility from experimental and laboratory research.[64]

The IOM committee goes on to make a basic assertion regarding presumptive service connection; namely that when "a veteran has a specific medical disease, the primary question for presumptive compensation is whether the disability is *attributable*, that is, caused by exposures during military service." They assert that the basic question is whether, absent service, the disability would have occurred at all or would have been less severe.[65]

The committee also draws a clear distinction between association and causation. They state that association is not the same thing as causation. Association is prima facie evidence for causation, but not sufficient for proving a causal relationship between exposure and disease. They use an interesting example to show the difference: In the early 1950s, Doll and Hill did a study on cigarette smoking and lung cancer. Although they did not record its presence, Doll and

[64] Ibid., 6-2.
[65] Ibid., 6-4.

Hill would presumably have found a high positive association between having tar-stained fingers and lung cancer mortality in their study. Clearly having tar stains on one's fingers does not by itself *cause* lung cancer. If it did, lung cancer could have been reduced by prescribing tar-solvent soap. This is an example of a spurious association, and the IOM highlights it to show that association—by itself—is inadequate for determining presumptive service connection.

II.4 Categorization of Evidence

Having determined that causation should be the standard for presumptive decision making, the IOM committee looked at categorization of the evidence of causation. As stated above, the prior categories, and their interpretation, had shifted from time to time. So, a new set of categories was clearly needed. The IOM committee recommended the following categories, which are based on causation, and the VA's longstanding policy to grant benefit of the doubt to veterans.

1. Sufficient: The evidence is sufficient to conclude that a causal relationship exists.
2. Equipoise and Above: The evidence is sufficient to conclude that a causal relationship is at least as likely as not, but not sufficient to conclude that a causal relationship exists.
3. Below Equipoise: The evidence is not sufficient to conclude that a causal relationship is at least as likely as not, or is not sufficient to make a scientifically informed judgment.
4. Against: The evidence suggests the lack of a causal relationship.

In contrast to the categories used previously by IOM Agent Orange committees, the new categories above provide a clear delineation for granting or denying a presumption. The new, proposed categories also allow for movement along the categorical scale as new scientific evidence is made available. Under the old scheme, there was initial reluctance to declare an association based on a finding of "limited/suggestive" evidence. However, as time progressed and additional reviews were done, decisions gravitated toward a position where "limited/suggestive" evidence was considered adequate to declare a presumption.

Use of the prior set of categories also led to another dilemma. Under these earlier categories, a disease would be categorized as having "limited/suggested" evidence of an association with exposure if a single significant study showed a correlation. Because of this definition, results of future scientific studies could not change the categorization of the disease. As the IOM's PDDM committee states:

> The categorization of the evidence as "limited/suggestive" by IOM has led to presumptions on the part of VA that appear to be irreversible once made, even though scientific evidence is dynamic. Stated in another way, even if further scientific evidence were unsupportive of previous research findings and a future IOM committee were to change its classification for strength of evidence, VA may not change its presumption.[66]

The IOM committee recommendations remove any reference to the strength of a single study. The IOM report also uses language, such as "equipoise" and "at least as likely as not," that is familiar to VA claims examiners. There is a long-standing policy at VA to give the veteran the benefit of the doubt. This concept has been confirmed through substantial case law that documents "equipoise" and "at least as likely as not" as the appropriate threshold for finding service connection and granting benefits claims.

This Commission believes the new proposed categories of evidence are far clearer than the prior set, and that promulgation of this new categorization will contribute to more fair and consistent results.

II.5 Scope of Scientific Reviews

In several places the IOM report notes that, in the past, reviews that preceded a finding of presumptive service connection have been limited in their scope. The case study on Agent Orange and prostate cancer includes the following statement: "The IOM Agent Orange committees have tended to rely largely on epidemiologic findings for the evidentiary classifications." In the same section the IOM report goes on to quote the 2003 IOM Agent Orange report: "On the basis of its evaluation of the epidemiologic evidence reviewed in this and previous reports on veterans and Agent Orange, the committee finds…The evidence regarding association is drawn from occupational studies in which subjects were exposed to a variety of pesticides, herbicides, and herbicide components and from studies of Vietnam veterans."[67]

Another example of limited scope is provided in the case study on amputees and cardiovascular disease. The case study found that "The scientific basis for this presumption was a single retrospective study of World War II veterans conducted by Medical Follow-Up Agency."[68]

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[66] Ibid., 5-17.
[67] IOM, *Presumptive Disability Decision-Making*, Case Study (CS) 8-3.
[68] Ibid., CS 4-5.

The IOM committee firmly states that a broad range of evidence must be reviewed:

> Provision of compensation to a veteran, or to any other individual who has been injured, on a presumptive basis requires a *general* decision as to whether the agent or exposure of concern has the potential to *cause* the condition or disease for which compensation is to be provided in at least some individuals, and a *specific* decision as to whether the agent or exposure has caused the condition or disease in the particular individual or group of individuals. The determination of causation for veterans is based on review and evaluation of all relevant evidence including: (1) measurements and estimates of exposures of military personnel during their service, if available, (2) direct evidence on risks for disease in relation to exposure from epidemiologic studies of military personnel, (3) other relevant evidence, including findings for epidemiologic studies of nonmilitary populations who have had exposure to the agent of interest or to similar agents, and (4) findings relevant to plausibility from experimental and laboratory research.[69]

The report then discusses various types of studies and their relative values.

The IOM committee provides significant narrative on the value of randomized controlled trials as a method for determining causation. They give this type of scientific evaluation very high marks. The IOM committee indicates that this design illustrates the kind of evidence they would like to have to assess causal claims. The randomized controlled trial allows the technician to directly observe the response of the same person when they are treated and not treated, so that the treatment can be reasonably inferred to be the "cause" of any differences in response under the two conditions.

The IOM committee also asserts the value of observational studies while acknowledging this type of study lacks many of the advantages of controlled studies. Then, the IOM committee discusses toxicological studies, animal studies, and mechanistic investigations, citing examples. Their conclusion is that data from each of these types of studies on how a given agent causes a health effect can be sufficiently convincing to support a causal conclusion. They can and should be used to clarify the findings and associations seen in epidemiological studies, and to draw more reliable conclusions regarding causation.[70]

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[69] IOM, *Presumptive Disability Decision-Making*, 6-2.
[70] Ibid., 7-3–7-5.

IOM's PDDM report discusses at great length the concept of service-attributable fraction (SAF), and recommends its use in the presumptive decision-making process. The attributable fraction (AF) is described as "the proportion of disease in an exposed group that can be attributed to the exposure…the AF is interpreted as the probability that among the exposed people with the disease, their disease has actually been caused by the exposure."[71] Calculating the SAF allows an examiner to gain an estimate of risk in assigning a presumption by comparing the rates of disability among those exposed and unexposed to a given risk agent. Use of this tool would help determine the risk of error if a presumption were assigned to a given exposure/disease relationship.

The strength of association between exposure and disease is typically measured with a statistic called the *relative risk* (RR). RR compares the incidence of disease among the exposed to the incidence in the unexposed. The ratio shows incidence of those exposed as the numerator, and the incidence of those not exposed as the denominator. A relative risk of 1.0 means that the frequency of disease among the exposed is the same as among the unexposed. A relative risk of 10 means that the rate of disease among the exposed is ten times as high as among the unexposed.[72] The IOM committee advocates use of this statistic in conjunction with the others, to quantify findings.

Ultimately, the IOM committee recommends use of the entire spectrum of evidence in evaluating causation. Their assertion is that relying on one (or few) sources of information limits the result reliability, and each type of analysis discussed can help to build the strongest possible case for or against causation.

This commission agrees that a broader spectrum of evidence should be used in assessing presumptive service connection. This should be reflected in the charters of the Advisory Committee and the Science Review Board, and in their standard operating procedures.

II.6 Inventory Research Related to the Health of Veterans

The IOM committee devotes an entire chapter of its report to gathering, storing, and sharing data between DoD and VA. The picture presented is of large organizations trying to capture important information, but in disjointed fashion. The disconnections are in methods, technology used in data collection and storage, and in organizational priorities.

[71] Ibid., 9-1.
[72] Ibid., 7-5.

The IOM committee report laid the groundwork about inventory research needs earlier in the report—in Chapter 6:

> Military personnel sustain a variety of exposures, some specific to the military and others not, that may increase risk for disease. If exposures of potential concern were tracked during military service and disease surveillance were in place and maintained, even for those who have left active duty, evidence could be generated directly relevant to the causation of disease in veterans. Lacking such evidence, reviewers turn to epidemiological studies of other populations and gauge the relevance of the findings for the exposures of veterans. Such groups also give consideration to toxicological and other research information. For a specific individual, the determination of eligibility for compensation would be based ideally in full knowledge of that individual's risk and an estimation of his or her probability of causation, given exposure history and observational information on the associated risk from similarly exposed people. However, this level of information and scientific understanding has not yet been fully achieved for individual causation for any agent.[73]

Another statement found in the case study summary on mental disorders strengthens the case for broader research. Among the "Lessons Learned" from that case study were the following:

> Presumptive decisions for mental disorders have been made for veterans who are former POWs and veterans who developed chronic mental problems during or shortly after military service. Although legislation has been informed by the scientific evidence available at the time, the scientific evidence in some instances has been limited and with inconsistency around the disorders included. For example, if the strength of evidence classification of limited/suggestive evidence leads to presumptive decisions for PTSD, dysthymia, and any anxiety state among former POWs, then there does not appear to be a clear basis for excluding other mental disorders with equal or stronger evidence of connection to being a POW, such as major depression. The presumptive decisions established in regard to the previously mentioned mental disorders make clear that these decisions have been influenced by not only scientific evidence, but political and social considerations that apply to these veterans (e.g., POWS) and the specific mental disorders they manifest. The need to develop a stronger evidence base and consistent evaluation of the evidence base with regard to these disorders is great, particularly in light of the anticipated high rates of mental disorders among military personnel assigned to and

[73] Ibid., 6-3.

> returning from Iraq and Afghanistan. This case study also illustrates the need for a process to continually carry out research and update the scientific base for presumptions.[74]

Chapter 10 of the IOM report catalogues a series of data collection systems managed by DoD, VA, and other entities. These include the DoD routine health assessments, event-driven assessments, and deployment-specific health assessments. It also includes DoD exposure assessments, VA-sponsored epidemiologic studies, as well as non-VA sponsored studies about veterans' health. As these listings progress, it becomes evident there has been a huge amount of information gathered about veterans' health. The efforts continue, and are even expanding, by the various stakeholders. However, it also becomes evident that improved *coordination* of effort is going to be needed.

In summarizing the findings in this report chapter, the IOM committee states that DoD and VA are clearly intent on improving the breadth, depth, and availability of health and exposure data, but much work is required. The committee offers a long series of recommendations to facilitate that desired improvement. These recommendations range from supporting the implementation of DOEHRS (Defense Occupational and Environmental Health Readiness System) to improved, periodic surveillance of active-duty servicemen (including exposure assessments) to better data linkages between DoD and VA.

The 11 report recommendations relating to health and exposure data are sorted into six areas of "important findings:"

1. Ensure that DOEHRS is implemented as planned.
2. Improve the interface between the electronic health record data systems used by DoD and VA—including capabilities for handling individual exposure information that is included as part of a soldier's health record.
3. Develop an interface that allows the VA to access the electronic exposure data systems used by DoD.
4. Develop DoD policy to ensure that classification/declassification (secrecy) issues are managed appropriately for both DoD and the veteran.

[74] Ibid., 5-3.

5. Strengthen the assessment of psychological stressors and symptoms.
6. Establish registries of service members and veterans based on exposure, deployment, and disease histories.[75]

The IOM committee felt strongly enough about the DOEHRS system implementation that it recommended "this Commission work though Congress to establish a specific DoD budget line for the DOEHRS implementation, including the appropriate training of personnel in exposure assessment and in use of the system, and that Congress receive annual reports from DoD on the status of DOEHRS development and implementation."[76]

This Commission notes the IOM committee's emphasis on DOEHRS development and also recognizes recent attempts by VA and DoD to improve communications and data sharing in other areas. The establishment of the Joint Executive Council (JEC) and its subordinate bodies, the Health Executive Council (HEC) and the Benefits Executive Council (BEC), are evidence of this renewed joint interest. Improvements must be made, though. The Commission supports all of the recommendations of the IOM committee on improved data collection, storage, and sharing (shown as Recommendations 9 through 19, in Chapter 13 of the IOM report). The large number of these data-related recommendations is a reflection of the complexity of the systems and related issues.

The Commission takes special note, though, of IOM Recommendation #15: Develop a plan for an overall integrated surveillance strategy for the health of service members and veterans. This step is critical to the entire process; without it, more and better data gathering probably will not have the anticipated results. As the IOM report states in Chapter 10, the

> activity must be jointly well managed by DoD and VA. A strong central organization, staffed jointly by DoD and VA with external expert advisors, should be given responsibility for the ongoing evaluation of health and exposure data quality, the regular review of registry and surveillance activities, the definition of surveillance and research strategies, and the coordination of surveillance and research projects. This joint DoD-VA soldier and veteran exposure and health surveillance organization would have broad responsibility for oversight of all DoD and VA surveillance and

[75] Ibid., 10-27–10-38.
[76] Ibid., 13-7.

> research activities whether they are conducted internally or externally by those organizations.[77]

Several key words and phrases jump out from this excerpt: "jointly well managed…strong central organization…broad responsibility for oversight of all DoD and VA surveillance." These concepts will be hard to establish and maintain; they run contrary to many of the current organizations' structures and culture. But it must be done. Fair, compassionate, timely service to our disabled veterans requires a holistic approach in this area.

II.7 Conclusion

The above narrative represents a very brief summary of the IOM committee report *Improving the Presumptive Disability Decision-Making Process for Veterans*, along with this Commission's reaction to their findings. The IOM committee clearly did an exhaustive review of the subject. As stated previously, this Commission generally endorses the IOM committee recommendations with two exceptions. The Commission is concerned that the recommended threshold of causation rather than association may be too stringent. In addition, the Commission suggests combining the Advisory Committee on presumptions with the Advisory Committee recommended by IOM on the Rating Schedule.

What needs to be done constitutes a major renovation of the presumptive decision-making process. The findings and recommendations of this IOM committee will save time and steps in the renovation process. They have already provided the outline:

1. Build a new framework for presumptions.
2. Recognize causation as the basis for presumptions.
3. Clarify the categorization of evidence.
4. Expand the scope of scientific reviews related to the presumptive decision-making process.
5. Expand and substantially improve coordination of the research related to the health of veterans.

[77] Ibid., 10-39.

II.8 Environmental and Occupational Hazards

II.8.A Agent Orange and Blue Water Veterans

II.8.A.a Issue

By statute (38 U.S.C. § 1116 [2006]), disabilities resulting from certain illnesses are service connected for Vietnam veterans due to presumed exposure to certain chemicals found in herbicides, such as Agent Orange. That is, veterans who served in Vietnam between January 9, 1962, and May 7, 1975, (the Vietnam Era) are "presumed to have been exposed during such service to an herbicide agent" (38 C.F.R. § 3.307[a][6][iii] [2006]) If such a veteran is subsequently disabled by an illness that VA recognizes is an effect of such exposure, the veteran may receive presumptive service connection for that disability. At issue is whether offshore ("blue water") Navy veterans of the Vietnam Era, who were never physically on Vietnamese soil, are entitled to presumptive herbicide exposure or presumptive service-connected status for certain illnesses connected to indirect herbicide exposure.

There are a number of federal statutes and regulations that apply to this issue. The first, 38 U.S.C. § 1116(f), states:

> For purposes of establishing service connection for a disability or death resulting from exposure to an herbicide agent, including a presumption of service connection under this section, a veteran who, during active military, naval, or air service, served in the Republic of Vietnam during the period beginning on January 9, 1962, and ending on May 7, 1975, shall be presumed to have been exposed during such service to an herbicide agent containing dioxin or 2,4-dichlorophenoxyacetic acid, and may be presumed to have been exposed during such service to any other chemical compound in an herbicide agent, unless there is affirmative evidence to establish that the veteran was not exposed to any such agent during that service.

That is, any veteran who "served in the Republic of Vietnam" during the Vietnam Era is presumed to have been exposed to herbicides during that service. As noted above, if such a veteran is diagnosed with certain illnesses, it is presumed that those illnesses were caused by herbicide exposure. The difficulty arises in defining the phrase, "served in the Republic of Vietnam." Prior to 1997, the VA M21-1 *Adjudication Procedure Manual* noted that receipt of the Vietnam Service Medal, which was awarded to all service members, including some blue water veterans, who served in or near Vietnam during the Vietnam Era, was adequate evidence of service in Vietnam. The Vietnam Service Medal was therefore used as an indication that the veteran had also been exposed to herbicides.

In 1997, VA General Counsel issued VAOPGCPREC 27-97 in an attempt to clarify the definition of "Vietnam Era," found in 38 U.S.C. § 101(29)(A). General Counsel held that blue water veterans who were never physically in Vietnam should not be included within the set of service members who "served in Vietnam during the Vietnam Era." As a result, blue water veterans were not eligible for presumptive herbicide exposure without first demonstrating that they set foot in Vietnam. The General Counsel first stated that the language of 38 U.S.C. § 101(29) is so vague that one must "look beyond the terms of the statute" for a definitive understanding of it.[78] The General Counsel went on to examine the report by the Senate Committee on Veteran's Affairs concerning 38 U.S.C. 101(29), which states that the code should apply "only with respect to those veterans who actually served *within the borders* of the Republic of Vietnam during that time frame."[79] Given this legislative history, the VA General Counsel determined that the wording of 38 U.S.C. § 101(29) must be interpreted to indicate that "service on a deep-water naval vessel in waters off the shore of the Republic of Vietnam does not constitute service in the Republic of Vietnam."[80]

In 2006, the United States Court of Appeals for Veterans Claims decided the case of *Haas v. Nicholson*, ruling that blue water veterans should, in fact, be granted presumptive herbicide exposure. The court ruled that it is unclear which definition Congress intended to use for "service in Vietnam," and that the legislative history of the relevant regulations is similarly ambiguous (*Haas v. Nicholson,* Vet. App. 04-0491, 10–11, 16 [U.S. Court of Appeals for Veterans Claims 2006]). In addition, the court found that VA has not been consistent in using a single definition for "service in Vietnam," and that it has misunderstood federal regulations (*Haas v. Nicholson,* p. 21). The court concluded that:

> VA's regulation defining "service in the Republic of Vietnam," 38 C.F.R. § 3.307(a)(6)(iii), is permissible…however, the regulation is ambiguous. VA's argued interpretation of the regulatory term "service in the Republic of Vietnam," affording the application of the presumption of exposure to herbicides only to Vietnam-era veterans who set foot on land and not to the appellant, is inconsistent with long-standing agency views, plainly erroneous in light of legislative and regulatory history, and unreasonable, and must be SET ASIDE. In this case, the M21-1 provision allowing for the application of the presumption of exposure to herbicides based on the receipt of the VSM controls (*Haas v. Nicholson,* p. 31).

Therefore, based on this most recent ruling, presumptive herbicide exposure is to be granted to any veteran who was awarded the Vietnam Service Medal, including blue water Navy veterans. On March 7, 2007, the Solicitor General

[78] VA General Council, *VAOPGCPREC 27-97*, 2.
[79] Ibid., 3.
[80] Ibid., 5.

approved the Secretary of VA's appeal of this decision to the Court of Appeals for the Federal Circuit, originally filed in October 2006. Therefore, all *Haas* cases will continue to be held under a stay in processing until the appeal is adjudicated.

II.8.A.b Findings

The guidelines governing presumptive herbicide exposure for Vietnam Era veterans are numerous and, in many ways, confusing. Due to this confusion, along with the ambiguous legislative history of the presumption, federal courts recently ruled that any veteran who received the Vietnam Service Medal should be presumed to have been exposed to herbicides during military service. Although this decision is currently under appeal, if it is upheld, blue water Navy veterans will be granted service connection for disabilities related to Agent Orange.

II.8.B Fort McClellan and PCB Exposure Risks

II.8.B.a Issue

At the May 19, 2006, meeting of the Veterans' Disability Benefits Commission, a veteran raised the issue of PCBs (polychlorinated biphenyls) and other chemical exposures at the U.S. Army installation at Fort McClellan, Alabama, between 1954 and 1978. Other veterans who have experienced ill health have provided comments at Commission meetings and site visits regarding the chemical exposure issue at Ft. McClellan. The Monsanto Chemical Plant in Anniston, Alabama, located a few miles from Fort McClellan, manufactured PCBs that polluted the water, soil, and air. By the time class action lawsuits were filed against the company, Fort McClellan veterans had separated from service and were unavailable or unaware of the Anniston health registry.

PCBs were used in a wide range of commercial and industrial applications, but production of PCBs declined in the late 1970s because of apparent health and environmental risks associated with the chemical compound. The health risks associated with PCBs differ depending on the chemical concentration strength. Skin conditions such as chloracne or other rashes are the most common health effect of PCB exposure. Tests on animals have revealed other health effects associated with PCBs. These include diseases of the liver, stomach, and thyroid gland; adverse effects on the immune system; behavioral alterations; and reproductive disorders. The Department of Health and Human Services (HHS), the Environmental Protection Agency (EPA) and the International Agency for Research on Cancer (IARC) agree that there is some correlation between exposure to PCBs and higher cancer rates.[81] Table 5.4 delineates the health risks of PCBs.

[81] EPA, "Health Effects of PCB."

Table 5.4 PCB Health Risks

Type of Risk	Condition	Study Organization
Known	Skin conditions: - Rashes - Chloracne	EPA
Associated	Injuries of the: - Liver - Stomach - Thyroid gland Changes to immune system Changes in behavior Impaired reproduction	EPA, HHS
Being studied	Cancer risk Neurological health impacts Diabetes	HHS, EPA, IARC CDC, ATSDR[a] CDC, ATSDR

[a] Agency for Toxic Substances and Disease Registry.

The Monsanto Company (Monsanto-Solutia and now Solutia Inc.) bought Swann's Anniston facility in 1935. The factory became a major producer of PCBs from 1935 to 1971. Residents of Anniston claim that the company knowingly dumped PCBs into a nearby river as well as buried chemicals in the landfill. In 1996 the PCB levels in the community exceeded the limits established by the Federal Government. In certain areas, levels were as high as "940 times the federal level of concern in yard soils, 200 times that level in dust inside residential homes, 2,000 times that level in Monsanto's drainage ditches."[82] Numerous lawsuits were filed against the company in the 1990s accusing it of knowingly polluting the Anniston community during the production of PCBs and related chemical compounds.

Bowie v. Monsanto (CV-2001-832 [Etowah County Cir. 1996]), which began in 1996, led to a class action lawsuit and settlement by Solutia Inc. Facing as much as $3 billion in legal and compensatory damages, the company "reached a $700 million settlement with citizens of Anniston, Alabama, who claimed PCB releases caused an assortment of health problems."[83] According to company documents that were produced at the trial, the company "flushed tens of thousands of pounds of PCBs into nearby creeks…and buried millions of pounds in a hillside

[82] Grunwald, "Monsanto Hid Decades of PCB Pollution."
[83] Taylor, "Solutia Settles Alabama PCB Case."

landfill."[84] Realizing that environmental damage had been done, Monsanto spent approximately $40 million on cleanup before the trial and plans to continue that work. During the trial, one member of Monsanto said: "Regardless of the result in this case, we're committed to doing what's fair to deal properly with the impacts of previous PCB production at our plant."[85]

Fort McClellan was an expansive base that became a center for training service members beginning in World War II and continuing through Vietnam. The Women's Army Corps (WAC) School was founded at Fort McClellan on September 25, 1952, and remained the leading training program for women until the school and center closed on May 13, 1977. Fort McClellan was also home to the U.S. Army Chemical Center and School, the U.S. Army Combat Developments Command Chemical Biological-Radiological Agency, and an advanced individual training infantry brigade. The Base Realignment and Closure process closed Fort McClellan on May 20, 1999. The Army must conduct extensive cleanup at Fort McClellan because it is a Superfund site under the Comprehensive Environmental Response, Compensation, and Liability Act due to the chemicals used on the post.

There are numerous cleanup activities taking place in Anniston, Alabama, due to the pollution caused by the Monsanto Company. According to the EPA, Solutia entered into an administrative order on consent (AOC) with the EPA to test properties for possible PCB contamination. Additionally, on March 25, 2002, the EPA and Solutia completed negotiations for a "remedial investigation/feasibility study." The consent decree "requires Solutia to perform a comprehensive study and evaluation of risks to human health and the environment caused by PCBs"[86] and calls for the establishment of a $3.2 million foundation to support special education needs for the area's children. Military children may be included in this study if they still live in the Anniston area. However, if they have relocated with their families to other states, they will not be included.

The Agency for Toxic Substance and Disease Registry (ATSDR) at the Center for Disease Control and Prevention (CDC) completed a study of the Anniston area in 2000. The study found that "exposures to PCBs in soil in parts of Anniston present a public health hazard" and lead to both cancerous and noncancerous results in people with a "prolonged exposure" to PCBs.[87] Furthermore, "PCBs in residential soils in some areas may present a public health hazard for thyroid and neurodevelopmental effects after exposure durations of less than 1 year."[88] ATSDR recommended further studies to

[84] Firestone, "Alabama Jury Says Monsanto Polluted Town."
[85] Ibid.
[86] Gaillard, "Alabama NPL/NPL Caliber Cleanup Site Summaries."
[87] Agency for Toxic Substance and Disease Registry, "Health Consultation Evaluation."
[88] Ibid.

elucidate the amount of PCBs still present in the community and the health effects associated with it.

Recently, ATSDR awarded Jacksonville State University funding for a number of studies that are being performed by the Anniston/Calhoun Research Consortium. The consortium consists of a dozen universities and includes residents of Anniston, but not military personnel, unless they were still living in the area at the time the study began. The group is performing four studies:

- Community Health Survey—This survey will randomly select 1,250 individuals from the affected and surrounding area. There will be a field visit as well as an office visit in which each individual will undergo an interview and a medical evaluation. Within this survey is a study for diabetes in which 400 individuals (200 studied and 200 used as a control) will undergo further blood testing.
- Neurocognitive Study—Three hundred children (approximately 270 have been studied thus far) between the ages of 11 and 15 are being investigated for PCB exposure and learning effects. The group is performing a 3-hour test and blood will be drawn. Parents (the mother ideally) will also undergo blood testing.
- Focus Group Study—This effort will study the attitudes in the community.
- Geospatial Modeling—This study will acquire and study geospatial modeling and PCB data from the EPA. Geospatial modeling involves researchers partitioning the ground into nearly equal sized blocks of land, taking samples, and assessing the extent to which the ground is polluted.

The studies are currently budgeted at approximately $3.2 million. The consortium is in the final phase of data collection and analysis, but it does not have an estimated time of publication at this point.[89]

On July 13, 2006, the DoD completed an information paper regarding PCB contamination at Fort McClellan. DoD concluded that "there is little or no environmental contamination at Ft. McClellan that may have exposed Army personnel at Ft. McClellan to PCBs."[90] Instead, the paper argues that contamination from the Solutia plant is located in Anniston, which is "on the other side of Anniston from the Anniston Army Depot and Ft. McClellan. There is no direct pathway from the contaminated sites to either installation."[91] The only group of military personnel that DoD cited as possibly exposed to PCBs are those "who have previously resided or currently reside within the identified

[89] Shelton, Christie, phone conversation June 29, 2006.
[90] DoD, "PCB Contamination Sources at Ft. McClellan," 2.
[91] Ibid.

contaminated areas in Anniston."[92] DoD recognizes that the town of Anniston has been polluted and that further study is needed.

DoD identifies the Solutia Inc. plant as the major polluter of PCBs in the Anniston area. Citing an ATSDR study, DoD concluded that "exposures to PCBs in the soil in parts of Anniston present a public health hazard" especially for "thyroid and neurodevelopment effects after exposure durations of less than 1 year."[93] ATSDR stated that it was limited by data gaps and needed to study the area further, but DoD maintains that Army personnel on the base were not affected. In 2002, ATSDR, the state of Alabama, and "local health departments informed residents of the contamination by one of several means" including direct communication, "public availability sessions," and a public information campaign in the local news media.[94] DoD did not state whether it contacted service members who had been stationed at Ft. McClellan.

II.8.B.b Findings

There is a possibility that service members who trained at Fort McClellan from 1935 until 1971 (and later depending on environmental contamination) came into contact with PCBs from the Monsanto Chemical Plant because of the base's proximity to Anniston and service members' participation in social and recreational activities in the town. The production of PCBs and the subsequent dumping performed by the company led to environmental and health damages in the area. Solutia settled class action lawsuits brought against it by civilians and faces tremendous cleanup costs as a result of PCB pollution in the Anniston area.

It is difficult to estimate the amount of PCBs or other chemicals to which service members might have been exposed during their time at Fort McClellan. VA service-connected disability is possible for service members that might have been exposed to PCBs while serving at Fort McClellan. There might be veterans who served at Fort McClellan who are service connected for medical conditions that might or might not be related to PCB exposure. However, since there is no VA registry of this information, a correlation cannot be determined. VA would need to create a registry to track health trends in these veterans to help determine whether a correlation exists between specific medical conditions and exposure to chemicals at the base.

The Commission contracted with the Institute of Medicine to assess the past process for establishing presumptions and to recommend improvements. The

[92] Ibid.
[93] Ibid., 1–2.
[94] Ibid., 2.

Commission's contract with IOM did not include assessments of any diseases such as those that might be the result of exposure to PCBs.

Although there are known health consequences in the Anniston area, these risks have not been directly linked to PCB exposure during service at the post. Veterans who served from 1935 to 1971 (and beyond) may be suffering from disabilities relating to PCBs without knowing that their illnesses may be related to this exposure. However, further testing for the presence of PCBs in the Anniston area and on the post and an epidemiological analysis would be needed to determine if there is sufficient justification for a presumption.

The full extent of PCB contamination in Anniston is not yet fully known. The cleanup and investigations being undertaken by EPA, CDC, ATSDR, and the Anniston/Calhoun Research Consortium are only beginning to elucidate the amount and effects of PCB pollution on the local community and on military personnel who might have been exposed while serving at Fort McClellan.

The Commission believes it is the responsibility of VA to initiate appropriate actions to create registries, monitor ongoing studies, and contract with an organization such as IOM, as needed, for further analysis and recommendations. The Ft. McClellan situation illustrates the critical need for the improved process for presumptions recommended by the IOM's PDDM committee.

II.8.C Chemical Exposure at Camp Lejeune

II.8.C.a Issue

In 1980, water tests at Camp Lejeune, North Carolina, revealed elevated levels of trichloroethylene (TCE) and tetrachloroethylene (PCE), two common industrial contaminants used as degreasers and dry-cleaning agents, in one of the base's water-treatment plants. Further testing in 1981 and 1982 revealed similarly elevated levels of those contaminants in two treatment plants, and a systematic sampling of the base's entire water supply revealed widespread contamination. As a result, during 1984 and 1985, the base closed 10 of its ground wells.[95] It is unclear to what extent, if any, exposure to these chemicals affected the health of the service members and their families who were stationed at Camp Lejeune while the contaminated wells were in service.

The Agency for Toxic Substances and Disease Registry (ATSDR) has initiated a number of scientific studies into the possible health effects of volatile organic

[95] U.S. Marine Corps, *Report to the Commandant*, 1.

compound (VOC) exposure on Camp Lejeune residents. A 1997 ATSDR scientific survey concluded that there is no scientific evidence to support the claim that VOC exposure at the levels present at Camp Lejeune would cause adverse health reactions in adults. However, that report also noted that, while there is not enough scientific evidence to be conclusive, VOC exposure may have adversely affected fetuses, since they are especially susceptible to the adverse effects of contamination and may be affected by lower doses of a contaminant than adults.[96] This prompted another ATSDR study, released in 1998, which concluded that, in certain circumstances, exposure to VOCs at Camp Lejeune made certain women more likely to give birth to underweight infants than unexposed women in similar circumstances.[97] Another preliminary study surveyed the parents of 12,598 children who may have been exposed to VOCs at Camp Lejeune and found that 103 of them suffered from birth defects or childhood cancers, which are the most likely results of VOC exposure in children.[98]

Based on these previous studies, ATSDR is currently engaged in a more comprehensive examination of the effects of VOC exposure at Camp Lejeune on fetuses. To date there have been no completed scientific studies into the health effects of VOC exposure at Camp Lejeune on adults or children, primarily because existing scientific evidence indicates that the level of contaminant and length of exposure that existed at the base were not sufficient enough to have an impact on the health of adults. The current study is looking into the 103 reported cases of birth defects and cancers, and once this initial study is finished, a comprehensive study will be initiated to establish whether a link exists between the drinking water at Camp Lejeune and birth defects or childhood cancers.[99] If this report reveals a link between the contaminated water at Camp Lejeune and adverse health effects among fetuses, then it may be necessary to initiate a scientific survey to firmly establish whether or not a similar link can be made for adults.

In addition, the Senate recently passed the 2007 Defense Appropriations Bill, which contains an amendment calling for an immediate study of the Camp Lejeune contamination by the National Academy of Sciences. The study team will perform a meta-review of all available "scientific and medical evidence [to] assess the strength of that evidence in establishing a link or association between exposure to [TCE] and [PCE] and each birth defect or disease suspected to be associated with such exposure." The study must be initiated within 60 days of the bill's passing, then completed and submitted to Congress and the Navy within

[96] Agency for Toxic Substance and Disease Registry, *Public Health Assessment*.
[97] Agency for Toxic Substance and Disease Registry, *Volatile Organic Compounds*.
[98] Agency for Toxic Substance and Disease Registry, *Survey of Specific Childhood Cancers*.
[99] Ibid.

18 months of initiation (*National Defense Authorization Act for Fiscal Year 2007,* S. 2766, Amend. 4349, 109th Cong.).

II.8.C.b Findings

As of this writing, all medical studies of the Camp Lejeune TCE VOC issue remain ongoing. There have been preliminary reports on the water-modeling issue, which aims to produce a working model of the contamination pattern in the base's water system. The first results from this study were expected to be released in June 2007, to include an interactive Web site where veterans stationed at Camp Lejeune during the period of contamination may input where and when they lived on base, and receive the water model's estimate of their contamination. In June 2007, ATSDR released the Executive Summary of this report, which provides an overview of the contamination pattern, along with information to allow former Camp Lejeune residents to determine if they were exposed to the contaminants. This report will be used by ATSDR in its study of the contamination's effect on fetal and infant development.[100] In May 2007, GAO also released a report on this issue. This report provides a thorough overview of the issue and its history, and examines the ongoing ATSDR study. The experts interviewed by GAO largely approve of the structure of the study, but point out several adjustments that could make the study more effective and efficient. [101] Since the ongoing health studies have not been completed, GAO's report is confined to an overview of existing information.

The Commission is satisfied that the Marine Corps seems to be responsive to the contamination issue at Camp Lejeune and that the current studies should be able to shed light onto this issue once they are completed.

Recommendation 5.27

VA should consider environmental issues such as blue water Navy and Agent Orange, Ft. McClellan and polychlorinated biphenyls, and Camp Lejeune and trichloroethylene/ tetrachloroethylene in the new presumptions framework.

III PTSD and Other Mental Health Disorders

This section discusses VA claims issues related to PTSD and, to a lesser extent, other mental disorders. Because the number of cases of PTSD is increasing faster than any other disabilities encountered by VA in both the number of veterans and the monetary value of benefits paid, the Commission wants to

[100] Agency for Toxic Substance and Disease Registry, *Analyses of Groundwater Flow.*
[101] GAO, *Defense Health Care,* 8–9.

ensure that PTSD claimants are evaluated fairly and consistently, in accordance with modern medical diagnostic techniques.

A 2005 report by the VA Office of the Inspector General summarized the trends in PTSD claims and compensation from FY 1999–2004.[102] The report identified the following trends:

> During FYs 1999–2004, the number and percentage of PTSD cases grew significantly. While the total number of all veterans receiving disability compensation grew by only 12.3 percent, the number of PTSD cases grew by 79.5 percent, increasing from 120,265 cases in FY 1999 to 215,871 cases in FY 2004. During the same period, PTSD benefits payments increased 148.8 percent from $1.72 billion to $4.28 billion. Compensation for all other disability categories only increased by 41.7 percent. While veterans being compensated for PTSD represented only 8.7 percent of all claims, they received 20.5 percent of all compensation benefits.[103]

Data tables provided to IOM from VA confirm these trends. Specifically, these tables show that as of September 30, 2005, the number of veterans with PTSD on VA disability rolls had risen to 244,846; and the monthly value of those payments was $347,867,708. VA treatment for PTSD has been provided to over 345,000 veterans. This means PTSD is by far the costliest disability for the VA Disability Compensation Program. The next costliest disability (as shown by the VA tables) is intervertebral disc syndrome, which carried a monthly value of $87,027,144.

The cost of disability payments alone for PTSD would warrant serious study of the processes associated with PTSD. But there are other issues as well. The Inspector General study cited above also showed significant variability in payments for PTSD (and other disabilities) among states, and there have been ongoing concerns about the methods used to diagnose PTSD, and the consistency of implementing those methods. A primary methodological issue has been the type and thoroughness of the medical examinations done in connection with PTSD disability claims. Finally, the appropriateness and viability of the VA Schedule for Rating Disabilities (Rating Schedule) has been questioned. This area was studied in depth by the IOM Committee on PTSD Compensation and Military Service.

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[102] VA Office of the Inspector General, *Review of State Variances*.
[103] Ibid.

III.1 Diagnosis and Assessment of PTSD

VA asked IOM to conduct a study on the diagnosis and assessment of, and treatment and compensation for, PTSD.

The IOM committee that undertook the study of diagnosis, assessment, and treatments for PTSD decided to separate its work into two parts. The first part, on diagnosis and assessment, was completed in 2006 and published as *Posttraumatic Stress Disorder: Diagnosis and Assessment*. A second study, on treatment, is in progress and will be published at a later date.

The IOM report on PTSD diagnosis and assessment contains several significant findings. These include:

- Confirmation of the description and current diagnostic criteria for PTSD. The current diagnostic criteria for PTSD are provided in DSM-IV; it includes several components. Those components are exposure to a traumatic event, intrusive reexperiencing of the event, avoidance and numbing, hyperarousal, at least a month of symptoms, and clinically significant distress or impairment that was not present before the trauma.
- The optimum approach to PTSD diagnosis is a face-to-face interview in a confidential setting, done by a health professional experienced in the diagnosis of psychiatric disorders, such as a psychiatrist, psychologist, clinical social worker, or psychiatric nurse.[104]
- The PTSD diagnostic interview should elicit the patient's symptoms, assess the history of potentially traumatic events, and determine whether the patient meets the DSM-IV criteria for PTSD and the frequency and severity of symptoms. It should also determine whether there are comorbid psychiatric and medical conditions.[105]
- Adequate time must be allocated for the PTSD assessment. "Depending on the mental and physical health of the veteran, the veteran's willingness and capacity to work with the health professional, and the presence of comorbid disorders, the process of diagnosis and assessment will likely take at least and hour or could take many hours to complete."[106]
- The instruments for assessing symptom severity do not provide diagnostic criteria for PTSD and should not be used in lieu of a comprehensive clinical interview. The report also stated that screening instruments are helpful for identifying people who might have a disease but are not very

[104] IOM, *Posttraumatic Stress Disorder*, 16–17.
[105] Ibid., 17.
[106] Ibid., 17.

> useful for assessing disorder progression, prognosis, or treatment efficacy.[107]

There are several significant items from the IOM *Posttraumatic Stress Disorder: Diagnosis and Assessment* report that the Commission endorses.

The diagnostic criteria for PTSD published in DSM-IV are sufficient for use by the VA Disability Compensation Program. Those criteria are clear, comprehensive, and generally accepted by the medical community. VA must adhere to these diagnostic criteria in conducting its medical evaluations and in assigning disability evaluations. When VA revises its disability rating criteria for PTSD, it must closely follow the diagnostic criteria in DSM-IV and its revisions by its publisher, the American Psychiatric Association.

In compensation examinations for PTSD, VA already conducts face-to-face interviews, with experienced health professionals. Generally, for mental health exams, the professional who conducts a compensation and pension (C&P) exam must be clinically privileged. Mental health examiner qualifications include:

- Board-certified psychiatrists
- Licensed doctorate-level psychologists
- Doctorate-level mental health providers under close supervision by a board-certified psychiatrist or a licensed doctorate-level psychologist
- Psychiatry residents under close supervision by a board-certified, or board-eligible, psychiatrist or a licensed doctorate-level psychologist

In addition, other mental health professionals with appropriate clinical credentials may perform review exams or exams related to claims for increased benefits. Specifically, licensed clinical social workers, nurse practitioners, clinical nurse specialists, and physician assistants under the close supervision of a board-certified or board-eligible psychiatrist or licensed doctorate-level psychologist may perform, review, or increase C&P mental disorder exams.[108] The Commission believes that this requirement should be continued.

The Commission is not persuaded that current VA exams are as uniformly thorough as recommended by IOM. VA should review its protocols for PTSD exams and mandate the kind of comprehensive exam described in the IOM report. This would include elicitation of the patient's symptoms, assessment of

[107] Ibid., 34.
[108] VBA Fast Letter 06-03.

the history of potentially traumatic events, and determination as to whether the patient meets the DSM-IV criteria for PTSD. The interview should also determine the frequency and severity of symptoms and the associated disability. It should also determine whether there are comorbid psychiatric and medical conditions. This will require allocation of sufficient time for each exam and interview. Strict quality control methods should be mandated to assure appropriate exam completion.

VA should mandate the use of assessment tools, such as the *Best Practice Manual for Posttruamatic Stress Disorder Compensation and Pension Examinations*. There are several instruments that include screening tools, diagnostic instruments, and trauma and symptom severity scales. Clinicians can choose to administer structured or semistructured interviews or self-report instruments. The Commission urges VA to standardize and mandate the use of appropriate tools in conjunction with the clinical interview, and describe the circumstances under which they are to be used. Guidance should be published emphasizing that use of assessment tools does not eliminate the need for a face-to-face interview with the veteran or claimant.

III.2 Compensation for PTSD

On behalf of the Commission, VA's Veterans Benefits Administration (VBA) asked the National Academies to convene a committee of experts to address the following issues:

- VA's compensation practices for PTSD, including examining the criteria for establishing severity of PTSD as published in the *Schedule for Rating Disabilities*;
- the basis for assigning a specific level of compensation to specific severity levels and how changes in the frequency and intensity of symptoms affect compensation practices for PTSD;
- how VA's compensation practices and reevaluation requirements for PTSD compare with those of other chronic conditions that have periods of remission and return of symptoms; and
- strategies used to support recovery and return to function in patients with PTSD.[109]

The IOM study *PTSD: Compensation and Military Service* was published in May 2007. It was broader in scope than the study on diagnosis and assessment. The PTSD compensation study reviewed the medical examination process, the Rating Schedule criteria used to assign disability ratings, the status of training for

[109] IOM, *PTSD Compensation*, S-2.

medical professionals and claims examiners, incentives and disincentives to recovery (including consideration of regular reexaminations and protection of some payment level), and data management. The IOM committee findings and recommendations are listed below, followed by associated justification and discussion:[110]

1. The Global Assessment of Functioning (GAF) score has limited usefulness in assessing PTSD as a disability for compensation. Therefore, VA should first ensure that its mental health professionals are well informed about the uses and limitations of the GAF and trained to implement it in a consistent and uniform manner. Secondly, VA should identify and implement an appropriate replacement for the GAF.
2. A standardized training program should be developed for clinicians conducting C&P evaluations for PTSD. Training should emphasize diagnostic criteria and comorbid conditions with overlapping symptoms, and it should include example cases that illustrate appropriate documentation of exam results for C&P purposes.
3. The choice to conduct psychological testing and which tests are appropriate should be left at the discretion of the examining clinician.
4. The Rating Schedule criteria for rating mental disorders are at best crude and overly general for the assessment of PTSD disability and do not use consistent criteria for rating remitting or relapsing conditions. New Rating Schedule criteria specific to rating PTSD based on the DSM-IV should be developed and implemented. A multidimensional framework for characterizing PTSD disability should be considered when formulating these criteria.
5. VA should establish a specific certification program for raters who deal with PTSD claims; VA should also provide the training to support the certification program and periodic recertification.
6. Data fields recording the application and reevaluation of benefits should be preserved over time rather than being overwritten when final determinations are made. Data should also be gathered at two points in the process where there is currently little information available: when claims are made and after compensation decisions are rendered.
7. VA should consider instituting a fixed long-term minimum level of benefits that would be available to any veteran with service-connected PTSD at or above some specified rating level without regard to that person's state of health at a particular point in time after the C&P examination. (In this context, IOM meant benefits in a broad context, not only compensation.)

[110] Ibid., S-4–S-9.

8. The determination of whether and when reevaluations of PTSD beneficiaries are carried out should be made on a case-by-case basis using information developed in a clinical setting. Specific guidance on the criteria for such decisions should be established so that these can be administered in a fair and consistent manner.
9. VBA should collect and analyze data on reevaluations so that the system can be improved in the future.
10. VA should conduct more detailed data gathering on determinants of service connection and rating levels for military sexual assault-related PTSD claims and develop and disseminate reference materials for raters that more thoroughly address the management of such claims.
11. More research is also needed on gender differences regarding vulnerability to PTSD.

The following discussion is based on the recommendations of the report of the IOM Committee on PTSD Compensation and Military Service.

The IOM report on PTSD compensation discussed various problems with the GAF score. The report states, "One of the many problems with the GAF is that it was derived from a scale used for the study of affective disorders and psychosocial function across a broad range of psychiatric conditions." The report further states that "the GAF anchors are conceptually relatively weak," that "reliability is a major concern for the GAF," and that "another weakness of the GAF is that it combines symptom levels with assessment of function and does not allow for a separation of these two areas."[111] Ultimately, this second IOM committee concluded that the GAF score has limited usefulness in the assessment of the level of disability for PTSD compensation, and that its emphasis on the symptoms of mood disorder and schizophrenia and its limited range of symptom content diminish its applicability to PTSD. However, they acknowledged that eliminating the GAF could be disruptive because it is widely used. This conclusion led to their recommendation that training be provided to mental health professionals about the limitations of GAF, until such time that VA can identify and implement use of a substitute tool.

As a general observation, the IOM report stated, "The key to proper administration of VA's PTSD compensation program is a thorough C&P clinical examination conducted by an experienced professional."[112] The report goes on to cite the recommendation from the IOM report on diagnosis and assessment and endorse it by inclusion. The report emphasizes this need while

[111] Ibid., 4-6, 4-7.
[112] Ibid., S-9.

acknowledging that doing more consistently detailed exams may result in increased up-front costs.

"PTSD is marked by high rates of comorbidity," which complicates the evaluation process.[113] As a result of this finding, the IOM committee recommended a standardized training program for clinicians who conduct C&P psychiatric evaluations. Their recommended training program would emphasize diagnostic criteria for PTSD and comorbid conditions with overlapping symptoms.[114]

The Rating Schedule requires separate evaluation, and therefore separating symptoms and effects, of comorbid disorders.[115] The IOM report on PTSD Compensation states that there is a scientific basis for defining PTSD and other conditions (e.g., depression) as discrete disorders. Further, the report states that clinicians doing C&P exams have described having difficulty in dealing with comorbid mental disorders. This is largely because the rating specialists who interpret the C&P exams need to attribute portions of the common symptoms to each rated disorder. This led to the recommendation that a national standardized training program be developed for clinicians.

The IOM committee criticized the Rating Schedule in several aspects:

> the committee did not identify a strong evidence basis for assigning any percentages to any particular disorder. Second, because each disorder has a unique set of symptoms, complications, objective findings, prognostic features, and treatment options and efficacy, there may be little or no common basis on which to make a comparison among disorders. Third, it is apparent that the ratings for each disease category were derived by the specialists responsible for documenting and describing the disease…Not only may different specialists view their particular sets of diseases differently, it is not clear that any cross-communication took place among different specialists in an effort to calibrate percentage ratings across diseases.

The IOM report goes on to conclude that seemingly similar conditions, such as chronic fatigue syndrome and fibromyalgia, can have widely disparate ratings.[116]

The report also compares the Rating Schedule criteria for rating mental disorders with those for rating physical disorders and makes several criticisms, namely:

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[113] Ibid., 4.
[114] Ibid., S-3.
[115] Ibid., 4-8.
[116] Ibid., 5-11.

1. There is one general rating scheme that is applied to all type of mental disorders (schizophrenia, mood, and anxiety disorders), which makes it necessary to lump together heterogeneous symptoms from multiple conditions into a single spectrum. Although other groups of disorders are handled with one general rating scheme, such as disorders of the spine, female reproductive system, and renal disease, this "lumping" is carried to an extreme in the case of mental disorders.
2. Some of the secondary factors shown in Table 5.6 of that report (objective findings; deformity; physical complications) that may influence percentage ratings cannot be met for mental disorders. This could theoretically put mental disorders at a relative disadvantage compared to physical disorders in terms of achieving higher percentage ratings.
3. Two important threshold levels for increases in disability benefits—40 percent and 60 percent—cannot be assigned to mental disorders.
4. Occupational and social impairment (OSI) is the central factor used in determining each level of disability for mental disorders. However, little guidance is given about how to measure either OSI or its differential impairment across different percentage ratings. Furthermore, the various secondary factors that are used in rating physical disorders (Table 5.6) are not applied to mental disorder ratings, which give OSI a disproportionately high value in determining the ratings."[117]

The IOM committee offered an alternative rating scheme for PTSD.[118] The committee's framework is distinguished from the current rating criteria in that five dimensions are assessed in rating disability: symptoms, psychosocial functional impairment, occupational functional impairment, treatment factors, and health-related quality of life. The framework's approach to occupational functional impairment illustrates an approach that should reduce or avoid disincentives to return to work. Also, "it specifies that the psychosocial and occupational aspects of functional impairment be separately evaluated and that a claimant be rated on the dimension on which he or she is more affected."[119]

The recommendation regarding a certification program for raters flows from discussion on the subjectivity, variability of results, and deficiencies associated with the current Rating Schedule criteria for rating mental disorders. Their specific conclusion is that

> Determining ratings for mental disabilities in general and for PTSD specifically is more difficult than for many other disorders because

[117] Ibid., 5-13, 5-14.
[118] Ibid., Table 5-11.
[119] Ibid., 5-21.

> of the inherently subjective nature of symptom reporting. To promote more accurate, consistent, and uniform PTSD disability ratings, the committee recommends that VA establish a specific certification program for raters who deal with PTSD claims, with the training to support it, as well as periodic recertification.[120]

Furthermore, the IOM committee suggests that this training and certification requirement lends itself to consideration of specialization—that "some ratings be done at a facility other than the one closest to the veteran in order to ensure that a qualified rater performs the evaluation."[121] The committee did not elevate this concept to a recommendation.

The recommendation about improved data collection resulted from the committee's conclusion that there are gaps in VA's current data collection process. The committee received substantial data about the characteristics of PTSD beneficiaries, but found that additional information that could have been helpful in their deliberations was not available. The committee felt that additional information about veterans' medical and physical status prior to their claim for benefits, and similar information tracked after claim decisions would be useful in future analyses of PTSD disability compensation issues.

The recommendation about a fixed long-term minimum level of benefits developed from the discussion about barriers or disincentives to recovery, and the effect of compensation on recovery.[122]

The IOM report cited lack of a veteran's postsecondary education and training as a major barrier to recovery. It also acknowledged that use of the GI Bill has shown positive effects in earning power for eligible veterans.[123]

The IOM report also discussed the issue of unintended consequences in disability income support policies; that they often contribute to underemployment and unemployment. It elaborates the problem that both private and public disability compensation systems often have regulations that mandate an administrative review of the individual's disability status upon return to work. The report adds that "research has indicated that people with psychiatric disabilities are aware of these disincentives and report that they plan their labor force participation accordingly." The IOM report further discusses changes to the Medicaid program as well as the SSI/SSDI programs to alleviate this problem.

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[120] Ibid., 5-24.
[121] Ibid.
[122] Ibid., 6-2–6-16.
[123] Ibid., 6-2.

IOM concluded that there are many barriers to recovery for veterans diagnosed with PTSD and "there are no easy solutions: experience with civilian benefits systems has shown that the problems will be difficult to remedy."[124]

The IOM report also mitigates these concerns by noting "there is also some evidence that receiving service-connected disability for PTSD actually encourages individuals to seek mental health treatment. Unpublished research by Sayer and colleagues indicates that the claim process may make it easier to gain access to medical services and that being awarded disability status for PTSD may facilitate access to mental health services.[125]

The IOM report goes on to state the following:

> Although it may seem logical that secondary-gain considerations would create obstacles and disincentives for therapy or treatment among combat veterans, and although there is a body of indirect evidence consistent with this logic, there is little direct evidence that either compensation seeking or receipt of compensation has secondary gain effects on PTSD treatment outcomes. Most empirical studies or trials conducted to date show no relationship between compensation seeking, PTSD disability status, and treatment outcomes."[126]

The authors of the one study that does show significant differences conclude that

> Seeking to obtain or maintain compensation status does not have an inhibiting effect on improvement in treatment among outpatients or among most inpatients. Among inpatients in programs that are designed to provide an extremely long length of stay (100 days on average), however, the motivation to apply for and maintain compensation does appear to inhibit improvement.

The IOM report concludes, "Thus, in spite of concerns that disability compensation for PTSD may create a context in which veterans are reluctant to acknowledge or otherwise manifest therapeutic gains because they have a financial incentive to stay sick, the preponderance of evidence does not support this possibility."[127] While some beneficiaries will undoubtedly understate their improvement in the course of pursuing compensation, the scientific literature suggests that such patients are in the minority, and there is some evidence that disability payments may actually contribute to better treatment outcomes in some programs.

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[124] Ibid., 6-3, 6-5.
[125] Sayer, unpublished manuscript.
[126] IOM, *PTSD Compensation*, 6-15.
[127] Ibid.

The IOM committee found that the scheduling of future exams diminished over the period from 1999 to 2006. Scheduling of future exams was found to be "most frequent for those veterans with depression and other mood disorders, PTSD, and fibromyalgia. Veterans with mental disorders as their primary diagnoses accounted for 37 percent of all future exams scheduled in 1999, and those with mental disorders as a primary or secondary diagnosis accounted for 48 percent of all future exams. By 2006, while the future exams continued to be concentrated among beneficiaries with primary or secondary mental disorders, the number of exams dropped sharply. For PTSD primary beneficiaries, the decline was from 14.2 percent to 5.6 percent."[128]

The reduction in scheduling reexaminations coincided with a period when the VBA claims workload had grown significantly (see Table 5.5). This increasing workload stress must be considered, along with the considerable latitude given to claims examiners in scheduling future exams, when assessing whether VA is appropriately using reexaminations. Regulations indicate that reexaminations should be scheduled "whenever VA determines there is a need to verify either the continued existence or the current severity of a disability. Generally, reexaminations are required if a disability has improved, if evidence indicates that there has been a material change in a disability, or if the current rating may be incorrect" (38 C.F.R. 3.327[a] [2006]). However, the same regulation goes on to list several factors (when the condition has been established as static, when the condition has persisted without material improvement for 5 years, etc.) that place limitations on the need for reexaminations. So, the reduction in future exams could be nothing more than a reaction to workload stress.

Table 5.5 VBA Workload Reports

Fiscal Year	Future Exam Reviews
1999	27,300
2000	25,158
2001	22,252
2002	15,867
2003	9,595
2004	13,533
2005	17,682
2006	51,832

SOURCE: COIN DOOR REPORT 1003, Veterans Service Center, Trend of Completed Compensation and Pension and End Products. 2006.

[128] Ibid., 5-16.

During that same period, the annual number of rating-related cases performed ranged from 481,000 (in FY 2001) to 839,000 (in FY 2006). These statistics clearly show that scheduling and conducting "future" exams is a very small portion of overall VBA workload.

The IOM committee reached its conclusion that across-the-board periodic reexaminations for veterans with PTSD are not appropriate based on two considerations:

- VA has finite resources to devote to exams and should focus on performance of high-quality initial C&P exams.
- There was no significant misreporting or exaggeration of PTSD symptoms by veterans, and the committee did not wish to single out PTSD claimants for unique and harsher requirements.[129]

The IOM committee acknowledged that disability symptomatology can improve, and that "it is reasonable to consider reexamination after such situations." The committee concluded, however, that "It would be important to structure reexamination policy in a way that limits disincentives for receiving treatment or rehabilitation services."[130]

The IOM report discusses the available literature on gender differences in PTSD frequency and the prevalence of sexual assault in the military. It states: "The prevalence of sexual assault in the military is alarming and has been the object of several recent congressional hearings and military reports. A narrative synthesis of 21 studies found that 4.2 percent to 7.3 percent of active-duty military females had experienced a military sexual assault, while 11 percent to 48 percent of female veterans reported having experienced a sexual assault during their time in the military."[131]

The IOM report also states: "In the only study found to address the issue, Murdoch and associates (2003) found that a significantly smaller percentage of females (52 percent) as compared to males (71 percent) had their PTSD deemed to be service connected. This was primarily related to the lower rates of combat exposure among females, with their increased rates of sexual trauma apparently not being taken into account. When military sexual assault was substantiated in

[129] Ibid., 6-17.
[130] Ibid., 6-18.
[131] Ibid., 6-19.

the claims file, service-connected PTSD determinations increased substantially."[132]

The IOM report also acknowledges that there are huge barriers to women being able to independently substantiate military sexual assault, especially in a combat arena. The report states further that very little research exists on the subject of PTSD compensation and female veterans.[133]

This Commission generally endorses most of the recommendations of the IOM study *Posttraumatic Stress Disorder: Compensation and Military Service*. Collectively, the recommendations offer opportunity for substantial improvement to the VA Disability Compensation Program. The Commission's endorsements and differences are detailed below.

The Commission agrees with the IOM findings about the GAF score. A short-term correction of this issue can and should be made quickly. VA needs to publish internal administrative guidance immediately. This should inform VBA claims examiners and medical professionals involved in C&P examinations about the limitations of GAF and how it can be used until a better instrument is implemented.

Training for clinicians and raters is imperative, as is the need for thorough C&P exams grounded in face-to-face interviews. Some training is already done; this should be reviewed and expanded, as appropriate. The National Center for PTSD should be included in this process. The recommendations on training and conducting C&P exams carry substantial cost, but their importance is high. As VBA and VHA analyze their training and exam needs, they should develop budget requests for ongoing training costs, including dedicated staffing. These budget requests should not wait for the next budgetary request (formulation) cycle; rather they should be submitted immediately as special requests. The need for these measures is critical to the success of the VA Disability Compensation Program. The costs associated with these activities should be considered infrastructure, not new developments.

It is clear that the Rating Schedule criteria for rating mental disorders need substantial revision. Assignment of evaluation levels needs to correlate directly with the basic diagnostic criteria of the disease. The IOM report on PTSD compensation offers a multidimensional approach to PTSD disability rating.[134] The Commission strongly agrees that disability ratings should reflect more than

[132] Ibid., 6-21.
[133] Ibid., 6-22.
[134] Ibid., Table 5-11.

"loss of earnings capacity"; the current Rating Schedule already takes additional dimensions into consideration in several areas (for example, disfiguring scars; diagnostic codes 7800–7804) (38 C.F.R. § 4.118 [2006]). The IOM framework includes five dimensions: symptoms, psychosocial functional impairment, occupational functional impairment, treatment factors, and health-related quality of life. This recommendation has implications beyond PTSD. The Commission believes each of these dimensions deserves consideration, and should be incorporated generally into the Rating Schedule. However, the Commission is highly sensitive to the complexity of such changes. VA must be allowed latitude in amending the Rating Schedule so as not to increase its complexity beyond practical utility.

Although the Commission endorses the multidimensional approach proposed by the IOM committee, it does not endorse the establishment of separate tables for each dimension of disability. VA should be permitted to incorporate criteria for any dimension (psychosocial impairment or quality of life, for example) into a single list of evaluation criteria for each disability. It should not be expected that each dimension be described for every condition at every level of disability. The IOM report states, "It is not the intent to require an individual to meet a particular severity level in every dimension in order to qualify for that Rating Schedule disability rating—for example, requiring that an individual be given level III ratings or greater on all five dimensions in order to attain a 50 percent disability rating."[135]

It is the Commissioners' belief that building separate tables into the Rating Schedule for each dimension would be overly complex and unwieldy. Such an approach would likely lead to less consistency, rather than more. Further, each dimension will not apply equally for every disability. Discretion should remain with VA to incorporate each dimension as appropriate.

The IOM committee on PTSD compensation recommends a fixed long-term minimum level of benefits that would be available to any veterans with service-connected PTSD. This recommendation grew from the discussion about incentives to recovery in which several studies are described. Some of the studies offer speculative opinions about veterans with PTSD based on civilian study data. However, the IOM report acknowledges mixed results by citing a presentation to the committee that said "data from evaluations of VA programs on the relationship between compensation seeking or disability status and treatment outcomes are inconclusive.[136]

[135] Ibid., 5-23.
[136] Ibid., 6-14.

Current VA policy mandates that "Rating on account of diseases subject to temporary or episodic improvement…will not be reduced on any one examination, except in those instances where all the evidence of record clearly warrants the conclusion that sustained improvement has been demonstrated" (38 C.F.R. 3.344[a] [2006]). Also, the *C&P Procedural Manual* directs claims examiners not to make drastic reductions in evaluations in ratings for psychiatric disorders if a reduction to an intermediate rate is more in agreement with the degree of disability. It goes on to require observation of the general policy of gradually reducing the evaluation to afford the veteran all possible opportunities for adjustment.[137] So VA policies already reflect an understanding of the sensitivity of rating reductions, as well as their impact. This policy change would take into account the remitting and relapsing nature of PTSD and some other diseases, take another step in VA's current approach to providing full consideration of veterans' needs, and increase the protection of veterans from "roller coaster" fluctuations in their ratings. Only when a second medical exam confirms the sustained improvement would an evaluation reduction be proposed. Currently, when VA proposes a reduction in evaluation, it notifies the veteran or claimant of the proposed reduction and the reasons for that reduction. VA allows 60 days for the veteran to respond and present evidence refuting the proposed reduction. If no new evidence is received, then VA takes action to effect the reduction at the end of the month after 60 additional days have elapsed. The VA Disability Compensation Program would benefit from improved incentives to recovery.

The IOM PTSD compensation study declined to make a recommendation for across-the-board reexaminations of PTSD claimants. The report cited the need to focus resources on initial C&P exams, since it found little misrepresentation by PTSD claimants. The Commission believes that reevaluations should occur every 2–3 years to gauge treatment effectiveness and encourage wellness.

III.3 CNA Corporation Findings Pertaining to Mental Disorders and PTSD

CNAC conducted surveys and analysis for this Commission that bear on the VA Disability Compensation Program as it provides for veterans with mental disabilities.

In analyzing quality of life, CNAC found that veterans with mental disorders had significantly lower overall satisfaction with life than veterans with physical disorders. The responses for mental disorders were lower at each level of

[137] VA, *Adjudication Procedure Manual*, III(iv).

disability, and the difference was significant at each level. Each category of mental and physical disabilities showed similar satisfaction patterns by age, but the satisfaction level averaged about 20 points lower for veterans with mental disabilities.[138] For example, at 10 percent, physically disabled vets showed overall life satisfaction at 80–85 percent; for 10 percent mentally disabled vets, overall life satisfaction was about 70 percent. At each disability level, the two categories showed similar age patterns, but the satisfaction level was about 20 percent lower for mentally disabled vets.

The CNAC analysis explored the following specific question from its statement of work: "How well do benefits provided to disabled veterans meet the congressional intent of replacing average impairment in earnings capacity?" The conclusion regarding mental conditions reflected significant disparity.

CNAC calculated an earnings ratio to gauge the overall replacement of earnings for veterans receiving disability compensation. This earnings ratio compared the overall earned income with VA compensation (for disabled veterans) with the overall earned income for nondisabled veterans. In the aggregate, they found an earnings ratio of 0.99, which shows very close comparability. However, for PTSD and other mental disabilities, the earnings ratio was much lower.[139] Specifically, at age 45, the earnings ratios for PTSD were .74 at 10 percent disabled, .78 at 20 to 40 percent, .87 at 50 to 90 percent. The corresponding earnings ratios for musculoskeletal disorders were .99 at 10 percent disabling, 1.02 at 20 to 40 percent, and 1.07 at 50 to 90 percent. Although the earnings ratios for veterans with PTSD were lower than the earnings ratios of veterans with other comparable ratings, the mortality rates for veterans with PTSD were lower (i.e., indicating a healthier status) than the mortality rates of veterans with other comparable ratings. Specifically, the mortality rates for veterans rated 100 percent PTSD are well below the rates for veterans rated 100 percent not PTSD; similarly, the mortality rates for veterans rated for PTSD and Individual Unemployability are well below the rates for veterans rated for Individual Unemployability without PTSD.

In summary, the CNAC analysis of the VA Disability Compensation Program found that the program does provide for reasonable earnings adjustments for most disabling conditions. VA compensation is implicitly awarded to address quality-of-life issues for many disabling conditions, but this does not seem to occur for mental disorders. Therefore, compensation awards for mental disorders do not reflect parity in restoration of earnings or quality of life.

[138] CNAC, *Final Report*, 66–67.
[139] CNAC, *Final Report*, 61.

CNAC suggested, as a means to rectify the current disparities for mental disabilities, that ratings for mental disorders be adjusted to a higher level. For example, the disabling effects that currently result in a 10 percent evaluation for a mental disorder would result in a 30 percent evaluation. CNAC cautioned that this suggestion would require a high number of reratings, and that it would not improve parity for those currently rated 100 percent service connected.

CNAC also suggested that VA could increase compensation for veterans who enter the VA Disability Compensation program at a young age, when disparity is high. They suggest this special adjustment could be done by adding a special monthly compensation factor for young entries with mental disabilities.

This Commission agrees that the current compensation disparities for veterans with mental disorders needs correction and believes the best solution is to revise the Rating Schedule criteria for PTSD and other mental disorders. During the revision process, concerns about earnings ratio and a quality-of-life adjustment need to be embedded in the new evaluation criteria. This means that VA will have to conduct additional data analyses to project and then validate the earnings and quality-of-life impacts of these changes. It should also be noted that certain Commission recommendations will improve the incentives inherent in the system for recovery and return to work, which, in turn, will address the compensation and quality-of-life disparities for veterans with mental disorders.

The type of analysis provided by CNAC must be replicated periodically. As changes occur in the future to the Rating Schedule and to medical diagnostic and treatment techniques, the relationships between disability payments and earning capacity, and between disability payments and quality of life, will need to be reevaluated.

As discussed at the beginning of this section, PTSD affects many of our returning veterans, thereby making it a primary concern for this Commission, which chose to address these issues with the assistance of IOM and CNAC. The findings and recommendations of these entities were taken under advisement and were incorporated into the Commission's deliberations. In doing so, the Commission ultimately was concerned with the Rating Schedule criteria for PTSD and other mental disorders; a baseline level of benefits; a holistic approach; the examination process; data collection and research; and examiner training and rater certification. The following recommendations are made by the Commission to improve and integrate VA's process for delivering benefits and services to veterans with PTSD and other mental disorders:

Recommendation 5.28

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

Recommendation 5.29

VA should consider a baseline level of benefits described by the Institute of Medicine to include health care as an incentive for recovery for posttraumatic stress disorder as it relapses and remits.

Recommendation 5.30

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

Recommendation 5.31

The posttraumatic stress disorder examination process:

- **Psychological testing should be conducted at the discretion of the examining clinician.**
- **VA should identify and implement an appropriate replacement for the Global Assessment of Functioning.**

Posttraumatic stress disorder data collection and research:

- **VA should conduct more detailed research on military sexual assault and posttraumatic stress disorder and develop and disseminate reference materials for raters.**

Recommendation 5.32

A national standardized training program should be developed for VA and VA-contracted clinicians who conduct compensation and pension psychiatric evaluations. This training program should emphasize diagnostic criteria for posttraumatic stress disorder and comorbid conditions with overlapping symptoms, as set forth in the *Diagnostic and Statistical Manual of Mental Disorders*.

Recommendation 5.33

VA should establish a certification program for raters who deal with claims for posttraumatic stress disorder (PTSD), as well as provide

training to support the certification program and periodic recertification. PTSD certification requirements should be regularly reviewed and updated to include medical advances and to reflect lessons learned. The program should provide specialized training on the psychological and medical issues (including comorbidities) that characterize the claimant population, and give guidance on how to appropriately manage commonly encountered rating problems.

References

Agency for Toxic Substance and Disease Registry (ATSDR). *Analyses of Groundwater Flow, Contaminant Fate and Transport, and Distribution of Drinking Water at Camp Lejeune.* Atlanta, GA: ATSDR, 2007, Executive Summary. http://www.atsdr.cdc.gov/sites/lejeune/docs/TT_Executive_Summary_June142007_508.pdf.

ATSDR. *Health Consultation Evaluation of Soil, Blood & Air Data from Anniston, Alabama Calhoun County, Alabama.* Atlanta, GA: ATSDR, 2000, Executive Summary. http://www.atsdr.cdc.gov/HAC/PHA/annpc/ann_toc.html.

ATSDR. *Public Health Assessment: U.S. Marine Corps Camp Lejeune, Onslow County, North Carolina (CERCLIS No. NC6170022580)*. Atlanta, GA: ATSDR, 1997, Section I: B: Conclusion. http://www.atsdr.cdc.gov/HAC/PHA/usmclejeune/clej_toc.html.

ATSDR. *Survey of Specific Childhood Cancers and Birth Defects: USMC Camp Lejeune*. Atlanta, GA: ATSDR, 2003, Executive Summary. http://www.atsdr.cdc.gov/sites/lejeune/survey_full.html.

ATSDR. *Volatile Organic Compounds in Drinking Water and Adverse Pregnancy Outcomes: U.S. Marine Corps Camp Lejeune*. National Technical Information Service; Springfield, VA. August, 1998. http://www.atsdr.cdc.gov/HS/lejeune/index.htm#content. Accessed September 27, 2007. Abstract.

CNAC (The CNA Corporation). *Final Report for the Veterans' Disability Benefits Commission: Compensation, Survey Results, and Selected Topics*. Alexandria, VA: The CNA Corporation, 2007.

Cohen, Danita. E-mail message to Commission staff regarding veterans beginning and receiving service-connected compensation in FY 2006. September 19, 2007

Congressional Budget Office. "Section 15 Veteran Benefits and Services. Option 700-02—Narrow the Eligibility for Veterans' Disability Compensation to Veterans Whose Disabilities Are Related to Their Military Duties." In *Budget Options March 2003*. http://www.cbo.gov/showdoccfm?index=4066&sequence =14.

Department of Defense (DoD). "Information Paper: Polychlorinated Biphenyls (PCB) Contamination Sources at Ft. McClellan, Alabama and Surrounding Areas." 2.

Surratt, Rick (Disabled American Veterans). Testimony before the Senate Committee on Veterans' Affairs, October 27, 2005. Washington, DC: DAV, 2005.

Dunne, Patrick (Assistant Secretary for VA Office of Policy and Planning). *Older Veterans Update.* Presentation before the Veterans' Disability Benefits Commission, Washington, DC: Veterans' Disability Benefits Commission. September 14, 2006.

https://www.1888932-2946.ws/vetscommission/e-documentmanager/gallery/Documents/September_2006/OlderVeteransUpdate_008_09-14-2006.pdf.

Federal Interagency Forum on Aging-Related Statistics. *Older Americans 2004: Key Indicators of Well-Being.* Hyattsville, MD: U.S. Government Printing Office, 2004. 18–19.

Firestone, David. "Alabama Jury Says Monsanto Polluted Town," *New York Times*. February 23, 2002.

Gaillard, Brenda. "Alabama NPL/NPL Caliber Cleanup Site Summaries." Washington, DC: Environmental Protection Agency. 1984.

Government Accountability Office (GAO). *Disability Benefits: Benefit Amounts for Military Personnel and Civilian Public Safety Officers Vary by Program Provisions and Individual Circumstances*. Washington, DC: GAO, April 2006, 11.

GAO. *Defense Health Care: Activities Related to Past Drinking Water Contamination at Marine Corps Base Camp Lejeune*. GAO 07-276. Washington, DC: GAO, 2007, 8–9.

GAO. *VA Benefits—Law Allows Compensation for Disabilities Unrelated to Military Service*. HRB-89-60. Washington, DC: GAO, 1989, 28.

Grunwald, Michael. "Monsanto Hid Decades of PCB Pollution." *Washington Post*. January 1, 2002.

Institute of Medicine (IOM). *Improving the Presumptive Disability Decision-Making Process for Veterans.* Washington, DC: The National Academies Press, 2007, Summary 9.

IOM. *Posttraumatic Stress Disorder: Diagnosis and Assessment*. Washington, DC: The National Academies Press, 2006.

IOM. *PTSD Compensation and Military Service.* Washington, DC: The National Academies Press, 2007.

President's Commission on Veterans' Pensions. *Findings and Recommendations: Veterans' Benefits in the United States*. Washington, DC: 1956, 393–397.

Sayer, NA. "The impact of disability compensation for PTSD on veterans' mental healthcare utilization." Unpublished manuscript provided to the IOM Committee on Veterans' Compensation for Post Traumatic Stress Disorder. 2006.

Shelton, Christie. Phone conversation with Paul Stepnowsky, Veterans' Disability Benefits Commission. June 29, 2006.

Surratt, Rick (Disabled American Veterans). Statement before the U.S. House Veterans' Affairs Committee, May 21, 1997. Washington, DC: DAV, 1997.

Taylor, James M. "Solutia Settles Alabama PCB Case," *Environment and Climate News*. Chicago: Heartland Institute, 2003. http://www.heartland.org/PublicationIssue.cfm?pblId=1&pisId=454.

U.S. Environmental Protection Agency, PCB Office. *Health Effects of PCB*. 2007 http://www.epa.gov/pcb/pubs/effects.html.

U.S. Marine Corps, Drinking Water Fact-Finding Panel for Camp Lejeune. *Report to the Commandant*. Washington, DC: U.S. Marine Corps, 2004, 1. http://www.usmc.mil/camplejeune/clbwatersurveyinfo.nsf.

VA. *Caring for the Older Veteran*. Washington, DC: VA, 1984, 3.

VA Compensation and Pension Service. 2007. Technical comments [on] draft position papers of the Veterans Benefits Commission. Unpublished assessment. Veterans' Disability Benefits Commission, Washington, DC.

VA Fiscal Year 2007 Budget Request for the Compensation and Pension Business Lines: Hearing before the H. Subcomm. on Disability Assistance and Memorial Affairs, 109th Cong. (2006) (statement of Daniel L. Cooper, Under Secretary,

Benefits, Veterans Benefits Administration, Department of Veterans Affairs), http://www.va.gov/OCA/testimony/hvac/sdama/06021620.asp.
VA. M21-1 *Adjudication Procedure Manual.* Washington, DC: VA, 2007.
VA Office of the General Counsel. Memo from the Acting General Counsel. Washington, DC: VA, January 12, 2007.
VA Office of General Counsel. *Precedent Opinion 61-91.* Washington, DC: VA, 1991. 3.
VA Office of General Counsel. *Service in the Republic of Vietnam for Purposes of Definition of Vietnam Era--38 U.S.C. § 101(29)(A): VAOPGCPREC 27-97*. Washington, DC: VA, 1997. 2.
VA Office of the Inspector General. *Review of State Variances in VA Disability Compensation Payments.* Report No. 05-00765-137. Washington, DC: VA, 2005.
VA. "Analysis of Presumptions of Service Connection." Presentation to Senate Veterans Affairs Committee. Washington, DC: VA, 1993, i.
Veterans Benefits Administration. *Annual Benefits Report Fiscal Year 2004*. Washington, DC: VBA, 2005.
Veterans Benefits Administration. *Annual Benefits Report Fiscal Year 2005*. Washington, DC: VBA, 2006.
Veterans Benefits Administration. "Qualifications for Examiners Performing Compensation and Pension (C&P) Mental Disorder Examinations." Fast Letter 06-03. Washington, DC: VA, 2006.
Veterans Benefits Administration, Office of Performance Analysis & Integrity, Data and Information Services. Data request from Veterans' Disability Benefits Commission regarding veterans with honorable for VA purposes and dishonorable for VA purposes character of service determinations. Request 06-176. Washington, DC: VBA, 2006.
Veterans' Claims Adjudication Commission (VCAC). *Report to Congress Pursuant to Public Law 103-446.* Washington, DC: Veterans' Administration, 1996, 347.