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Introduction

As U.S. casualties began returning from combat in Iraq and Afghanistan, Congress debated long-standing issues regarding the most effective ways to deliver benefits and care to the Nation's veterans. To help resolve the many pressing and complex concerns about veterans' benefits, the President and Congress created this independent Commission under Public Law 108-136, The National Defense Authorization Act of 2004 (see Appendix A).

The first Commission of its kind in over 50 years, the Veterans' Disability Benefits Commission has 13 commissioners, whose biographies appear in Appendix B, and 19 staff. Five members of the Commission were appointed by the President. Two members each were appointed by the Speaker and the Minority Leader of the U.S. House of Representatives and the majority and minority leaders of the U.S. Senate. Because the Federal Advisory Committee Act requires transparency in the Commission's deliberations, all decisions have been made in a public forum and are a matter of public record.

I Commission's Charter and Scope of Work

The purpose of the Veterans' Disability Benefits Commission is to study the benefits and services available to U.S. veterans and their dependents and survivors to compensate for and assist with disabilities and deaths attributable to military service. Specifically, the Commission's charter directed the group to evaluate and assess

- the appropriateness of the benefits,

- the appropriateness of the level of benefits, and
- the standards for determining eligibility for benefits.

Also, the Commission was granted the authority to examine any related issues that it deemed relevant to the purposes of the study.

II Methodology

II.1 Commission Analyses

Issues of interest to the veteran community have come to the attention of the Commission in many ways. Some have been presented by interested members of the public, at public meetings either in Washington, DC, or at eight dispersed locations the Commission visited. Many of these issues were identified from previous studies, largely from the Government Accountability Office (GAO), or reports of other commissions or from the Commissioners themselves. These issues are discussed throughout the chapters of the report. The Commission structured its analysis by developing 31 research questions, which appear in Appendix C. The Commission staff drafted 11 white papers that analyzed 16 of those questions and presented options to the Commission to deliberate. The white papers covered the following subjects:

- Lump sum payments
- Concurrent receipt
- Survivor concurrent receipt
- Line of duty
- Character of discharge
- Pending claim ends with death
- Time limit to file
- Age as a factor
- Apportionment and garnishment
- Vocational rehabilitation and employment
- Transition

Attorneys conducted legal analyses of several of these issues and gave the Commission an in-depth historical context for much of the legislation that

currently affects the benefits available to disabled veterans, their families, and survivors.

II.2 Site Visits

In addition, the Commission collected information by conducting a series of eight site visits to Tampa/St. Petersburg, Florida; San Antonio, Texas; Chicago, Illinois; St. Louis, Missouri; San Diego, California; Seattle, Washington; Boston, Massachusetts; and Atlanta, Georgia. Each of these site visits included a town hall meeting with local veterans and extensive meetings with representatives of veteran service organizations, state departments of veterans affairs, and officials and staff at VA regional offices and medical centers and military installations. These visits brought the Commissioners in direct contact with disabled veterans, family members, transitioning service members, and those who deliver benefits and services to them. The focus of the official visits was the disability evaluation processes within VA and DoD and issues related to the transition of service members from active duty to civilian life. The Commission also examined the nature of communication and outreach from VA and DoD to veterans and their families and between the two departments. Appendix D is a consolidated summary of these site visits.

II.3 Consultation with the Institute of Medicine

Part of the Commission's founding legislation required consultation with the Institute of Medicine (IOM) to review the medical aspects of the VA disability compensation procedures and programs. To accomplish this goal and to address additional research questions, the Commission contracted with IOM. The Commission also gleaned information from two studies on posttraumatic stress disorder (PTSD) that IOM conducted on behalf of the Veterans Health Administration (VHA).

IOM established several committees to answer the statements of work presented to it. These committees included the following:

- Medical Evaluation of Veterans for Disability Compensation
- Evaluation of the Presumptive Decision-Making Process for Veterans
- Veterans' Compensation for Posttraumatic Stress Disorder
- Posttraumatic Stress Disorder (PTSD): Diagnosis and Assessment

- PTSD Treatment (at the time of this report release, the third VHA contract with IOM on PTSD Treatment is incomplete and not available for inclusion)

The Commission tasked the IOM Committee on Medical Evaluation of Veterans for Disability Compensation to study the VA Schedule for Rating Disabilities (Rating Schedule) to determine whether the schedule is an appropriate, valid, and reliable instrument for evaluating impairment, rating degree of disability, and compensating disabled veterans for the impact on quality of life and impairments of earning capacity. The IOM committee compared the Rating Schedule to other modern diagnostic techniques and considered whether the schedule is based on the most current scientific evidence. This expert panel also looked at methods for assessing the severity of single and multiple conditions, as well as secondary and aggravated service-connected conditions. The committee's final report also included an evaluation of the current use of Individual Unemployability (IU) as a supplemental rating tool in lieu of rating criteria that might more accurately reflect a veteran's ability to participate in the economic marketplace.

The Commission charged the IOM Committee on the Evaluation of the Presumptive Decision-Making Process for Veterans to conduct a comprehensive review of the historical and current methodologies used to identify diseases associated with the environmental and occupational hazards of military service. Since 1921, many decisions have been rendered to presumptively grant service connection to numerous categories of diseases. Often, these decisions are made by the VA Secretary or by Congress based on limited or even conflicting information. The IOM Presumption Committee was asked to assess the current process and propose improvements, including a more scientific approach, such as an epidemiological model, that could be used to support future decisions.

VHA contracted with IOM to study and report on several aspects of PTSD in relation to military service, and the Commission evaluated two of the resulting reports. One of these reports, *PTSD Compensation and Military Service*, examined VA's methodology for rating and compensating veterans diagnosed with PTSD. The authoring committee reviewed the Rating Schedule criteria used to determine the level of severity of disability, taking into account how changes in frequency and intensity of symptoms might affect ratings and compensation. The committee considered how periods of remission and return of symptoms compare with other chronic conditions, both in practice and reevaluation requirements. Strategies used to support recovery, return to function, and possibly work for patients with PTSD also factored into the committee's approach to evaluating how veterans with PTSD are compensated.

The second IOM report on PTSD that the Commission examined was *Posttraumatic Stress Disorder: Diagnosis and Assessment*. The committee that authored this report conducted a review of the scientific and medical literature on PTSD and provided a foundation for discussing the characteristics of PTSD and known risk factors. This committee also commented on current diagnostic criteria and the validity of assessment instruments, concluding with a recommended approach to screening veterans for PTSD.

IOM accomplished these tasks by conducting literature reviews, inviting expert witnesses, hearing veteran and other stakeholders' testimony, and through its deliberations. IOM, as part of the National Academies of Science, has a peer-review protocol, and its reports are available to the general public.

II.4 Consultation with the CNA Corporation

The Commission also examined the results of studies undertaken on its behalf by the CNA Corporation (CNAC). Some of these studies were literature reviews on quality of life, earnings capacity, Individual Unemployability, and lump sum payments. Additionally, CNAC surveyed VA raters, service officers from veteran service organizations, and disabled veterans and survivors. These surveys were scientifically valid and reliable. A random sample methodology was used for the veterans and survivor surveys. VA, DoD, the Office of Personnel Management, and the Social Security Administration provided data for matches and subsequent analysis by CNAC.

II.5 Commission Meetings

The Commission also gathered information through its 28 public sessions, which consumed 55 days over more than 2 years. During those sessions, the Commission heard from subject-matter experts, federal and state officials, military and veteran service organizations, researchers, contractors, the public, and other stakeholders. VA, DoD, and specific federal administrations and agencies covered a broad range of topics during their briefings, including seamless transition, the VA rating process, the DoD disability evaluation system, certification, environmental hazards and exposures, severely injured programs and treatment, Social Security Disability Insurance, and employment. Additional information reached the Commission in the form of letters, faxes, phone calls, and nearly 4,000 e-mails.

III Definitions of Disability

As part of its initial investigative work, the Commission—along with IOM—studied various definitions of *disability* to develop parameters for terms and concepts used by the medical community to understand the differences between impairment, handicap, and disability. VA does not have an explicit definition of disability, but does codify functional impairment as follows:

> The basis of disability evaluations is the ability of the body as a whole or of the psyche, or of a system or organ of the body to function under the ordinary conditions of daily life including employment….lack of usefulness of these parts or systems, especially in self-support (38 C.F.R. § 4.10 [2006]).

The VA disability rating "is based upon the average impairment in earning capacity, that is, upon the economic or industrial handicap which must be overcome and not from individual success in overcoming it" (38 C.F.R. § 4.15 [2006]).

To further its understanding, the Commission turned to the World Health Organization (WHO), which makes clear distinctions between impairment, disability, and handicap. WHO defines impairment as, "the loss of physiological integrity in a body function or anatomical integrity in a body structure; caused by disease, injury, or congenital defect."[1] Therefore, the term *impairment*, for example, can be applied to the inability to move the leg at the joint, which may worsen over time without treatment.

The term *handicap* connotes a disadvantage for a given individual resulting from an impairment or a disability that limits or prevents the fulfillment of a role that is normal (depending on age, sex, and social and cultural factors) for that individual. However, *handicap* is regarded by the disability community as "possessing negative connotations that are inconsistent with current views on disability and its meaning in the Americans with Disabilities Act (ADA)" of 1990 (Pub. L. 101-336, [1990]).[2] Thus, the Commission did not consider this concept further.

[1] WHO, *International Classification,* 2001.

[2] ADA prohibits discrimination on the basis of disability. Provisions of the act became effective at various times ranging from 30 days to 30 years after the law was passed. In general it became effective on July 26, 1992.

The WHO definition of disability is any restriction or lack of ability (resulting from impairment) to perform an activity in the manner or within the range considered normal for a human being.[3] IOM viewed disability as a "broad term" and saw the disabling process as having four domains: pathology, impairment, functional limitation, and disability and includes mediating factors (i.e. lifestyle and environment), which impact quality of life.[4] Therefore, disability, unlike impairment, would denote an inability to walk, which may be overcome with physical therapy or special equipment. Thus, a person may have an impairment that does not necessarily create a disability if the impairment can be treated or corrected using therapy or special equipment.

The definition of disability underlying the CNAC analyses for the Commission related disability to military service and rating of severity by VA. According to CNAC:

> A disability is defined as either an injury or a disease that resulted from service or a preexisting injury or disease that was aggravated by service. A veteran can have multiple disabilities, each of which is assigned a rating reflecting its severity. The combination of the disability ratings for all disabilities determines a veteran's level of compensation.[5]

IV Definition of Quality of Life

Throughout the Commission's 30 months of discussions and deliberations about disability benefits and compensation policies, quality of life remained a central concept. Several of the Commission's guiding principles reflect this sentiment both implicitly and explicitly. Findings and recommendations from IOM and CNAC also consider quality of life to be integral to discussions of disability.

In 1993, WHO put forward a definition of *quality of life* linked to health:

> the perception by individuals of their position in life, in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns.[6]

[3] WHO, *International Classification,* 1980.
[4] Institute of Medicine (IOM), *21st Century System*, 72.
[5] CNAC, *Final Report*, 133.
[6] WHO, "Quality of Life," 153–159.

This definition is the basis for IOM's usage of the term *quality of life* in the report *A 21st Century System for Evaluating Veterans for Disability Benefits*. IOM's usage considers several dimensions of a person's life and reflects changes over time.[7] The report also uses the term *health-related quality of life,* which measures "what an individual values and whether there is much satisfaction in one's life."[8] Chapter 3 of *A 21st Century System for Evaluating Veterans for Disability Benefits* is entirely dedicated to impairment, disability, and quality of life; the definitions of these terms include such mediating factors as lifestyle and aspects of behavior, biology, and environment. "By definition, the concept of quality of life covers many dimensions of one's life: cultural, psychological, physical, interpersonal, spiritual, financial, political, temporal, and philosophical,"[9] wrote the IOM Committee on Medical Evaluation of Veterans for Disability Compensation. The group also observed the need to integrate quality of life into clinical assessments:

> In general, the health care establishment is committed to helping reduce the burden of disease, but has become increasingly aware of patient priorities, which include the desire to be independent, to maintain valued activities, and to have a sense of well-being in all aspects of daily life—in short, to achieve a good quality of life. The Centers for Disease Control and Prevention (CDC) defines quality of life as the perception of physical and mental health over time.[10]

In chapter 4 of this report, the Commission endorses IOM's recommendation to compensate disabled veterans for three consequences of service-connected injuries and disease: work disability, loss of ability to engage in usual life activities other than work, and loss of quality of life. Chapter 7 presents the results of CNAC's surveys on veterans' quality of life and contains a discussion of the subject.

V Other U.S. Government Comparisons

During its exploration of different employee benefit programs similar to VA benefits, the Commission looked at the programs for disabled employees offered by other federal, state, and local governments. CNAC and GAO comparisons on public safety officers were reviewed. The Commission found there was a great deal of variance in how these benefits were defined and delivered.

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[7] IOM, *21st Century System*, 72.
[8] Ibid.
[9] IOM, *21st Century System*, 59.
[10] Ibid., 67.

References

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