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STATEMENT OF GEORGE KETTNER, PhD
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BEFORE THE SENATE COMMITTEE ON VETERANS' AFFAIRS
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Chairman Akaka, Ranking Member Burr, and members of the Committee, thank you for the opportunity to appear before you today to present the major results of Economic Systems' Study of Compensation Payments for Service-Connected Disabilities completed last year for VA. This study was requested largely as a follow on to the President's Commission on Care for America's Returning Wounded Warriors, known as the Dole-Shalala Commission.

VA Disability Compensation Rating System
The VA Disability Compensation Program provides monthly benefit payments to veterans who become disabled as a result of or coincident with their military service. Payments generally are authorized based on an evaluation of the disabling effects of veterans' service-connected physical and/or mental health impairments. Monthly payments are authorized in percentage increments from 10% ($117 in 2008) to 100% ($2,527 in 2008). The process for determining ratings for disability compensation benefits uses the VA Schedule for Rating Disabilities (VASRD) to assign the level of severity of the disabilities.

The VASRD contains over 700 diagnoses or disability conditions, each of which may have up to 11 levels of medical impairment. The lowest level of impairment starts at 0% then increases in 10% increments up to a maximum of 100%. Disability compensation, as determined by the VASRD, is intended to replace average impairment in earnings capacity.

Eligibility requires that a determination be made that the condition is a service-connected disability. Service-connected means that the condition occurred during or was aggravated by military service, is one of several "presumed" conditions, or, for chronic conditions, became evident within one year of discharge from the military. It does not require that the disability be work related or be caused by conditions in the work environment. In this regard the VA Disability Compensation Program combines elements of both disability insurance voluntarily provided by employers and workers' compensation programs mandated by government.

Claimants with a combined rating between 60 to 90% who are determined to be unemployable solely as a result of service-connected conditions qualify for Individual Unemployability (IU). Claimants determined to be entitled to IU receive the same benefit payment amount as those rated at the 100% disability level. Conditions or circumstances that result in the claimant not being employable override the medical impairment rating. IU is similar to the Social Security Disability Insurance (SSDI) program in that both provide payments because the beneficiary is deemed to be unemployable.

Special Monthly Compensation (SMC) is a benefit paid in addition to or instead of the VASRD-

based benefits. Examples include: loss of or loss of use of organs, sensory functions, or limbs; disabilities that confine the veteran to his/her residence or result in the need for regular aid and attendance; a combination of severe disabilities that significantly affect mobility; and the existence of multiple, independent disabilities each rated at 50% or higher.
We were asked by VA to address three major areas in our analysis: earnings loss resulting from service-connected disabilities, the impact of those disabilities on quality of life, and a possible transition benefit for veterans engaging in VA's vocational rehabilitation and employment program. Some of our most significant findings relate to the following topics:
• Adequacy of Disability Compensation
• Disabilities Without Earnings Loss
• Additional Diagnostic Codes
• Earnings Loss for Veterans with Posttraumatic Stress Disorder (PTSD), Other Mental Health Disorders, and Traumatic Brain Injury (TBI)
• Methodology Used to Calculate Combined Degree of Disability
• Individual Unemployability Benefits
• Special Monthly Compensation
• Quality of Life Payment Options
• Transition Benefit Options.

Adequacy of Disability Compensation
A crucial part of the loss of earnings analysis is determining the wages that the veteran would have received if he or she had not experienced a service-connected disability (SCD). The estimates of these potential earnings depend on tracking the actual earnings of individuals in a comparison group who did not have SCDs but who were otherwise matched to the disabled veterans on personal characteristics. The personal characteristics used to match the disabled veterans and the veterans without SCDs were age, gender, education at the time of entry into the service, and status as an officer or enlisted person when discharged from active duty. The analysis of loss of earnings was primarily based on comparisons of the earnings in 2006 of veterans with SCDs and without SCDs as provided to the study by the Social Security Administration.

Assessment of the adequacy of disability compensation in relation to earnings loss requires determining if the payments are equitable vertically and horizontally. Vertical equity means that actual earnings loss should increase in proportion to increases in disability ratings and that compensation should offset that earnings loss. We found that overall, veterans with service-connected disabilities have earnings plus disability compensation 7 percent above their average expected earnings. The average was higher at each rating level except at the 100% rating level where the combined earnings and compensation was 9 percent less than expected. On average, veterans with a 30% or less combined disability rating did not experience serious wage loss. Approximately, 55% of 2.6 million veterans receiving disability compensation in 2007 were rated at 30% or less. Earnings losses for veterans with 40% to 90% combined rating did have wage losses, but their VA disability compensation more than made up the loss. In contrast, actual earnings losses plus disability compensation for veterans with 100% combined rating fall short of average expected earnings by about 9%. In 2007, 9.1 percent of veterans receiving disability

compensation had a combined rating of 100%, up from 7.5 percent in 2001. Thus, vertical equity is not fully achieved.

Horizontal equity means that actual earnings loss should be the same or similar for the same disability ratings but with different types of disabilities. We found considerable differences in earnings loss across different diagnoses for a given rating level, resulting in serious inequity in the payment system. For example, for veterans with a 50% combined rating, the range was from no earnings losses for genitourinary or endocrine medical conditions to over 40 percent earnings losses for non-PTSD mental conditions. Veterans with PTSD, Other Mental Disorders, and infectious diseases experience greater earnings losses than veterans diagnosed with other medical conditions rated at the same level. Thus, horizontal equity is not achieved.

One factor that is important to understanding the results of our earnings analysis is that it concentrates on veterans discharged since 1980. Our results, therefore, differ from the previous study conducted by CNA Corporation for the

Veterans' Disability Benefits Commission
as that study included veterans discharged before 1980. Our study does not include veterans of World War II, Korea, and Vietnam (relatively few) because they are largely past or approaching retirement age and because data on their essential demographic and human capital characteristics are not available from the Department of Defense (DoD) for analysis. We believe that this focus on more recent veterans is more appropriate for policy considerations for the future. More detailed discussion of the differences between our study and the study for the Veterans' Disability Benefits Commission (VDBC) is provided later.

Disabilities without Earnings Loss
In addition to examining the broad comparisons cited above, our analysis identified several diagnostic codes that are candidates for changes to the Rating Schedule because the impact of these conditions on earnings is not commensurate with the level of the rating. In particular, for several of the most prevalent diagnostic conditions, there is no earnings loss at the 10% or 20% combined rating levels. Examples of these diagnoses include: arthritis; lumbosacral strain; arteriosclerotic heart disease; hemorrhoids; and diabetes mellitus. The Rating Schedule criteria for the rating of these conditions could be adjusted so that a rating of zero percent instead of 10% or 20% would be assigned in the future to reflect that no earnings loss occurs at this level for these conditions.

Additional Diagnostic Codes
We were asked to identify diagnostic codes that could be added to the over 700 existing codes in the Rating Schedule. Analogous codes are currently used in 9 percent of all cases. By sampling 1,094 cases in which analogous codes were used, we identified 33 ICD-9 codes that were used often enough to warrant addition to the Rating Schedule. These include disturbance of skin sensation, mononeuritis of lower limb, and unspecified hearing loss.

PTSD, Other Mental Disorders, and TBI

Our analysis and previous studies conducted by the Bradley Commission in 1956, the Economic Validation of the Rating Schedule in 1972, and the Veterans' Disability Benefits Commission in 2007, are consistent in finding that mental health disorders in general have a much more profound impact on employment and earnings than do physical disabilities. We found that earnings loss for PTSD is 12 percent for veterans rated 10% and up to 92 percent for those rated 100%. For other mental disorders (other than PTSD), the earnings loss is 14 percent for those rated 10% and 96 percent for those rated 100%. Earnings loss for TBI rated 100% is similar at 91 percent.

A policy option for consideration is to adjust the VA Schedule of Rating Disabilities to eliminate rating PTSD at 10% and use the rating criteria for 10% to rate 30%, 30% to 50%, 50% to 70%, and combine the criteria for 70% and 100% at 100%. We note that this will not eliminate the deficiency at 100%; veterans rated 100% will still be receiving less in disability compensation and earnings combined than their expected level of earnings. We also note that these changes, especially if also made for mental health disorders in general, would have a significant impact on the issue of Individual Unemployability (IU). Veterans whose primary diagnosis is PTSD made up 32 percent of IU cases on the rolls in 2007 and 47 percent of new IU cases during the period 2001-2007. Including PTSD with all mental disorders, 44 percent of IU cases on the rolls in 2007 were mental disorders and 58 percent of new IU cases from 2001-2007 had mental disorders. Since the criteria for rating mental disorders at 100% require veterans to be unemployable, it is not clear why veterans with mental disorders who are unemployable are not rated 100% instead of IU.

Methodology Used to Calculate Combined Degree of Disability
VA has used certain formulas over the years to assign a Combined Degree of Disability (CDD) when veterans have more than one service-connected disability. Veterans receiving disability compensation have on average 3.3 disabilities that they are rated for. The earliest known formula dates from 1921 and has changed very little since then. The CDD determines the amount of the disability compensation payment. The table below provides examples of how various individual ratings are combined using the four formulas. The formulas do not take into account the types of disabilities being combined.

Rating Schedule 1921 1930 1933 1945 to Present
Two 10% Ratings 19 19 20 20
Three 10% Ratings 28 19 30 30
Four 10% Ratings 37 19 30 30
Five 10% Ratings 46 19 40 40
One 30% and four 10% 58 58 50 50
One 70% and four 10% 82 82 80 80

A claimant who has three disabilities with each disability rated at 10%, receives a combined rating of 30%. A veteran with two service-connected disabilities, one rated 60% and one rated 10%, receives compensation only at the 60% rate. The current formula for combining additional ratings gives greater weight to multiple 10% ratings. The effect of additional 10% ratings is diminished if the primary diagnosis has a high rating. Having multiple low ratings increases the

payment dramatically for a veteran whose primary diagnosis has a low rating; it has a negligible or much smaller effect for veterans who have a single condition with a high rating such as 80%.

In our analysis we found that actual earnings, on average, were higher for veterans with more disabilities at a given rating level such as 30%. This paradoxical result suggests that the rating for the first medical condition captures most of the impact of the veteran's overall medical conditions on his or her potential earnings. The ratings for the second, third, or additional medical conditions increase the CDD but the additional conditions do not further affect the veteran's earning capacity. The formula for combining disabilities results in ratings that over compensate veterans for lost earnings.

An option to the current single lookup table is to replace the current table with tables that reflect specific combinations of different disabilities. This will require conducting additional analysis of the impact of combinations of disabilities on earnings. The tables could be programmed for ease of use rather than manually applied as is the current practice. Such programmed tables could actually reduce the burden on raters.

Medical science has established for many years that certain diseases are prevalent together, examples of which include PTSD and major depressive disorder, and diabetes and cardio-vascular diseases. It is quite likely that there are many diseases that are present together in individuals and that they cause a greater impact on the individual's earning capacity than would be the case with multiple unrelated minor ailments. Additional analysis of the impact of multiple diseases or disabilities could result in an enhanced approach to ratings for combinations of diagnoses. For example, nearly 30,000 service-connected veterans have a diagnosis of traumatic brain disorder and some 4,600 of these (15 percent) also have a service- connected diagnosis of PTSD and almost 800 (3 percent) also have a diagnosis of major depressive disorder. Likewise, of some 307,000 veterans with a service-connected diagnosis of PTSD, some 5,200 (1.7 percent) also have a service-connected diagnosis of major depressive
disorder. Further analysis could determine if these diagnoses in combination have a greater or lesser impact on earnings.

Individual Unemployability Benefits

The number of IU cases has grown from about 101 thousand in September 2001 to 190 thousand cases in September 2007, an increase of almost 90 percent. PTSD cases constituted about one-third of the IU cases in 2007 and one-half of new IU cases between 2001 and 2007. Forty-four percent of the IU cases in 2007 were for veterans age 65 and older; 64 percent for veterans age 55 and older.

Although age is clearly related to employment, it is not considered in IU determinations. While IU is not intended for veterans who voluntarily withdraw from the labor market because of retirement, new awards are often made to veterans who are near or past normal retirement age for Social Security. In light of these circumstances it appears that IU determinations are made for

veterans approaching or past retirement age based on providing retirement income or in recognition of loss of quality of life rather than for employment loss.

IU determinations depend on decisions about substantially gainful employment. In order to further facilitate the decision-making process for IU determinations, a work-related set of disability measures would be worth assessing. Consideration of this could supplement the medical impairment criteria in the VASRD.

An option for consideration would be for VA to adopt a patient-centered, work disability measure for IU evaluations. As with the current IU evaluation, assessments would address the individual's work history but also consider other factors including motivation and interests. Work disability evaluations would include relevant measures of impairment, functional limitation, and disability. Particular care should be taken to include measures of physical, psychological, and cognitive function. Assessments would evaluate the individual in the context of his or her total environment.

Special Monthly Compensation for Quality of Life

Special Monthly Compensation (SMC) is a series of awards for anatomical loss or loss of functional independence. These awards are evaluated outside of the Rating Schedule. SMCs are known by the letter designations K, L, M, N, O, P, R, and S. SMC K is the only award that can be made to veterans who are rated less than 100% and can be awarded one, two, or three times with each award $91 per month (2008 rates). SMC K is paid in addition to the amount paid for the Combined Degree of Disability rating. As of December 1, 2007, there were 188,747 veterans receiving SMC K awards. SMCs other than K are paid instead of the amount payable for 100% ratings, not in addition to the amount paid for 100% ratings. Since SMCs are not awarded with the intent of compensating for average loss of earnings capacity, they can be thought of as payments for the impact of disability on quality of life.

SMC for Assistance

Four different SMCs can be paid to veterans for assistance: L, S, R1, and R2. SMC L can be awarded either for loss of or loss of use of limbs or organs or to veterans rated 100% without such loss if they are in need of regular Aid and Attendance; in other words, if they need assistance with activities of daily living. In 2007, 48 percent of 13,928 veterans receiving SMC L were receiving that award because they needed assistance, rather than for loss of or loss of use of organs or limbs. SMC S can also be awarded to veterans rated 100% if they are housebound but do not meet the required level of assistance for SMC L. SMC R1 and R2 are awarded to catastrophically injured veterans, primarily to those with spinal cord injuries, who need the highest levels of assistance. The table below depicts the number of veterans receiving SMCs other than K and the amount of the award that is above the normal amount paid to veterans rated 100% without SMC. In the case of R1 and R2, the veteran must be awarded SMC O or P due to the severity of disability in order to qualify for the additional assistance provided by R1 or R2. Thus, if a veteran receives SMC L for assistance, the veteran is receiving only $618 per month above the normal 100% amount; and a veteran receiving SMC S for housebound is receiving

only $302 above the 100% amount.
In 2007, 45,773 veterans received SMC L, S, R1, or R2 for assistance and $30,223,540 above the amount paid for the 100% rating. This was an average of $660 per month.
Special Monthly Compensation Rates Compared with Schedular 100% Rating

Quality of Life

L
$3,
14
5
$2,
52
7
$6
18

5,3
55
$3,
30
9,3
90
L}4
$3,
30
7
$2,
52
7
$7
80
1,8
87
$1,
47
1,8
60
M
$3,
47
0
$2,
52
7
$9
43
1,8
39
$1,
73
4,1
77
M}4

$3,709
$2,527
$1,182
1,650
$1,950,300
N
$3,948
$2,527
$1,421,477
$677,817
N}4
$4,180
$2,527

$1,653,250	
$413,250	O/P
$4,412	
$2,527	
$1,885	
2,661	
$5,015,985	Total

14,119	
$14,572,779	**Assistance**

L

$3,145

$2,527

$618,944

$3,057

5,392

L}4

$3,307

$2,527

$780,171,742

$1,358,760

S $2,829

$2,527

$302,361

$9,471,022

R1

$6,305

$4,412

$1,893

5,576

$10,555,368

R2

$7,232

$4,412

$2,820

2,151

$6,
06
5,8
20
To
tal

45,
77
3
$3
0,5
06,
36
2

Source: Department of Veterans Affairs, Special Monthly Compensation, 12/1/07

Using the results of surveys conducted by the National Alliance for Caregiving and the American Association of Retired Persons and by the Veterans' Disability Benefits Commission, we estimated monthly costs of hiring assistance ranging from $520 for 8 hours of caregiving per week to $10,800 for full time, around the clock 24/7 care. The CNA Corporation issued a report for the Department of Defense in September 2008 on the average earnings and benefits loss of caregivers of seriously wounded, ill, and injured active duty service members and estimated those losses as $33,500 annually or $2,800 per month. Regardless of which estimates are used, the current amount of the SMCs for assistance is well below either the cost of hiring such care or of the lost earnings and benefits of family caregivers.

Quality of Life Payment Options

Our review of the literature led us to define quality of life (QOL) for veterans as an overall sense of well-being based on physical and psychological health, social relationships, and economic factors. Our in-depth analysis of the data from the Veterans' Disability Benefits Commission's survey of more than 21,000 disabled veterans found that QOL loss occurred for veterans at all levels of disability and for all 40 diagnostic codes for which sufficient responses were available. We also found that loss of QOL increases as disability increases, but it does not increase as sharply as disability does, and that there is wide variation in the loss of quality of life at each disability rating. QOL is an individualized perception, and people adjust to disability. About one-half of individuals with severe disabilities report high degrees of life satisfaction.

The quality of life loss analysis paralleled the earnings loss analysis in many regards. In particular, we found that veterans receiving Individual Unemployability benefits and those receiving SMC payments report mental and physical QOL loss significantly greater than for other service-connected veterans. Fewer severe disabilities are associated with a greater loss of quality of life than a greater number of less severe conditions at a given level of combined disability.

Three broad options were presented to VA for implementing a QOL payment:

1. Statutory rates for QOL payments by combined degree of disability
2. Separate, empirically-based normative rates for QOL loss
3. Individual clinical and rater assessments plus separate empirically-based rates for QOL loss.

All three options would require periodic surveys to assess QOL impact. Option 3 would be the most complex and costly to implement and would require clinical and rater assessments each time a claim is filed. Options 1 and 2 would not be subject to veteran appeal if Congress approves the rate scale. However, in conjunction with implementing any QOL options, the criteria and benefits contained in the VA Schedule for Rating Disabilities should be adjusted to reflect average actual lost earnings, to ensure an overall equitable system.

Payment rates for QOL would have to be set by policy or statute and placing an economic value on QOL would be subjective and value laden. Options that use empirical data are provided in our report as examples of how such rates could be established. The monthly amounts depicted in the options range from $99 to $974. Volume III of our report contains an extensive description of the findings of the QOL analysis and of the possible rationales or bases for setting the amounts.

Foreign countries that award QOL payments link them closely to impairment and consider the circumstances of the individual veteran. QOL payments are considered the primary disability benefit and earnings loss payments are made only for actual earnings loss or a specified loss of earnings capacity. A veteran in Canada, for instance, must demonstrate inability to work in order to receive an earnings loss payment in addition to a QOL payment and must complete three years of vocational rehabilitation that results in unemployment before receiving ongoing earnings loss payments.

VA could structure its disability benefits like the foreign programs so that they are based primarily on QOL. QOL could be inferred from impairment, or it could be measured directly, with earnings loss paid only when an actual earnings loss occurred.

The systems used in both the United Kingdom (UK) and Canada pay QOL in lump sum payments and have several low rating levels for QOL payments. While making QOL payments in all 15 of its ratings, the UK system does not pay for earnings loss in the 4 lowest ratings of its 15-point rating scale. The Canadian schedule increases proportionally so that in 2008, after the 10% rating, each 5% rating increase in Canada has a payment increase of $12,909. The UK payments do not increase with a multiplicative constant. For instance, the highest payment is $565,000, the second highest payment is $399,000, the third highest is $228,000. The lowest pain and suffering payment in UK is $2,080. These payment schedules reflect their societies'

view that severe disability merits very high QOL payments and low levels of disability merit recognition payments. These benchmarks suggest great flexibility in establishing payment levels for U.S. veterans.

Although our study focused on monetary compensation for QOL, the literature review and the analysis of the survey data indicates that greater QOL is supported by a strong family or social network and that employment is associated with a better quality of life. QOL of service-connected veterans may be improved by programs aimed at family members to help them to understand and support the disabled veteran, through case management directed to the holistic needs of the veteran, and employment assistance programs.

Our earnings analysis found that on average veterans' earnings plus disability compensation exceeds the expected earnings level by 7 percent. There are exceptions such as for mental health and TBI and those rated 100% where earnings plus compensation is significantly less than expected earnings. Some SMC payments can be thought of as payment for QOL. Taken together, a judgment could be made that veterans are currently compensated for QOL.

Transition Benefit Options

Disabled veterans face a number of living expenses during their transition to civilian life before and during their participation in the VA Vocational Rehabilitation and Employment (VR&E) Program.

Providing transition assistance payments offset the foregone cost of earnings (time spent in rehabilitation and not working), which in turn increases the likelihood of entry and completion of rehabilitation. Providing transition assistance benefits to caregivers and family members could reduce the levels of stress and depression for veterans and caregivers, which in turn could raise the overall quality of life for both the patient and family members and caregivers. Providing and aligning financial incentives with successful completion of specific rehabilitation tasks could increase the likelihood that patients enter and successfully complete rehabilitation.

In order to estimate what an appropriate level of transition benefit should be, we selected housing, food, and transportation expenses to comprise a core group of living expenses that one would expect a living expense benefit to cover. We also considered additional "menu items" such as apparel and services, health care (for dependents of disabled veterans not rated 100%), personal care products and services, household operations, and child care. Based on statistical analysis of average living expenses, the core living expense option would be $1,898 for the veteran alone or $2,981 for a veteran with two dependents. This includes the average monthly housing allowance paid by DoD in the 11 most populous veteran population centers, the same rates that would be paid under the Chapter 33 Education program. The payment for additional expenses would be $511 for the veteran alone or $935 for a veteran with two dependents. A new transition benefit would be in lieu of the current subsistence allowance and precede the start of permanent disability compensation benefit. The 2007 monthly subsistence allowance was $521 (no dependents) and $761 (two dependents).

We identified several groups of veterans who could be eligible for such payments based on

medical discharges, severity of disability, and time since discharge. Defining the purpose of a transition benefit is essential: would it be intended to ease the transition from military service to civilian life? If so, it is important to realize that veterans participating in the VR&E program fall into three groups: those who applied from just before discharge to two years after discharge (39 percent), those who applied from three years to ten years after discharge (29 percent), and those who applied more than 10 years after discharge (32 percent.)
The possible eligibility groups would range from a small group consisting of severely injured/ill who are medically discharged with ratings of 70% or higher who enter rehabilitation within two years of discharge, to a much larger group that would include all veterans currently eligible for VR&E. The most limited option would include 3,400 applicants per year and the most inclusive option would include approximately 29,000 each year.

Important policy decisions would need to be made in order to determine which veterans participating in VR&E would be eligible for a transition benefit.

Methodology Differences with the Previous Study
As discussed previously, our methodology differed in significant ways from the approach taken by the CNA Corporation in 2007 for the Veterans' Disability Benefits Commission (VDBC). Our study focused on service-connected and non service-connected veteran populations discharged since 1980. Data from the Defense Manpower Data Center (DMDC) is reliable for veterans discharged since that time and provides important demographic or human capital characteristics for individuals such as education level at time of entry into the military, gender, and officer or enlisted status. These characteristics can be used to ensure that the observed differences in earnings are due to the service-connected disabilities and not some demographic differences.
The study for the VDBC also used earnings data for non service-connected veterans from the Current Population Survey (CPS) which were self reported, in comparison with the actual earnings of service-connected veterans discharged prior to 1980. We conducted a thorough analysis of the CPS data and concluded that it was not reliable for this purpose for several reasons. Self-reported earnings are not as accurate as actual Social Security Administration earnings data and the CPS sample has 50 percent fewer veterans than the general population. Post 1980 veterans have better health, fewer limitations from disabilities, and higher rates of employment. Thus we focused on comparing earnings of veterans discharged since 1980.
Although we obtained actual earnings data from the Social Security Administration on the entire population of 2.6 million veterans receiving disability compensation, we limited our analysis to the 1,062,809 service-connected disabled veterans discharged since 1980 and a demographically selected sample of 432,947 non service-connected veterans also discharged since 1980. These two populations were compared to determine the impact of service- connected disabilities on earnings. Actual earnings were compared, thus avoiding the use of survey data. A detailed explanation of why CPS data is not reliable for this comparison is provided in pages 132-136 of Volume III of our report. We believe that this comparison of veterans discharged since 1980 enables policy makers to focus more on veterans that VA rates today and will be rating in the future.
Another difference between our analysis and the CNA analysis was that we conducted a more detailed analysis of rating levels using the entire range of rating levels (10% through 100%, in 10% increments) while CNA used four groupings of ratings (10%, 20-40%, 50-90%, and 100%).

We did this so as to be able to analyze all ten rating levels individually. We also used individual diagnostic codes to the maximum extent possible within the restrictions on release of individual-level data. The over 700 codes in the Rating Schedule were grouped into 240 similar diagnoses so as to avoid the possibility of individual veterans being identified. In contrast, the CNA study aggregated veterans into the 15 body systems with PTSD the only individually analyzed diagnosis. We also placed emphasis on analysis of veterans receiving Special Monthly Compensation and Individual Unemployability. Finally, we used 2006 earnings without estimating lifetime earnings while CNA used 2004 earnings to estimate lifetime earnings. We obtained annual earnings for veterans since 1951 but time constraints prevented including this information in our analysis as we would have preferred.

We realize that limiting the earnings analysis to veterans discharged since 1980 excludes 1.6 million of the 2.6 million veterans receiving disability compensation, especially most Vietnam veterans. However, demographic and human capital data available from DMDC is not considered accurate on veterans discharged prior to 1980. Therefore, it is not possible to identify a sample of non service-connected veterans from DMDC data closely matched on human capital characteristics to serve as a comparison group in an analysis of the impact of disability on earnings. It could be possible to randomly select a sample of non service- connected veterans from either the DMDC data or from the VA Beneficiary Identification and Records Locator Subsystem (BIRLS) matched on a more limited set of known characteristics such as age, military rank, and date of discharge. This sample would lack key characteristics such as education level, military occupational series, and Armed Forces Qualification Test scores as is available on the post 1980 group and may not be as well matched to the service- connected veteran population. This limitation would need to be recognized.
In addition, if more time were available for the analysis, more detailed analysis of the earnings data for veterans discharged prior to 1980 and since 1980 could be completed, especially an analysis of lifetime earnings. Social Security Administration retains annual earnings for individuals from 1951. These annual earnings were captured last year but there was not sufficient time to analyze that data.

We note that of the estimated seven million living Vietnam Era veterans, 28.4 percent are age 65 or older and 44.6 percent are age 60 to 64 and thus are nearing the normal retirement age. Thus, the earnings of Vietnam Era veterans are likely to be already diminishing or very limited already.

For those already service-connected, it is unlikely that benefits would be reduced in any way. We suggest that the focus of policy or statutory adjustments should be on future earnings and that the emphasis of future analysis should be on veterans discharged since 1980 so that more precise comparisons can be made, even if veterans discharged prior to 1980 are also analyzed.

Concluding Remarks
In closing, our study completed last year provides a great deal of information on the adequacy of disability compensation and ways in which the program can be improved to better serve veterans. There are clear indications that overall the amount of compensation exceeds the

average expected earnings loss yet it is inadequate for mental health and for those rated 100%. The methodology used to assign the overall combined degree of disability, and hence the amount of compensation paid, results in over compensating many veterans, especially at the lower rating levels. There are several diagnoses that either do not result in loss of earnings or the rating is higher than necessary. It could be concluded that quality of life is somewhat compensated by the amount compensation exceeds expected earnings loss and by some SMC payments. SMC payments for assistance are not equal to either the cost of hiring assistance or the lost earnings and benefits of family caregivers.

While the findings cited in this testimony provide accurate and reliable information upon which to base policy decisions, the timeframe for that study (seven months) did not permit a thorough analysis of certain aspects of the disability compensation program and of the inter-related nature of the findings. We would recommend that additional analyses be conducted. Restrictions intended to safeguard the privacy of individuals prevented the Social Security Administration from providing earnings at the individual veteran level. This meant that we could not analyze the impact on earnings of combinations or comorbidities of disabilities. We have discussed this issue with the Social Security Administration and believe a methodology could be used that safeguards the privacy of individuals yet enables such analysis. For the long term, we agree with the recommendation of the VDBC that VA and DoD should be granted statutory authority to collect and study appropriate data from the Social Security Administration and the Office of Personnel Management, namely earnings data, only for the purpose of assessing the appropriateness of benefits.

Additional demographic or human capital characteristics could be analyzed in future studies to ensure that the impact on earnings is not due to factors such as education level at discharge, military occupational series, or Armed Forces Qualification Test scores. Also, consideration of such factors as time in service, period of service, and timing of diagnosis could shed additional light on the impact of disability on earnings.
In addition to analysis of earnings at the individual veteran level, earnings and quality of life results should be integrated so as to see the overall impact of disability on veterans. This could include assessing how comorbidities and the timing of the diagnoses as indicated by the date of original service-connected disability impact earnings and QOL. A technique called shadow pricing could also be used to measure the economic impact on quality of life.

Mr. Chairman, I thank you for the opportunity to appear before you today and would welcome any questions you or the Committee members may have.