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SHOULD VETERANS DISABILITY COMPENSATION BE CONDITIONED UPON VETERANS WORKING TOWARDS REHABILITATION AND RETURN TO EMPLOYMENT

Heather Ansley & Aniela Szymanski*

INTRODUCTION

The Department of Veterans Affairs (VA) has experienced dramatic increases in its budgets since September 11, 2001.1 Increasing federal deficits during this time has led Congress to seek spending cuts, causing tensions in efforts to ensure that a declining veteran population receives the quality benefits and services they earned through years of service.2

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2 See generally Statutory Pay-As-You-Go Act of 2010, Pub. L. No. 111-139, 124 Stat. 8. (stipulating that new legislation that changes taxes, fees, or mandatory expenditures must not increase the overall budget, and if a bill reduces revenues or increases mandatory expenditures, it also must be fully offset by a corresponding increase in revenues or decrease in spending).
While the number of veterans in the United States has steadily been declining due to veterans of World War II, Korea, and Vietnam dying, the number of veterans receiving disability compensation has risen dramatically due to injuries sustained by service members in conflicts in Iraq and Afghanistan, and the increased survivability of many of the injuries they have sustained. The high cost of compensation has prompted policymakers to consider whether fundamental changes are needed in the VA disability system. Some legislative and policy recommendations would tie disability benefits to work incentives and medical treatment requirements to reduce long-term dependence on federal benefits.

Such drastic alterations to the VA benefits system would be inconsistent with the intent that Congress set forth for the VA in establishing such a disability benefit. Further, such changes may even be unconstitutional. This article explores the legal and practical aspects of such changes and argues that conditioning receipt of disability compensation upon either pursuing medical treatment or return to employment is not a sound course of action. First, the article reviews the structure of the VA’s disability system, other relevant VA programs, why veterans seek assistance from the VA, and the cost of those benefits. Next, the article discusses critiques of the existing system and proposals to change it. Then, the legality of those potential changes is set forth, including a discussion of whether placing conditions on benefits is constitutional and practical, historical results of forced treatment schemes, and the permissibility of requiring employment as a condition of receiving benefits. Finally, the article will explain why imposing such a job or treatment requirement is not a reasonable solution to the challenges lawmakers seek to remedy and suggest other means to achieve these ends.

I. VA’S DISABILITY SYSTEM

It is important to understand the principles upon which veterans’ disability is structured before considering whether policy changes would be consistent with the original intent of the benefit.

The veterans’ disability system includes monetary compensation to veterans for disabilities incurred in or aggravated by military service. These are known as “service-connected disabilities.” When Congress instituted the system, it directed that the VA “shall adopt and apply a schedule of ratings of reductions in earning capacity” and that the “ratings shall be based, as far as practicable, upon the average impairments of earning capacity resulting from such injuries in civil occupations.”

This concept is mirrored in the VA’s regulations at Section 4.1 of Part 38 of the Code of Federal Regulations (C.F.R.), which states:

The percentage ratings represent as far as can practicably be determined the average impairment in earning capacity resulting from such diseases and injuries and their residual conditions in civil occupations. Generally, the degrees of disability specified are considered adequate to compensate for considerable loss of working time from exacerbations or illnesses proportionate to the severity of the several grades of disability.7

The regulations also contain a cautionary note in section 4.10: “It will be remembered that a person may be too disabled to engage in employment although he or she is up and about and relatively comfortable at home or upon limited activity.”8 This implies that the VA should not consider the loss of nonwork capacity in assigning a rating.

The VA rating schedule is a detailed guideline for each disability. It must contemplate, however, that veterans will continue to work while receiving disability compensation. According to the VA’s most recently published data, as of 2017, a majority of veterans receiving VA disability compensation (1.32 million) received between zero and twenty percent ratings.9 Only 609,322 veterans out of 4.55 million received a 100 percent rating.10 Nearly 4 million veterans receiving compensation in 2017 received less than 100 percent.11 Veterans receiving less than 100 percent disability are presumed to have a disability that reduces their earning capacity but which does not eliminate their employability.12

The VA uses what it terms “generally applicable guidelines” to determine lost earnings capacity, as opposed to individualized assessments. Generally applicable guidelines merely mean that the VA assumes that a particular disability has the same impact on earning capacity for every veteran that suffers from it, instead of assessing individually what that specific disability’s influence is on each veteran’s earning capacity. To establish such a system, the VA evaluated the disabling effects of the medical conditions and set forth the results in a rating schedule first developed in 1945.13 The results of this were translated into 38 C.F.R., Part IV, Schedule for Rating Disabilities, rating various medical conditions in ten percent increments. The VA updates the rating schedule “from time to time,” so it has been updated since 1945, but the principles remain the same.14

The schedule is medical in nature and generally focuses on objective factors, such as range of motion or the presence or absence of symptoms. For example, section 4.71a of 38 C.F.R. sets criteria for rating disabilities of the musculoskeletal system, with the rating percentages based on how many degrees a veteran can move their arm, leg, foot, shoulder, or wrist. The schedule does not consider factors such as whether the veteran is employed or seeking medical treatment to

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10 Id.
11 Id.
address the disabling condition. The absence of such factors tends to indicate that neither Congress nor the VA intended these be requirements of the disability scheme for veterans.

A 2012 RAND study evaluated the extent to which a service-related disability impacts the earnings of active duty service members and reservists and the role government benefits play in filling earnings gaps. RAND found that retirement and disability payments from the VA and the U.S. Department of Defense typically “more than fully compensate AC members [active component service members] with very serious injuries for estimated earnings losses.” Non-reservist veterans with “serious or very serious injuries have [income] replacement rates in year 4 of 122 and 154 percent, respectively” from all benefits. These payments give members of the reserve component “even greater replacement for labor market earnings” than the active component veterans. In the fourth year following deployment, reservists who have been seriously injured, defined as having sustained a life-altering injury, have income replacements of 143 percent and those who were very seriously injured, defined as having suffered a life-threatening injury, have income replacements of 183 percent.

The current VA disability compensation structure, therefore, meets the original intent of Congress for such beneficiaries by providing a rough replacement for lost earning potential. Veterans are expected to earn the remainder of the money required to sustain their livelihoods.

Disability compensation is vital to veterans and their families. Depending on the level of disability, benefits may include tax-free monthly compensation, access to health care for service-connected disabilities, and educational and employment opportunities. Veterans with the highest levels of service-connected disabilities may also receive compensation for housing adaptations, auto adaptations, dependent health care and education. Benefits may be

16 See RAND CORP., www.rand.org (last visited Oct. 4, 2019) (The RAND Corporation is a nonprofit entity that offers research and analysis for policy issues to the U.S. military).
18 Id. at 47 (“(T)hose with very serious injuries receive $9,373 more in total household income in year 4 than they would have received had they not been injured.”).
19 Id. at 52.
20 Id. at 48.
21 Id. at 52.
22 Supra notes 6, 17.
critically important to making disabled veterans and their families whole for their injuries, wounds, and illnesses. Barriers to receiving these benefits conflict with the purpose of the system. The VA’s mission is “[t]o care for him who shall have borne the battle, and for his widow, and his orphan. . . .” Consequently, it is neither advisable, nor in keeping with the spirit of a grateful nation, in caring for those who have been injured, wounded, or developed illnesses as a result of their military service to impose additional burdens on receiving these benefits. The veteran has upheld his/her end of the bargain by serving the nation, and the government must follow through on its obligation to care for them.

Veterans with service-related disabilities apply for VA disability compensation for a variety of reasons. A veteran must have a disability incurred or aggravated during military service. It can take years or even decades for some veterans to prove their eligibility for benefits. Many times this is due to a lack of in-service record keeping of injuries or conditions incurred while the service member was active. Although the VA’s disability compensation program is meant to be pro-veteran, it can be difficult for veterans to receive their benefits.

It is important to understand why veterans who face substantial barriers in seeking compensation choose to endure the process. For example, are they seeking monetary benefits to replace income lost in the workforce due to their disabilities? Are they seeking validation for their conditions? What is the impact of going through the disability compensation application process on them—a process that can be quite lengthy?

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32 The VA publishes weekly reports called Monday Morning Workload Reports that include the average number of days that a newly filed claim takes for the VA to complete. Veterans Benefits Administration Reports, U.S. DEP’T OF VETERANS AFF, https://www.benefits.va.gov/reports/detailed_claims_data.asp (last visited Nov. 2, 2019). As of August 2019, the average number of days an original claim took from filing to the decision was 112 days. This data, however, does not include the time that it takes for a claim to be finally decided if it is appealed past the initial decision. According to the Board of Veterans’ Appeals Annual Report to Congress for Fiscal Year 2018, the average number of days elapsed from the time an appeal was initiated until a final Board decision was 1,703 days or over four years. U.S. DEP’T OF VETERANS AFF., BD. OF VETERANS’ APPEALS, ANN. REP. (2018), https://www.bva.va.gov/docs/Chairmans_Annual_Rpts/BVA2018AR.pdf.
33 Although the VA does not make information publicly available revealing categorical reasons why claims are denied, practitioners, including the authors, routinely witness disability claims being denied for lack of in-service notations of an injury, symptoms, or condition.
34 Nina A. Sayer et al., Veterans Seeking Disability Benefits for Post-Traumatic Stress Disorder: Who Applies and the Self-Reported Meaning of Disability Compensation, 58 SOC. SCI. & MED. 2133-43 (2004), https://www.researchgate.net/publication/8653925_Veterans SEEKING Disability Benefits for Post-traumatic stress disorder_Who applies and the self-reported meaning of disability compensation (“Veterans who apply for service connection for [PTSD] must be sufficiently motivated not only to undergo the steps involved in the compensation application process, but also to describe their trauma histories to virtual strangers.”).
Understanding the goals of veterans in applying for disability compensation can help determine what types of incentives will help them to take advantage of the programs and services that help them to meet their life goals.\(^{36}\) A 2004 study surveyed the reasons veterans sought VA disability compensation for post-traumatic stress disorder (PTSD).\(^{37}\)

The study provided interesting insights into why Vietnam-era veterans applied for VA benefits. Of those surveyed, seventy-five percent believed “that becoming service connected for PTSD was important because ‘it will show that the government acknowledges how I was affected by my military experiences’ and ‘it will show that there is a reason for my problems.’” Only about half of these veterans “were receiving any mental health treatment at the time of application.”\(^{38}\) But more than fifty percent said they did so because “‘[i]f I get service connected for PTSD, I can focus on getting better.’”\(^{40}\) Interestingly, the importance of the financial aspects of compensation was only important for approximately twenty-five to thirty-five percent of applicants.\(^{41}\) Thus, they intended to get help to meet their health care goals.\(^{42}\)

The process of applying for disability compensation is already complicated. Additional requirements could prompt veterans to avoid the process altogether, which would negatively impact their health and well-being. For example, forty-five percent of veterans in the survey of those seeking compensation for PTSD agreed with the statement that being awarded disability compensation would make them “feel less like a failure.”\(^{43}\) Considering that veterans are committing suicide at a rate of 1.5 times to that of non-veterans, veterans’ views on why they seek disability compensation should not be ignored.

Aside from disability compensation, the VA also provides a variety of other types of benefits. In some circumstances, the VA takes into account whether a veteran can obtain and maintain employment as a basis for granting those benefits.

One benefit defined solely by a veteran’s ability to obtain and maintain employment is called “individual unemployability.” The VA grants this benefit to veterans who cannot work because

\(^{36}\) Sayer, supra note 34, at 2134 (“It would be important to know what disability applicants hope to achieve through the obtainment of disability status, and then subsequently to determine whether those goals are better attained through participation in a disability program or through other means.”).

\(^{37}\) Id. at 2134-35.

\(^{38}\) Id. at 2138; Douglas Mossman, MD, Veterans Affairs Disability Compensation: A Case Study in Countertherapeutic Jurisprudence, 24 BULL. AM. ACAD. PSYCHIATRY & L. 1, 27-44 (1996), https://pdfs.semanticscholar.org/2f21/38fc11f8ca42b30c165aa7b8146aa8b91180.pdf (stating that becoming 100 percent service disabled “vindicates their past sacrifices to country and fully justifies poor social and work function”).

\(^{39}\) Sayer, supra note 34, at 2133, 2137.

\(^{40}\) Id. at 2138.

\(^{41}\) Id. at 2139.

\(^{42}\) See id. at 2138 (stating that the motive for seeking compensation to improve the disability “contrasts with the disincentive assumptions regarding disability benefits.”).

\(^{43}\) Id. at 2140 (The researchers further discovered that for low-income veterans’ validation about their disabilities was even more critical than it was for higher-income veterans.).

of their service-connected disabilities. Their compensation is set at the 100 percent level even though his/her actual disability rating is below 100 percent.

Veterans seeking individual unemployability benefits must provide detailed information regarding their last employment and any attempts to find jobs since becoming disabled. The VA requires a veteran’s prior employers to complete a form stating the amount of time the veteran lost from work due to disability, how much the veteran got paid, why the veteran stopped working, and other details. The VA grants individual unemployability benefits only after confirming that a veteran is unable to secure substantially gainful employment due to his/her service-connected disability.

The VA also has a program, called Vocational Rehabilitation and Employment (VR&E), to help veterans return to employment fit for their capabilities and service-connected disabilities. Its goal is “to help [veterans] with job training, employment accommodations, resume development, and job seeking skills.” VR&E can include payment for post-secondary training or education. In this program, much like for the individual unemployability benefit, the primary factor is whether a veteran can be employed. Once the VA establishes that a veteran has an employment handicap due to a service-connected disability, the veteran is eligible for the VR&E program to enter an occupation that he/she can perform with their disability.

The cost of benefits paid to disabled veterans has drawn attention from policymakers and Congress. VA benefits, including disability compensation, are a mandatory expenditure within the VA’s budget. Mandatory spending is a majority of the federal budget and includes programs such as Social Security and Medicare.

Spending on disability compensation has increased in recent years. The VA’s fiscal year 2020 budget request to Congress for benefits was $123.1 billion in mandatory spending, a 7.5

47 Veteran’s Application for Increased Compensation Based on Unemployability, U.S. DEP’T OF VETERANS AFF. (Oct. 2017), https://www.vba.va.gov/pubs/forms/VBA-21-8940-ARE.pdf (requiring veterans to list all employment for the last five years, everywhere that the veteran tried to obtain employment since he/she became too disabled to work, as well as all schooling and other training that the veteran has engaged in).
54 What is the difference between mandatory and discretionary spending?, CONG. BUDGET OFF., https://www.cbo.gov/content/what-difference-between-mandatory-and-discretionary-spending (last visited Nov. 2, 2019).
percent increase, or $6.5 billion more, than for the fiscal year 2019 and up from $95.6 billion in 2015.

“The Veteran population has been declining since 1990 while the number of veterans with service-connected disabilities has risen” as a result of combat operations overseas. In 2008, 2.9 million veterans had service-connected disabilities, and by 2015, that number had risen to nearly 4.2 million. By 2019, the total number had increased to 4.89 million.

Veterans are also receiving disability compensation at higher ratings than in previous years. As of June 30, 2019, more than 750,000 veterans received disability compensation at the 70-100 percent rate. This is in sharp contrast to only approximately 83,000 veterans receiving disability compensation at the 70-100 percent rate in 2000.

The steep climb in the VA’s benefits budget corresponds with veterans having higher disability ratings and more veterans receiving benefits, even though there are fewer veterans than in previous years. At the same time, there are concerns that disability compensation’s monetary benefits create disincentives for veterans to improve their health or work for fear that they will lose their benefits. Specifically, is disability compensation counter therapeutic for veterans who might improve with treatment? Should it matter whether or not veterans choose to improve, when it is possible?

Yes, because although treatment may improve a veteran’s condition it may also have consequences for his/her disability rating and end eligibility for certain benefits. For this reason, some argue that receiving disability compensation may discourage veterans from returning to, or remain in, the workforce. After being out of the workforce for a long time, some veterans may

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55 President’s Budget Request, supra note 53, at 117.
56 Id.
58 Id.
60 Id.
62 See Mossman, supra note 38, at 35; B. Christopher Frueh et al., U.S. Department of Veterans Affairs Disability Policies for Posttraumatic Stress Disorder: Administrative Trends and Implications for Treatment, Rehabilitation, and Research, 97 AM. J. PUB. HEALTH. 12, 2143 (2007), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2089098/pdf/0972143.pdf; see also Richard J. McNally & B. Christopher Frueh, Why are Iraq and Afghanistan War veterans seeking PTSD disability compensation at unprecedented rates?, J. OF ANXIETY DISORDERS 524 (2013) (stating that the effect of the VA’s outreach to veterans about the incidence of PTSD may have the effect of “fostering an expectation of permanent disability”).
63 Frueh, supra note 62, at 2143 (explaining that an analysis showed that sixty-seven percent of individuals who finished treatment for PTSD “no longer met criteria for the disorder”; however, “little evidence of efficacy was found among veteran samples”).
64 See Mossman, supra note 38, at 33-34 (noting that community service providers informed the VA that they had on several occasions, “heard these men talk of their unwillingness to participate in employment efforts because they do receive that money [VA compensation]”); see Frueh, supra note 62, at 2143, quoting Drew D., et
be convinced that they are not able to work, and thus get discouraged about returning to work.\textsuperscript{65} In fact, returning to work may be a factor itself in VA’s decision to lower a veteran’s disability rating.\textsuperscript{66}

\section*{II. Critics of the Current VA Disability System}

Those critical of the current VA disability structure note that there are few, if any, incentives for veterans to improve their health and reduce their disability rating.\textsuperscript{67} Further, critics argue that there are more disincentives than incentives for veterans to get better.

Some legislators and policy advocates assert that providing financial compensation to disabled veterans actually harms them by making them dependent and discouraging them from seeking treatment for remediable conditions.\textsuperscript{68} These individuals contend that cash benefits to a veteran penalizes the veteran for returning to work, particularly if they are also granted individual unemployability benefits, and may hamper their ability to become a productive member of society again.\textsuperscript{69} They allege that veterans are encouraged to view themselves as disabled and, potentially, suffer “the humiliation of government dependency.”\textsuperscript{70}

Proponents of changing the VA disability model point to the 1990 Americans with Disabilities Act (ADA)\textsuperscript{71} to argue that having a disability does not mean an individual is unemployable. After the enactment of the ADA, most employers were required to make reasonable accommodations for disabled employees.\textsuperscript{72} Critics contend the VA’s disability system, which focuses on compensatory payments, misses opportunities to help veterans get rehabilitation, retraining, and reorientation to participate in the labor market.\textsuperscript{73} But this argument downplays existing VA programs such as VR&E that are specifically designed to help veterans return to the workforce.
Critics have used these contentions to influence not only legislation, but also charitable organizations by discouraging them from engaging in actions that may “decrease a veteran’s desire to participate in the labor force, while encouraging “sweat-equity requirements, financial co-pays, and concrete expectations of employment.” These positions are based on the presumption that veterans who receive a “hand out” are less likely to want to work. Although charitable organizations do not directly impact the provision of benefits through the VA system, their actions lend credibility to the critics, and the same principles used to influence those organizations are then echoed in Congress.

There is limited research supporting these arguments. In 2015, the National Bureau of Economic Research explored the impacts of expanding disability-compensation eligibility for Vietnam veterans in terms of the overall number of military veterans in the workforce. It examined Vietnam veterans who became eligible for VA disability compensation as a result of expanding benefits for those with type 2 diabetes. It concluded that the expansion of benefits had a significant effect on the labor supply of Vietnam-era veterans, in that eighteen percent who became eligible for benefits dropped out of the labor force. A 2007 congressional study analyzed the average employment rate of service-disabled male veterans compared to the general population and to non-disabled veterans. It reported that disabled veterans are employed at lower numbers than the other groups, but that the gap varies based on age. Disabled veterans in their twenties and thirties are employed only five percent less than non-disabled veterans. By age fifty, disabled veterans are employed twenty-four percent less. The gap narrows with advancing age, where both disabled and non-disabled men are less likely to work.

Other research and statistics, however, have supported the position that the VA disability system does not discourage veterans from seeking medical treatment or seeking or retaining employment.

The 2004 National Defense Authorization Act created a Veterans’ Disability Benefits Commission to assess the appropriateness of VA benefits for disabled veterans and their survivors. The commission issued a report in 2007 that explored whether VA benefits become disincentives for disabled veterans to work or to receive recommended treatment or therapy, after having surveyed veterans to determine how many avoided medical treatment because they did

74 Gade, supra note 68.
76 Id.
77 Id. at 30.
79 Id. at 31.
80 Id. at 32.
81 Id.
not want their disability compensation reduced. The commission reported “that only 0.45 percent … do not accept, exactly follow, or complete … medical treatment” due to concerns that their disability benefits may be impacted. It also stated that, as their disability rating increased, a veteran was less likely to be concerned that complying with medical-treatment recommendations would impact their benefits. However, the study estimated that only twelve percent of disabled veterans do not seek employment because of their disability benefits. The commission concluded that “veterans failing to comply with recommended medical treatments because they felt it might impact their disability benefits do not appear to be an issue” and “VA compensation providing a disincentive to work is not an issue.”

In 2016, the U.S. Department of Labor’s Bureau of Labor Statistics (BLS) analyzed this question. The BLS compared the labor supply of veterans with disabilities to those that were not disabled. It concluded that changes made to the disability system in 2000 that “expanded benefits” did not appear to cause any decrease in disabled veterans participating in the workforce.

A study to evaluate the impact of disability compensation on treatment outcomes was conducted between 2005 and 2010 with a sample of over 775 veterans who sought inpatient care for PTSD through the VA’s specialized PTSD programs. It examined the impact of compensation status to determine whether veterans of Iraq and Afghanistan had different expectations about treatment and outcomes than veterans of other eras. The study focused on veterans receiving disability compensation, seeking compensation, and seeking an increase in their disability rating. The number of veterans not receiving compensation was too low to be considered statistically significant for study.

The study found that veterans with positive expectations about their treatment had longer stays in treatment and a commensurate decrease in their symptoms. Although veterans who seek an increase in their disability rating for PTSD have lower expectations for their treatment prospects, researchers found “no significant differences in symptoms at discharge between

83 Christensen, supra note 78, at 1.
84 Id. at 92.
85 Id. at 93.
86 Id. at 94-95.
87 Id. at 97.
89 Id.
91 Id. at 493.
92 Id. at 495-96.
93 Id. at 496.
94 Id. at 499.
veterans seeking increased compensation and veterans receiving compensation.”95 Veterans seeking, but not yet receiving, disability compensation “[do] not report lower treatment expectations or endorse greater symptoms at discharge.”96 Thus, the researchers concluded there is no apparent connection between symptoms reported and those veterans’ compensation status.97 The data indicate that veterans report the same symptoms regardless of compensation status, contrary to the assertions by some researchers that veterans exaggerate symptoms to increase compensation.98

Moreover, another study focused on the impact of changes to the VA’s disability compensation system for Vietnam veterans, with the addition of type 2 diabetes as a condition presumptively related to military service due to exposure to the toxic herbicide Agent Orange.99 Unsurprisingly, the study concluded that the addition resulted in increased enrollment in the disability program and, correspondingly, increased expenditures.100 However, data analysis provides little support for any correlation between an increase in the number of veterans who receive disability compensation and their participation in the labor force.101 Although veterans’ higher disability ratings result in a decrease in labor participation, it is not clear whether the decrease is due to the increased financial compensation or the severity of disability.102 The researchers noted that compensation alone does not prompt veterans to exit the workforce, probably because a veteran may remain employed while receiving benefits, but they suggested that a veteran’s unemployment may prompt them to apply for disability benefits.103

A study published in 2015 based on different data showed that Vietnam veterans have lower levels of workforce participation, following a liberalization of service-connected disability benefits.104 Notably, veterans who are unable to work as a result of their service-connected disabilities may be eligible for disability compensation at the 100 percent rate even though their actual rating is less than 100 percent if they are determined to be unemployable.105 The authors of this study argued that veterans able to receive individual unemployability benefits have left

96 Id.
97 Id. at 501.
98 Frueh, supra note 62, at 523-524, 2143. 523-524.
99 Autor, supra note 75, at 1.
100 Id.
101 Id. at 383, 393. However, there was some indication that veterans’ wives may have left the workforce as a result of the increase in compensation.
102 Id. at 390.
103 Id.
104 Autor, supra note 75, at 30 (“For every 100 individuals who entered the DC [disability compensation] program as a result of the policy change, we estimate that 18 drop out of the labor force.”); Id. at 5 (indicating that the availability of benefits versus Vietnam veterans seeking earlier retirement led to decreased workforce participation); Id. at 23; See also Courtney Coile et al., Veterans’ Labor Force Participation: What Role Does the VA’s Disability Compensation Program Play?, NAT’L BUREAU OF ECON. RES., http://nber.org/papers/w20932 (noting that “the recent age-specific drops in veterans’ labor force participation line up fairly well with the policy-induced medical liberalizations” for veterans of different eras).
the workforce.106 Further, they conclude that, because veterans may receive both Social Security Disability Insurance (SSDI) and VA benefits at the same time, the “receipt of either DC [VA disability compensation] or SSDI benefits increases the odds of [a veteran] applying for the other.”107 Another study, however, examined the impact of relaxed rules for establishing service connection for Vietnam and Gulf War veterans with certain disabilities, noting a correlation between liberalization and veterans leaving the workforce, but also citing the likelihood of other factors being at play.108

In contrast to critics of the current VA disability system, the above referenced studies suggest that veterans who are receiving disability compensation do not necessarily leave the workforce. Further, when they do leave the workforce, it is not proven that their decision is prompted by the mere receipt of disability compensation. In light of the importance of disability compensation to veterans and their families, it would be unwise to change the current scheme without some definitive proof that the changes would provide long-term benefits to them.

III. PROPOSALS TO CHANGE THE VA DISABILITY SYSTEM

Since at least 1996, proposals have been made to change the type of disability payment from monthly to lump-sum, and to change the timing of the payment to be at the time of transition from active duty to veteran status.109 One advantage of these changes would be to increase incentives for veterans to rehabilitate, so they can work again.110

Some proposals focus on requiring veterans to “get well” to return to the workforce and no longer receive disability compensation.111 For example, in 2016, one member of Congress proposed introducing legislation that would condition the receipt of disability compensation for PTSD on the veteran’s participation in mental-health services provided by the VA.112 This was intended to deter a veteran from receiving compensation for a condition he/she did not wish to improve. The legislation was not introduced after the congressional representative discussed the proposal with veterans service organizations that promised to oppose it.

106 Autor, supra note 75, at 9.
107 Id. at 10 (explaining that the study results suggest that the liberalization of VA benefits “likely spurred additional SSDI enrollment, which may in turn have magnified any reduction in labor force participation among eligible veterans.”); Id. at 21.
108 Coile, supra note 104, at 10.
110 Id. at 265.
111 See supra Part II.
112 Because this bill was never introduced into Congress following objections by veterans service organizations, the text of the proposed bill is unavailable. Reference to the proposed bill, however, were made by news outlets. See Tom Lutey, Zinke to veterans: Be wary of dependence on government services, BILLINGS GAZETTE (Mar. 29, 2016), https://billingsgazette.com/news/zinke-to-veterans-be-wary-of-dependence-on-government-services/article_5d0c0e19-843b-5718-b013-79eece2fa475f.html.
Other similar proposals have periodically been discussed during times when Congress has attempted to perform a dramatic overhaul to the veterans’ disability system. Despite the identical outcomes of both the 2016 BLS analysis113 and the 2007 Veterans’ Disability Benefits Commission report114 that veterans do not voluntarily remain unemployed or avoid medical treatment, a common misconception still persists that veterans refuse treatment in order to receive monetary benefits.115 Much of this perception, however, seems to be based on anecdotal evidence because no studies have reached this conclusion despite the fact that researchers have examined it.

In 2019, former VA Secretary David Shulkin proposed that the VA should incentivize veterans’ well-being and financial independence by linking disability compensation and health care.116 Shulkin’s plan seemed driven by growing costs. Shulkin cited to the fact that the budget for VA benefits in 2009 was $100 billion, which had “more than quadrupled since the year 2000.”117 His proposal was to require veterans seeking disability compensation to actively receive medical treatment, so they could become employable and no longer need disability compensation.118 Shulkin cited the study about veterans becoming eligible for disability compensation due to type 2 diabetes, which did not definitely conclude that those veterans left the workforce as a result of receiving disability benefits, but Shulkin did not address the other two reports described herein that contradicted his assertion.

The issue is not new to the federal government. Congressional and presidential commissions have long turned their attention towards the issue of disability compensation. In 1996, Congress commissioned a report on the VA’s benefit claims adjudication system.119 Known as the Melidosian Report,120 it compared the increase of VA claims to claims in SSDI, Federal Employees’ Compensation, and other similar programs administered by state governments and private insurance companies.121 The commission found that all the related programs experienced unexpected growth and shifts over the preceding decade.122 The number of claims has increased each year, across programs, whereas the number of beneficiaries recovering, or otherwise leaving the programs, has decreased.123 These changes have prompted other disability programs to redefine “disability” and restructure insurance policies.124 The commission also noted that the VA’s disability compensation program is intended to compensate for lost earning capacity, whereas commercial disability insurance aims to achieve “maximum medical recovery,” then get recipients back to work.125 In its report, although other proposals were made about the way VA

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114 Christensen, supra note 78, at 97.
115 Shulkin, supra note 67, at 2.
116 Id. at 3.
117 Id. at 1.
118 Id.
120 Melidosian Report, supra note 116, at 3.
121 Id. at 223.
122 Id.
123 Id. at 223-24.
124 Id. at 227-28.
125 Id. at 232.
handles adjudication and other matters, the commission ultimately did not recommend that the VA’s goals be changed to mirror those of commercial disability insurance programs.

In 2007, President George W. Bush formed the President’s Commission on Care for America’s Returning Wounded Warriors\(^{126}\), and tasked it with examining and recommending improvements for returning service members’ transition to civilian life. The commission suggested that, in administering a disability compensation program, the VA’s goal should be to return veterans to their normal activities as quickly as possible.\(^{127}\) The commission added that it is necessary to incentivize veterans to rehabilitate, and recommended the integration of vocational rehabilitation and disability compensation.\(^{128}\) Currently as the two programs still operate independently, veterans need not participate in VR&E to obtain disability benefits.\(^{129}\)

It is doubtful, however, whether the VA can tie each veteran’s disability compensation to their participation in VR&E. In 2008, Congress mandated that the VA conduct a twenty-year longitudinal study of VR&E to determine the long-term outcomes associated with this program.\(^{130}\) A 2018 interim report notes that some ninety percent of veterans who participate in VR&E were employed the preceding year.\(^{131}\) The 2018 fiscal-year cost of VR&E was $1.67 billion\(^{132}\) and, in that year, 12,126 veterans successfully completed the program.\(^{133}\) The cost per veteran was more than $137,000. The study does not provide information on whether the amount of those veterans’ disability compensation was reduced. It is possible that, even after becoming employed, they continue to receive the same amount of disability compensation as they had prior to participating in the VR&E program.

Government agencies have also proposed budget savings targeting veterans’ benefits. Each year, the Congressional Budget Office (CBO) examines options to reduce spending. In recent years, the CBO has suggested that the government terminate individual unemployability benefits for veterans once they reach the age of sixty-seven.\(^{134}\) This would end benefits for approximately 235,000 veterans and save $47.6 billion over ten years.\(^{135}\) The rationale for this change is that, at age sixty-seven, a veteran would likely not work, regardless of disability.\(^{136}\) Advocates of such a change question why the VA should continue paying unemployability benefits to those who would not likely remain employed, given their age.\(^{137}\)

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\(^{127}\) Id. at 23.

\(^{128}\) Id. at 6-8.


\(^{132}\) Id. at 1-14.

\(^{133}\) Id. at 1-15.


\(^{135}\) Id.

\(^{136}\) Id. at 110-11.

\(^{137}\) In actuality, there are numerous reasons that this benefit should continue for veterans past age 67. One of the most important reasons is that veterans who have not worked because they were too disabled to be employed,
Non-governmental entities have also proposed drastic changes to the VA system. One proposal by psychiatrist Dr. Douglas Mossman suggests three changes that would attempt to address some Congressional concerns about the cost of benefits and also increase a veteran’s ability to exercise autonomy over all aspects of their life.\textsuperscript{138} The first change would end the dynamic nature of the current system and replace it with a specific determination from a point in time.\textsuperscript{139} Payments could be made in lump sum, similar to tort settlements, or monthly, as they currently are.\textsuperscript{140} Dr. Mossman argues that such a change would allow veterans the freedom to pursue health-care treatments as they choose and eliminate concerns about how health-care providers document improvements in a veteran’s health condition.\textsuperscript{141} Mossman acknowledges that such a change would eliminate the ability of veterans to receive increases in their ratings and compensation if their condition deteriorates.\textsuperscript{142}

Mossman’s second proposed change would tie the amount of compensation received to the amount the veteran loses based on their skills and career path.\textsuperscript{143} This would mean different levels of compensation for veterans with similar disabilities but different skill levels. A third change would remove an increase in pay for veterans hospitalized for longer than twenty days and require copayments to incentivize judicious use of the VA’s health care system.\textsuperscript{144}

Although such changes may help veterans to better direct their health care goals by removing possible disincentives, they would fundamentally alter the current approach of the nation toward its responsibility to care for injured veterans. They would repeal benefits and add burdens by implementing copayments. Solutions that place more burden on veterans to care for their service-related disabilities are not the right choice for our veterans or our nation, considering an all-volunteer military force and decades of war. If an all-volunteer force is to be maintained during a time of unending conflict, then veterans must be able to receive care and benefits without additional burden. Otherwise, our nation may be unable to sustain our military without resorting to compulsory service requirements.

\textbf{IV. UNCONSTITUTIONAL CONDITIONS}

Is it permissible under the U.S. Constitution to require veterans to seek medical treatment and/or employment as a condition of receiving disability compensation? Congress would need to consider this question before imposing such requirements on veterans.

who were therefore receiving individual unemployability, also did not have the opportunity to save for retirement or contribute to Social Security. Individual retirement savings and Social Security contributions are mainly made through one’s employer. Absent such contributions, once a totally disabled veteran reaches age 67, he/she will have no income on which to live.

\textsuperscript{138} Mossman, \textit{supra} note 38, at 39.
\textsuperscript{139} Id.
\textsuperscript{140} Id.
\textsuperscript{141} Id. at 40.
\textsuperscript{142} Id.
\textsuperscript{143} Id.
\textsuperscript{144} Mossman, \textit{supra} note 38, at 40-41.
The Constitution does not require benefits to veterans for disabilities related to their service. From the beginnings of the nation, however, military service has provided veterans with a variety of benefits. Following the ratification of the Constitution in 1789, Congress has continued the pension system for veterans originally established by the Continental Congress. Benefits have continued to expand as military service falls on a smaller number of Americans due in part to an all-volunteer force.

The government may not impose conditions for the receipt of those benefits that violate the recipient’s constitutional rights. The issue arises “when government offers a benefit on condition that the recipient perform or forego an activity that a preferred constitutional right normally protect[ed] from government interference.” Requirements on benefits that touch on fundamental constitutional rights are subject to strict scrutiny. These fundamental rights include exercise of religion, the right to travel, and freedom of speech. To be constitutional, the requirement must serve a compelling state interest.

In Sherbert v. Verner, the U.S. Supreme Court held that a state’s denial of unemployment benefits as a result of an individual’s refusal to accept employment that would conflict with the free exercise of religion was an impermissible burden on a constitutional right. The Court stated that “not only is it apparent that appellant’s declared ineligibility for benefits derives solely from the practice of her religion, but the pressure upon her to forego that practice is

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147 The Military-Civilian Gap: Fewer Family Connection, PEW RES. CTR. (Nov. 23, 2011), https://www.pewsocialtrends.org/2011/11/23/the-military-civilian-gap-fewer-family-connections/ (noting the decreasing likelihood of having a family member who served in the military for those adults who are 50 and younger); By The Numbers: Today’s Military, NPR (July 3, 2011 11:30 PM), https://www.npr.org/2011/07/03/137536111/by-the-numbers-todays-military (stating that only one percent of America’s population was serving in the active duty, reserves, or National Guard in 2010).
148 See Koontz v. St. Johns River Water Mgmt. Dist., 570 U.S. 595, 604 (2013) (noting that the Court has found in “a variety of contexts” that the government may not condition receipt of a benefit on an impermissible burden on constitutional rights); Kathleen M. Sullivan, Unconstitutional Conditions, 102 HARV. L. REV. 1413, 1415 (1989).
149 Sullivan, supra note 148, at 1421-22 (stating that a condition on a benefit “might be imposed in the form ‘recipients of this benefit may not do x’ or ‘must do y’ so long as the benefits lasts, where x or y are normally matters of the recipient’s constitutionally protected choice.”); Id. at 1427 (explaining that, in the alternative, a condition on a benefit “might be imposes as a prerequisite for the benefit in the form ‘this benefit will be granted only to recipients who will do x’ or ‘will not do y.’”).
154 Shapiro, 394 U.S. at 638.
155 Sherbert, 374 U.S. at 402-09.
unmistakable.”156 The Court further found that the state provided no compelling interest justifying the burden.157

In Shapiro v. Thompson, the Court held that imposing a residency requirement that limited eligibility for the receipt of welfare benefits was not permissible.158 The appellants in the case, multiple states and the District of Columbia, sought to justify the requirement for satisfying the residence condition to receive welfare benefits based on the need to ensure the fiscal health of the program to serve their long-term residents.159 The Court agreed that the residency requirement served its purpose, which was to deter needy residents from moving for any reason, however, held that such a purpose is an unconstitutional violation of the right to travel.160 A law must have an objective that meets the need of a state other than to penalize an individual for exercising their constitutional rights.161

In Memorial Hospital v. Maricopa County, the Court relied on Shapiro to reverse the Arizona Supreme Court’s decision to uphold a state law requiring counties to provide medical care to low-income residents only if the resident met a one-year residency requirement.162 The Court determined that a fundamental constitutional right, the right to travel, was implicated and thus the state must have a compelling reason for the requirement.163 Of note, the Court said that whether or not the beneficiary was in receipt of federal funds was irrelevant to Shapiro’s penalty analysis.164

Despite the Court’s holdings of unconstitutional conditions in these cases, its application of the doctrine “is riven with inconsistencies.”165 For example, the Court has held that a state’s failure to subsidize the exercise of a right, such as the right to bear children, is not unconstitutional.166 In Dandridge v. Williams, the Court upheld a state’s decision to impose limits on welfare payments available to recipients even though the result led to unequal treatment of families based on size.167 Although welfare benefits provide essential support to low-income families, the Court stated that the proper standard to test the constitutionality of the statute was whether the state had a rational basis for its decision to limit benefits to larger families.168 The Court found that the state indeed had a “legitimate interest in encouraging employment and in

156 Id. at 404.
157 Id. at 409 (quoting “‘(o)nl[y the gravest abuses, endangering paramount interest, give occasion for permissible limitation.’”).
158 Shapiro, 394 U.S. at 627 (finding that “interests which appellants assert are promoted by the classification either may not constitutionally be promoted by government or are not compelling government interests”).
159 Id. at 627-28.
160 Id. at 629.
161 Id. at 631 (quoting the Court in United States v. Jackson, 390 U.S. 570, 581).
163 Memorial Hosp., 415 U.S. at 254.
164 Id. at 261.
165 Sullivan, supra note 148, at 1416.
167 Id. at 487.
168 Id. at 485.
avoiding discrimination between welfare families and the families of the working poor.”169 As
the case law demonstrates, the doctrine of unconstitutional conditions has limits.

Is refusing to access medical treatment a right that is protected by the Constitution? If so, the
question is whether there is a state interest able to overcome the strict scrutiny that courts apply
to such challenges.170 If the right to refuse health care is not a fundamental right,171 then the state
must simply have a rational basis to compel acceptance of medical treatment.172

The courts have long recognized that individuals have a right to bodily integrity.173 Persons
have the right to control what happens to their bodies and must provide assent to any touching,
including for medical purposes, of their persons.174 Over time, informed consent and
constitutional protections have served as the basis for the right to refuse medical treatment.175

In Washington v. Harper,176 the U.S. Supreme Court ruled that mentally ill inmates have a
constitutional right to refuse medication in some circumstances.177 The Court found that these
inmates have a liberty interest derived from the Fourteenth Amendment’s Due Process Clause.178
The Court stated that “[t]he forcible injection of medication into a nonconsenting person’s body
represents a substantial interference with that person’s liberty.”179

In Cruzan v. Director, Missouri Dept. of Health, the Court recognized a constitutionally
protected right to liberty based on the Due Process Clause in finding that an individual may
refuse medical treatment, even when needed to sustain life.180 The Court stated that the ability of
an adult to refuse medical treatment is “the logical corollary of the doctrine of informed
consent.”181 This is true even in situations where the refusal of medical treatment will likely
result in the individual’s death.182

There are limits, however, to individuals’ ability to refuse medical treatment. Rights can be
limited in balancing the interests of the state with those of the individual’s liberty interest to

169 Id. at 486.
170 See Sullivan, supra note 148, at 1493 (“Preserving autonomous private decision-making not only
promotes self-determination by right holders; it also checks the power of the state.”).
171 Memorial Hosp., 415 U.S. at 254-55 (stipulating that fundamental rights are those recognized by the
court and include the right to travel); Sherbert, 374 U.S. at 402-403 (the free exercise of religion).
172 See Shapiro, 394 U.S. at 638.
years and sound mind has a right to determine what shall be done with his own body. . . .”).
175 Id.
177 Id. at 221-22.
178 Id.
179 Id. at 229.
180 Cruzan, 497 U.S. at 279.
181 Id. at 270.
182 See id. at 279.
avoid medical treatment.\textsuperscript{183} In Harper, the Court held that a state’s law allowing for involuntary treatment represented an “accommodation between an inmate’s liberty interest in avoiding the forced administration of antipsychotic drugs and the State’s interests in providing appropriate medical treatment to reduce the danger that an inmate suffering from a serious mental disorder represents to himself or others.”\textsuperscript{184} Later, in Riggins v. Nevada,\textsuperscript{185} the Court found that it would not have been a violation of due process for a state to forcibly medicate an individual who was incarcerated while awaiting trial for murder and robbery, if the state proved “that treatment was medically appropriate and, considering less intrusive alternatives, essential for the sake of [the individual’s] own safety or the safety of others.”\textsuperscript{186} In this case, the Court found that the state had not sufficiently explored those alternatives.\textsuperscript{187} In Sell v. United States,\textsuperscript{188} the Court provided further guidance to determine when the interests of the state are sufficient to outweigh the liberty interest of the individual and justify the forced administration of medication.\textsuperscript{189} A state must have an important interest that can only be furthered by limiting an individual’s rights but the limitation must be necessary and the least intrusive alternative.\textsuperscript{190} Thus, the government may compel medical treatment but only with limitations.

\textbf{V. IS REQUIRING MEDICAL TREATMENT AN UNCONSTITUTIONAL CONDITION ON THE RECEIPT OF DISABILITY COMPENSATION BENEFITS?}

An individual’s liberty right to refuse medical treatment under the Due Process Clause\textsuperscript{191} can be overcome by weighing the interests of the government against those of the individual. When an adult is competent and not a danger to themselves or others, the government has limited authority to require medical treatment.\textsuperscript{192}

For instance, the government does not compel Americans receiving SSDI or Medicare to undergo therapy or take medications as a condition of receiving benefits, even though doing so might make the individual more employable. Placing such a condition only on veterans would

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\textsuperscript{183} Id.; See also Mills v. Rogers, 457 U.S. 291, 299 (1982) (finding that “the substantive issue involves a definition of that protected constitutional interest, as well as identification of the conditions under which competing state interests might outweigh it”).
\textsuperscript{184} Harper, 494 U.S. at 236.
\textsuperscript{186} Id. at 135.
\textsuperscript{187} Id. at 127-28.
\textsuperscript{188} Sell v. United States, 539 U.S. 166 (2003).
\textsuperscript{189} Id. at 167; See also id. at 180-81 (holding that in order for the government’s interest to outweigh the individual’s interests, a court must; first, determine “that \textit{important} governmental interests are at stake”; second, would need to find that forcibly medicating a defendant for trial “will significantly further” the government’s interest and make it “substantially likely,” without significant side effects, that the individual will be able to stand trial; third, find that the forcible treatment “is necessary to further those interests” and that alternatives have been considered; and lastly the medication must be “medically appropriate”).
\textsuperscript{190} Id. at 167.
\textsuperscript{191} Malinski v. New York, 324 U.S. 401, 415 (1945) (finding that the Due Process Clause of the Fifth and Fourteenth Amendments has been interpreted to provide the same rights). (Frankfurter, J. concurring).
\textsuperscript{192} Carlos L. Rodriguez, \textit{Scope and Limits of Right to Refuse Medical Treatment: The Case of Jehovah’s Witnesses}, 82 REV. JUR. U.P.R. 1067, 1070 (2013); Cruzan, 497 U.S. at 262 (noting that an incompetent person may not have a right to refuse life-sustaining treatment because of the inability to provide informed consent).
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not serve any government interest and would most likely be deemed impermissible for a few reasons.

It could be argued that the goal of returning individuals to work is too attenuated from a requirement to seek health care. And the requirement to seek health care may have no effect on the receipt of benefits such as SSDI. SSDI has different eligibility requirements from VA disability compensation and thus, veterans eligible for one benefit are not necessarily eligible for the other.

The VA can require periodic medical exams to determine the ongoing status of a veteran’s condition. In determining whether a veteran still meets the requirements of the benefit—a current disability, such exams meets a justifiable interest. They do not require the veteran to receive treatment or take medicine. The exams simply allow the VA to determine the current disability level.

Also, requiring veterans to seek medical treatment as a condition of receiving disability compensation would allow the VA to manipulate veterans’ health status in a way that harms personal liberty. The doctrine of unconstitutional conditions should guard against such overreach. Requiring medical treatment might lead to impermissible social control over veteran’s lives. Although such control is permissible among service members because of the need to ensure readiness to defend the country, it is not for veterans and the disabilities that resulted from their service for the country.

VI. Is Requiring Treatment Practical?

Veterans with service-connected disabilities are eligible for health care through the VA’s Veterans Health Administration. The VA provides acute health care to service-disabled veterans via medical centers, community-based outpatient clinics, and community health care providers. The VA also provides long-term services and supports to veterans through VA

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193 38 U.S.C. § 101(16) (2018) (“The term “service-connected” means, with respect to disability or death, that such disability was incurred or aggravated, or that the death resulted from a disability incurred or aggravated, in line of duty in the active military, naval, or air service.”).
194 How Do We Define Disability? SOC. SEC. ADMIN. https://www.ssa.gov/redbook/eng/definedisability.htm (last visited Nov. 11, 2019) (stipulating that the requirement for SSDI is that the individual be unable to participate in any substantial gainful employment due to a physical or mental impairment that will either result in death or has or is predicated to continue for at least 12 months).
195 38 C.F.R. § 3.327(a) (2018) stating that the VA requests a reexamination whenever, it “determines there is a need to verify either the continued existence or the current severity of a disability.”).
196 Id.
197 See Sullivan, supra note 148, at 1490 (arguing that the best way to understand why conditions that implicate constitutional rights should be reviewed as direct threats is because of the role such conditions play in the redistribution of power between individuals and the government, between those who will and those who will not accept the conditions, and between those who depend on a government benefit and those who do not).
provided home-based care programs, community living centers, as well as contracting with long-
term care settings in the broader community to provide care for veterans.\textsuperscript{200}

Requiring veterans who may not want treatment to access VA care would likely exacerbate
costs and stretch capacity. As of March 2019, 4.84 million veterans were receiving disability
compensation benefits from the VA.\textsuperscript{201} Approximately nine million veterans were enrolled in the
VA’s health care system in fiscal year (FY) 2018.\textsuperscript{202} For FY 2019, Congress allocated $73.1
billion for veterans’ health care.\textsuperscript{203}

Priority access to VA health care depends on whether a veteran’s disability is “service-
connected.”\textsuperscript{204} The VA prioritizes how it allocates resources and the benefits that a veteran will
receive.\textsuperscript{205} A total of eight priority groups provide eligibility based on factors such as disability
rating, eras of conflict and locations of service, presence of catastrophic disabilities, certain
awards and honors, and income status.\textsuperscript{206} Veterans who are rated fifty percent or more are
assigned to priority group one.\textsuperscript{207} Veterans rated at least thirty or forty percent are in group
two.\textsuperscript{208} Veterans rated between ten and twenty percent are in group three.\textsuperscript{209}

Further, the VA has encountered more demands to increase these veteran’s access to care in
the last five years. In 2014, the VA’s health care system made national headlines due to wait
time scandals at the VA medical center in Phoenix, Arizona.\textsuperscript{210} The scandal highlighted the
failure of Congress to fully invest in the VA’s health care system despite decades of conflict,
including the wars in Afghanistan and Iraq. It also provided support for veterans seeking greater
access to health care in the community, outside of the VA system.\textsuperscript{211} Following congressional

\textsuperscript{200} \textit{Benefits & Health Care Utilization}, supra note 59. (There are approximately 170 VA medical centers and 1,240
outpatient medical facilities within the VA’s health care system).

\textsuperscript{201} Id.

\textsuperscript{202} Id.

\textsuperscript{203} Energy and Water, Legislative Branch, and Military Construction and Veterans Affairs Appropriations

\textsuperscript{204} 38 C.F.R. § 17.36(b) (2018).

\textsuperscript{205} U.S. DEP’T OF VETERANS AFF., ENROLLMENT PRIORITY GROUPS, (Apr. 2018)

\textsuperscript{206} 38 C.F.R. § 17.36(b) (2018).

\textsuperscript{207} Id. § 17.36(b)(1).

\textsuperscript{208} Id. § 17.36(b)(2).

\textsuperscript{209} Id. § 17.36(b)(3).

\textsuperscript{210} Timeline: The Story Behind the VA Scandal, USA TODAY (May 22, 2014),
https://www.usatoday.com/story/news/politics/2014/05/21/veterans-healthcare-scandal-shinseki-timeline/9373227/;
Dennis Wagner, Deaths at Phoenix VA Hospital May Be Tied to Delayed Care, THE REPUBLIC (Apr. 9, 2014),

\textsuperscript{211} See generally Darin Sehnick and Stewart Hickey, \textit{Transforming VA Care: A Way Forward}, THE HILL,
(agreeing for significant transformation within the VA health care system); Josh Keefe, \textit{Is the VA Being Privatized? This Koch-Backed Group Says it Just Wants ‘Choice’ But Veterans Aren’t So Sure}, NEWSWEEK (Apr. 5, 2018),
https://www.newsweek.com/koch-brothers-backed-group-could-determine-future-va-870693 (discussing the various
forces at play in the effort to transform the way the VA provides health care).
hearings\textsuperscript{212} and the resignation of then VA Secretary Eric Shinseki,\textsuperscript{213} Congress passed the Veterans’ Access to Care through Choice, Accountability, and Transparency Act of 2014, which created the Veterans’ Choice Program.\textsuperscript{214}

The Veterans’ Choice Program increased opportunities for veterans to receive care in their communities as a way to reduce pressure on the VA’s health facilities and providers. Congress also passed the VA MISSION Act of 2018.\textsuperscript{215} The VA MISSION Act further expanded access to care in the community through the establishment of the Veterans Community Care Program.\textsuperscript{216} The impact of the VA MISSION Act’s expanded access to health care on veterans and the VA’s health care system will unfold over a long period of time.

In light of these challenges, it is difficult to see how the VA can handle providing additional care should veterans be required to seek treatment as a condition for receiving disability compensation.\textsuperscript{217} Historically, fewer veterans have sought care than are enrolled in the VA health care system.\textsuperscript{218} Requiring veterans to seek medical treatments to ensure continued access to their benefits would add a new burden on the current VA system.

In addition, Congress, which already faces enormous budget deficits, may not adequately address the fiscal strain on the VA. Although the VA’s budget has increased in recent years while most other agency budgets have not, the rising cost of providing care that in turn increased the cost of disability compensation could result in pressure to limit benefits for veterans without service-connected disabilities. Veterans with catastrophic disabilities have access to the VA’s health care system under priority group four.\textsuperscript{219} Would they lose access to VA care? It would be of no gain to veterans, the budget, or society as a whole to shift the burden to Medicare and Medicaid\textsuperscript{220} to provide needed care for these veterans.


\textsuperscript{217} See Frueh, supra note 62, at 520, 525 (stating that prior to veterans “pursuing certification as disabled” through the VA they should first engage in evidence-based treatments for PTSD).

\textsuperscript{218} Erin Bagalman, \textit{The Number of Veterans That Use VA Health Care Services: A Fact Sheet}, CONG. RES. SERV. (June 3, 2014), https://fas.org/sgp/crs/misc/R43579.pdf.


Requiring medical care for veterans who may not want it and who may be able to do well without it would likely have a negative impact on other veterans who depend on care for their well-being. Care providers and administrators also would have to report to the Veterans Benefits Administration (VBA) regarding an individual veteran’s compliance with their treatment regimens. A mandate could damage the relationship between veterans and their health care providers since their providers would play a role in veterans maintaining access to disability compensation. Veterans should not be hindered from seeking benefits they have earned. Congress and the VA should remove barriers to health care, rather than erect them.

Even if the VA’s health care system could handle the demands of requiring veterans to seek health care to maintain their benefits, it is not clear that such an effort would be effective in improving a veteran’s long-term health. Although the context is different, most states allow for a person with mental illness to be subject to involuntary outpatient commitment, even if the individual is legally competent and not a danger to the public or themselves. Also, as a condition of remaining in the community, a court can require an individual, to follow a regimen that often requires medication and other treatments.

But there is little evidence to show that involuntarily treatment leads to better outcomes. In fact, compelling treatment may cause those who could benefit from treatment to retreat due to fear and loss of control. It would also result in diverting funds from voluntary services and supports.

It seems that improved health outcomes result “from the intensive services that have been made available to participants rather than the existence of a court order mandating treatment.” Alternatives to involuntary outpatient commitment include outreach and peer engagement. Such services avoid more coercive treatment and focus on encouraging individuals with mental

https://familiesusa.org/product/cutting-medicaid-would-hurt-veterans (As of 2017, around 1.75 million veterans use Medicaid.).

221 Assisted Outpatient Treatment Laws, TREATMENT ADVOC. CTR., https://www.treatmentadvocacycenter.org/component/content/article/39 (last visited Nov. 18, 2019) (“Forty-seven states permit the use of assisted outpatient treatment (AOT), also called outpatient comment.”).

222 Michael Allen & Vicki Fox Smith, Opening Pandora’s Box: The Practical and Legal Dangers of Involuntary Outpatient Commitment, 52 PSYCHIATRIC SERVS. 3 (Mar. 2001).

223 Involuntary Outpatient Commitment (IOC) Myths and Facts, BAZELON CTR. FOR MENTAL HEALTH L. (on file with the author).

224 Allen & Smith, supra note 222, at 342; see M Susan Ridgely et al., The Effectiveness of Involuntary Outpatient Treatment: Empirical Evidence and the Experience of Eight States, RAND HEALTH: RAND INSTITUTE FOR CIVIL JUSTICE, 98-102 (2001) (“In contrast to the paucity of studies on involuntary outpatient treatment, our analysis of evidence-based reviews found clear evidence that some intensive community treatments produce good outcomes for people with severe mental illness.”); id. at 99.

225 See Allen & Smith, supra note 222, at 344.

226 Id. at 344.

227 BAZELON, supra note 223.

228 Michael Rowe, Alternatives to Outpatient Commitment, 41 J. AM. ACAD. OF PSYCHIATRY & L. 3, 334 (2013).
illness to enter into treatment. Feedback from a peer specialist, positive or negative, has been associated with higher levels of motivation to seek treatment.\footnote{229}

As evidenced in the above example, it is doubtful whether forced treatment would be effective. An individual’s freedom to accept or decline treatment appears to be a better predictor of success than a requirement to seek treatment. Mandated treatment would put new burdens on the VBA if a veteran did not comply. There are many steps to remove benefits, as a veteran has a property interest in the benefit and due process must be followed.\footnote{230} VBA would face additional burdens if required to track treatment and subsequently remove benefits from those who do not comply with imposed requirements.

VII. \textbf{IS IT PERMISSIBLE TO REQUIRE EMPLOYMENT AS A CONDITION OF RECEIVING A BENEFIT?}

Another condition for receiving disability compensation urged by some policy makers is to require veterans to seek employment. Work requirements in exchange for government benefits is not a new idea.\footnote{231} Welfare reform in 1996 included new work requirements for beneficiaries,\footnote{232} and some states have implemented work requirements to receive Medicaid benefits.\footnote{233}

The constitutional implications of such requirements have not been addressed by the courts.\footnote{234} This includes consideration of whether such work requirements are constitutional under the Thirteenth Amendment.\footnote{235} Recent lawsuits challenging Medicaid work requirements have focused on whether they violate Medicaid’s authorizing statutes as opposed to constitutional implications of involuntary servitude in exchange for a needed health care benefit.\footnote{236} Based on the U.S. Supreme Court’s precedent,\footnote{237} it is likely that a challenge to work

\footnote{229} \textit{Id.}
\footnote{230} 38 C.F.R. § 3.103 (2018).
\footnote{233} According to the Kaiser Family Foundation, as of July 2019, four states have implemented Medicaid waivers allowing work requirements (Kentucky, Arkansas, Indiana, and New Hampshire), five states have received approval to implement requirements, and seven states have requested waivers to allow for them to implement Medicaid work requirements. Rachel Garfield et al., \textit{Understanding the Intersection of Medicaid and Work: What Does the Data Say?} (Aug. 8, 2019), https://www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work-what-does-the-data-say/ [hereinafter Garfield 2019].
\footnote{234} Nice, \textit{supra} note 231, at 358 (citing the decisions in Brogan v. San Mateo County, 901 F.2d. 762 (9th Cir. 1990); Dublino v. N.Y. Dep’t of Soc. Servs., 348 F. Supp. 290 (W.D.N.Y. 1972), rev’d on other grounds, 413 U.S. 405 (1973); and Ballentine v. Sugarman, 344 N.Y.S.2d 39 (Sup. Ct. 1973) (which “relied exclusively on language from prior decisions that only addressed the narrower statutory prohibitions.”).}
\footnote{235} \textit{Id.} at 356 (arguing that welfare work requirements should be deemed an unconstitutional condition on benefits because they violate the Thirteenth Amendment’s right against involuntary servitude).
\footnote{237} \textit{Supra} notes 149 to 168.
requirements based on an unconstitutional condition would be unsuccessful. Instead, consider whether a work requirement as a condition for receiving disability compensation would be practical.

Work provides individuals with a variety of important benefits. First and foremost, it allows individuals to meet their basic material needs. Pride in providing for one’s self and family, or contributing to society, however, may be even more valuable to individuals. This may be especially true for persons with disabilities. Not working can lead to feelings of worthlessness, anxiety, and depression.238

According to data released in March 2019 by the BLS, veterans with service-connected disabilities had higher unemployment rates, 5.2 percent versus 3.5 percent in August 2018, than those without disabilities.239 During the reporting period, nearly thirty percent of respondents reported having a VA service-connected disability rated at less than thirty percent.240 Approximately forty percent of veterans reported having a VA disability rating of greater than sixty percent.241 Of these veterans, over fifty-five percent of those with disability ratings of less than thirty percent were in the labor force compared to forty percent of those with disability ratings of sixty percent or greater.242

Many factors may play a role in a veteran’s decision about whether it is possible to work with a service-connected disability. One is the assumptions that potential employers make about the needs and abilities of veterans with disabilities.243 A study by the Northeast ADA Center in conjunction with the National Society of Human Resource Management and the National Network of ADA Centers244 found that about forty percent of employers were unaware of how to find resources to help them accommodate the needs of veterans with disabilities.245 More than sixty percent indicated that it would take “more effort on the part of the employer” to accommodate a veteran with PTSD or a Traumatic Brain Injury in the workplace.246 The study showed “that, though employers do have good will in this area, goodwill alone may not be enough to ensure that workplaces are geared up to enable [veterans with disabilities] to fully contribute their talents on the job.”247

238 Mossman, supra note 38, at 38.
240 Id.
241 Id.
242 Id.
243 Hannah Rudstam et al., Beyond Yellow Ribbons: Are Employers Prepared to Hire, Accommodate and Retain Returning Veterans with Disabilities?, J. OF VOCATIONAL REHABILITATION 36 (2012) 87-95, 89 (noting that employers report having significant knowledge gaps related to creating effective employment practices for employees with PTSD and [Traumatic Brain Injury]).
244 Id. at 88.
245 Id. at 90.
246 Id. at 91.
247 Id. at 93.
The BLS survey on the employment situation of veterans also found that one-third of veterans with service-connected disabilities work for federal, state, or local governments. It is possible that generous leave policies and other benefits available to government employees contribute to this phenomenon as well as policies that provide veterans with preference in hiring. Factors promoting the employment of disabled veterans in the public sector should be studied and considered for adoption in the private sector.

Overall, people with disabilities are underrepresented in the workforce. A study of veterans with disabilities by the Northeast ADA Center with collaboration from the Kessler Foundation, Tip of the Arrow Foundation, and SM Clark, U.S. Army, found that nearly half of respondents indicated that they believed “that their disability would prevent them from obtaining many jobs.” Fewer than one-third felt that they would be able to “advocate for themselves as a person with a disability in the workplace.” Fewer than half believed they could easily communicate needed workplace accommodations to an employer.

In addition to societal barriers, it is unclear whether the VA is prepared to fully support a work requirement for disability compensation. Would work requirements only apply to certain veterans? Those below a certain level of disability? Those below a certain age? Those in areas with good job markets? Would any job satisfy the requirement? Any number of hours? The number of questions that would need to be resolved is substantial.

The need to find employment would likely place additional burdens on the VA’s Vocational Rehabilitation and Employment program. The VA already struggles to keep caseloads within reasonable bounds, even with only 125,000 participants. Recently, the VA hired a sufficient number of additional vocational rehabilitation counselors to meet the needs of veterans seeking assistance. With millions of veterans of working age receiving disability compensation, the impact on the VA’s service system would likely be significant.

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252 Id.
253 Id.
In a study focused on the employment outcomes of veterans with PTSD in the VA’s Compensated Work Therapy (CWT) program, researchers found that “veterans with PTSD were nineteen percent less likely to be competitively employed at discharge from CWT.” Also, “of those who worked in their last ninety days of CWT participation, veterans with PTSD worked fewer days compared to individuals without PTSD.” Some of the reasons offered for lower employment rates for these veterans were that they saw no future for themselves or that there were not enough workplaces able to meet their needs. They may also choose to remain in environments in which they have more control over the situations to which they are exposed than if they were employed. Researchers concluded that the CWT program may need to provide services focused on the unique needs of veterans with PTSD to help them secure employment.

VIII. COMPPELLING WORK FOR BENEFITS IS NOT THE ANSWER

Some states have tried to implement work requirements for Medicaid recipients. Supporters of these mandates think they will prompt the unemployed to get work to maintain benefits. Opponents are concerned that work requirements are a specious means of getting Medicaid recipients off the rolls.

As of August 2019, Arkansas, Kentucky, New Hampshire, and Indiana received waivers from the Centers for Medicare and Medicaid Services that allow them to implement work requirements. Other states are seeking similar waivers. All waivers (except Indiana’s) have been set aside pending litigation.

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256 U.S. DEP’T OF VETERANS AFF., INFORMATION FOR VETERANS—COMPENSATED WORK THERAPY, https://www.va.gov/health/cwt/veterans.asp (explaining that the CWT program is a vocational rehabilitation program that assists veterans with disabilities, both service-connected and non-service connected, who have barriers to obtaining and retaining competitive integrated employment).


258 Id.

259 Id.

260 Id.

261 Id. at 434.


263 Nicholas Bagley, Are Medicaid Work Requirements Legal?, 8 JAMA 319, 763 (Feb. 27, 2018).

264 Id.

265 Garfield 2019, supra note 233, at 1. (noting that work requirements would be imposed on Medicaid recipients who are deemed able-bodied, but only three percent of recipients could be deemed able-bodied and choosing not to work); Aaron Carroll, JAMA Forum: The Problem with Work Requirements for Medicaid (Feb. 20, 2018), https://newsatjama.jama.com/2018/01/11/jama-forum-the-problem-with-work-requirements-for-medicaid/.
Work requirements were a part of welfare reform in the 1990s but failed to improve the employment situation of recipients. They also failed to change poverty rates and were not cost effective.

Based on the failure of welfare to work initiatives to improve labor force participation among recipients, such requirements in the Medicaid program may also prove to be ineffective. Work requirements for Medicaid would be costly due to the need to track whether recipients are working or looking for work and to determine who is exempt from requirements. As previously noted, work requirements for veterans would put similar administrative burdens on the VA.

There are concerns about the impact on those who need Medicaid benefits but would lose them due to noncompliance with work requirements for whatever reason, especially since the requirements would likely result in “little or no long-term gain in employment.” Individuals who have mental illness or substance use disorders may face special challenges in keeping access to Medicaid in light of work requirements. Although those deemed medically frail are exempt from the requirements, only half of Medicaid recipients have that designation. Some clinicians are concerned that many who have mental illnesses and substance use disorders will likely lose their Medicaid benefits, even though access to health care improves the opportunity for workforce participation.

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266 Garfield 2019, supra note 233, at 1.
267 Id.
269 Carroll, supra note 265.
270 Id.
271 Hannah Katch, Medicaid Work Requirement Would Limit Health Care Access Without Significantly Boosting Employment, CTR. ON BUDGET & POL’Y PRIORITIES 1-7, 1 (July 13, 2016) (“Its main effect likely would be the loss of health coverage for substantial numbers of people who are unable to work or face major barriers to finding and retaining employment.”).
272 Id. at 5 (noting that the cost burdens associated with administering work requirements may remove any cost-savings from reductions in benefits from those who are able to leave Medicaid); Garfield 2018, supra note 262, at 7 (noting that mandatory work requirements would divert funding from programs that help job seeking individuals obtain employment).
273 Katch, supra note 271, at 5 (“Work requirement waivers generally require beneficiaries to verify their participation in certain activities, such as employment, job search, or job training programs, for a certain number of hours per week or verify an exemption to receive or retain Medicaid coverage.”); Garfield 2019, supra note 233, at 8.
274 Katch, supra note 271, at 1.
275 Frank & Giled, supra note 262, at 626.
276 Id.
277 Id. (noting that “taking Medicaid—and the care it finances—away from people with these conditions is likely to further reduce their participation in work”); Katch, supra note 271, at 5 (stating that the results of TANF work requirements “strongly suggest that imposing work requirements in Medicaid could cause significant numbers of impoverished individuals to lose their health coverage”).
278 Frank & Giled, supra note 262, at 627; Katch, supra note 271, at 7 (stating that efforts to improve participation in the workforce must involve “effective education, training, and employment programs”).
If work requirements were implemented for disability compensation benefits, veterans would likely face similar compliance issues. It is unclear how the VA would decide which veterans would be excused from work requirements and how an individual would appeal any such determinations. Work requirements could also create conflicts with other benefits programs, including Social Security Disability Insurance (SSDI).

There might be short-term gains in employment as a result of work requirements, but those gains have failed to continue over time when tried elsewhere. Non-mandatory programs that provide employment opportunities, however, “can increase earnings and employment without worsening the situations of people who have significant barriers to employment and driving them deeper into poverty.” Providing better opportunities to access employment services through VA’s Vocational Rehabilitation & Employment program and other initiatives on a voluntary basis may result in improved workforce participation.

IX. **If Mandates Are Not the Answer, How Can Veterans Be Encouraged to Seek Medical Treatment and Participate in the Workforce?**

Housing First is a program that provides housing to the homeless without requiring adherence to medication protocols or abstinence from drug abuse. Those needing housing have access to other social supports and services without being compelled to use them. The model is premised on the belief that giving clients a choice will make them “more successful in remaining housed and improving their life.” A Canadian program showed that providing homeless persons with serious mental illness access to housing led to greater adherence to antipsychotic medication versus those who received traditional services.

Although using services such as drug treatment programs is not a requirement for housing, an important aspect of Housing First is ensuring that individuals have opportunities to receive such services. The model focuses on harm reduction to “confront and mitigate the harms of drug

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279 For example, individuals who receive SSDI are exempt from Medicaid work requirements, however, there are many Medicaid recipients who have medical conditions that inhibit their ability to work but who do not receive these benefits. Garfield 2019, supra note 233, at 5.

280 Katch, supra note 271, at 2 (“[W]ithin five years, employment among comparable cash assistance recipients not subject to a work requirement was the same or higher than employment among the individuals subject to the requirement.”).


282 Id. at 2.


284 Id. at 2.


286 Stefanie N. Rezansoff et al., *Housing First Improves Adherence to Antipsychotic Medication Among Formerly Homeless Adults with Schizophrenia: Results of a Randomized Controlled Trial*, 43 SCHIZOPHRENIA BULL. 4, 852, 855, 859 (2017).

and alcohol use through non-judgmental communication.”288 It includes motivational interviewing which can help individuals “acquire and utilize new skills and information.”289 The model does not ignore improvement in an individual’s health. Instead, access to housing meets an important need and fosters conditions that can lead to adherence to medications and acceptance of services.290

As demonstrated by the increased adherence to medication in the Housing First model, veterans with service-connected disabilities should continue to receive monetary compensation and health care without conditions. Disability compensation allows many veterans to take care of their families and replace lost income. Access to health care can be equally important, especially for veterans previously unable to get quality, effective health care.

More should be done to improve veterans’ access to the services and supports available to them for service-related disabilities. Instead of requiring veterans to seek medical care, the VA should make access to services more convenient, and include child care services291 and expanded appointment times that include nights and weekends.292 The VA has a pilot child care program293 and legislation has been introduced to make it permanent.294

Congress has also increased access to care in local medical facilities to supplement care available at VA facilities. The VA MISSION Act of 2018 established the Veterans Community Care Program295 so that veterans far from VA facilities or facing long wait times for care can go to a provider closer to their home.296 This may increase their participation in care and improve their health.

Expansion of services, such as telehealth, which allow veterans and providers to connect by video will further improve opportunities for veterans to receive the care they need. The VA is promoting the use of telehealth to reach veterans who may have difficulty getting to

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288 Id.
289 Id.
290 NAT’L ALLIANCE TO END HOMELESSNESS, supra note 285, at 1.
291 Press Release, Brownley Testifies on Veterans’ Access to Child Care Act Before Rules Committee, REP. JULIA BROWNLEY (D-CA) (Feb. 6, 2019), https://juliabrownley.house.gov/brownley-testifies-on-veterans-access-to-child-care-act-before-rules-committee/ (stating that “VA research has shown that the lack of access to child care is a barrier to receiving VA healthcare for many of our veterans.”).
appointments. Telehealth is also being used to promote wellness, including access to therapies and treatments that help veterans maintain function and improve their overall well-being. As ways to reach veterans in need expand, the VA has to evaluate these efforts to determine their success or failure.

Fostering an environment in which veterans are supported and encouraged—but not compelled—to receive treatment and to adhere to treatment protocols will improve veterans’ health. The VA’s goal should be improving care, not cutting costs. Getting access to the services and supports available to them will help disabled veterans reach their full potential.

**CONCLUSION**

Veterans stand at the intersection of the nation’s fiscal constraints and the need to fulfill promises to those who served. As set forth in this article, the VA disability system was designed to fulfill the promises this nation made to those who have served, continue to serve, and will serve in the future. In a time of unending conflict that has resulted in increased costs to care for veterans, the system has become a potential target for reducing budget outlays. Many legislative and policy proposals have been set forth over the past several years in an attempt to find ways to make the system less expensive, including requiring veterans to attempt to improve their conditions and reenter the workforce.

These proposals are of questionable legality and even more questionable practicality. They may, in fact, have the opposite of the intended effect and alienate veterans from their health care providers because of the potential for creating an adversarial relationship. Further, requiring treatment or employment in exchange for benefits has had no proven efficacy when it was attempted in other government benefit contexts. Moreover, some of the assumptions underlying these proposals are contradicted by the research discussed in this article which shows that many disabled veterans actually do work, even when they receive disability compensation. It also demonstrates that workforce participation for those who do not work would not be significantly altered if such changes were made.

Reducing barriers to benefits would do more to improve veterans’ health and long-term recovery than conditioning benefits on medical treatment or employment. Veterans deserve to exercise their free will in pursuing their life goals just as every other American, and to not be treated as burdens to the federal budget. For the reasons set forth in this article, proposals to condition the receipt of veterans’ benefits on employment or forced acceptance of medical treatment are unwise legally and practically.

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