THE LONG-TERM COSTS OF THE CURRENT CONFLICT

HEARING

BEFORE THE
OF THE

COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

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THE LONG-TERM COSTS OF THE CURRENT CONFLICT

WEDNESDAY, OCTOBER 17, 2007

U. S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 10:03 a.m., in Room 334, Cannon House Office Building, Hon. Bob Filner [Chairman of the Committee] presiding.

Present: Representatives Filner, Brown of Florida, Michaud, Herseth Sandlin, Mitchell, Hall, Hare, Rodriguez, Donnelly, McNerney, Space, Walz, Buyer, Moran, Brown of South Carolina, Boozman, Brown-Waite, Lamborn, and Buchanan.

OPENING STATEMENT OF CHAIRMAN FILNER

Mr. CHAIRMAN. Good morning. This meeting of the House Committee on Veterans' Affairs is called to order.

We thank the witnesses for being here to help us understand the long-term costs of the current conflict.

In my view, just as we were unprepared for the aftermath of the war in a military sense in Iraq, we have gone into the war unprepared to deal with the consequences for our veterans, their physical and mental health, their employment, their education, their reintegration into civilian life.

Over a million and a half servicemembers have now been deployed in Iraq and Afghanistan. We know the death and injury rate not only to Americans but to Iraqis and those numbers are increasing every day.

Half of those deployed, and that is over 800,000 as I understand the testimony, have already been separated and are veterans. One-third of them have, in fact, sought U.S. Department of Veterans Affairs (VA) medical care or made benefit claims since the war began.

So not only do we have the increasing needs of an aging veterans' population stretching back to World War II, but heavily dominated presently by Vietnam-era veterans and their needs, we have the needs of our new veterans. It is up to us to deal with both. That is our obligation as a nation. That is our obligation here in Congress.

And as we try to struggle still with the older veterans, we have to have a commitment that although the country is divided over the war in Iraq, we have a difference of opinion, we are united in saying that every young person that comes back from that war is going to get all the care and attention that we can give as a nation.

So whether it is traumatic brain injury (TBI), whether it is post traumatic stress disorder (PTSD), we must deal with these issues and we know what happens if we do not get this right. We look at our Vietnam veterans who were not treated with honor and respect, who did not get their healthcare in a timely fashion. It has been estimated that about half of the homeless on the street tonight, 200,000, are Vietnam vets.

I think it is a tragedy and unacceptable to us as a nation that many Vietnam veterans have now died by suicide than were killed in the original war. That means we did something wrong as a nation and we have got to do it right with these young men and women coming back while we still struggle getting it right for our older veterans.

We know about the backlog in claims. We know the frustration of having to deal with those claims whether it is monetary and losing a house or it is the psychological problems of fighting a bureaucracy for so many years.

So how are we going to deal with this? How are we going to meet the demands of our older veterans and our new veterans?

There have been a variety of estimates about the cost. I have seen costs as high as $60 billion a year for the next decade for our new veterans. I mean, that is 60 percent of our total budget now. How are we going to do that if that is true?

The Congressional Budget Office (CBO), I think, estimates a lot less, but we should figure out what that number is. The Department of Veterans Affairs must, even though it is a little late, even though we have had some success, but we are still straining to the breaking point with these new demands.

Walter Reed was not a VA hospital, but it showed that we were not taking care of the veterans the way the American people thought we should and that we must do. And we have heard similar horror stories at VA installations around the country.

So we have to take this very seriously. We have to prepare in a way that has not been done. And we want to thank both the Congressional Research Service (CRS) and the CBO for being here this morning to help us understand that, to give us the background for the discussion, and we look forward to Dr. Kussman and Admiral Cooper's testimony to give us the VA perspective.

We have to know the truth here. And I will say now to the VA panel, we need to know what you need, not that everything is all right. We always hear everything is fine, we do not need help and, yet, horror stories come to our attention every single day.

So we look forward to a frank hearing. We look forward to giving us the understanding because every Member of this Committee and every Member of this Congress wants to do this job right and we need your help to do it.

Mr. Buyer, you are recognized for an opening statement.

[The prepared statement of Chairman Filner appears on pg. 41.]

OPENING STATEMENT OF HON. STEVE BUYER, RANKING REPUBLICAN MEMBER

Mr. BUYER. The British philosopher and political theorist John Stuart Mill once wrote, "War is an ugly thing, not the ugliest of things. The decayed and degraded state of moral and patriotic feel-

ings which thinks that nothing is worth war is much worse. A man who has nothing for which he is willing to fight, nothing he cares about more than his own personal safety is a miserable creature who has no chance of being free unless made and kept so by the exertions of better men than himself."

We are here today to discuss the cost of taking care of those better men and women. In the current environment, some become lost in the heated political rhetoric and complexities of the war in Iraq and Afghanistan, thereby emotionally using veterans' issues to pull people into the trap of just simply feeling sorry for the men and women who fight. For many, this is easier than understanding their military duties and the realities of soldiers' lives after they return home.

To my colleagues I would say our men and women in uniform who fight are not victims of the current conflict. Each and every one of them is a volunteer who swore and took an oath to defend this country. As one officer stated recently, "I am a warrior, it is my job to fight." This is the statement of a hero, not a victim.

As we look to take care of our returning military personnel, we need to admire and respect them for who they are and what they have done, not view them through a prism as though they are a victim class who require the Nation's pity.

Our duty here today is to explore the cost and the options for taking care of these heroes. At the end of the day, that is the primary bipartisan mission of this Committee. It has always been so.

In 2005, during my Chairmanship, we discovered a significant budget shortfall at the VA and rapidly moved to eliminate that shortfall. As the Chairman said, things were not included in those budgets that should have been and we had some very stale data and inputs.

Today, however, the funding in the VA MilCon Appropriations Bill is being held up for what I believe to be partisan purposes and to use that bill as leverage to pass other appropriations bills or to put more pork in the legislation.

We are now 16 days past the new fiscal year. I would urge the Chairman and my colleagues to rapidly move to encourage our leaders to move the VA MilCon Appropriations Bill in an expeditious manner so that our veterans can get the funding they need for fiscal year 2008.

The Republicans have now appointed conferees and Democrats should do the same.

Today we have a new challenge before us. The current compensation disability system needs to be reformed. This is the message we have heard from our veterans and confirmed by the findings of the Dole-Shalala Commission and the Disability Commission. These reforms cannot wait.

Yesterday, the White House officially submitted their recommendations to Congress and it is our turn to act. The House and Senate Armed Services Committees are prepared to act and have said that they will take many parts of these recommendations to be incorporated in the Wounded Warrior provisions of the bill that is presently in conference.

In *CQ Today,* it states, and I would appreciate for the Chairman to clarify, that you intend not to take up these measures from the

commissions this year, but to delay and to take it up in a single bill next year. The first I heard anything like that was in today's CQ. So I am anxious to hear your response.

In war, passivism and defeatism have never been America's values. Neither should we give in to defeat and sit passively by in the face of the challenge before us.

Mr. Chairman, I urge you and all my colleagues to move ahead with reforming the compensation and disability systems this year and not wait until next year. The "better men and women among us" deserve no less.

I yield back.

[The prepared statement of Mr. Buyer appears on pg. 42.]

Mr. CHAIRMAN. Let us get started on our first panel. I welcome Amy Belasco from the Congressional Research Service. Amy is a Defense Budget and Policy Expert with 25 years of Legislative and Executive Branch experience. And after Amy, we will hear from Matthew Goldberg from the Congressional Budget Office. Matthew is the Deputy Assistant Director for the National Security Division and has been a Defense Analyst since 1980.

We welcome you both. Your experience, I hope, will help us, and we look forward to your opening remarks.

STATEMENTS OF AMY BELASCO, SPECIALIST IN U.S. DEFENSE POLICY AND BUDGET, CONGRESSIONAL RESEARCH SERVICE, LIBRARY OF CONGRESS; AND MATTHEW S. GOLDBERG, PH.D., DEPUTY ASSISTANT DIRECTOR FOR NATIONAL SECURITY, CONGRESSIONAL BUDGET OFFICE

STATEMENT OF AMY BELASCO

Ms. BELASCO. Chairman Filner, Mr. Buyer, and other Members of the Committee, my name is Amy Belasco and I appreciate your asking CRS to testify about the important issue the Committee is considering, the long-term cost of the current conflicts in Iraq and Afghanistan.

I would like to provide some context for the discussion by making several points. About 60 percent of the 1.6 million individuals who have been deployed to the Afghan and Iraq theaters of operation are in their first tour.

To date, Congress has provided about $615 billion to the Department of Defense (DoD), the State Department, and the Department of Veterans Affairs for the cost of the conflicts in Iraq and Afghanistan and enhanced security at defense bases.

Future costs will depend on the number of troops deployed, how long they stay, the intensity of conflict, and other factors.

Thus far, DoD has spent about $300 million for the treatment of the two signature illness of these conflicts, post traumatic stress disorder, PTSD, and traumatic brain injury.

And, finally, predicting future costs is difficult partly because of unexplained discrepancies in DoD information.

So, first, before turning to costs, I would like to give a profile of the 1.6 million individual servicemembers who have been deployed to Iraq and Afghanistan in the 6 years of operation since 9/11.

The typical deployed servicemember has been a young, white male, first term enlisted personnel, a profile similar to the active-

duty force. Some 60 percent have been between the ages of 17 and 30 and are in their first tour.

Because of frequent turnover, how often individual servicemembers have been deployed may be a better way to measure stress on the force than how often a unit is deployed. About 90 percent of those deployed thus far have been in their first or second tour of duty. The remaining personnel have been deployed three or more times including some like Air Force pilots for brief periods.

Now turning to costs. CRS developed estimates of war cost because DoD's estimates have been incomplete and do not include the breakdown by operation of all the funds received to date.

Concerned about the accuracy of its war cost reporting, DoD has asked a private accounting firm to conduct an audit.

CRS estimates that Congress has provided a total of about $615 billion to date as of the fiscal year 2008 Continuing Resolution for Iraq, Afghanistan, and other counter-terror operations and enhanced security at U.S. bases generally referred to by the Bush Administration as the Global War on Terror (GWOT).

DoD has received over 90 percent of the funds. The $615 billion includes $573 billion for DoD, $41 billion for the State Department's foreign aid and reconstruction programs and for building and operating new embassies, and $1.6 billion for VA medical care for veterans of these conflicts.

On a monthly basis, CRS estimates that DoD is spending about $11.7 billion for all three GWOT, Global War on Terror, operations, well above the $8.8 billion in fiscal year 2006 and the $7.7 billion in fiscal year 2005.

These increases reflect both higher spending for new weapon systems and higher operating costs, though explanations for the increases are fairly limited.

CRS estimates that Congress has provided about $455 billion just for Iraq with average monthly spending running about $9.7 billion a year, well above previous years. Only a small amount of the increase in fiscal year 2007 reflects the surge or increase in troop levels in Iraq this year. For Afghanistan, CRS estimates about $127 billion with monthly obligations running about $1.7 billion, again higher than previous years.

One way to put Iraq and Afghanistan war costs into perspective is to compare them to those of previous wars. Based on estimates by CRS Specialist Stephen Daggett of military costs in inflation adjusted dollars, the cost of all three GWOT operations after 6 years equals about 90 percent of the cost of the 12-year Vietnam War and about double the cost of the Korean war. Looking only at Iraq, the cost thus far is 65 percent of the cost of Vietnam and 50 percent more than the cost of the Korean war.

Just briefly, the Administration has requested $152.4 billion for war costs in fiscal year 2008. This total does not include $42.3 billion for defense and possibly additional State AID funds that Secretary of Defense Gates announced in late September would be requested shortly. If these additional funds are requested, the fiscal year 2008 total would reach $194.7 billion or more.

Estimating future war costs. Future costs, as I mentioned, will depend on how long the wars last, the number of troops, the inten-

sity of conflict, facing strategies, the items that DoD and Congress consider to be war related, and the scope of post war costs.

CBO recently estimated the 10-year costs of several draw-down scenarios. If current troop levels fall to 30,000 troops by 2010, CBO estimates suggest that war costs would total $1.1 trillion to $1.2 trillion by 2017. If troop levels fell more gradually to 75,000, costs would reach a total of $1.5 trillion to $1.6 trillion after 10 years.

Looking at annual costs just to get some sense of what you are talking about once the steady status is reached, CBO estimates suggest that 30,000 troops would cost about $22 billion, 55,000 troops about $33 billion, and 75,000 troops about $61 billion.

Now I would like to turn briefly to DoD spending and experience with post traumatic stress disorder and traumatic brain injuries. Estimating the cost of these two signature medical problems may be difficult. But looking at DoD's initial costs may give a window into what to expect into the future.

Based on DoD data, about 60,000 troops or about 4 percent of all servicemembers deployed have been diagnosed with either PTSD or TBI including some with both conditions. Treating those patients has cost $291 million over the past 5 years and annual costs per patient have averaged about $1,850 for PTSD and $5,500 for TBI.

In the fiscal year 2007 Supplemental, Congress provided DoD with $600 million for treatment of these conditions over 2 years and also permitted the Secretary of Defense to transfer any funds in excess of requirements to the VA for the same purposes. It is not clear whether DoD will need all of these funds.

Finally, I would just like to talk briefly about problems in identifying deployed troop levels which raise some oversight questions. Predicting future cost depends on accurate information about current costs and the factors that drive costs. Yet, even in the sixth year of operations, figures for troop levels in the Iraq and Afghan theater of operations range from 160,000 for those personnel in country to 320,000 for all those dedicated to the two operations.

DoD has not publicly explained the differences between these numbers. When Congress lacks a clear picture of something as basic as deployed troop levels either in the past or today, predication of future cost becomes problematic whether estimating the cost of PTSD or TBI or assessing weapons replacement costs.

Thank you for inviting CRS to testify. I am happy to answer questions.

[The prepared statement of Ms. Belasco appears on pg. 44.]

STATEMENT OF MATTHEW S. GOLDBERG, PH.D.

Dr. GOLDBERG. Good morning, Chairman Filner, Congressman Buyer, and other distinguished Members of the Committee. I appreciate the invitation to represent Congressional Budget Office and talk to you today about some of the challenges our Nation faces in caring for veterans returning from Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF).

I will be talking about the number of troops who have served in those operations, the numbers who have been injured, and some measures of the severity of their injury. I will also talk about the extent to which those veterans have sought care from the VA and the types of care they have received.

And, finally, I will talk about the CBO's projections of the resources that VA may require over the next 10 years to continue providing medical care and some of the other major benefits that key off of deployments to those two theaters, disability compensation for disabled servicemembers and also Dependency and Indemnity Compensation (DIC) benefits paid to survivors of servicemembers.

The U.S. Military has been engaged in OEF since 2001 and OIF since 2003. As was said earlier, over a million active-duty military personnel have been to one or the other operation and over 400,000 Reservists as well.

The casualty rates, we have had 3,800 troops who have died in OIF and 400 who have died in OEF and a total of almost 30,000 who have been wounded in one or the other operation.

Now, the good news, if there is any, is that with advances in body armor as well as battlefield medicine and some remarkable advances in air medical evacuation, the survival rates are better in this conflict than they were, for example, in Vietnam. The survival rate among troops wounded was 86 percent during Vietnam and it is over 90 percent in OIF and OEF.

The downside of that is we have a lot of troops, as is well known, who survive what might otherwise have been fatal injuries to the chest and abdomen due to body armor, but they suffer injuries to the limbs often resulting in amputation.

As far as the amputations, DoD keeps what I believe is a pretty complete census. There have been about 800 amputations from the two operations combined as of the beginning of this year. The amputation rate is 3.3 percent among all wounded troops.

Regarding the other two injuries that get a lot of attention, the so-called signature injuries, traumatic brain injuries and post traumatic stress disorder, let me say a little bit about each of those.

Traumatic brain injuries are difficult to tally because some of them go undiagnosed, but the number that have been diagnosed by DoD is about 2,700, 2,700 traumatic brain injuries or TBIs. That is about 8 percent of all wounded troops.

An important distinction among the TBIs is that neurologists classify them as either mild, moderate, or severe. And about two-thirds of the diagnoses have been for mild TBIs. According to the medical evidence that we have examined, most mild TBIs result in natural recovery. The patient will recover in a matter of weeks or months even if untreated and particularly if treated, although there is a small fraction of patients with mild TBIs who will have long-run persistent symptoms.

One of the problems with TBIs is that because the helmets are so good, you can sustain a concussion and not know about it. One of the advances that is currently being practiced is whenever any soldier is evacuated to Landstuhl in Germany for any reason, they are screened for TBI.

Post traumatic stress disorder, PTSD, is also difficult to diagnose. Based on data from the VA, it appears that the veterans and the Reservists who have sought care at the VA, which is about a third of all those who have come home, a third of them who have come home and sought care from the VA, and among those, 37 per-

cent have had some kind of mental health diagnosis and 17 percent have had some kind of diagnosis for PTSD.

I qualify that a little because the diagnosis for PTSD, the 17 percent is a preliminary number. Some of those individuals, it is later determined they are rule-outs. They had a visit with a psychiatrist who determined they did not have PTSD.

So we really do not know with great precision what the PTSD rate is. Perhaps in the second panel, they will have some better numbers. But the number I am using is about 17 percent of those who have come back and been seen at VA.

As far as the utilization and costs, the natural question is, how much of the resources and how much of the workload at the VA is being accounted for by the veterans and the Reservists who are getting care, particularly under the two-year special eligibility that applies for troops returning from the combat theater.

Well, of the about 700,000 returning servicemembers who are eligible for VA care, as I mentioned, a third of them have actually presented and demanded care at the VA. The VA keeps an account of how much of their budget goes toward treating those OIF and OEF veterans.

In 2007, the number that the VA used was $573 million to treat that particular group of veterans in 2007. In the 2008 budget request, the number they were using was $750 million, three-quarters of a billion. That includes dental care, readjustment counseling, mental health initiative, and any other care that those veterans will require at the VA.

The 230,000 patients, veterans of those two operations who have been seen at the VA have constituted about 3 percent of the total veterans workload at the VA. So, in other words, as severe as the problems are, the numbers of veterans who have come back and sought care at the VA have not, from the numbers I have looked at, overwhelmed the system numerically.

And in addition, the average cost of care for the OIF or OEF veterans has been about $2,600 per veteran per year as opposed to the average for all veterans who have been seen of nearly $6,000 per year. And that is partly a reflection of the fact that the veterans who come back, many of whom are severely injured, most of whom are not severely injured and are younger than the Vietnam and Korean era veterans that were mentioned earlier who were at a stage in their life where they are more expensive to treat.

What CBO has done, if I can turn to our projections of future costs, is we have taken two scenarios. Of course the costs will be keyed off of how many troops are wounded in action, come back home, seek care in the VA. So we have some models that do the arithmetic there.

But you need a scenario for how long the conflict will last, how many troops are exposed, and that will determine our forecast of how many troops will be injured and in turn the cost of care for them.

So we have two scenarios. I believe they are the same two that Ms. Belasco mentioned earlier. We have one scenario where the troop levels would decline. Current levels of about 210,000 decline to 30,000 by 2010 and remain at that level through 2017, which is our 10-year projection window. However, the second scenario in

which the withdrawal is more gradual, so 75,000 were there in 2013 and remain at that level through 2017.

We are not saying that either of those are what will actually happen. No one knows, but we are trying to bracket some high and low cases.

In the first case, actually in the lower case, we are projecting that VA's cost to treat the veterans returning from OEF and OIF would be about $7 billion over that 10-year window, 2008 through 2017. And in the higher case where troop levels remain higher for longer, we are projecting it would take about $9 billion to treat those same veterans. So the range is $7 to $9 billion.

In addition, we looked at some of the other benefits that might change in a significant way based on the number of troops who remain in those two theaters. The two we looked at specifically where the numbers are the largest are disability compensation and survivors' benefits and those could add another $3 to $4 billion to those totals.

So what we are talking about in total for the major programs that VA runs, we are talking between $10 and $13 billion in total over the ten-year period that we looked at.

That concludes my remarks and I would be happy to take your questions. Thank you.

[The prepared statement of Dr. Goldberg appears on pg. 50.]

Mr. CHAIRMAN. Thanks to both of you.

I will recognize Ms. Brown for questions.

Ms. BROWN OF FLORIDA. Thank you, Mr. Chairman, for holding this hearing.

It is important for us to continue to remember the warriors when debating this war. I have opposed this war from the beginning and will continue to oppose it until every last American soldier is taken out of harm's way. However, I have supported each and every funding bill that would make the job of these men and women easier and safer.

The military is doing the job they were sent to do. There was a flaw in the mission from the beginning and the flaw lies with us.

I just want, as always, to remind us of the words of the first President of the United States, George Washington. These words are worth repeating at this time: "The willingness with which our young people are likely to serve in any war, no matter how justified shall be directly proportional as to how they perceive the veterans of earlier wars are treated and appreciated by their country."

And so I go to my question. I am very interested, Ms. Belasco, in how you were able to pull out the VA funding numbers for Iraq and Afghanistan and the Global War on Terror since Congress and the VA do not make a difference when passing the funding bills. Can you please explain that a little bit?

Ms. BELASCO. Yes. I believe that actually CBO and I, and CRS, are using the same numbers. There are, in fact, figures within the VA's budget justification material where they separate out the funding for OIF and OEF vets. So those are the figures that I use.

Ms. BROWN OF FLORIDA. The VA had a budget shortfall of $1.5 billion a few years ago because the formula they used did not take into account the war and the veterans returning from it. Do you see the VA and the Bush Administration continuing to underesti-

mate the effects of the war on their service, the returning vets, the cost?

Ms. BELASCO. I cannot really address that question because I am a defense budget person, not VA. CBO might have a better take on that.

Dr. GOLDBERG. I have some visibility into the process that VA uses to build the budget request. I do not have perfect visibility. But they have shared some of their modeling with me.

And the best answer I can say is I know they are very cognizant of this issue. I know they have been improving the models every year for the three or 4 years that I have been following them. So I cannot guarantee you that they have got it right this time, but I think they will probably be closer now than they were when we had the problems 2 years ago.

Ms. BROWN OF FLORIDA. Well, tell me, do the VA or the Secretary have the last word or does the Office of Management and Budget (OMB) have the last word on the budget that actually comes out and comes to Congress?

Dr. GOLDBERG. My understanding is that OMB has the last word.

Ms. BROWN OF FLORIDA. That is the problem.

What do you believe are some of the greatest misconceptions that the general public have regarding the costs that we have incurred in this war and the future costs that VA may be forced to meet? For example, we talk about the coalition of the willing. How much does the American people pay of the cost of this war or do other countries actually make any major contributions? I am talking to Ms. Belasco.

Ms. BELASCO. I do not have those figures at the top of my head, but the overwhelming share of the costs are U.S. costs because we have almost all of the troops. I believe there are maybe 10,000 from other countries. I could look it up and get back to you, but, you know, it is really very small.

Ms. BROWN OF FLORIDA. Well, when some of the other countries actually send soldiers, do we pay that cost?

Ms. BELASCO. No. I mean, you know, when the British have had about 5,000 troops, I mean, they pay those costs. The only costs of other nations that we pay is there is a category called coalition support.

So that, for example, we pay, if I remember correctly, about a billion dollars to Pakistan a year and that covers some of the costs of their troops and we pay it because they are helping us with counter-terror operations on the border. So I mean, coalition costs in those cases, and it is mostly Pakistan and Jordan, those are costs where we do, in fact, pay the cost of other soldiers.

Ms. BROWN OF FLORIDA. I understand. We are the coalition of the willing.

I yield back my time.

Mr. CHAIRMAN. Thank you, Ms. Brown.

Mr. Brown.

Mr. BROWN OF SOUTH CAROLINA. Thank you, Mr. Chairman.

I was just curious, Dr. Goldberg, I guess. You mentioned that of the injured warriors coming back, 3 percent or a little over three

percent actually have some form of amputation. Is that the number?

Dr. GOLDBERG. I will check the number for you, sir. I believe the number was three percent. 3 percent, yes, sir.

Mr. BROWN OF SOUTH CAROLINA. Okay. And that has been a fairly constant percentage, I guess?

Dr. GOLDBERG. It has been constant.

Mr. BROWN OF SOUTH CAROLINA. So you can use that projected, I guess, through the next 10 years or whatever that timeline?

Dr. GOLDBERG. That is precisely what I do.

Mr. BROWN OF SOUTH CAROLINA. Okay. That is how you came up with those numbers.

Okay. And where do we get the 30,000?

Dr. GOLDBERG. I am sorry. Could you repeat that?

Mr. BROWN OF SOUTH CAROLINA. We have an estimated force of some 30,000 that will be needed through that last cycle. Is that——

Dr. GOLDBERG. We have two cases that run through 2017. In one case, in the lower case, the force levels will bottom out at 30,000. In the higher case, they bottom out at 75,000. And so the numbers of amputations and casualties in general would be proportional to those force levels.

Mr. BROWN OF SOUTH CAROLINA. Okay. All right. Thank you very much.

And thank you, too, Ms. Belasco.

Mr. CHAIRMAN. Thank you, Mr. Brown.

The Chairman of our Health Subcommittee, Mr. Michaud.

Mr. MICHAUD. Thank you very much, Mr. Chairman, for having this hearing.

And I want to thank both the panelists for your excellent testimony and for your estimates.

PTSD and TBI are frequently called the signature wounds of this war. Capturing all the treatment costs associated with these conditions, I think, can be very difficult. For instance, substance abuse or depression, that is related.

When the cost of treatment was calculated, were these costs included in the calculation as well?

Dr. GOLDBERG. I have to tell you that on my side, we did not calibrate those costs as precisely as I would like to capture everything that you are asking for. What we did is took a coarser look based on the total number of casualties and the number of those folks who would return to the U.S., separate from the military, and end up in the VA.

But at this point, we are trying to refine our modeling to bring in more precise estimates of the cost of PTSD and TBI in particular and we are not quite there yet. So the numbers are a bit approximate.

Mr. MICHAUD. And do you have the estimates for the cost of treating severe TBI or PTSD over the lifetime of a veteran from OEF or OIF?

Dr. GOLDBERG. I do not have those.

Mr. MICHAUD. Is that something that you can pull out or——

Dr. GOLDBERG. I can take that question for the record and coordinate with the VA and if you would like, I will try to provide that.

[The following was subsequently received from Dr. Goldberg:]

Question: What assumptions did CBO make in projecting the number of veterans who would require VA healthcare, particularly those with traumatic brain injuries (TBIs)? How much does it cost to treat veterans with TBIs?

Answer: CBO projects future VA medical costs in a "top-down" rather than a "bottom-up" fashion. A "bottom-up" analysis would consider every medical condition that could possibly afflict an OIF/OEF veteran, project the number of veterans likely to develop that condition, and multiply that number of veterans by the year-to-year costs of treating a representative patient having that condition. The bottom-up approach is impractical because there are (depending on the specificity with which diseases are classified) thousands of conceivable medical conditions, some very rare and difficult to forecast, and others with widely varying treatment paths (and corresponding costs) depending on the individual patient. Also, a bottom-up approach might not capture the fixed and overhead costs of running the VA medical system that are unrelated to the treatment of specific diseases.

By contrast, CBO's "top-down" approach starts with VA's costs to treat OIF/OEF veterans in the base year of the analysis, 2007. CBO then grows that base-year cost to reflect two factors: medical inflation and the growing cumulative number of veterans who have returned wounded from OIF/OEF. Regarding inflation, CBO applies projections of per capita growth in national health expenditures developed by the Center for Medicare and Medicaid Services (CMS). CBO projects the number of wounded troops under the assumption that historical casualty rates (per deployed servicemember per year) for operations in Iraq and Afghanistan over the 2003–2006 period will continue into the future. Applying those casualty rates to CBO's two illustrative scenarios for the force levels in theater yields a projected stream of annual casualties. CBO recognizes that the wounded are not the only OIF/OEF veterans who use VA medical care, but CBO uses the number of wounded as an index of the overall number of medical problems attributable to the two combat operations.

The top-down approach does not require projections of the numbers of veterans likely to develop specific conditions (like TBI), nor the pattern of treatment costs for those specific conditions. However, the approach does implicitly assume that the mix of medical conditions remains roughly constant through time. For example, data from the Defense and Veterans Brain Injury Center imply that about 8 percent of troops wounded during OIF/OEF have been diagnosed with a TBI, of which over two-thirds were classified as mild. CBO's estimates implicitly carry that percentage forward into the future, as well as assuming that the cost to treat that condition will inflate at the same rate as other medical conditions (i.e., at the CMS rate). Those assumptions seem reasonable except, perhaps, in the event that veterans with specific conditions (like TBI) experience delayed onset and will eventually present to the VA at rates exceeding the historical averages.

Mr. MICHAUD. Okay. Thank you.

Mr. Goldberg, your colleague earlier in the year, Allison—is it Percy——

Dr. GOLDBERG. Allison Percy.

Mr. MICHAUD [Continuing]. Percy testified in February before the Appropriations Subcommittee and the CBO's estimate was that then over a ten-year period, VA's cost for medical care related to Iraq and Afghanistan could be between $5 and $7 billion depending on U.S. troop strength in the region. That was this past February.

Your estimates today said that could be anywhere from $7 to $9 billion. What factors caused that increase? What was the different scenario?

Dr. GOLDBERG. Well, we are seeing troop levels being sustained a bit longer in the scenarios and that in turn drives the cost. So longer details in the U.S. presence in turn drive higher costs, more years.

Mr. MICHAUD. And not much has changed since February, though, because the surge was already——

Dr. GOLDBERG. The surge is pretty much winding down. We are starting off with the 210,000 troops that are currently in theater and we have them going out for 12 months. So basically February

to February and then you start to draw down from there and it does bump out the cost a bit. That is the main difference.

[The following was subsequently received from Dr. Goldberg:]

Question: Why have the 10-year projected medical, disability and survivors' costs to the VA associated with OIF/OEF veterans increased from the $6 to $8 billion as detailed in CBO's "Estimated Costs of U.S. Operations in Iraq Under Two Specified Scenarios" (July 2006) testimony to the current estimate of between $9.7 and almost $13 billion?

Answer: Two factors have been instrumental to the upward revision in costs. First and most importantly, the original projections assumed significantly lower troop levels deployed in and around Iraq than the most recent ones. The former assumed that either all troops would be withdrawn from the Iraqi theater of operations by the end of calendar year 2009, or that troop levels would decline to 40,000 by the end of calendar year 2010 and would remain at that lower level through 2016. The latter projections assume a surge in troop levels for 2007 and part of 2008 with declines thereafter. However, troop levels are assumed to bottom-out at 30,000 in 2010 and remain at that level thereafter, or alternatively to decline to 75,000 by 2013 and stay at that level.

Second, VA treated significantly larger numbers of OIF/OEF veterans (and at higher cost) in 2006 than it had in 2005 and than it had anticipated for 2006. Because CBO uses VA's spending as its base for its projections, CBO's projections correspondingly increased.

Mr. MICHAUD. Okay. Ms. Belasco, in your written statement, you wrote, and I quote, "That Congress lacks a clear picture of the number of or allocation of all military personnel dedicated to Iraq and Afghanistan either in the past or today makes prediction of future cost, whether future operational or medical cost, problematic. For example, troop location may be important engaging the likelihood that servicemembers face intensive combat and, hence, have a higher risk of developing PTSD or TBI."

Are there any types of data that you would like to see the Department of Defense and the VA for that matter compile so that you can look at this in a more comprehensive manner?

Ms. BELASCO. Yes, I think so. And I think the very discussion we have had this morning gives some sense of this because, you know, Matt was saying, well, CBO estimates started from a level of 210,000 which is different, of course, from 320,000 and different from 160,000.

Now, I can piece together where some of those other people are from other data sources, but I think it would be very useful for Congress, you know, it could be very useful in terms of knowing the population you are dealing with if Congress had figures from the Defense Department that explained what the numbers are.

And, for example, in the 320,000 figure that they use in their budget justification material for fiscal 2007 and fiscal 2008 war costs, they only break them down between 140,000 in Iraq and 20,000 in Afghanistan. And it is not even clear whether the 320,000 includes the 20,000 or so surge. I think it does, but I am not sure.

Now, you know, where are the rest of those 160,000 people? Well, as near as I can tell from some other data sources, some of them are in neighboring countries, a fair number of them are in Kuwait as you would expect because a lot of people come through Kuwait en route to Iraq, some of them in Qatar, some of them are in the neighboring countries, some of them are activated Reservists serving at home, and there are about 30,000 from one database I have where they do not know where they are.

It seems to me that it would be appropriate for the Defense Department to resolve these discrepancies so that, you know, it would help in a lot of ways. I mean, I could give you four different sources for troop levels, all of them Defense Department sources. And I think resolving this would be very good. And, you know, after 6 years, you have to ask yourself why do we not know the answers to these questions.

Mr. MICHAUD. Thank you very much. Appreciate it.

Mr. CHAIRMAN. Thank you for that chilling question.

Ms. Brown-Waite?

Ms. BROWN-WAITE. I just have a follow-up question. If you do not know, if you are not sure the DoD figures included the surge, did you ask that question?

Ms. BELASCO. Yes, I did. And they were not sure either.

Ms. BROWN-WAITE. So DoD was not sure if those figures included those troops in the surge as of the time period that you did your study; is that correct?

Ms. BELASCO. Well, I asked that question obviously of only one office within the Pentagon. You know, the Pentagon is a very large place obviously. They thought that the 20,000 was in there.

You have to sort of cast your mind back to the timing. The justification material is prepared in January and presented in February. And the President announced the surge in January. So there may be some uncertainty whether the numbers were adjusted for that.

But within their justification, they said there were 140,000 troops in Iraq. Well, you know, if you consider the surge, it would have been more like 160,000. So, like I said, you know, they were not too sure themselves.

Ms. BROWN-WAITE. But you did ask that question?

Ms. BELASCO. Oh, yes.

Ms. BROWN-WAITE. I appreciate that. Thank you.

Dr. Goldberg, in your opinion, what has led to the higher projected cost for this conflict compared with previous conflicts? Is it TBI? Is it PTSD? Is it the loss of limbs? What would you say is the major cost driver here?

Dr. GOLDBERG. I think part of it is just the fact that the VA has been so open and made the space for everybody coming back. I know there have been a lot of complaints about veterans trying to get ratings for disability payments. But this is a different issue. You do not have to have a disability rating to come back and get seen in the VA. And the VA has been——

Ms. BROWN-WAITE. Because you get that care for 2 years after you serve.

Dr. GOLDBERG. Two years. And, of course, there is legislation that would extend that to five.

With your indulgence, if I could go back to the question you asked Amy——

Ms. BROWN-WAITE. Absolutely.

Dr. GOLDBERG [Continuing]. We got numbers from the Joint Chiefs and the numbers we are looking at are 210,000 troops including the surge which is 30 to 40,000 higher than the pre-surge number. So we have one source we use that we think is reliable.

I know there are multiple sources in the Department. It depends how you ask the question.

For example, there are Air Force troops who will do a mission in theater and then return to another base. For some purposes, you say, yes, they have been in theater, but they have not actually been stationed on the ground. So it is not necessarily that the people in the Pentagon do not know what they are doing. It depends what question you are trying to answer.

We tend to look at troops on the ground and we have gotten a reliable set of data from the Joint Chiefs. Pretty much month by month, we talk to them and we have seen that the surge is numbered at 30,000 troops. Not all of that is Army and Marines as you might expect because now they have a lot of Air Force personnel and Navy are doing what they call "in lieu of" missions. They are taking the missions that might ordinarily be handled by the Army because the Army is so stretched.

Ms. BROWN-WAITE. Thank you very much for that clarification. Yes, a further clarification.

Ms. BELASCO. I was just going to say, you know, there are a lot of different ways to look at these numbers. I asked the Defense Department, one of their data collectors to put together the number for something called average strength, which in terms of cost is probably the best number because, after all, what average strength does is it counts everybody over a period, everybody as one person-year just like full-time equivalents. And, for example, for 2007, the figure is likely to end up being around 255,000 roughly which, again, you know, it is 40,000 larger.

Again, I have asked people in the Defense Department to resolve the discrepancy and we are working on it. But, you know, I find average strength to be a very good measure. It does not measure those in country, but it does capture people in terms of person-years.

Ms. BROWN-WAITE. With troops coming and going, that has to be a very fluid figure.

Ms. BELASCO. Right. But the thing is the average strength figure, in fact, captures that because the way it is calculated is for every month, it looks at how many people are there for that month so that it captures all the comings and goings. And, in fact, part of the difference between the figures may be that there are a lot of people on temporary duty.

Ms. BROWN-WAITE. So the average strength per month is what you were looking at and it would not include those on temporary duty?

Ms. BELASCO. It would.

Ms. BROWN-WAITE. It would? And those, for example, that Dr. Goldberg pointed out who may be Air Force who were really just flying over and/or there for a day?

Ms. BELASCO. No. But it would include the Air Force people as only 1 day.

Ms. BROWN-WAITE. Okay.

Ms. BELASCO. And, actually, the average I mentioned is an average for the year for 2007, an estimated average of all the months for the year.

Ms. BROWN-WAITE. Thank you. Thank you very much. My time is up.

Mr. CHAIRMAN. Thank you.

The Chairman of our Oversight Investigations Subcommittee, Mr. Mitchell. You pass.

Mr. Walz? Mr. Walz, you are recognized.

Mr. WALZ. Thank you, Mr. Chairman.

And thank you to both of you for coming. This issue of trying to get the data and trying to put a matrix to this is critically important, so we appreciate the work that you have done. And I understand that it is so difficult.

I would like to also mention the Ranking Member has always been so kind. He gave me a really good history lesson once on a 1946 testimony on the Merchant Marines. So I think in response to the Ranking Member's testimony, I think it should be interesting to point out that although this entire body is disappointed that we have not passed the MilCon VA Appropriations, it has not passed on time in 10 years. And, in fact, in the 2 years under the Ranking Member's Chairmanship, it did not pass on time and we passed a continuing resolution.

So no one cares more about this than this group here, but this idea that we are going to inject some of that into this is a bit disarming to me and I think that setting that straight, it is nothing to be proud of that we have been late 12 of the last 13 years. But that is the fact on this.

And we simply, and the question I have to you is, for the last 3 years, the President has had to come back, Mr. Goldberg, and ask for this. Now, this is the CEO President, the one that is supposed to put the best practice and the matrix to this. You just testified to us here that 3.3 percent of the VA's budget is caring for, the health budget is caring for OEF and OIF veterans. Okay.

How do you explain then if it was not an overwhelmingly unexpected number that came here that this Administration so poorly projected and the VA so poorly projected the needs if there was not, by your account is what it seems like you are telling me, not an unexpected surge here in terms of cost? Can you explain that to me?

Dr. GOLDBERG. Well, my understanding is this, Mr. Walz, that a big reason that the VA has had budget problems in the last 2, 3 years is not so much the inability to plan for the veterans returning from Iraq and Afghanistan. It is much more so the difficulty in projecting the veterans from previous conflicts who are aging and many of whom are having problems maintaining their civilian healthcare, the healthcare provided by employers, and are turning to the VA because the VA is attractive to them, the copayments are less.

And so it is not so much the younger veterans coming back. It is a lot of the older veterans who are reaching that stage where they need help and they are turning to the VA.

Mr. WALZ. With that being the case and some independent budget projections like the "Independent Budget" by the veterans service organizations (VSOs), the DAV and so forth, they were able to much more accurately predict the need than the VA.

Now, my question to you is, I guess, what matrix are they using? At what point does CBO have a responsibility to talk as they just answered to Ms. Brown on this? When does CBO have a responsibility to tell the VA Secretary your projections are not realistic and you are going to be going back to Congress and ask for more money? Do you have a responsibility in that?

Dr. GOLDBERG. Well, the closest responsibility that we have is when there is legislation, for example, the MilCon VA Appropriation, that we do an assessment of that legislation, an independent assessment of how much it would cost, whether there are mandates on the private sector, et cetera.

It is not really within our charter to go back to the VA and critique their budgeting process. I do not really have the authority to do that. That would be more of a U.S. Government Accountability Office (GAO) type of engagement.

Mr. WALZ. Okay. And I am noticing, and I am going back to that question again, does CBO have any, I guess as you are looking at this and you are seeing the cost, maybe this is a GAO question again, this year's appropriation that we will get passed and hopefully sooner than later, are we getting closer to the total needs based on what your analysis is?

Dr. GOLDBERG. I would have to take that for the record and take a closer look.

[The following was subsequently received from Dr. Goldberg:]

Question: Is there adequate funding for VA medical care in the VA-Military Construction appropriation bills that have been passed by the House and Senate for fiscal year 2008?

Answer: CBO cannot evaluate the adequacy of funding without being given a standard for defining "adequate." One possible perspective is to compare the proposed funding level for 2008 to the enacted level for 2007 increased by healthcare inflation. VA's 2008 Budget Submission projects an increase in outlays for medical care of OIF/OEF veterans from $573 million in fiscal year 2007 to $752 million in fiscal year 2008 (31 percent). Given that VA expects an increase in the number of OIF/OEF patients from 209,000 to 263,000 (26 percent), their requested funding would allow an increase in annual cost per patient from $2,735 to $2,860, or 4.4 percent. In January 2007, the Centers for Medicare and Medicaid Services (CMS) issued a projection of a 6.6 percent increase in national per-capita healthcare expenditures.[1] If that projection is correct and if it applies to VA medical care, a full allowance for both inflation and increases in the number of OIF/OEF patients would require dedicated funding of $768 million in 2008 (as opposed to the $752 million contained in VA's Budget Submission).

[1] As noted in House Report 110–186 to accompany the Military Construction, Veterans Affairs, and Related Agencies Appropriation Bill, 2008, p. 43.

Mr. WALZ. All right. Very good. Well, thank you.

And I yield back.

Mr. CHAIRMAN. Thank you, Mr. Walz.

Mr. Boozman.

Mr. BOOZMAN. I do not have any questions. Thank you, sir.

Mr. CHAIRMAN. Mr. Hare?

Mr. HARE. Thank you, Mr. Chairman.

I think this hearing today is very important as we continue to be involved in the two conflicts because the cost of this war is going to be with us for generations to come. And I must say that based upon the testimony of the first panel, I am deeply troubled because of the reoccurrence of such words as unknown and problematic.

And I think everyone here can agree that budget projections are complicated on their merits, but this goes beyond the general complications and to the fact that we simply do not know what kind of long-term effects injuries will have or how many servicemembers will come into the system and what the cost of the wounds such as TBI and PTSD are going to be.

But I would like to ask this panel. I am trying to get a sense of how you determine what the care for veterans would cost. You know, what sort of factors do you use in determining the 10-year projections of the VA health system of $7 to $9 billion for OEF and OIF?

Dr. GOLDBERG. As I mentioned earlier, we do not have great accuracy in the cost of particular disorders such as PTSD or TBI. And I am being candid about that. But what we do is we take sort of a higher level look at the number of troops who are in theater under the two scenarios that run out through 2017 and we have the historical casualty rates, you know, how many folks get injured and we know how many folks get evacuated to Landstuhl, Germany. We know how many folks get evacuated back to the U.S., sort of an indication of severity. And based on that kind of coarse classification of what severity of wounds, we have applied historical factors to try to project the cost forward.

We have not built it from the bottom up. I do not really have the data, the wherewithal, the staff to do this, to build from the bottom up and look at every particular illness and disability and cost it out separately. But I will concede that we need to take a closer look at the TBI and the PTSD and we have ongoing efforts at CBO to improve that aspect of our projection.

Mr. HARE. I appreciate that.

There were two different numbers used in both your testimonies relating to TBIs diagnosed by the Department of Defense.

Ms. Belasco, you said that 26,000 troops have been diagnosed by the DoD of TBI between fiscal year 2003 and fiscal year 2007. Mr. Goldberg stated that through December 2006, only 1,950 TBIs have been diagnosed by DoD physicians. I was wondering if you could explain the discrepancies in those numbers, a pretty significant difference?

Ms. BELASCO. The 26,000 figure that I used, I got from the Department of Defense. I asked them to pull the data together for all those OIF/OEF people who had been treated for TBI or PTSD. And what I did is I gave them the codes for TBI that the VA uses so that there would be some comparability.

What they did is they provided me figures both in terms of the number of patients and the cost under three conditions. One table showed the cost if, and this was true for both PTSD and TBI, showed the cost if the primary diagnostic code was TBI. The second version of the cost showed how much it would be if TBI was one of the several codes used by a doctor or medical practitioner when they treated someone. And the third version was any care that was provided to someone who was initially diagnosed with TBI or PTSD.

And the cost figures that I used reflect the middle. In other words, it covers anyone who was diagnosed by the medical practitioner where TBI was a symptom. And they gave me the number

of patients, patient loads for each year, and then they also gave me the number of those who were eligible for care that year because, you know, DoD unlike VA, people are treated and then they leave. You know, their enlistments are up and they leave.

So that, for example, all the 26,000 TBI patients between fiscal 2003 and May of 2007, by the end of that period, only about 13,000 of them were, in fact, eligible for care at that point because the rest of them have left the system.

Dr. GOLDBERG. To give you the other side of the equation, today was the first time I had heard those higher numbers and I would like to speak to Ms. Belasco about her source and try to reconcile.

I can tell you my source. I actually have two numbers in my testimony. The one I may have mentioned today verbally was the 1,950 TBIs that have been diagnosed through January of this year. And through July, I just got an update of 2,700. Still a much smaller number.

My source is the Defense and Veterans Brain Injury Center which is a joint endeavor of the two departments, DoD and VA, and it is housed up at Walter Reed. We have been up there and we have spoken to the folks there.

They purport to have not a complete census but a nearly complete census of the number of traumatic brain injuries and their numbers, they said, are running now at 2,700. They claim to have 80 to 90 percent coverage, so maybe the number is 3,000 by that source total. So I am frankly mystified that there is another source within DoD and I am very curious to track down——

Mr. HARE. I would be interested. I know my time is up, but I would just be very interested once you two confer on it, if you could get back me with me, I would be very interested.

Thank you, Mr. Chairman.

[The following was subsequently received from Dr. Goldberg:]

Question: What factors explain the difference between CBO's and CRS's estimates of the number of TBIs incurred during OIF/OEF?

Answer: Different organizations with DoD and VA use different criteria to estimate the number of TBIs.

Military and VA hospitals assign an ICD–9 (International Classification of Disease, version 9) code to each patient discharge. Those codes are assigned not by the examining physicians, but rather by coding specialists upon discharge for the purpose of billing third-party insurance (a more important issue for certain family members and retirees than for active-duty personnel).

ICD–9 codes are often used to estimate the number of TBI cases diagnosed; however, neurologists have not agreed on a standard set of codes that correspond to a TBI. (There is no single code or set of codes specific to TBI.) The data that CRS requested used a broad definition of TBIs in an attempt to capture mild TBI cases that may not have been treated at major DoD or VA centers. However, CRS's counts include facial injuries as well as injuries to the optic nerve that may have had very different transmission mechanisms and may not correspond to TBIs. CRS is also subject to double-counting because they include ICD–9 code 310 (post-concussive syndrome), a psychological condition that is assigned later, not as an initial diagnosis.

CBO's cited counts of TBIs diagnosed by the Defense and Veterans Brain Injury Center (DVBIC), a joint activity of the two departments with multiple sites and with headquarters at Walter Reed Army Medical Center. DVBIC's counts of TBIs are based on medical diagnoses made by physicians, not financial codes assigned by coding specialists. CBO considers DVBIC's data more reliable than the ICD-based data used by CRS.

Mr. CHAIRMAN. Thank you.

Let me just put 5 minutes on for my questioning. We appreciate the testimony. Numbers sometimes allow one to be more removed, and provide a supposedly more objective picture. I think your numbers have really disguised the real issues here.

You paint a picture with your numbers of systems that are adequate to meet all the needs, low percentages here and there, although the 50,000 missing soldiers or whatever that you calculated, maybe they are in Pakistan, maybe they are in Iran. You know, maybe we just discovered something that we should know.

But they do not tell us the human story that all of us have to deal with every single day. And even on their own, just to take the figures on their own distorts the picture, I think, because, you know, there is a systematic dismissal of PTSD as an illness in the military.

We have stories of people who say their questionnaires were turned in, came back to them because real Marines do not admit mental illness. We have people scared to say they have problems because of promotions. There is a whole range of things we do not have to go into now which you are aware of which would change the nature of your figures.

But, more important, I think sometimes our anecdotal or human picture is more real. We have people who cannot get into our VA facilities because there is no room to treat them. They have PTSD. We have stories of people going home and committing suicide because they could not get in. We have waiting lists.

I do now know. Four percent of the DoD claims of PTSD, I mean, that is a ridiculous figure given all the information we have. Something is wrong with the way DoD gives the figure if they are saying 4 percent. We know that. So why are we even using that as a basis?

Even the percentages, I do not know how you got 3 percent of an impact on the VA. I mean, I just took 300,000 OEF/OIF versus 5 million enrolled patients and that comes out double your 3 percent, but it does not even matter.

I think we are vastly, systemically, underestimating the issues that we come into contact with every single day. There is a difference between your numbers and the reality that our constituents face and these veterans face. And I am not sure that these numbers today are going to be very helpful.

We have had a vast, what shall I say, difference in estimates from other sources. I have seen estimates as high as, as I said in my opening statement, $60 billion a year for the next 10 years. Why do we have 60 versus 1? I mean, that is not just a difference in source.

I mean, there is something going on here that your figures produce such low numbers compared to everybody else in the world. Why is that?

Dr. GOLDBERG. Well, there are other studies out there. And I did not really come here with the intention of fighting with people who are not here to defend themselves. But I tried to be very careful in rather than just saying, you know, there was a newspaper article that said 20 percent of troops have TBIs, for example, that there was an article in Boston Globe, and a lot of folks would go and say, well, let us just take 20 percent of everybody and cost

them out as though they have lifetime of, you know, bedridden, around-the-clock care. And there simply are not tens of thousands of people, to my knowledge, who are in that situation.

Every one of these cases is tragic and I am not here to deny. You know, I have been to Walter Reed as I am sure you have, Mr. Chairman. But the fact is, I am a numbers guy and I am trying to give you the numbers to best inform the deliberations on what appropriations are necessary and other legislation that might be needed. And the human tragedy is undeniable, but the numbers——

Mr. CHAIRMAN. Yes. But why is there such a difference between a $1 billion a year and $60 billion a year? I mean, what is going on here?

Dr. GOLDBERG. I do not know that $60 billion, but, I mean, $60 billion, it is twice the capacity of the entire—it is twice the entire VA health budget what it is now and, yet, only 3 percent of the patients.

If I could make one correction, Mr. Chairman, 229,000 veterans have been seen for care, but many of them are young. Only 3 percent of them have ever been in for a hospitalization at the VA. Most of them come in for outpatient care and they are simply not consuming the resources on the whole. Most of their care is much more routine. It is handled on an outpatient basis.

I should also mention to be candid about it that these numbers do not include, my numbers do not include the care that is provided at DoD, at Walter Reed, and the other facilities, Walter Reed, Bethesda, Wilford Hall before these injured veterans get to the VA. That is a different matter and I do not have those estimates today.

Mr. CHAIRMAN. I think the human picture is so much different than we have painted here and I think it is more real because we are dealing with—I mean, Sunday's paper and *The Washington Post* talked about this one soldier, but there are thousands like him with PTSD. He is not getting enough money from the disability system. His wife had to quit everything to take care of him 24 hours a day.

And we hear stories. This is not an isolated incident. Every one us can tell you a story of somebody that we know someone in our district that is facing this stuff and it is just not a real picture to say we have this covered.

Mr. Buchanan, do you have any questions?

Mr. BUCHANAN. No.

Mr. CHAIRMAN. Mr. Donnelly?

Mr. DONNELLY. Thank you, Mr. Chairman.

And I want to thank both of you for being here today.

There are also a number of contractors in Iraq and what I was wondering is if a contractor suffers a significant injury, is our government on the hook at any point for those costs later on, 5, 10 years later, whether in the VA budget or in another budget?

Dr. GOLDBERG. My understanding, and I am not absolutely certain on this—perhaps the VA officials could correct me—but DoD will provide care in theater at some level, but I do not believe that they will provide the care in the VA years out unless we are talking about someone who happens to be a veteran which many of the contractors are.

Mr. DONNELLY. That was going to be my next question was many of the contractors are veterans and when they come back, those injuries that they may suffer in Iraq as they go back to VA care when they come home, does the VA system then assume the cost of those additional injuries as well?

Dr. GOLDBERG. It would depend on the classification, which of the eight priority groups they fall into. Again, correct me, the second panel, if I am wrong, but I do not believe those would be considered service-connected injuries because at this point, we are speaking of contractors who have separated or retired from the military. And they would have to gain entry notwithstanding the freeze on priority eight veterans. So they may be able to get into the VA or they may not be depending on their income and whether or not they had prior service-connected disabilities that would provide their entry.

Mr. DONNELLY. Okay. And one other question I had is in regards to TBI. There has been some discussion about using other facilities as well like the Rehabilitation Institute of Chicago, for instance, not far from where I live, as vets separate from the service, at that point where they become nonactive, that they be given a year where they can choose either using the VA facility or one of those facilities.

If we provided that in veteran services as an alternative, would that increase our costs?

Dr. GOLDBERG. I would suspect it would and I do not have estimates of those costs. I know the VA does work and has some sharing arrangements now. The question is were those sharing arrangements augmented, how much would it increase the cost. I do not have an estimate of that.

Mr. DONNELLY. Okay. Thank you very much.

Ms. HERSETH SANDLIN [Presiding]. Mr. Hall, you are now recognized.

Mr. HALL. Thank you, Madam Chairwoman.

And thank you, Ms. Belasco and Mr. Goldberg, for your testimony. I have a couple of questions. Many of mine have already been covered by other Members.

But do you know what the average age of separation is at this point from these conflicts OIF/OEF so far?

Dr. GOLDBERG. It is probably on the order of 25, but I would have to check that for you.

Mr. HALL. That was my guess. And average age of deployment or enlistment?

Ms. BELASCO. The average age of those deployed?

Mr. HALL. That is correct.

Ms. BELASCO. Well, what I have is some figures that say 60 percent of those deployed are between the ages of 17 and 30.

Mr. HALL. Okay. So if you take the 60 percent as being representative, then, you know, somewhere in the early twenties?

Ms. BELASCO. Yeah. I mean, as I said, if you were to look at what the typical servicemember deployed, it would be someone who was young, white, male, first-term enlistee.

Mr. HALL. So maybe 22 on average? Of course, the other 40 percent, I am not sure if that would skew it upward more. I know there have been several men who——

Ms. BELASCO. Not terribly much.

Mr. HALL [Continuing]. Deployed at the age of 56 that I know of, but——

Ms. BELASCO. I think there are another 25 percent who are between 30 and 40.

Mr. HALL. Right.

Ms. BELASCO. So, therefore, 40 and over is——

Dr. GOLDBERG. Mr. Hall, the Reservists tend to be a little older.

Mr. HALL. Right. I am trying to get at what the life expectancy is for the average person who separated from the military after serving in these conflicts.

And I am guessing that you are talking about, depending, of course, on the injuries they suffer, it sounds to me like you are describing a universe of people in whom the injuries, the real serious ones are not that bad, so you are maybe looking at 70, 75 years life expectancy in this country at this point for men which would seem to indicate that you might want to multiply by five in order to get the lifetime care is what I am trying to figure out.

So far, the expense incurred by the American people for the lifetime care of those who need it, whatever level of care that is. Some of them, it is round-the-clock, 24-hour nursing or supervision and some of them, it is periodic visits to a doctor. But you may be talking about, using your figures, about another $40 billion or so added on top of the $7 to $9 billion medical care for the years 2008 to 2017.

Dr. GOLDBERG. Are you asking my reaction to that?

Mr. HALL. Yeah.

Dr. GOLDBERG. My reaction to that is I think 50 years of additional life is probably a fair average number. I think it might be a little bit high to just do a straight multiplication and the reason is that a lot of the veterans who come back will either get cured, the ones who have lesser severity illnesses, or they will find that they will transition back to their civilian jobs and pick up healthcare through their employer and over time, fewer and fewer will rely on the VA. So the costs on the VA budgets will come down.

Now, later in their life, they may return to the VA when they retire and they no longer have that civilian sector healthcare.

Mr. HALL. Right. The way Vietnam vets now are coming in in big numbers because they reach an age where their injuries, you know, or the exposures to certain chemicals or substances that cause disease start to crop up like prostate cancer, for instance, and Agent Orange exposure.

Dr. GOLDBERG. Exactly.

Mr. HALL. So there could be a bump later on as they get older and need more care?

Dr. GOLDBERG. I think that is fair. But I think going out beyond the 10 years and you are talking about someone 40 years old, many of them, like I said, will be back in civilian jobs where they have their own healthcare and would rely less on the VA.

In fact, we make that assumption even in our 10-year window that some of the veterans come back, the ones who do not have the horrific injuries, many of them will transition out of VA.

Mr. HALL. Okay. But it is safe to assume, though, that there is beyond the year 2017, there are going to be substantial costs for continuing care?

Dr. GOLDBERG. Oh, absolutely. I did not mean that to be interpreted as zero, simply that we have a 10-year window.

Mr. HALL. Okay. And have you heard, either of you, stories that are seen on news articles about diplomats, U.S. diplomats who claim to be suffering from PTSD from serving in Iraq and Afghanistan?

Dr. GOLDBERG. I have seen the articles and it is quite possible. And those numbers are not reflected here.

Mr. HALL. Of course, I am only saying that to raise the suggestion that perhaps the PTSD numbers that are being given by DoD or VA for the reason that the Chairman gave may be low.

I mean, I have heard stories directly from families and also read articles about family members, children, not that they are covered under the VA in the same way that a veteran is, but that peripheral contact and exposure repeatedly to the deployments that this war has involved and the dangers involved have caused psychological damage, you know, to those people so that, well, we get back to the anecdotal versus the numerical which is, you know, your world.

And, anyway, I am over my time. Thank you very much for your testimony.

I yield back.

Ms. HERSETH SANDLIN. Thank you, Mr. Hall.

Mr. McNerney, you are recognized for 5 minutes.

Mr. MCNERNEY. Thank you, Madam Chairwoman.

The Capital Asset Realignment for Enhanced Services (CARES) report that is being used to justify closure of VA facilities uses such figures as the CBO's projection earlier this year that the number of veterans is supposed to decline between now and the year 2025.

Could you address what impact that OEF and OIF will have on that trend.

Dr. GOLDBERG. I think the trend will continue despite the fact that we still have people coming back adding to the pool of veterans. The larger numerical effect is that the World War II veterans and now increasingly the Korean war veterans are heading up to the age where many of them are starting to die. And we still see a trend where the overall population will be declining.

Mr. MCNERNEY. Well, you have presented a terrific amount of information. I mean, there is a ton of data here to sort through and it is going to take me a while to absorb it all. I am sure you can appreciate that.

The numbers that were thrown out here this morning, $7 to $9 billion cost for veterans of this war between now and 2017, this compares to the roughly $30 billion VA budget for this year. It seems unrealistically low. The $7 to $9 billion seems unrealistically low compared to the yearly budget that we are putting into the Veterans Administration.

Dr. GOLDBERG. The VA budgets, depending which categories, is on the order of $34, $35 billion, I believe. But, again, I would remind you that only about 3 percent of the patient load at the VA hospitals is comprised of the veterans of OEF and OIF. So even if

those numbers are growing, they do not overwhelm the care that is being given to the veterans of previous conflicts.

Mr. MCNERNEY. Well, we have, using that number of $7 to $9 billion and the projection for the war cost, this $1.2 trillion to $1.6 trillion, that is only about six-tenths of a percent of the cost of the war.

Is that comparable to prior conflicts? Is that six-tenths of a percent? Can either one of you address that?

Dr. GOLDBERG. I have not looked at it in precisely those terms. But I would point out, you know, in defense of your calculation that, again, as I mentioned earlier in response to a question, much of the care is received in DoD and I do not have those numbers.

And also, when you look at the cost of military operations, we are talking about cost of activating Reservists, we are talking about special pays for being in the war zone, we are talking about all the fuel costs to run all the vehicles and all the transportation to and from the theater. So those costs are staggering compared to the cost of treating 229,000 veterans in the VA.

Mr. MCNERNEY. So the $7 to $9 billion, does that include facilities? I mean, what all does that include and what does it not include?

Dr. GOLDBERG. It includes an apportionment, a share of the facilities, the overhead that would go toward treating these veterans, their share in the mental health initiatives, the Vet Centers that provide rehabilitation, and a few other things.

And, again, I might defer to the experts on the second panel, but my understanding is it was in the budget justification. It is intended to be a pretty complete picture of a portion of all the programs, healthcare and other programs that are devoted to this particular group of veterans.

Mr. MCNERNEY. Thank you.

I am going to reserve back the balance of my time.

Ms. HERSETH SANDLIN. The gentleman yields back.

I would now recognize the Ranking Member, Mr. Buyer, for questions he may have of our witnesses.

Mr. BUYER. Thank you.

Dr. Goldberg, would you say that you have an extensive knowledge with regard to the VA budget modeling system that is used to finance?

Dr. GOLDBERG. I would not say extensive. I have worked with the VA staff, some of whom are here today, and they have shared with us the documentation on the model and they have answered specific questions, but I have never had the opportunity to actually sit down and run the model and gain the kind of firsthand knowledge that they have at VA.

Mr. BUYER. Do you have working knowledge of the flaws that were discovered in the model back in 2005?

Dr. GOLDBERG. I have some knowledge of the flaws. And in particular, I know the GAO and others have reported on the flaws, so you probably know as much or more than I do about that.

Mr. BUYER. Well, I should say not the flaws on the model. It was really the flaws of the inputs into the model. There was no error in the model itself.

Dr. GOLDBERG. One of the problems that we face, and it is the same in other agencies, it is the same in DoD, for example, I know a bit about the DoD budgeting process——

Mr. BUYER. Well, hold on. Hold on. I do too.

Dr. GOLDBERG. Okay.

Mr. BUYER. I do not have a lot of time. So I just want to make sure that I have got the right witness. I was exhausted every year we would go through this process with the DoD and have to come in and do supplementals because of their health model. And so that is why back in 2005, we got into the VA model so I could better understand their inputs and then we discovered all of the stale data.

Now, as I understand the shortfall back then, it was attributed to underestimated VA long-term care costs, greater than expected workload growth in priorities one through six, the OIF/OEF workload and expense, utilization of services by those already in the system, contract medical care to reduce the waiting list, energy costs, and CHAMPVA workload.

Now, that was back in the 2005. I then asked the GAO to look into the VA's flawed budgeting process. Back on September 20, 2006, these were the GAO findings: unrealistic assumptions, errors in estimates, insufficient data, and an unresponsive budget model.

The GAO recommendations were do a better job of linking policy changes with their effects on their budgets, strengthen internal controls, improve budget calculations, and improve budget reporting to Congress.

So my question to you, as you were formulating your work product for the Committee, do you have an opinion or a comment relative to the GAO's recommendations to the VA that, in fact, they are being carried out and you have better confidence today than what you had in 2005?

Dr. GOLDBERG. In my professional opinion on that, I cannot certify that VA has done everything that GAO recommended, but my opinion is that VA has taken a lot of steps each year in each generation of the budget model to make it better. They are aware of the stale data problem. They have tried very hard to improve their methods. And I cannot certify they have done everything they should have, but I think they made a lot of steps.

Mr. BUYER. I compliment your work product, Dr. Goldberg. You went right in on somebody else's study how they calculated lifetime costs for all amputations and you said, well, wait a minute, 14 percent of those are toes, fingers, things that would not require those types of costs.

So you went into specific detail, but I have to come back to you because I have one item that I need some help with. At the very end of your report, on page 18, we are going to talk compensation and pension.

Dr. GOLDBERG. Yes.

Mr. BUYER. We focus on healthcare. I guess that is what gets all the attention. But when I look at one of the cost drivers, it is going to be compensation——

Dr. GOLDBERG. Yes.

Mr. BUYER [Continuing]. and the pension costs. Now, your counsel to us is that at the very end, you are saying CBO applied pro-

jections to the annual payments to people with varying disability ratings to estimate total cost for disability compensation.

CBO assumed that approximately three times the number of claims associated with medical evacuations would eventually be made by a veteran who incurred service-connected conditions as a result of operations in Iraq and Afghanistan that are not severe enough to require medical evacuations from theater.

So you are assuming then, even though they come out of that theater and are not as severe, you go ahead and plug in that through that lifetime, they will incur 40 percent. How do you get to that?

Dr. GOLDBERG. What is the basis for that?

Mr. BUYER. Yes. What is the basis for that?

Dr. GOLDBERG. The basis for that is looking at previous conflicts and data we have gotten from the VA that a lot of folks who get disability ratings and who will get compensation or qualify for care at the VA hospitals were never actually wounded.

They were never shot, but they come back and, for example, they have strained their back, their knee goes out. We know the conditions in Iraq are very intense, carrying very heavy backpacks and the heat, getting dehydrated. Some of these, as we mentioned in response to an earlier question, some of these are Reservists who are older, in their forties, fifties even, and you may never have been shot, but when you come back, you find that your health has deteriorated and you can legitimately apply for a VA disability and receive that disability rating.

And so we project there will be more of those folks showing up than the ones who were actually reported as wounded in the theater.

Mr. BUYER. Wow. That is a very large and alarming number.

Can I ask one——

Ms. HERSETH SANDLIN. Certainly.

Mr. BUYER. You are saying that you do this and you are relying upon past wars?

Dr. GOLDBERG. Yes. If you look at the number of folks who have been seen at the VA, Vietnam era, for example, and look at how many were actually wounded, there are a lot more people coming in now who were never wounded.

For example, it was mentioned earlier by one of the Committee Members, I think it was by the Chairman, of the number of homeless people, many of whom are Vietnam veterans, and some of them were wounded and many of them were not and, yet, here they are.

Mr. BUYER. All right. Well, thank you very much.

We will be able to ask the VA in the next panel whether they are taking that into account in their prospective budgets.

Thank you. I yield back.

Ms. HERSETH SANDLIN. Thank you.

Let me pick up from there. Ms. Belasco, you state on page four of your written testimony that CRS estimates do not, however, include any VA disability benefits for Iraq and Afghanistan veterans since CRS was not able to get figures from the VA.

When did you request those figures from the VA and were you given any reasons for why this information was not provided?

Ms. BELASCO. Yes. I asked for the figures last week sometime and they told me that they do not have cost figures and that their figures for the number of disability, those who apply for disability benefits, which they did give me, includes both those who requested disability payments before they were deployed and those who requested disability payments benefits after they were deployed.

So I asked them to give me the figures for only those who requested disability benefits after coming from a deployment because I figured if you wanted to capture just Iraq and Afghanistan veterans, you would only want someone who had been deployed. And they said they could not do it. I do not know why.

Ms. HERSETH SANDLIN. We will follow-up with the witnesses on the second panel on some of those same questions.

But then, Dr. Goldberg, do you, based on the questions posed by the Ranking Member and some of what you state in the last few pages of your report, did you get any information from the VA in making those projections?

It sounds like you did, but it sounds like maybe one of the reasons you are plugging in making some of the projections you are making may not be based on some of the information you are getting from the VA.

Let me start with, do you have the information from the VA that Ms. Belasco requested?

Dr. GOLDBERG. We do not have that information directly from the VA. We have done our own projections. Now, part of the reason, of course, you might want to ask this question of the next panel, but part of the reason is I know it is the VA philosophy to treat what they call the whole veteran.

And if a veteran has a disability rating, it could be the composite of many disabilities that add up to, say, a 70-percent rating. And some of those disabilities may have been incurred in this conflict and some of them may have been incurred in the first Persian Gulf War and they do not make that distinction. They are treating the whole veteran.

And so I find it entirely plausible that the VA does not separate out the disabilities by unique single periods of conflict.

Ms. HERSETH SANDLIN. Okay. I think that is a good point. I also think we need to keep in mind when we are utilizing our experiences from past wars for the VA for your projections, for example, I know of a number of individuals who did not actually go to the VA to get a disability rating until 20 years after they were home and were diagnosed with PTSD.

So I think we have some other complicating factors, but I appreciate your response. And we will pursue that with the second panel.

One final question and, again, this may be more appropriate for the next panel as well, but I would be interested to get each of your perspectives based on the information you are getting either from DoD or VA.

If we have active-duty servicemembers that are wounded, say traumatic brain injury, and they are getting treatment in a VA facility, say a polytrauma center, who is paying and when are they paying? Is it DoD and then DoD reimburses the VA? Is the VA pay-

ing up front and then gets reimbursed later? I mean, do you know how that is happening? Are costs being transferred and then who is accounting for what cost? Do you see what I am getting at?

Dr. GOLDBERG. I understand the question. And I would have to tell you that my own knowledge of that is a little fuzzy and I would like to take that for the record and investigate it for you.

[The information was requested from the VA witnesses, Dr. Kussman, Colonel Kearns, and Admiral Cooper, during their question and answer session of the hearing. The information has been provided for the record from VA.]

Ms. HERSETH SANDLIN. Okay. Thank you, Dr. Goldberg.

Ms. BELASCO. As near as I understand it, the figures that I got reflect that DoD treatment costs are for those who are eligible for DoD treatment costs which means they would still be in the military. There may be some transitional periods when or maybe sharing of facilities like the Defense Veterans and Brain Injury Center which I believe receive funding from both DoD and VA. So those may be murky things.

I would like to just very briefly say that, you know, one of the difficulties with doing budget stuff is budget and budgets and figures are sort of inherently heartless kinds of things. And as my husband warned me before I testified before today, he said stories trump numbers every time. And I can certainly understand that.

I think the thing is with figures, what you are trying to get at is where to focus money, whereas sometimes people do not get care that they need because the processes make it very difficult and then it is a matter of dealing with, you know, how agencies operate and what the criteria are and all of those other things. And those are really not dollar figures.

Mr. BUYER. Will the gentlelady yield?

Ms. HERSETH SANDLIN. Mr. Buyer, yes.

Mr. BUYER. I think your question is right on the mark. Just as you are sensitive about testifying relative about people and emotions and you put it in numbers, we also like a holistic approach, but we also understand our jurisdiction.

So when that active-duty soldier ends up at the VA, it seems a little harsh that we have got to say, okay, who is going to pay and when do they pay. But that is our budgetary responsibility.

And so you are hitting it right on the point and I think hopefully on our next panel, Dr. Kussman will be able to share some insight further. So thank you for your inquiries.

Ms. HERSETH SANDLIN. Well, I thank the Ranking Member, and we will pursue that.

Ms. Belasco, I thank you for your observations as well, and thank you both for coming this morning for your testimony.

This does conclude the first panel. So I would like to ask the witnesses on the second panel to come forward. And as they make their way to the table, I would ask unanimous consent that all Members have five legislative days to revise and extend their remarks and that written statements be made part of the record. Hearing no objection, so ordered.

Joining us from the Department of Veterans Affairs is Dr. Kussman, the Under Secretary for Health, and Admiral Cooper, who is the Under Secretary for Benefits.

Gentlemen, welcome back to the Committee. Thank you both for being here today. You will each be given 10 minutes for your oral remarks and your written statement in its entirety will be included in the hearing record.

So, Dr. Kussman, please proceed with your statement.

STATEMENTS OF HON. MICHAEL J. KUSSMAN, M.D., MS, MACP, UNDER SECRETARY FOR HEALTH, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY COLONEL W. PAUL KEARNS, III, USA (RET.), CHIEF FINANCIAL OFFICER, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; AND HON. DANIEL L. COOPER, VADM (RET.), UNDER SECRETARY FOR BENEFITS, VETERANS BENEFITS ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY JIMMY NORRIS, CHIEF FINANCIAL OFFICER, VETERANS BENEFITS ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

STATEMENT OF HON. MICHAEL J. KUSSMAN, M.D., MS, MACP

Dr. KUSSMAN. Thank you, Ms. Chairman and Mr. Ranking Member and other Members of the Committee. It is a pleasure to be here today. And my testimony focuses on how the VA is meeting the needs of our newest generation of veterans.

Since 2002, 751,273 OEF/OIF veterans who left active duty have become eligible for VA healthcare. Thirty-five percent or 263,909 of the total separated veterans have come to the VA to obtain healthcare.

VA is adapting and creating new services to meet the medical needs of the returning OEF/OIF veterans. A very visible example exists in our polytrauma system of care.

In 2003, recognizing a need to address injuries caused by the improvised explosive devices led the initiative to adapt and change our already existing four traumatic brain injury lead centers into state-of-the-art polytrauma rehabilitation centers.

These centers provide acute medical and rehabilitation care to veterans suffering from severe TBI and one or more major traumatic injury such as amputations of a limb or blindness.

In addition, we have created a polytrauma system of care that provides a continuum of care when these heroes are able to move from the acute care to less intensive levels of care. These are located throughout the VA's 21 networks, one in each VISN. The polytrauma system provides three levels of care for acute to less intensive outpatient care.

To give this Committee a sense of the magnitude of the severe injuries in the OEF/OIF population, there have been 681 patients with amputations and 110 patients with spinal cord injuries. VA has accepted 436 transfers from military treatment facilities to our polytrauma centers.

The Secretary of Veterans Affairs recently announced a decision to locate a fifth polytrauma center in San Antonio,Texas.

There are mild to moderate forms of TBI that exist as well outside the polytrauma centers. VHA now screens all returning veterans seeking care at VHA facilities for symptoms of TBI. Veterans

who screen positive are referred to a specialist for a complete and in-depth neurocognitive assessment.

We have developed a thorough training program on screening and follow-up evaluation for all our providers. VHA has developed new programs to provide transition assistance and case management for OEF/OIF veterans.

In 2007, the VHA this year hired a hundred transition patient advocates (TPAs). These TPAs serve as veteran advocates when severely injured veterans transition to the VA from the military treatment facility. These specialized case managers are located in VA medical centers. Annually, VA distributes approximately $19 million among the networks to cover these TPA services.

Vet Centers provide veterans and their families professional readjustment counseling. From fiscal year 2003 through the end of the third quarter of fiscal year 2007, the Veterans Centers provided services to 183,030 veterans in their outreach program and clinical services to 58,504 veterans.

During the same period, more than 1,570 family members have been referred to the Vet Centers for bereavement counseling.

Moreover, starting in 2003, the Vet Centers recruited the first 50 of the total of 100 Global War on Terror veteran outreach specialists to conduct a focused outreach campaign to their fellow veterans returning from OEF/OIF. The second 50 GWOT outreach specialists were hired in 2005. The associated recruitment costs for the 100 GWOT veterans was approximately $5 million.

In February 2007, the VA announced plans to increase the number of Vet Centers from 209 to 232 and to augment the staff at its 61 existing vet centers. The expansions will be completed in 2008 and will increase the Vet Centers program annual recurring budget by approximately $14 million.

Of the OEF/OIF veterans who sought care from the VA, about 38 percent have received at least a preliminary diagnosis of a mental health condition and 18 percent have received a preliminary diagnosis for PTSD making it the most common but by no means the only mental health condition related to the stress of deployment.

To meet the specific mental health needs of these returning veterans, VHA has developed new and enhanced existing mental health programs and services. General and psycho-geriatric mental health services are also being integrated into the primary care clinics.

We have also initiated an aggressive recruiting campaign with the goal of hiring over 4,000 new mental health providers. So far, we have successfully hired approximately 3,600 of that goal.

In late July of this year, VHA implemented a national toll-free suicide prevention hotline housed at the Canandaigua, New York, VA Medical Center. The call center is integrated with the VA's mental health services through suicide prevention coordinators at each medical center.

Care initiated through the hotline is handed off to the coordinators who work with the patients to help them engage in mental healthcare or if they are already in treatment, to address any problems with their care.

The cost of mental health services and programs specifically dedicated to OEF/OIF veterans has increased fourfold from fiscal

year 2005 to fiscal year 2007. Presently OEF/OIF veterans represent approximately ten percent of all veterans with a mental health diagnosis and, therefore, the cost of their mental healthcare can be estimated at ten percent of the over $3 billion of expenditures in this area.

Ms. Chairman, this concludes my statement. Thank you very much.

[The prepared statement of Dr. Kussman appears on pg. 62.]

Ms. HERSETH SANDLIN. Thank you, Dr. Kussman.

Admiral Cooper, please proceed whenever you are ready.

STATEMENT OF HON. DANIEL L. COOPER, VADM (RET.)

Admiral COOPER. Madam Chairman, Members of the Committee, I appreciate the chance to be here today to describe the budget formulation process used to project the long-term costs of our Veterans Disability Compensation Program.

I am accompanied by Mr. Jimmy Norris, Chief Financial Officer for VBA. VBA is responsible for administering a wide range of benefits and services for veterans, their families, and their survivors. At the heart of our mission is the Disability Compensation Program. It provides monthly benefits to veterans who are disabled as a result of injuries or illnesses incurred or aggravated during their military service.

Today, there are over 2.8 million veterans of all periods of service receiving VA compensation benefits. This is a net increase of more than 500,000 veterans since the year 2000. In 2007, these veterans were paid $29 billion in compensation benefits.

To predict the changing trends in veterans' compensation benefits payments, VBA developed a benefits project forecasting model. The model uses a combination of historical data, current experience, and workload and performance projections. This model was developed in 2004 in conjunction with OMB, CBO, VA's Office of the Actuary, and other internal VA offices.

The basis for projecting both the total caseload and the average amount of benefits to be paid for the next 10 years is the detailed historical data which we have accumulated. Our model incorporates specific data for approximately 99 percent of the beneficiaries dating back to 1992.

By comparing data from 1 year to the next, we are able to recognize developing changes in our recurring caseload and to predict trends for both accessions and terminations.

To forecast obligations, we must also estimate the average dollar amount for benefits that will be paid to each beneficiary. The average degree of disability for these beneficiaries increased 26 percent over the last 10 years from 30.9 percent in 1996 to 38.9 percent at the end of 2006. That is the average for the individual veteran on our books. And then there are the concomitant increases in average benefit payments as a result of that.

Projections of incoming claims are one of the keys in the formulation of our mandatory budget request. Disability claims from veterans from all periods of service increased from 578,000 claims in 2000 to 838,000 incoming claims in 2007.

It should be realized that resubmitted claims for increased benefits from veterans who are already on our books continue at about 54 percent of our total claims volume.

The budget model analyzes changes to individual benefit payments. This method has been determined to be reliable for projecting total compensation costs. However, it does not provide long-term cost projections for veterans of a specific era or conflict.

As a result of VA and DoD's current efforts to enhance data sharing, we now have a means to identify GWOT, that is OIF/OEF combat veterans, and are able to begin to analyze their usage. This latest match identified 223,000 veterans who have filed claims for disability benefits either prior to or following their deployment. That represents approximately 30 percent of the OIF/OEF veterans separated through May 2007.

Of these claims, that is the 30 percent of the veterans who have filed claims, 89 percent have received decisions on their claims. Of those veterans who have received decisions, 91 percent have been awarded service connection for at least one of the issues that they designated on their claim.

Projecting future demand and long-term costs for the OIF/OEF conflict remains extremely difficult for a number of reasons. First, many of those veterans served in earlier periods and their injuries or illnesses could have incurred either prior to or subsequent to their present deployment. We are unable to identify which OIF/OEF veterans filed a claim for disabilities only during their actual overseas recent deployment.

Second, we have significantly expanded our outreach to separating servicemembers. Over the last 5 years, we conducted over 38,000 briefings attended by 1.5 million active-duty and Reserve personnel.

Additionally, through the Benefits Delivery at Discharge Program, servicemembers are encouraged to file and are assisted in filing for disability claims prior to their separation and that allows them to start their compensation payments earlier. Many servicemembers with disabilities are submitting disability claims earlier than they have historically.

And, third, VBA lacks historical data for claims activity by veterans of prior wars on which to base projections of benefits usage for the OIF and the present war. The only data available that we have are numbers and percentages of veterans currently receiving benefits separated by the era of their service.

We continue to add veterans to our compensation rolls many years after their service. Many of these are the result of additional conditions presumed to be related to service in Vietnam.

PTSD claims have also increased dramatically for Vietnam veterans. We have no basis for determining if service in Iraq and Afghanistan will result in similar claims patterns.

Madam Chairman, this concludes my statement. I will be happy to answer all questions.

[The prepared statement of Admiral Cooper appears on pg. 64.]

Ms. HERSETH SANDLIN. Admiral, thank you very much.

I would now like to recognize Mr. Brown for 5 minutes if he has questions.

Mr. BROWN OF SOUTH CAROLINA. Thank you very much, Madam Chair.

I certainly appreciate the service of both of you gentlemen and for your testimony today and for your insight in looking out for our warriors that have come back with some terrible, terrible inflictions of injuries.

And I do not have any questions. I just want to thank you for coming and being part of this discussion.

Dr. KUSSMAN. Thank you.

Admiral COOPER. Thank you, sir.

Ms. HERSETH SANDLIN. Mr. Michaud, you are recognized.

Mr. MICHAUD. Thank you very much, Madam Chair.

One of my biggest concerns is to ensure that we have adequate, safe, and quality healthcare for veterans who reside in rural areas. And as you know, about 40 percent of the returning veterans are from rural areas.

In your testimony, you state that the VA continues to promote the recruitment and retention of mental health professionals. Could you elaborate specifically on new recruitment efforts in rural areas on mental health professions and what difficulties do you foresee VHA experiencing in recruitment in rural areas?

Dr. KUSSMAN. Thank you for the question.

If you would not mind, I just want to introduce Retired Colonel Kearns who is the Chief Financial Officer (CFO) for VHA. I neglected to introduce him and I apologize. So do not hold it against me.

To specifically answer your question, obviously services across the board including mental health are very important to us in rural health. And as you know, we have set up an office. We are recruiting a Director for that.

Our effort is to push community-based outpatient clinics as far forward as we can to put them into where the veterans live. But as you alluded to, sir, that there have been challenges that the infrastructure in many rural areas really does not exist whether it is the VA or in the civilian community, particularly in mental health.

And there are challenges hiring people or getting them to come or stay in the rural areas and we are trying very hard to push that service as far forward to where the veterans live. We have at all our Community Based Outpatient Clinics either mental health people or contracts with local people to provide the services where they are, but that is a continuing challenge for us.

Mr. MICHAUD. Without objection, since we just got called for votes, Madam Chair, I would ask permission to submit my additional questions for the record.

[The post hearing questions for the record for VA from Mr. Michaud appear on pg. 72.]

Ms. HERSETH SANDLIN. Okay. Thank you, Mr. Michaud.

We do have votes. I believe we are trying to clarify. I think that we may have three votes, one 15-minute followed by two 5-minute votes. So we do have some additional time before we need to head over. I know it may be hard for some of the other Members to come back. I would encourage them to do so if they can.

But, Mr. Boozman, I think we can get to you and maybe one other Member before we head down.

Mr. BOOZMAN. I will pass in the interest of time, Madam Chair.

Ms. HERSETH SANDLIN. Okay.

Mr. BOOZMAN. Thank you all.

Ms. HERSETH SANDLIN. Mr. Mitchell?

Mr. MITCHELL. Thank you, Madam Chair.

I just have a couple questions of Admiral Cooper. One, you mentioned in trying to figure out the model for which you are going to base all of these benefits on was the VA's Office of the Actuary. What does that office do?

Admiral COOPER. Well, basically that will tell us the time line for a person's lifetime. So as you try to project out, you try to project how long you will be paying those individuals for the disabilities they have.

What we have seen in our pension program is that people are leaving the program faster than they are coming in. But, the situation in compensation is that we are now, increasingly getting people. There are more being added to the rolls than those from World War II or previous eras who are dying.

Mr. MITCHELL. So this office is not looking at future veterans, but only those that are in the program already?

Admiral COOPER. Those in the program, yes, sir.

Mr. MITCHELL. We had a hearing yesterday on the discrepancies for benefits State-by-State. And one of the things I see on page four of your testimony, you mentioned that 54 percent of the total claims volume was based on those who resubmitted their claims. Is there a way that you can cut this down?

One of the things that was brought out yesterday in the hearing that we had was that those veterans who are represented by counsel do much better than those who try to do it on their own. And I would think that when you resubmit and 54 percent of the claims are based on resubmittals that this is really a lot of duplication and that there could be some real improvement in this area.

Admiral COOPER. There are several factors. One factor is these gentlemen and ladies are getting older. And as they get older, there are some diseases, diabetes is a primary one, that cause other conditions and more and more things happen to you. You can come back in with a claim for increased benefits and we would determine the degree of disability that you have as a result. That should, in fact, increase the compensation. That is one thing.

Secondly, some conditions are presumed to be related to exposure to Agent Orange in Vietnam. And about 5 years ago, type two diabetes became a presumptive and so that represents a large increase.

But it is a fact that people do get worse, whether they have a bad knee and it gets worse as it goes. And there is no time limit on a person filing a claim. We occasionally have claims from people who would be considered quite elderly.

Mr. MITCHELL. Just as an example real quickly, I know we have to go, but yesterday's testimony, there was a gentleman who contracted Hepatitis C and he tied that into an injection he got.

Another person came along with Hepatitis C and he filed a claim for benefits believing that it was because he had some surgery and

they used a blood transfusion. Well, they found that that was not the case, but he did have Hepatitis C as a result and he had to refile because in the initial filings, they did not include all the possibilities.

But I understand as people get older, they get different diseases, but it seems to me that the proof has been shown that if you are represented by counsel, you have a much better chance of getting your——

Admiral COOPER. You do because the VSO or counsel—and we have lots of veterans service organizations who do this—helps the veteran look at the record to understand what disabilities might be there. Now, we may find that they are not valid, but the VSO helps the veteran to identify those for which he should be compensated.

He helps if a veteran comes in and we determine that we will accept two but not all four of the disabilities claimed. Then, the VSO will look and will say, well, wait a minute, you can appeal. So the VSOs understand. They have gone through it.

The veteran maybe never has gone through this and so it is brand new. It is a difficult system and that is the reason it takes this long to process a claim. You have to understand a lot of different things about the rating schedule.

Mr. MITCHELL. Well, just one last thing. I would think it would really be a way to cut the cost and time by looking at how you can take care of those resubmittals. Fifty-four percent is a big number.

Admiral COOPER. The "Veterans Claims Assistance Act," passed about six years ago, requires that, when we do get a claim from you, for instance, and you only list a couple things, we still are required to go through that record to see if there are other things that we might cite.

And, again, that is one of those things that lengthens the time to do it, but it requires that we look at your record and determine if there are valid issues that we should at least consider.

Mr. MITCHELL. Thank you.

One last thing I just thought. I would hope that you would look at the testimony given yesterday as to the discrepancies State-by-State. There were huge discrepancies on the benefits.

Admiral COOPER. Let me assure that I am very aware of that whole problem. Part of the discrepancy is the percentage of veterans of each State who file claims. If you look at the average across the United States, about 11 percent of the veterans per State come in with a claim. But in the low States, it will be in the single figures, 7 percent, 8 percent, and that makes a big difference.

Ms. HERSETH SANDLIN. Admiral, I am going to interject. I thank Mr. Mitchell for his line of questioning and we will continue to work on this issue.

I know Mr. Hall has some questions. He has been kind enough to submit those for the record and we will get those to you in writing.

And the Ranking Member and I are going to share the next 5 minutes, but we will have other questions that we will also submit. But as I am sure you can anticipate, there are a couple of areas we want to pursue just briefly based on some of the questions we posed to the first panel.

So let me start on this issue of active-duty servicemembers being treated in a VA facility and the VA having the authority to do that. But, again, the reimbursement by the DoD, is there a memorandum of understanding (MOU)? What is the current estimate of the DoD pending reimbursement balance for VA's treatment of active-duty servicemembers? Dr. Kussman, could you shed some light on that?

Dr. KUSSMAN. Yes. Thank you.

We have an understanding. A lot of times, somebody will come to us before they get their DD–214. They are not really a veteran. They are still on active duty. And TRICARE reimburses us for that care on an agreement that we have with DoD.

Ms. HERSETH SANDLIN. In a timely way?

Dr. KUSSMAN. I have not recently heard any real complaints about that, but I cannot swear to you what the timeframe is. But we do get reimbursed.

Ms. HERSETH SANDLIN. Okay. If you could check on that——

Dr. KUSSMAN. Sure.

Ms. HERSETH SANDLIN [Continuing]. And get us the information if there have been any delays in payment. And what was the date that the MOU was negotiated?

Dr. KUSSMAN. I would have to get that for you. It has been going on for a number of years with them. When they get their DD–214——

Ms. HERSETH SANDLIN. Even prior to OIF and OEF, was there an MOU?

Dr. KUSSMAN. I believe that they——

Ms. HERSETH SANDLIN. Okay.

Dr. KUSSMAN [Continuing]. Reimbursed us regularly for that when we did it. But once they transition and get their DD–214, then they have options. As you know, they can use their TRICARE benefit and go some place else or use the VA, but we would not bill DoD anymore when they have transitioned to being a veteran.

Ms. HERSETH SANDLIN. Well, how are the active-duty episodes of care tracked, in terms of billing DoD, in terms of getting the reimbursement from TRICARE? Is there a way in which the VA is tracking that care?

Dr. KUSSMAN. Well, there are local sharing agreements that are done facility by facility with the TRICARE entity in the region of the country. And so I am not sure if we track it nationally, but we can try to get that information for you.

Ms. HERSETH SANDLIN. Please do because that raises some concerns for me because, for example, in my region of the country, we do not have as many TRICARE providers. So I want to make sure that we do not have delays in reimbursement in certain regions versus other regions.

Mr. Buyer.

Mr. BUYER. The Chairwoman is asking great questions.

When you view the patient in your holistic manner, do you also view the reimbursement as a Federal dollar that is fungible?

Dr. KUSSMAN. We look at the full patient and do whatever we think is right clinically and do not worry about who is paying for it.

Mr. BUYER. Okay. Right answer.

Second question, though, is, now let us worry about who is paying for it. Okay? Now let us put on the business hat. That is what we are having to do in this hearing.

So now with regard to the CFO over here and you have to get your reimbursements, we want to know how is DoD doing as a bill payer to the VA and/or do you ever write that off?

Colonel KEARNS. To my knowledge, we do not write it off, sir. I will have to get for the record the timeliness. We have it going both ways.

[The following were all related to the questions on DoD reimbursement for VA-provided care:]

Question 1: What is the timeframe for payments from DoD (TRICARE)? Are DoD (TRICARE) payments ever delayed?

Response: TRICARE contractors are required to process 95 percent of claims within 30 days from date of receipt. One hundred percent of claims are required to be processed within 60 days of receipt. The TRICARE Management Activity (TMA) government performance assessment staff track these requirements monthly. VA has not received reports of systemic problems in receiving payment.

TMA reports that since April 2005 TriWest, the TRICARE contractor for western United States (including South Dakota), has consistently processed over 99 percent of retained claims in 30 days, and 100 percent within 60 days. TriWest has also consistently met the standard for processing of 100 percent of "excluded" claims within 120 days. "Excluded" claims are those in which the contractor needs some additional information for processing, and represent significantly less than one percent of total volume.

Question 2: What is the mechanism for tracking and billing DoD (TRICARE) for VA care for service members—is it done nationally? Is there a way VA is tracking care?

Response: VA uses its VistA billing software to process and submit claims for care provided to service members. TRICARE's Managed Care Support Contractors (MCSCs) are required to process 95 percent of VA claims within 30 days from date of receipt and a hundred percent of these VA claims within 60 days of receipt. The TRICARE Management Activity (TMA) government performance assessment staff track these requirements on a monthly basis. National VA Reimbursable Earnings reports are available that break out DoD/Sharing and TRICARE reimbursements.

Question 3: Provide details on arrangements (MOU's et cetera) for DoD (TRICARE) reimbursement. What was the date the MOU was negotiated?

Response: There are two sets of broad agreements which cover VA DoD/TRICARE arrangements:

- VA and DoD signed a Memorandum of Understanding (MOU) in 1995, which established broad policies. These policies were included in the TRICARE Policy Manual. It is currently being updated
- VA approved "boilerplate" agreements with the three TRICARE MCSCs. These agreements cover procedures for VA Medical Centers to provide services to TRICARE beneficiaries. VA Medical Centers use these agreements as the basis for providing services. All but six VA Medical Centers have signed these agreements

Mr. BUYER. Are these transfers directly from TRICARE contractors or does it come from DoD health affairs?

Colonel KEARNS. It would be a combination and it is very often done locally based on the agreements that we have locally.

Mr. BUYER. All right. So we have got an individual transferred from Landstuhl to a polytrauma center. When does it kick in for the VA? As soon as the plane lands and the medical team hands off? When does the TRICARE reimbursement begin for us?

Dr. KUSSMAN. Sir, generally speaking, they would go to Landstuhl to a military treatment facility and then transition to us.

Mr. BUYER. Right.

Dr. KUSSMAN. But that transfer takes place when the person is transferred and then they are in the VA facility. Then if they are already a veteran and they have been discharged, we pay for it. If they are still on active duty, then the military health system pays for it.

But there are two ways of TRICARE and I would have to go back. I do not want to give you the wrong information. But it can be through the contractor or directly if there is a sharing agreement with the facility.

Mr. BUYER. All right. We will have follow-up questions for the record in detail with regard to this.

The only other question I have is, what was your carry-over figure for VHA healthcare for fiscal year 2007 to 2008?

Dr. KUSSMAN. The only reason I was hesitating, as you know, we got a significant supplement in 2007. And so without the supplement, the carryover was $498 million. But the total carry-over is larger than that because of the supplement that we got. And it is around $830 million.

Mr. BUYER. All right. And, Admiral Cooper, I will send a question to you, if you could explain the difference between the last sentence of your testimony and the last paragraph of CBO's testimony. They do say that there is a baseline based on previous wars. You say there is no basis. So I will give you a written question if you could explain that for the record. Thank you, Admiral.

Admiral COOPER. Yes, sir.

[The information from VBA follows:]

Question: Explain the difference between the last sentence of Admiral Cooper's testimony and the last paragraph of the CBO's testimony. CBO says that there is a baseline based on previous wars. Admiral Cooper stated there is no basis.

Response: We believe the question refers to the following excerpts:

CBO's Testimony: CBO has more recently constructed long-term scenarios in which the United States maintains a military presence of about 55,000 troops in Iraq, similar to the level of U.S. forces in the Republic of Korea and the Northeast Asia region; see Congressional Budget Office, The Possible Costs to the United States of Maintaining a Long-Term Military Presence in Iraq (September 2007). However, the current testimony, which focuses on the next 10 years, does not provide projections of VA's costs under those alternative long-term scenarios.

Admiral Cooper's Testimony: VBA lacks historical data on benefits claims activity by veterans of prior wars or conflicts on which to base projections of benefits usage for OIF/OEF veterans. VBA does not have data to show how many veterans of prior wars or conflicts ever filed claims or received benefits specifically due to service in combat theatres. The only comparative data available are the numbers and percentages of veterans currently receiving benefits by era of service (e.g. World War II Era or Vietnam Era). First-time claimants continue to be added to our compensation rolls many years after military service, primarily as a result of diseases added to the list of conditions presumed to be related to exposure to Agent Orange while serving in Vietnam and post-traumatic stress disorder. We do not have a basis for determining whether service in Iraq and Afghanistan will result in similar claims patterns.

Response: The above paragraph from the CBO's testimony indicated that scenarios were constructed in which the United States maintained a military presence of about 55,000 troops in Iraq, similar to the historical troop levels maintained in the Republic of Korea and the Northeast Asia region. On page 12 of the CBO's testimony, additional information was provided about the assumptions made projecting VA disability compensations costs related to operations in Iraq and Afghanistan. The testimony states that the number and VA disability ratings of service members who were injured in and evacuated from Iraq and Afghanistan and who later separated from the military were used in developing the projected costs. CBO applied projections of annual payments to people with varying disability ratings to estimate

total costs for disability compensation. In addition, CBO assumed that approximately three times the number of claims associated with medical evacuation would eventually be made by veterans who incur service-connected conditions as a result of operations in Iraq and Afghanistan that are not severe enough to require medical evacuation from the theater. CBO assumed that those additional veterans would, on average, receive a 40 percent disability rating.

The CBO used historical troop levels in developing projections of force levels, to which various assumptions about benefits usage were applied. In developing these scenarios, it does not appear that the CBO was stating that there is a baseline based on prior wars. We therefore do not believe that the CBO testimony is in conflict with the testimony of Admiral Cooper, which states that we do not have baseline historical data to show how many veterans of prior wars or conflicts ever filed claims or received disability benefits specifically due to service in combat theatres.

Mr. BUYER. Thank you to both of you.

I yield back.

Ms. HERSETH SANDLIN. Thank you, Mr. Buyer. And we are going to hustle down and vote.

But is the $498 million carryover, is that the two-year money?

Colonel KEARNS. Most of it is no year money, ma'am. And we had a total of $498 million plus $830 million from the supplemental.

Ms. HERSETH SANDLIN. Okay. Thank you.

Colonel KEARNS. And the $498 million regular was the lowest we have had in the last 8 years.

Ms. HERSETH SANDLIN. Okay. Thank you again.

Sorry. They will hold the vote open a little while, but not necessarily that long, so I am going to try to go with the Ranking Member so that we are both in the same boat.

So, again, thank you, Dr. Kussman, Admiral Cooper. Thank you both. And we will look forward to following up with you.

The hearing is now adjourned.

[Whereupon, at 12:01 p.m., the Committee was adjourned.]

APPENDIX

Prepared Statement of Hon. Bob Filner, Chairman, and a Representative in Congress from the State of California

The Committee on Veterans' Affairs will come to order. I would like to thank the Members of the Committee, our witnesses, and all those in the audience for being here today.

On October 7, 2001, almost exactly six years ago, we commenced military operations in Afghanistan, and this coming March will be the four year anniversary of the start of Operation Iraqi Freedom.

1.6 million servicemembers have been deployed. According to the Defense Manpower Data Center, as of Saturday, 4,261 have died and 29,958 have been wounded. Sadly, these numbers increase nearly every day.

According to the Congressional Budget Office, nearly half of those deployed have separated from the active component or have become eligible for VA care as reservists. One-third of these have sought VA medical care since 2002.

As the VA is facing increased demand from an aging veterans' population, it must also meet the challenges of caring for servicemembers returning from Iraq and Afghanistan.

In VA's budget submission for FY 2008, it estimated that it will treat 5.8 million veterans out of an enrolled population of 7.9 million. There are approximately 24 million veterans alive today. VA estimated that it will treat 263,345 OEF/OIF patients.

We are concerned with the extent of post-traumatic stress disorder (PTSD) and traumatic brain injuries among our returning servicemembers. We are concerned over the ability to treat these veterans in the coming years while not forgetting the needs of veterans from previous conflicts.

We wish to learn not only what these costs might be, but what the VA is doing—planning-wise—to meet all the challenges it faces not only today, but in the coming years.

We are also faced with a crisis when it comes to disability claims, with a backlog of claims that numbers more than 400,000. We must address this crisis not only for our returning servicemembers, but for all of our veterans who are seeking benefits and having to wait longer and longer for a decision.

CRS estimates that we have provided over $600 billion so far for Iraq, Afghanistan, and other costs associated with the War on Terror, a figure that equals 90 percent of what we spent in Vietnam over a 12-year period and double the cost of the Korean War. CBO estimates that it may cost $7 to $9 billion over the next decade to provide health care for our returning servicemembers, and roughly $3 to $4 billion for disability compensation and survivors' benefits.

Our hearing today will explore the costs we have incurred so far, and begin the process of exploring the costs we may face in the future. We also look to the VA to provide us with the estimates they have made, and, more importantly, what extra steps they are taking today, if any, to meet the needs of our returning servicemembers in terms of infrastructure, staffing, and the provision of health care and benefits over the coming years.

We look forward to an informative hearing, and a frank exchange. We wish to thank Mr. Goldberg and Ms. Belasco on our first panel for coming before us today to provide us with the background we need to begin this discussion, and we thank Dr. Kussman and Admiral Cooper for joining us to give us the VA's perspective on this important topic.

I believe that once we know the costs we must incur to care for our veterans, that this Congress, and the American people, will gladly bear the burden.

No matter where we stand on the war in Iraq, we all stand together in our desire to make sure that our returning servicemembers get the health care they need, and the benefits they have earned. We cannot fund the war, but fail to fund the warriors.

Prepared Statement of Hon. Steve Buyer, Ranking Repubican Member, and a Representative in Congress from the State of Indiana

Thank you Mr. Chairman,

The British philosopher and political theorist John Stuart Mill once wrote:

> "War is an ugly thing, not the ugliest of things, the decayed and degraded state of moral and patriotic feeling which thinks that nothing is worth war, is much worse. A man who has nothing for which he is willing to fight, nothing he cares about more than his own personal safety is a miserable creature who has no chance of being free, unless made and kept so by the exertions of better men than himself."

We are here today to discuss the cost of taking care of those "better men." In the current environment, some become lost in the heated political rhetoric and complexities of the war in Iraq and Afghanistan, thereby emotionally using veterans' issues to pull people into the trap of just simply feeling sorry for the men and women who fight.

For many, this is easier than understanding their military duties and the realities of soldier's lives after they return home.

To my colleagues I would say our men and women in uniform who fight are not victims of the current conflict. Each and every one of them is a volunteer who swore an oath to defend this country. As one Army officer stated recently "I'm a warrior. It's my job to fight." This is the statement of a hero—not a victim. As we look to take care of our returning military personnel, we need to admire and respect them for who they are and what they have done—not treat them like a victim class who require our pity.

Our duty here today is to explore the costs and the options for taking care of these heroes.

At the end of the day, that is the primary, bipartisan mission of this Committee. It has always been so. In 2005 during my chairmanship, we discovered at significant budget shortfall at the VA and rapidly moved to eliminate that shortfall. This year, our current chairman worked to increase VA discretionary spending. Today, however, that funding in the VA–MILCON Appropriations Bill is being held up for partisan purposes and used as leverage to pass other appropriations bills. Seventeen days past the fiscal New Year, I would urge the Chairman and his colleagues to rapidly move to pass the VA–MILCON Appropriations bill in an expeditious manner so that our veterans can get the funding they need for FY 2008—Republicans have appointed conferees.

Today, we have a new challenge before us. The current compensation and disability system needs to be reformed. This is the message we've heard from our veterans and confirmed by the findings of the Dole-Shalala Commission and the Disability Commission. These reforms cannot wait. Yesterday, the White House officially submitted their recommendations to the Congress. It is out turn to act.

The House and Senate Armed Services Committees are prepared to act and have many parts incorporated in the Wounded Warriors provisions of the bill. In CQ Today, it states, Mr. Chairman, you intend to do it next year in a separate bill. Please explain?

In war, pacifism and defeatism have never been American values. Neither should we give in to defeat and sit passively by in the face of the challenge before us. Mr. Chairman, I urge you and all my colleagues to move ahead with reforming the compensation and disability system this year and not wait until next year. The "better men" and women among us deserve no less.

Thank you, I yield back.

Prepared Statement of Hon. Stephanie Herseth Sandlin, a Representative in Congress from the State of South Dakota

Thank you to everyone for being here. I congratulate Chairman Filner and Ranking Member Buyer for holding today's hearing to examine the long-term costs of the current conflicts in Iraq and Afghanistan.

Now, as the wars in Iraq and Afghanistan are producing a new generation of sick and wounded veterans, it is important that Congress evaluate what has been provided thus far to care for the servicemembers of Operation Iraqi Freedom and Operation Enduring Freedom. We must also evaluate the future costs that will be incurred when these servicemembers return home and seek care and benefits from the Department of Veterans Affairs.

All too often, we consider the cost of the war, but ignore the cost of caring for the warrior. Congress has a responsibility to shine a light on the long-term costs of these conflicts, so that in future years, when the wars are over, we are prepared and committed to ensure the brave men and women who each day endure the cost of freedom are not left behind.

I am pleased that we have the opportunity to hear from today's panelists and am grateful to have the opportunity to hear their suggestions and answers to the critical issues involved. I look forward to hearing their testimonies.

Again, I want to thank everyone for taking the time to be here and discuss these important matters.

Prepared Statement of Hon. Harry E. Mitchell, a Representative in Congress from the State of Arizona

Thank you Mr. Chairman.

I appreciate you calling this hearing today.

When I was elected to Congress last November, my fellow Arizonans told me that we need to start watching our spending in Washington.

One of the biggest expenses we have today is the war in Iraq. But even when the conflict comes to an end, we will continue to have a financial commitment. We will continue to have an obligation to provide the best care possible for to those that served so bravely.

We took a big step earlier this year by passing a VA appropriations bill which made the single-largest investment in veterans' health care in the 77-year history of the agency.

I think we can all agree that more needs to be done.

This war has not been like others in the past. Advancements in field medicine and body armor have saved thousands of lives. However, new weapons, like IEDs, have inundated the VA with disabilities like Traumatic Brain Injury and Post Traumatic Stress Disorder.

At last count, nearly 30,000 servicemen and women have been wounded in action, and the VA has estimated that it will treat more than 260,000 veterans of this war in the years to come.

Yesterday, the Subcommittee on Oversight and Investigation held a hearing on disability claims disparities. In this hearing, we learned how the VA is not prepared to handle disability ratings, especially related to PTSD.

Improving this system will cost more time and more money, but these expenses are necessary to ensure that all veterans, regardless of age and period of service, receive the best and most fair disability benefits.

I believe that if we are willing to spend 12 billion dollars a month on war, we ought to be able to provide the highest level of assistance to those who fought and suffered.

I am looking forward to hearing from our distinguished panelists on how we can do this, and I yield back.

Prepared Statement of Hon. Ginny Brown-Waite, a Representative in Congress from the State of Florida

Thank you Mr. Chairman.

I want to thank you for testifying before this Committee today.

As a country, we need to ensure that we take care of all of our returning veterans, especially those who have been wounded on the battlefield. This Committee has paid close attention to the needs and concerns of those returning home from Operation Iraqi Freedom and Operation Enduring Freedom. In fact, we have received testimony and recommendations on numerous occasions on how we can improve the VA system for these returning soldiers.

The purpose of this hearing today is to discuss the projected long-term costs of caring for these injured soldiers. There are varying opinions on how much this will truly cost and unfortunately, like in many instances today, it has been suggested that these numbers vary depending on one's support for the war. I look forward to getting to the bottom of these projections and hope that we can put aside any partisan feelings that may exist, so that we get the most accurate assessment of the future financial needs of our nation's veterans.

Once again, I welcome you to the hearing and look forward to hearing your thoughts on the issue before us today.

Prepared Statement of Amy Belasco, Specialist in U.S. Defense Policy and Budget, Congressional Research Service, Library of Congress

Chairman Filner, Congressman Buyer and distinguished members of the committee, my name is Amy Belasco, and I'm a Specialist in U.S. Defense Policy and Budget at the Congressional Research Service (CRS). Thank you for asking me to testify about the important issue the Committee is considering: the long-term costs of the current conflicts in Iraq and Afghanistan. This testimony is based on my work on defense budget issues at CRS as well as on over 25 years of experience working in the executive and legislative branches.

As you requested, my testimony is designed to set the stage for this hearing on long-term costs by addressing the cost-to-date as well as future estimates of costs for the three operations that make up what the Bush Administration refers to as the "global war on terror" (GWOT):

- Operation Iraqi Freedom: the war in Iraq;
- Operating Enduring Freedom: predominantly Afghanistan but also including DoD's counter-terror operations from the Philippines to Djibouti; and
- Operation Noble Eagle: enhanced security for Department of Defense (DoD) bases.

This testimony will also briefly discuss DoD costs for Post-Traumatic Stress Disorder (PTSD) and Traumatic Brain Injury (TBI), two signature medical problems of these wars. Finally, I'll suggest oversight issues that Congress may want to address.

PROFILE OF SERVICE MEMBERS DEPLOYED SINCE 9/11

Before discussing costs, I would like to cite several DoD figures that can give committee members a profile of the demographic characteristics of the 1.6 million individual service members who have been deployed for Operation Iraqi Freedom (OIF) or Operation Enduring Freedom (OEF) since the 9/11 attacks.[1] Since most of the troops and costs are for Iraq and Afghanistan and little is known about DoD's other counter-terror operations, I'll refer to the two operations as simply Iraq or Afghanistan.

Of the 1.6 million service members who have been deployed thus far, 72% have been active-duty personnel and 28% have been activated reservists and National Guardsmen. Nine out of ten have been male. Not quite half have been single and the rest married. Some 72% have been white and the remainder black, Hispanic, other minority, or unknown.[2]

About 60% of all those deployed have been between the ages of 17 and 30, another 25% between 30 and 40 years old and the remaining 13% between the age of 40 and 60. And over 60% of those deployed have been in their first tour of duty. Finally, enlisted personnel have accounted for about 85% and officers about 15%.[3] Thus, the typical deployed service member has been a young, white, male, first term enlistee, demographic characteristics that are similar to the make-up of the active-duty force.

CONCERNS ABOUT DEPLOYMENTS

Many observers have raised concerns about how many military personnel have been deployed for more than one or two tours. Press accounts typically report that a particular unit has been deployed for the third or fourth time implying that this applies to all members of that unit. But because of high turnover as service members change assignments, complete enlistments, or retire, military personnel in a particular unit are often not the same individuals who were previously in that unit. Thus, the frequency of a unit's deployment does not necessarily tell us how often an individual has been deployed.

A better measure of potential stress on the force is the number of individual service members who have been deployed more than once or twice within the past six years of operations. According to DoD data, about two-thirds or one million of all the 1.6 million individuals who have been deployed thus far are in their first tour of duty. Another 25% have been deployed twice. Another 10% have been deployed three or more times, including many Air Force pilots with brief tours. As would be

[1] This DoD figure does not include additional activated guard and reservists who backfilled positions of those deployed or provided enhanced security at U.S. bases since 9/11. Defense Manpower Data Center, Contingency Tracking System, "Profile of Service Members Ever Deployed as of August 31, 2007."

[2] *Ibid.*

[3] *Ibid.*

expected, active-duty personnel are more likely than reserve component members—which includes both reservists and National Guardsmen—to deploy more than once.[4]

Another frequently voiced concern has been the extent of DoD's reliance on the reserve component in these conflicts. Since 9/11, DoD has deployed a total of 443,000 in the reserve component. In the past two years, DoD has called up about 100,000 National Guard and reservists, a level that is well below the 150,000 activated each year between FY2003 and FY2005. Some of those activated have been deployed and some have served in the United States filling the positions of those deployed or providing enhanced security at bases. The decrease in activations may reflect the fact that many of those in the reserve component have bumped up against the DoD policy cap of 24 months deployed.[5]

COST-TO-DATE OF IRAQ AND AFGHANISTAN

Now to costs. There are several ways to look at the cost of the current conflicts in Iraq and Afghanistan. DoD witnesses often cite the current "burn rates" or monthly obligations as of a particular date. While this figure reflects current spending, it does not reflect overall costs.

DoD's war cost reporting system captures the amounts that have been obligated for Iraq, for Afghanistan, and for enhanced security and hence shows how funds have been allocated *after the fact* or once contracts or purchase orders are signed and military or civilian personnel are paid. DoD's figures do not reflect the total amount that Congress has appropriated to date which includes funds that remain to be obligated in later years.

Nor does DoD's reporting system capture some intelligence funding that DoD does not administer and it may not include some funds that are not strictly war-related such as moneys to restructure Army and Marine Corps units. Nor does DoD capture amounts that have actually been spent.[6] Concerned about the accuracy of its reporting, DoD asked a private firm to conduct an audit on war cost tracking.[7] Although DoD's current FY2008 request identifies the funds for Iraq vs. those for Afghanistan, DoD has not presented a breakdown by operation of all funds received to date.[8]

To present a more complete picture, CRS has estimated how all funds appropriated-to-date are split between Iraq, Afghanistan and enhanced security relying on DoD and other data. In addition, CRS includes not only DoD appropriations but also State Department funds for its diplomatic operations, AID funds for reconstruction and aid programs, and Department of Veterans Affairs (VA) funds for medical care of veterans of these two conflicts. CRS estimates do not, however, include any VA disability benefits for Iraq and Afghan veterans since CRS was not able to get figures from the VA. About 90% of total funds appropriated to date have been for DoD military operations in theater as well as to train Iraq and Afghan security forces.

Total Cost-To-Date. CRS estimates that Congress has provided a total of about $615 billion for Iraq, Afghanistan and other counter-terror operations, and enhanced security at U.S. bases, often referred to by the Bush Administration as the global war on terror (GWOT). This total includes about:

- $573 billion for DoD;
- $41 billion for foreign aid, reconstruction, and building and operating embassies in Iraq and Afghanistan; and
- $1.6 billion for VA medical care for veterans of these conflicts.

On a monthly basis, CRS estimates that DoD is spending about $11.7 billion for the three GWOT operations. This year's average monthly spending for Iraq and Afghanistan is running substantially higher than the $8.8 billion in FY2006 and the

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[4] Analysis by CRS of Defense Manpower Data Center, Contingency Tracking System, "Total Number of Deployment Events by Service and Component," August 2007.

[5] Data from Defense Manpower Data Center, Report 17523, *Monthly Average Deployed Personnel and Activated Reservists,* from September 2001 through July 31, 2007. DoD has a longstanding policy that places a cumulative cap of 24 months on activations of those in the reserve component.

[6] DoD's financial systems do not segregate "amounts spent" or outlays for war expenses from its regular or baseline budget because the funds are mixed in the same account.

[7] CRS Report RL33110, *The Cost of Iraq, Afghanistan, and Other Global War on Terror Operations Since 9/11* by Amy Belasco. For example, DoD does not consider the ten C–17 aircraft added by Congress in the FY2007 supplemental to be war-related.

[8] See Table 1a. In DoD, *FY2008 Global War on Terror Request,* February 2007 http://www.dod.mil/comptroller/defbudget/fy2008/fy2007_supplemental/FY2008_Global_War_On_Terror_Request.pdf.

$7.7 billion in FY2005. These increases reflect both higher spending by the services to buy new weapon systems to replace and upgrade war-worn equipment and higher operating costs—particularly in Iraq—much of it unexplained.[9]

Cost of Iraq. CRS estimates that Congress has provided about $455 billion for Iraq including:

- $423 billion for DoD;
- $31 billion for State/AID; and
- $1.5 billion for VA medical care.

Average monthly spending for Iraq is running about $9.7 billion, well above the $7.4 billion in FY2006 and the $6.5 billion in FY2005. Only a small amount of the increase in FY2007 reflects the "surge" in troops in Iraq.[10]

Cost of Afghanistan. CRS estimates that Congress has provided a total of about $127 billion for Afghanistan including about:

- $117 billion for DoD;
- $10 billion for State/AID; and
- $100 million for VA Medical costs.

Average monthly obligations are running about $1.7 billion for Afghanistan, again substantially more than the $1.4 billion in FY2006 and the $1.1 billion in FY2005. The increase may reflect higher troop levels and operating costs.

Enhanced Security and Other. CRS estimates that Congress has appropriated about $28 billion for enhanced security at DoD bases. Average monthly obligations for enhanced security now run about $30 million a month, less than half of last year's level.

Of the $615 billion total for the three missions appropriated thus far, CRS was unable to allocate about $5 billion in war-related appropriations that appear not to have been captured by DoD's tracking system, a problem also identified by GAO.[11]

COMPARISONS TO OTHER MAJOR WARS

One way to put Iraq and Afghanistan war costs into perspective is to compare them to those of previous wars. Looking strictly at military costs and using estimates prepared by CRS Specialist, Stephen Daggett that are adjusted for inflation, the discussion below compares the cost-to-date after six years of operations to previous wars.[12]

First, let's first compare the cost of all funds appropriated thus far for the three GWOT operations. That total now equals about 90% of the 12-year war in Vietnam ($670 billion) and about double the cost of the Korean war ($295 billion).[13]

The cost of all three operations thus far is now over six times as large as the cost of the first Persian Gulf War ($94 billion). Comparisons to that war are problematic, however, because the United States paid some $7 billion or about 7% of the cost of the war because our allies, principally Kuwait and Saudi Arabia, reimbursed the United States for most of the cost.[14]

Some would prefer to look only at the cost of the Iraq war. On that basis, Iraq has thus far cost about 65% as much as Vietnam. On the other hand, Iraq has cost about 50% more than Korea to date and about four and a half times more than the costs incurred for the first Persian Gulf War.

STATUS OF FY2008 REQUEST

Congress has not yet acted on the Administration's FY2008 request for war funding with one exception. As of today, the Administration has requested $152.4 billion for war-related activities in Iraq and Afghanistan including DoD costs, State and AID, and VA medical.[15] This figure also includes an additional request of $5.2 bil-

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[9] Table 6, *Ibid.*

[10] CRS estimates that the increase of 30,000 troops in Iraq cost between $3.5 billion and $4 billion in FY2007, adding about $300 million to monthly spending and accounting for 13% of the increase.

[11] The $615 billion includes the $5.2 billion provided to DoD in Sec. 123, H.J. Res 52, P.L. 110–92, FY2008 Continuing Resolution, Sept. 29, 2007. See also, Table 3 in CRS Report RL33110, The Cost of Iraq, Afghanistan, and Other Global War on Terror Operations Since 9/11 by Amy Belasco.

[12] Calculations prepared by CRS Specialist, Stephen Daggett of DoD costs, relying on a variety of data and converted to FY2007 dollars.

[13] *Ibid.*

[14] Department of Defense, Annual Report to Congress for Fiscal Year 1994, January 1993; converted to FY2007 dollars by CRS.

[15] This figure includes $141.7 billion for DoD, $4.6 billion for State/AID and $800 million for VA Medical costs that was requested in the Administration's FY2008 budget in February within agencies baseline request and as additional emergency requests. It also includes an additional

lion for Mine Resistant Ambush Protected (MRAP) vehicles, trucks with a V-shaped hull that have proven more effective against attacks from Improvised Explosive Devices than uparmored HMMWVs. Congress provided funds for MRAP vehicles in the FY2008 Continuing Resolution.[16]

The total of $152.4 billion does not include the $42.3 billion and possibly additional State/AID funds that Secretary of Defense Robert Gates stated in late September would be requested shortly.[17] If those additional funds are requested, the total for FY2008 will reach $194.7 billion.

Senior appropriators have said that they may not consider the FY2008 supplemental request until January or February of 2008, though some interim or bridge funding may be included in DoD's FY2008 regular Defense Appropriations bill which has been passed by the House and Senate.[18] When DoD receives its regular or baseline appropriations, it is expected to finance war costs until a supplemental is passed by using regular funds slated to be needed at the end of the year and any interim funds provided.

ESTIMATING FUTURE WAR COSTS

Future war costs depend on several factors:

- the duration of the wars in Iraq and Afghanistan;
- the number of troops deployed each year;
- the intensity of conflict;
- the number, size, and location of bases; and,
- the scope of post-war costs.

DoD's current plans call for ending the current "surge" in troops by June 2008, and Secretary of Defense Gates has suggested that troop levels could be reduced to 100,000 in Iraq by the end of 2008.[19] DoD has not, however, provided Congress with any estimates of future costs beyond its FY2008 request and a $50 billion "placeholder" figure for FY2009.[20] Since 2003, the Congressional Budget Office has estimated future war costs over 10-year periods based on assumptions specified by members of Congress. Typically, DoD has requested larger amounts than CBO has predicted even when troop levels are similar, in part, because DoD has included many expenses as war costs that could be considered part of its baseline budget.[21] Since there are no DoD requests, CRS is unable to identify or assess potential differences between CBO and DoD.

This year, CBO estimated the cost over the next ten years of several different scenarios for Iraq and Afghanistan which, at least, lays out a range of future costs depending on various troop levels. These scenarios assume:

- a draw down of current troop levels to 30,000 by 2010;
- a more gradual draw down to 75,000 troops by 2013; and
- a steady-state "Korea" like scenario with 55,000 troops.[22]

CBO's Ten-Year Cost of Two Drawdown Scenarios. CBO estimates the U.S. government would incur additional costs of $481 billion to $603 billion for Iraq and Afghanistan over the next ten years, assuming troop levels in Iraq and Afghanistan are drawn down to 30,000 troops by 2010 and remain at that level. The range in the estimate reflects different assumptions about how long the Administration's cur-

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$5.3 billion for DoD for Mine Resistant Ambush Protected (MRAP) vehicles requested on July 31, 2007 in a budget amendment.

[16] See Sec. 123, *H.J. Res 52, P.L. 110–92* enacted September 29, 2007.

[17] See Senate Appropriations Committee, Transcript of hearing, "Fiscal 2008 War Supplemental," September 26, 2007.

[18] Conferees to H.R. 3222, the FY2008 DoD Appropriations bill have been appointed by the House but not the Senate.

[19] Philadelphia Inquirer, "Bush Says U.S. Will Shift More Troops To Support Role," September 16, 2007.

[20] See **Table 3** in CRS Report RL33999, *Defense: FY2008 Authorization and Appropriations* by Pat Towell, Stephen Daggett, and Amy Belasco, updated September 28, 2007.

[21] For example, CBO recently estimated that 40% of the Army's request for reset to repair and replace war-worn equipment was not war-related; see CBO, *Replacing and Repairing Equipment Used in Iraq and Afghanistan: The Army's Reset Program,* September 2007; http://www.cbo.gov/ftpdocs/86xx/doc8629/09-13-ArmyReset.pdf

[22] Testimony of Robert A. Sunshine before the House Budget Committee, "Estimated Costs of U.S. Operations in Iraq and Afghanistan and of Other Activities Related to the War on Terrorism," July 31, 2007; and CBO, Letter to Senator Conrad, "The Possible Costs to the United States of Maintaining a Long-Term Military Presence in Iraq," September 20, 2007; http://www.cbo.gov/ftpdocs/86xx/doc8641/09-20-ConradLTpresenceinIraq.pdf.

rent troop increase continues and when a draw down would begin.[23] With these assumptions, CBO estimates would total between $1.1 and $1.2 trillion by 2017 including all funds appropriated to-date and future estimated costs.[24]

Assuming a more gradual draw-down scenario in which troop levels drop to 75,000 by 2013, CBO estimated that costs over the next ten years could total between $924 billion and $1.010 trillion, again with the range again reflecting how long the current troop "surge" is maintained. Under that scenario, costs would reach a total of between $1.5 trillion and $1.6 trillion by 2017. Under both scenarios, CBO includes not only DoD's operational and investment costs but also $50 billion to train and equip Afghan and Iraqi security forces, $16 billion for diplomatic operations and foreign aid and $9 billion to $13 billion for veterans' benefits and medical care.[25]

Alternative Steady State Annual Cost. Another way to look at future costs is the annual spending when the troop draw down reaches a steady-state level. CBO estimates that the annual steady-state cost of would be about $22 billion for 30,000 troops and $61 billion for 75,000 troops. These figures include not only the cost of DoD's military operations and support but also the cost of training Iraqi and Afghan security forces, State Department diplomatic costs, and aid programs, and VA medical costs.[26] These levels are considerably lower than the FY2007 appropriation of $173 billion.[27]

In a new analysis, CBO estimates the annual cost of maintaining a long-term presence of 55,000 troops in Iraq, characterized as a "Korea" option. With this troop level, CBO estimates the cost would be $25 billion in a "combat" scenario similar to today's Iraq.[28] This estimate, however, does not include State, AID, and VA medical costs. Making a rough adjustment for those costs based on CBO figures, the cost to maintain 55,000 troops in combat conditions would be about $33 billion a year.[29]

POST-WAR COSTS: POST-TRAUMATIC STRESS DISORDER AND TRAUMATIC BRAIN INJURY

There are many challenges in estimating not only future costs but also post-war costs—those that could be incurred after the conflicts in Iraq and Afghanistan have ended. For DoD, the largest unknown may be reset costs, the amount needed to repair and replace war-worn equipment. In the case of military personnel, however, the greatest unknown may be future medical treatment costs for those injured.

For DoD, war-related medical costs are generally short-lived because many of those injured complete their enlistments and leave the service.[30] At that point, they may turn to the Department of Veterans' Affairs for treatment. Nevertheless, it may be useful to look at the number of patients and costs that DoD has experienced to date for two of the signature medical problems of these wars—Traumatic Brain Injury or TBI and Post-Traumatic Stress Disorder or PTSD. Although this may give a window into the incidence and cost of TBI and PTSD in the first few years, it does not necessarily capture those whose symptoms are not caught or which appear later on, or the difficulties faced by individuals.

Based on DoD data, about 60,000 troops have been diagnosed with either PTSD or TBI. This total includes about 34,000 with PTSD and 26,000 with TBI between

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[23] The low end of the CBO estimate assumes the draw down begins in FY2008 and the high end that the draw down does not begin until FY2009; see Table 5 in *Ibid.*

[24] Testimony of Robert A. Sunshine before the House Budget Committee, "Estimated Costs of U.S. Operations in Iraq and Afghanistan and of Other Activities Related to the War on Terrorism," July 31, 2007, p. 6-p. 7 and Table 1.

[25] Testimony of Robert A. Sunshine before the House Budget Committee, "Estimated Costs of U.S. Operations in Iraq and Afghanistan and of Other Activities Related to the War on Terrorism," July 31, 2007, p. 7-p. 8 and Table 1.

[26] *Ibid,* Table 1.

[27] CRS Report RL33110, *The Cost of Iraq, Afghanistan, and Other Global War on Terror Operations Since 9/11* by Amy Belasco.

[28] CBO also estimates the cost of keeping 55,000 troops in Iraq in a "non combat" scenario with low-intensity operations and troops remaining at established bases for extended tours; see CBO, Letter to Senator Conrad, "The Possible Costs to the United States of Maintaining a Long-Term Military Presence in Iraq," September 20, 2007.

[29] See Testimony of Robert A. Sunshine before the House Budget Committee, "Estimated Costs of U.S. Operations in Iraq and Afghanistan and of Other Activities Related to the War on Terrorism," July 31, 2007; CRS adds $7.7 billion, the annual average of CBO's 10-year estimate that covers the cost to train security forces, support diplomatic operations and foreign aid and provide VA benefits and services.

[30] For example, as of May 2007, about 44% of those patients diagnosed with either TBI or PTSD between FY2003 and May 2007 were still eligible for DoD medical care; see DoD data provided to CRS by the Office of the Secretary of Defense, Health Affairs, May 31, 2007.

FY2003 and FY2007.[31] Based on these figures, about 4% of the 1.6 million service members who have deployed to Iraq and Afghanistan have been diagnosed with these conditions while in the service. As an overall average, this figure does not capture the likelihood for those deployed multiple times or for longer periods or for those personnel on the ground—primarily Army and Marine Corps soldiers—who would be expected to be more likely to experience these conditions.

Treating these patients has cost about $291 million over the past five years counting all care associated with TBI or PTSD symptoms. Some might argue that *all costs* for the care of those individuals should be counted even if the symptoms were not related to the diagnosis. If that broader definition were used, treatment costs have been $782 million over the past several years.[32]

The annual DoD cost per person has averaged about $1,850 for PTSD and $5,500 for TBI, counting all treatment, mental health and pharmacy costs related to those conditions. Using the broad definition of all care provided to those patients including care not related to either condition, the cost would be $6,600 for those with PTSD and $11,200 for those with TBI.[33]

During the past several years, annual costs for both TBI and PTSD have increased rapidly from $18 million in FY2003 to $90 million in FY2006, which may reflect higher patient loads as the wars have continued. Each year, DoD has requested emergency funds to cover the costs of war-related medical care including the cost of treating PTSD and TBI.

Concerned about these conditions, Congress recently appropriated $900 million in the FY2007 Supplemental (P.L. 110–28) specifically for TBI and PTSD, including $600 million for treatment and $300 million for research. These funds will be available in FY2007 and FY2008. The language in the act permits the Secretary of Defense to transfer any funds that are "in excess of DoD requirements" to the Department of Veterans' Affairs for the same purpose.[34]

It is not clear whether DoD will need all the funds appropriated in the next two years. Recently, the 2-year cost of TBI and PTSD has been running about $170 million including costs related to these conditions. If all care for individuals diagnosed with either condition is counted, total treatment costs have been about $500 million.[35]

PROBLEMS IN IDENTIFYING THOSE DEPLOYED AND OVERSIGHT ISSUES

Predictions of future costs depend on accurate information about current costs as well as understanding the factors that drive costs. Yet even in the sixth year of conflict, some basic information remains in dispute and explanations for the rapid increase in DoD costs are few. One good example is the various figures identifying the number of service members deployed to the Iraq and Afghanistan theaters of operations.

In justification material for the FY2007 and FY2008 supplementals, the Defense Department estimated that some 320,000 military personnel were dedicated to Iraq and Afghanistan operations including most of the increase or "surge" in troops this summer.[36] This figure is almost twice as large as the total of 160,000 including some 140,000 troops in Iraq and another 20,000 troops in Afghanistan that is commonly reported in the press, and sometimes referred to as "boots on the ground."

The increase in troop levels in Iraq (as well an increase in Afghanistan) could account for some but by no means all of the difference. Assuming an additional 30,000 for the "surge" would still leave unaccounted for another 130,000 troops of those identified by DoD in its justification material. DoD has not publicly explained the mission or location of these other personnel or allocated these personnel between Iraq and Afghanistan.

From other DoD data sources, it appears that some of these other military personnel are deployed or training up in neighboring countries such as Kuwait, Bahrain, Qatar, and the United Arab Emirates, some may be backfilling positions for

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[31] DoD data for FY2003–May 2007 provided to CRS by the Office of the Secretary of Defense (OSD), Health Affairs.

[32] DoD provided data showing the number eligible as well as the number of patients each year.

[33] CRS calculations based on DoD data from the OSD, Health Affairs, May 31, 2007.

[34] See section, "Defense Health Program," Title III, Chapter 3, P.L. 110–28 May 25, 2007.

[35] CRS calculation using FY2005 and FY2006 cost, the two most recent complete years of data.

[36] DoD, *FY2007 Emergency Supplemental Request for the Global war on Terror,* Feb. 2007, p. 16; http://www.dod.mil/comptroller/defbudget/fy2008/fy2007_supplemental/FY2007_Emergency_Supplemental_Request_for_the_GWOT.pdf; and DoD, *FY2008 Global War on Terror Request,* February 2007,p. 12; http://www.dod.mil/comptroller/defbudget/fy2008/fy2007_supplemental/FY2008_Global_War_On_Terror_Request.pdf.

those in the United States, and about 30,000 are in unknown locations.[37] Earlier years pose the same problem.

That Congress lacks a clear picture of the number or allocation of all military personnel dedicated to Iraq and Afghanistan either in the past or today makes prediction of future costs—whether future operational or medical costs—problematic. For example, troop location may be important in gauging the likelihood that service members face intensive combat and hence, a higher risk of developing PTSD or TBI.

Similarly, the cost of future operations and the extent of stress on the force depend on how many troops are dedicated to Iraq and Afghanistan operations. Thus far, however, DoD has not resolved this basic discrepancy and has provided little analysis of the factors that drive cost trends whether for medical costs or operating tempo. While there is considerably more detail in DoD's latest justification materials, there is little transparency about the assumptions and rationale for requests for funding for reset, operating tempo, procurement or medical costs, gaps which may limit Congressional oversight.

Prepared Statement of Matthew S. Goldberg, Ph.D., Deputy Assistant Director for National Security, Congressional Budget Office

Chairman Filner, Ranking Member Buyer, and other distinguished Members of the Committee, I appreciate the invitation to appear before you today to discuss the challenges that our nation faces in caring for veterans returning from Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF). My testimony will focus on the numbers of troops who have served in those operations and the numbers who have sustained injuries and provide some indication of the severity of those injuries. I will also address the extent to which veterans of those operations have sought medical care from the Department of Veterans Affairs (VA) and the types of care they have received. Finally, I will discuss the Congressional Budget Office's (CBO's) projections of the resources that VA may require over the next 10 years not only to continue providing that medical care, but also to provide associated benefits such as disability compensation paid to veterans with service-connected disabilities and dependency and indemnity compensation (DIC) paid to survivors of service members.[1]

Summary

CBO's analysis to date indicates the following:

- As of December 2006, more than 1 million active-duty military personnel and over 400,000 reservists had deployed to combat operations in the Iraq and Afghanistan theaters. Of those, 690,000 have either separated from the active component or become eligible for VA health care as reservists. In turn, one-third of those personnel (numbering 229,000) have sought VA medical care since 2002.
- About 3,800 U.S. troops have died while serving in OIF, and over 400 have died in OEF. A total of almost 30,000 troops have been wounded in action during those two operations.
- The survival rate among all wounded troops has averaged 90.2 percent during OIF and OEF combined. By comparison, the survival rate during the Vietnam conflict was 86.5 percent. Among seriously wounded troops, the survival rate was lower—76.4 percent—during the Vietnam conflict and has also been lower—80.6 percent—for OIF and OEF combined. Higher survival rates during OIF and OEF reflect the widespread use of body armor, as well as advances in battlefield medical procedures and aeromedical evacuation.
- A census conducted by the Department of Defense (DoD) indicates 749 amputations from OIF and 42 amputations from OEF through January 2007. The amputation rate is 3.3 percent among all wounded troops.

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[37] Defense Manpower Data Center, *DRS 11280, Country Analysis,* September 2001 through April 2007; this data series includes some double-counting as service members move from one location to another such as those who go to Kuwait before going to Iraq.

[1] This testimony does not address issues that veterans face in obtaining disability ratings from the Departments of Defense and Veterans Affairs or the coordination of medical care and other benefits between those two departments. Many of those issues were recently studied in the following report: President's Commission on Care for America's Wounded Warriors, *Serve, Support, Simplify: Report of the President's Commission on Care for America's Wounded Warriors,* co-chairs Bob Dole and Donna Shalala (July 2007).

- Through December 2006, DoD physicians had diagnosed a total of 1,950 traumatic brain injuries (TBIs), of which over two-thirds were classified as mild.[2] The rate of TBI diagnosis is 8.2 percent among all wounded troops. Some TBIs, however, are difficult to diagnose and may go unrecognized unless screening is performed after a soldier returns to the United States from deployment.
- Post-traumatic stress disorder (PTSD) is also difficult to diagnose. Among OIF and OEF veterans who have received VA medical care, about 37 percent have received at least a preliminary diagnosis of mental health problems, and about half of those (17 percent) have received a preliminary diagnosis of PTSD. The overall mental health incidence rate may be lower to the extent that OIF and OEF veterans who have not sought VA medical care do not suffer from those conditions. On the other hand, some veterans with PTSD or other mental health problems may not seek care because they fear being stigmatized.
- Of the total 229,000 OIF/OEF patients seen by the VA, 3 percent (fewer than 8,000) have been hospitalized in a VA facility at least once since 2002; the other 97 percent were seen on an outpatient basis only. Not all of those patients visit VA medical facilities in any single year; in 2006, for example, 155,000 OIF/OEF patients were treated by VA, accounting for 3 percent of the total veteran patient load. VA estimates an average annual cost of $2,610 per OIF/OEF veteran who used VA health care in 2006, versus an overall average of $5,765 per year for all VA patients.
- VA's medical budget is discretionary (that is, lawmakers appropriate funds on an annual basis); it is not possible to project definitively VA's future medical appropriations because they depend on future acts of the Congress. However, depending on the future force levels deployed to OIF and OEF, if the Congress chooses to fully fund medical care for veterans of those operations, VA medical costs explicitly associated with those operations could total between $7 billion and $9 billion over the 10-year period 2008 through 2017, CBO projects. The costs of disability compensation and survivors' benefits could add another roughly $3 billion to $4 billion over the same period.

VA's Health Care System

The Department of Veterans Affairs, through the Veterans Health Administration, operates a system consisting of 153 medical centers, 882 ambulatory care and community-based outpatient clinics (CBOCs), 207 Vet Centers, 136 nursing homes, 45 residential rehabilitation treatment programs, and 92 comprehensive home-care programs providing medical services to eligible veterans.[3] Those facilities provide inpatient hospital care, outpatient care, laboratory services, pharmaceutical dispensing, rehabilitation for a variety of disabilities and conditions, mental health counseling, and custodial care provided in either VA or contracted nursing homes. In total, VA facilities employ about 200,000 full-time-equivalent employees, including over 13,000 physicians and nearly 55,000 nurses.

VA estimates that in 2006 there were about 24 million living veterans of the U.S. military. In that year, VA provided medical services to over 5 million veterans and more than 400,000 other patients.[4] An additional 2.9 million veterans were enrolled in the VA medical system in 2006 but did not seek care from VA facilities that year.

To better care for the injuries suffered by veterans returning from OIF and OEF, VA, in 2005, established a Polytrauma System of Care, which includes four Polytrauma Rehabilitation Centers and additional secondary sites and support.[5] Those facilities provide rehabilitation and treatment for veterans or returning service members recovering from polytraumas and traumatic brain injuries. VA also provides readjustment services and counseling through its Vet Centers. In addition, in

[2] The classification is based on the length of time a patient remains unconscious immediately after an injury, the duration of post-traumatic amnesia (loss of memory of events immediately following the injury), and the patient's score on the Glasgow Coma Scale. For example, a mild TBI would involve loss of consciousness for less than one hour and post-traumatic amnesia of less than 24 hours.

[3] Vet Centers provide readjustment counseling, postwar rehabilitation, and other social services to help improve veterans' postwar work and family lives.

[4] Nonveteran patients include employees (who receive services such as tests and vaccinations required for employment at VA facilities); dependents and survivors of disabled veterans who are eligible for the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA); and patients seen through sharing agreements with other providers, including DoD's TRICARE program.

[5] VA defines polytrauma as injury to the brain in addition to other body parts or systems resulting in physical, cognitive, psychological, or psychosocial impairments and functional disability.

recent years, VA has added about 3,000 new mental health professionals to its staff as part of a mental health initiative.

Under funding provided by continuing resolution in 2007, VA expected to obligate $573 million that year for veterans of OIF and OEF before considering any supplemental funding. VA received additional supplemental appropriations in 2007 for medical administration costs, medical and prosthetics research, medical services for veterans of OIF and OEF, and other related purposes.[6]

The President's budget proposal for 2008 requests budget authority of $34.6 billion for VA health care services and research (excluding construction costs and net of collections), an increase of 5.9 percent over 2007 levels (the latter excluding supplemental appropriations). The vast majority of the 2008 obligations, $29.7 billion, would be allocated to providing health care services such as ambulatory care, inpatient acute care, and pharmacy services.[7] The remainder is allocated for long-term care ($4.6 billion), other health care programs such as the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) and dental care ($2.1 billion), and the mental health and other initiatives ($0.4 billion). The portion of VA's 2008 budget request specifically designated for the health care needs of service members returning from OIF and OEF—including their share of VA's total obligations for dental care, readjustment counseling, and VA's mental health initiative—is $752 million.

Service Members' Eligibility for VA Medical Care

More than 1 million active-duty military personnel have deployed to either the Iraq or Afghanistan theaters of operation. Of the current Army force, more than half have deployed in support of those operations at least once, and 15 percent have deployed to those theaters on two or more occasions. In addition to the active-duty troops, reserve personnel have been mobilized in large numbers—a total of 580,000 reservists had been mobilized through March 2007. Of those, more than 410,000 reservists had deployed to combat operations through December 2006. Troop levels in Iraq have climbed by between 30,000 and 40,000 over the past six months, in turn increasing the number of service members who may qualify for VA medical care in the future.

As of April 2007, about 320,000 active-duty veterans of Operation Iraqi Freedom and Operation Enduring Freedom had separated from military service and become eligible for health care provided by VA. In addition, about 370,000 members of the Reserve or National Guard have returned from OIF or OEF and become eligible for VA health care, even though many of them continue to affiliate with the military.[8]

Traditionally, reserve-component personnel who return from a deployment but remain on the military rolls would not qualify for VA health care until some later date when they were discharged from the service. However, legislation enacted in 1998 (the Veterans Programs Enhancement Act, Public Law 105–368) gave veterans and demobilized reservists returning from combat operations a special two-year period of eligibility for VA health care, waiving any requirements for them to satisfy a means test or demonstrate a service-connected disability. VA provides health care under that authority for free for medical conditions potentially related to military service in combat operations.[9] VA has established three criteria that indicate non-combat-related conditions, in which case VA will continue to provide health care but may charge a veteran copayments or bill the veteran's third-party insurance:

- Congenital or developmental conditions (such as scoliosis),
- Conditions that are known to have existed before military service, or
- Conditions that begin after military combat service (such as bone fractures that occur after a service member's separation from the military).

Casualty Statistics for U.S. Military Forces

The number of fatalities among troops serving in Operation Iraqi Freedom reached 3,000 in January 2007. Those deaths in Iraq were accompanied by 22,834

[6] U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act, 2007 (Public Law 110–28).

[7] An obligation is a commitment that creates a legal liability on the part of the government to pay for goods and services ordered or received. Such payments may be made immediately or in the future.

[8] Between April 2007 and July 2007, the total number of returning service members eligible for VA medical care increased from 690,000 to 717,000. However, the smaller number will be used in the subsequent discussion because the timeframe through April 2007 more closely matches the timeframe for other types of data used in CBO's analysis.

[9] Pending legislation would increase the special eligibility period from two years to five years. See H.R. 1585, National Defense Authorization Act for Fiscal Year 2008, Section 1708, passed by the House of Representatives on May 15, 2007.

troops who were wounded in action. Wounded troops can be classified in two ways: whether or not they return to their units for duty within 72 hours; and, among those who do not return to duty, whether or not they require aeromedical evacuation (see Table 1). Troops wounded in action are distinct from those with nonhostile injuries or disease; the latter are often combined as disease/nonbattle injuries (DNBI). The total number of troops medically evacuated includes those who were wounded as well as others with nonhostile injuries or disease.

Through January 2007, wounded-to-fatality counts stood at a ratio of 7.6 to 1. That oft-cited ratio is higher than the ratios recorded during earlier U.S. military conflicts, reflecting the effects of the widespread use of body armor in Iraq as well as advances in battlefield medical procedures and aeromedical evacuation. However, differences in statistical treatment have hindered some comparisons between the wounded-to-fatality ratio for OIF and those for the Vietnam conflict or other previous conflicts.[10]

Table 1.

U.S. Military Casualties Sustained in Operation Iraqi Freedom and in the Vietnam Conflict

	Operation Iraqi Freedom		**Vietnam Conflict**	
	Number of Casualties	**Rates per 100,000 Person Years**	**Number of Casualties**	**Rates per 100,000 Person Years**
Person-Years of Exposure	721,220	n.a.	2,608,650	n.a.
Deaths				
Hostile[a]	2,417	335	47,424	1,818
Other	584	81	10,785	413
Total deaths	3,001	416	58,209	2,231
Wounded in Action				
Returned to duty (Within 72 hours)	12,643	1,753	150,332	5,763
Not returned to duty (Within 72 hours)				
Medical evacuation required	6,670	925		
No medical evacuation required	3,521	488		
Total not returned to duty	10,191	1,413	153,303	5,877
Total wounded in action	22,834	3,166	303,635	11,640
Memorandum:				
Medical Evacuations				
Wounded	6,670	925		
Nonhostile injuries[b]	6,640	921		
Disease	18,183	2,521		

[10] One author asserted a wounded-to-fatality ratio as high as 16 to 1. See Linda Bilmes, "Soldiers Returning from Iraq and Afghanistan: The Long-Term Costs of Providing Veterans Medical Care and Disability Benefits" (Working Paper RWP07–001, Harvard University, Kennedy School of Government, January 2007), p. 3; and "The Battle of Iraq's Wounded: The U.S. Is Poorly Equipped to Care for the Tens of Thousands of Soldiers Injured in Iraq," *Los Angeles Times,* January 5, 2007. In the latter, she states, "for every fatality in Iraq, there are 16 injuries." The statistic of 16 to 1 is also quoted in the graphic ("The Human Cost of War") on p. 43 of *Newsweek,* April 2, 2007. That statistic is too high because it includes among the "wounded" troops who were medically evacuated because of nonhostile injuries or disease.

	Operation Iraqi Freedom		Vietnam Conflict	
	Number of Casualties	**Rates per 100,000 Person Years**	**Number of Casualties**	**Rates per 100,000 Person Years**
Total medical evacuations	31,493	4,367		

Source: Congressional Budget Office based on data obtained from the following Department of Defense Web site: For casualties in Iraq (as of January 6, 2007), http://siadapp.dmdc.osd.mil/personnel/CASUALTY/castop.htm and (as of January 10, 2007) www.defenselink.mil/news/casualty.pdf. For casualties in Vietnam, http://siadapp.dmdc.osd.mil/personnel/CASUALTY/vietnam.pdf and http://siadapp.dmdc.osd.mil/personnel/CASUALTY/WCPRINCIPAL.pdf.

Notes: Estimates of casualties sustained in Operation Iraqi Freedom are from the start of that operation (March 19, 2003) through January 10, 2007. (The Iraq theater of operations includes the Arabian Sea, Bahrain, Gulf of Aden, Gulf of Oman, Iraq, Kuwait, Oman, Persian Gulf, Qatar, Red Sea, Saudi Arabia, and United Arab Emirates) Casualties suffered by Department of Defense civilian personnel and contractors are excluded from the table. Estimates of the number of casualties that occurred during the Vietnam conflict cover an 11-year period (1964 to 1975).

Person-years to exposure in Vietnam are taken from Samuel H. Preston and Emily Buzzell, "Mortality of American Troops in Iraq" (working paper, University of Pennsylvania, Population Studies Center, 2006), Person-years of exposure in Iraq were computed by th Congressional Budget Office using methods similar to those used by Preston and Buzzell.

n.a. = not applicable.

a. Hostile deaths are synonymous with troops killed in action.

b. Nonhostile injuries describe those not sustained in combat.

There are several ways to calculate both the numerator and denominator of the wounded-to-fatality ratio. Because only troops wounded in action are included in the numerator—not those suffering nonhostile injuries or disease—it could be argued that the denominator should include hostile deaths only, not deaths characterized as nonhostile (in other words, those resulting from vehicle accidents, disease, or other causes). Substituting the 2,417 hostile deaths in Iraq (through January 10, 2007) for the 3,001 total deaths results in a higher ratio of 9.4 to 1 (see Table 2).

Table 2.

Wounded-to-Fatality Ratios for U.S. Troops in Recent Military Conflicts.

	Vietnam Conflict	Operation Iraqi Freedom **(OIF)**	Operation Enduring Freedom **(OEF)**	**OIF** and **OEF** Combined
Number of Wounded Compared with Total Number of Deaths (Hostile and Nonhostile)[a]	5.2	7.6	3.1	7.1
Number of Wounded Compared with Number of Hostile Deaths	16.4	9.4	5.6	9.2
Number of Wounded (Not Returned to Duty) Compared with Number of Hostile Deaths	3.2	4.2	3.3	4.2

Source: Congressional Budget Office.

Note: Operation Iraqi Freedom includes operations in the Arabian Sea, Bahrain, Gulf of Aden, Gulf of Oman, Iraq, Kuwait, Oman, Persian Gulf, Qatar, Red Sea, Saudi Arabia, and United Arab Emirates. Operation Enduring Freedom includes operations in and around Afghanistan.

a. Hostile deaths are synonymous with troops killed in action. Nonhostile deaths describe those that occur as a result of injury not sustained in combat or disease.

If policymakers' objective is to measure U.S. troops' ability to survive serious wartime wounds, it can be argued that, if the denominator is restricted to hostile deaths, the numerator should be restricted to wounds of such severity that the soldier could not return to duty within 72 hours. Because only 45 percent of the wounds in Iraq have met that criterion (a factor that has remained remarkably constant throughout the duration of OIF), the wounded-to-fatality ratios are cut by more than half using that method of computation (see Table 2).

Computed by any of those methods, the wounded-to-fatality ratios are higher in Iraq than they were in Vietnam—indicating a greater possibility of surviving a wound in the current conflict—but the margin is not as large as is sometimes sup-

posed. In addition to the well-known roughly 58,000 deaths that occurred in Vietnam (of which about 47,000 were the result of hostile action), the 153,000 serious wounds imply a ratio of 3.2 wounds per hostile death. Put differently, among troops seriously wounded in Vietnam, 76.4 percent survived their wounds; the corresponding survival rate has been 80.8 percent in Iraq (and 80.6 percent when OEF is included).[11]

Classification of Injuries Among Surviving Wounded Veterans

The protection afforded by body armor has enabled many soldiers to survive what might otherwise have been fatal injuries to the chest or abdomen. However, the same incidents (for example, detonation of improvised explosive devices, or IEDs) have led to numerous injuries to the extremities, some resulting in immediate or subsequent surgical amputation. Other writers have referred to traumatic brain injury as the "signature injury" of the current conflict. The psychological syndrome known as post-traumatic stress disorder has also received considerable attention in media coverage of the war.

Amputations. Amputees receive their initial care at DoD medical facilities, many at Walter Reed Army Medical Center after having been medically stabilized at Landstuhl Regional Medical Center in Germany. Patients may stay at Walter Reed for an extended period (typically months), receiving prosthetic limbs with attendant physical and occupational therapy as well as any other required medical care. Some amputees petition to return to active military service, but most are eventually discharged from the military and transition to the VA medical system.

A census conducted by DoD indicates that, through January 2007, 749 amputations had occurred during OIF and 42 during OEF. The incidence rates are 3.3 percent among all troops wounded in OIF and 3.8 percent among all troops wounded in OEF. Further, of the 671 amputations from either conflict that were attributable to combat injury, 95 (14 percent) involved fingers or toes only (albeit sometimes multiple fingers or toes), not hands, feet, or entire limbs. Although those injuries are still serious and partially disabling, the costs to care for patients losing finger or toes are much lower because most such patients do not receive prosthetic devices.

Traumatic Brain Injuries. The number of traumatic brain injuries attributable to service in OIF or OEF is much more difficult to measure; although DoD has compiled estimates, a complete census does not exist. Some TBIs are identified in-theater (for example, immediately after an IED attack), in which case the soldier would most likely be medically evacuated to Landstuhl Regional Medical Center. Other TBIs may escape initial diagnosis because they are associated with closed wounds rather than with obvious penetration wounds (such as gunshot or shrapnel wounds). Those TBIs often arise in polytrauma victims in which the head injury is a comorbidity (secondary to some other injury). Current medical practice is for military doctors to screen 100 percent of patients evacuated to Landstuhl for any types of injuries for TBI.

The military conducts post-deployment health-assessment surveys at the major U.S. bases to which service members return after an overseas deployment (for instance, Ft. Bragg, Ft. Carson, or Camp Pendleton). TBIs sustained, but undiagnosed, in-theater would not generally be evident from neuroimaging conducted months later in the United States. Instead, initial screening of a TBI is based on a soldier's responses to post-deployment survey questions related to:

- The injury-causing event itself (for example, proximity to an explosion);
- Loss of consciousness or altered consciousness immediately following the injury-causing event; or
- Subsequent physical, cognitive, or emotional consequences, including:
  - memory problems or lapses,
  - balance problems or dizziness,
  - ringing in the ears,
  - sensitivity to bright light,
  - irritability,
  - headaches, or
  - sleep problems.

Between October 2001 and December 2006, DoD physicians diagnosed 1,950 TBIs among the wounded in action from OIF and OEF combined. Neurologists classify TBIs as mild, moderate, or severe. Of the 1,950 total TBIs, some 1,322 (or just over two-thirds) were considered mild. Those figures imply that 8.2 percent of wounded

[11] Considering all hostile wounds, whether or not they are classified as serious and whether or not wounded service members return to duty within 72 hours, the survival rates were 86.5 percent in Vietnam, 90.4 percent in Iraq, and 90.2 percent for all of OIF and OEF.

troops suffered a TBI, of which 5.5 percent suffered a mild case and the remainder either a moderate or severe case. (A data update indicates 2,669 TBIs through July 2007, although the split by severity level was not provided.)[12] Some TBIs may go undiagnosed, but absent obvious penetration wounds or other indications that acute care is required, those TBIs are likely to have been mild. Those patients may already be asymptomatic by the time their units return to the United States, although a small portion may have lingering effects.

Post-traumatic Stress Disorder and Other Mental Health Problems. An oft-quoted statistic is that 37 percent of the 229,000 OIF/OEF veterans (some 84,000) were seen for mental health problems; many of those same veterans were seen for other medical conditions as well.[13] It is difficult to estimate the long-run costs stemming from those mental health diagnoses. VA states that some of the visits were "rule-outs," during which the physician determined that the veteran did not have a mental health problem; other mental health diagnoses were provisional (pending further evaluation). Some veterans with confirmed mental health diagnoses may simply require limited counseling sessions or prescription medicine management.

One-third of OIF/OEF veterans (229,000 out of 690,000) have sought VA medical care since 2002. If veterans who suspect they have mental health or other medical problems are more likely than other veterans to seek VA medical care, it would be incorrect to extrapolate and reach the conclusion that 37 percent of all OIF/OEF veterans have mental health problems. For example, the overall mental health incidence rate may be lower because OIF and OEF veterans who have not sought VA medical care do not suffer from those conditions. However, some veterans with mental health problems may not seek care out of concern for being stigmatized. Reservists, in particular, might fear that their deactivation (and return to their hometowns) could be delayed until treatment was completed.

With regard to post-traumatic stress disorder, 39,000 of the 84,000 veterans who were seen for mental health problems received a diagnosis of PTSD (albeit sometimes a provisional diagnosis); some were diagnosed with other mental health conditions as well. Based on those data, the incidence rate of PTSD is 17 percent among the 229,000 OIF/OEF veterans who have sought VA medical care since 2002. The PTSD incidence rate among the entire OIF/OEF veteran population could be either higher or lower. A 2004 study in the *New England Journal of Medicine (NEJM)* reported PTSD rates of 12 percent for soldiers and Marines three to four months after returning from deployment to Iraq with infantry units, and a rate of 6 percent for infantry soldiers returning from Afghanistan (where the intensity of combat has been lower).[14] The rates for soldiers in combat-support or combat-service-support units could be lower than in the infantry because those units have less direct exposure to combat situations. However, the deployments studied in the NEJM article were for durations of between six and eight months, whereas current deployments for Army units may be as long as 12 or even 15 months, increasing the potential combat exposure.

Cost Analysis of Traumatic Brain Injuries

If the Congress seeks projections of VA's future resource needs, then the costs of treating all current and future TBI patients are relevant. However, to estimate costs specifically associated with OIF and OEF, it is important to exclude an estimate of the number of TBIs that might have been experienced in a comparably sized military population during peacetime. In 1999, incidence rates in the Army per 100,000

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[12] It has also been reported that among patients medically evacuated to Walter Reed Army Medical Center for battle-related injuries, 28 percent were diagnosed with a TBI. However, the 28 percent incidence rate applies only to patients at Walter Reed, not to the much larger (and, on average, less seriously wounded) pool of all wounded troops, over half of whom return to duty within 72 hours. See Deborah L. Warden and others, "The Defense and Veterans Brain Injury Center (DVBIC) Experience at Walter Reed Army Medical Center (WRAMC)," *Journal of Neurotrauma* 22 (2005), p. 1178; and Deborah L. Warden, "Military TBI During the Iraq and Afghanistan Wars," *Journal of Head Trauma Rehabilitation* 21 (2006), pp. 398–402.

[13] The source for that statistic is Veterans' Health Administration, Office of Public Health and Environmental Hazards, *Analysis of VA Health Care Utilization Among U.S. Southwest Asia War Veterans* (April 2007).

[14] Charles W. Hoge and others, "Combat Duty in Iraq and Afghanistan, Mental Health Problems, and Barriers to Care," *New England Journal of Medicine,* vol. 351, no. 1 (July 1, 2004), pp. 13–22. A more recent study reports that between 4.8 percent and 9.8 percent of soldiers and Marines screen positive for PTSD on the post-deployment health-assessment survey that DoD administers one or two weeks after units return to the United States; see Charles W. Hoge and others, "Mental Health Problems, Use of Mental Health Services, and Attrition from Military Service After Returning from Deployment to Iraq or Afghanistan," *Journal of the American Medical Association,* vol. 295, no. 9 (March 1, 2006), pp. 1023–1032.

soldiers were as follows: mild TBIs, 34.0; moderate TBIs, 6.1; severe TBIs, 10.6; and TBIs of unknown severity, 11.6.[15] Given a deployed force that has averaged about 180,000 troops on the ground (including Marines as well as Army soldiers), one would expect to see annual counts of about 110 TBIs in Iraq and Afghanistan, of which at least 60 would be classified as mild.[16] TBIs in those theaters have been diagnosed at the rate of about 500 per year, but about one-fifth of that total might have occurred even in a peacetime environment.

The cost of treating a TBI patient must take into account the severity of the injury. A 2005 paper by Wallsten and Kosec reported:

> "We made the conservative assumption that only those with severe brain injuries and amputations would require lifetime care. Estimates commonly used by medical experts suggest a lifetime cost of care for brain injuries ranging from $600,000 to $4,000,000 per person and about $45,000 to $57,000 for amputees, plus the cost of prosthetic limbs ranging from about $12,500 to about $100,000."[17]

Despite their stated attempt to estimate costs conservatively, Wallsten and Kosec did not take into account the fact that about two-thirds of the TBIs from OIF and OEF have been classified as mild. While some have expressed concern that there may be lingering effects from mild TBIs, medical evidence suggests that the most common path is for natural recovery within a matter of weeks or at most months, although a small percentage of patients with mild TBIs exhibit persistent symptoms.[18] Instead, Wallsten and Kosec equated all TBIs (regardless of severity) to "severe head injuries" sustained in automobile crashes, as defined and calibrated by the National Highway Transportation Safety Administration. On the basis of that equation, Wallsten and Kosec estimated between $600,000 and $4 million for lifetime care of a brain-injured victim.

The two types of injuries—TBIs sustained in combat and severe head injuries sustained in automobile crashes—are actually quite different. All U.S. soldiers are issued Kevlar helmets that are capable of deflecting some bullets and shrapnel, or at least significantly reducing their velocity upon penetration. Motorists do not generally wear helmets, and not all wear seat belts (although many vehicles are equipped with air bags); therefore, their head injuries are much more likely to affect the brain directly.[19]

Linda Bilmes and Joseph Stiglitz present arguments similar to those offered by Wallsten and Kosac:

> "There is a special category of health care expenditures that go beyond those included in the above calculation—for those with brain injuries. To date, 3213 people—20% of those injured in Iraq—have suffered head/brain injuries that require lifetime continual care at a cost range of $600,000 to $5 million. The government will be required to commit resources through intensive care facilities, round-the-clock home or institutional care, rehabilitation and assisted living for these veterans. For the conservative estimate, we have used a midpoint estimate of a net present value of $2.7 million over a 20 year expected survival rate for this group, which is about $135,000 per year, yielding a cost of $14 billion. This amount seems low for brain-injured individuals who will require round-the-clock care in feeding, dressing and daily functioning. For the moderate estimate, we use a higher cost estimate ($4m) and assume longer life duration for a total cost of $35 billion. In both cases we

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[15] Brian J. Ivins and others, "Hospital Admissions Associated with Traumatic Brain Injury in the U.S. Army During Peacetime: nineties Trends," *Neuroepidemiology,* vol. 27, no. 3 (2006), pp. 154–163.

[16] The total number of soldiers and Marines has averaged about 160,000 in the Iraq theater (including Kuwait and other nearby countries) and 20,000 in Afghanistan. The recent surge in forces in Iraq was achieved largely by deploying troops sooner than was previously planned and by extending the deployment of forces already in that theater. The surge has increased the U.S. military presence in Iraq by between 30,000 and 40,000, but a force that large was not on the ground during the period in which the wartime casualty statistics were generated.

[17] Scott Wallsten and Katrina Kosec, "The Economic Costs of the War in Iraq," Working Paper No. 05–19 (Washington, D.C.: AEI–Brookings Joint Center for Regulatory Studies, September 2005), p. 22.

[18] See H.S. Levin and others, "Neurobehavioral Outcome Following Minor Head Injury: A Three-Center Study," *Journal of Neurosurgery,* vol. 66, no. 2 (February 1987), pp. 234–243; and M.P. Alexander, "Mild Traumatic Brain Injury: Pathophysiology, Natural History, and Clinical Management," *Neurology* 45 (1995), pp.1253–1260.

[19] Similarly, Wallsten and Kosec applied their "lifetime care" estimate to all amputations, even though 14 percent of amputations from OIF and OEF have involved only fingers or toes, obviating the need for prosthetic limbs.

assume that the number injured will rise in a manner consistent with the duration of the conflict."[20]

On the basis of the DoD medical census, 1,950 TBIs had been diagnosed through December 2006 and 2,669 through July 2007, but still not the 3,213 that Bilmes and Stiglitz assert had occurred as early as January 2006. More important, two-thirds of the diagnoses were for mild TBIs, from which most patients should recover naturally, especially if given prompt treatment. The scenario of "lifetime continual care" applies to a group of wounded soldiers numbering perhaps in the hundreds but not to the vast majority of those diagnosed with TBIs. To further illustrate the implausibility of Bilmes and Stiglitz's cost estimates, note that in 2007 VA obligated $573 million for medical care (for all injuries and illnesses) of veterans of OIF and OEF. Yet Bilmes and Stiglitz's low estimate implies annual expenditures averaging about $900 million, and their high estimate implies average annual expenditures of $1.6 billion extending for decades to treat just the brain-injured veterans.[21]

Utilization of VA Medical Care

Of the 320,000 active-duty veterans of OIF and OEF who have separated from military service through April 2007, 112,000 have received health care from VA. In addition, 370,000 members of the Reserve or National Guard have returned from OIF or OEF and become eligible for VA health care, of which 117,000 have received care. Among that total of 229,000 patients, 3 percent (fewer than 8,000) have been hospitalized at least once in a VA facility since 2002; the other 97 percent were seen on an outpatient basis only.

Not all of the 229,000 OIF/OEF patients visit a VA medical facility during any single year. In 2006, for example, VA treated over 5 million veterans, including 155,000 OIF/OEF veterans, who accounted for 3 percent of the total veteran patient load (see Table 3).

Table 3.

Number of Veterans of OIF and OEF Treated at VA Medical Facilities and the Average Annual Cost of Treatment

	2005	2006	2007	2008
Number of OIF/OEF Veterans Treated	101,000	155,000	209,000	263,000
Annual Cost per OIF/OEF Patient (Dollars)	2,310	2,610	2,740	2,860

Source: Department of Veterans Affairs (VA) based on budget submissions for fiscal years 2007 and 2008.
Notes: OIF = Operation Iraqi Freedom; OEF = Operation Enduring Freedom.
Numbers for 2005 are from VA's fiscal year 2007 budget submission.
Numbers for 2006 through 2008 are from VA's fiscal year 2008 budget submission.

VA is treating a certain number of recent veterans for the amputations and severe brain injuries discussed above, as well as for other serious injuries, although those veterans may be treated for many months by DoD (for example, at Walter Reed Army Medical Center) before being released to VA. VA estimates an average annual

[20] Linda Bilmes and Joseph Stiglitz, "The Economic Costs of the Iraq War: An Appraisal Three Years After the Beginning of the Conflict," Working Paper No. 12054 (Cambridge, Mass.: National Bureau of Economic Research, February 2006), p. 9. The authors' research was originally presented at the Allied Social Sciences Association Annual Conference, Boston, January 2006.

[21] Bilmes and Stiglitz's estimate of a 20 percent incidence rate of brain injuries was adopted from the earlier paper by Wallsten and Kosec. That estimate, in turn, was based on a misinterpretation of a research paper by an Air Force ear-nose-and-throat specialist (or otolaryngologist) and head-and-neck surgeon who had been was stationed at Landstuhl Regional Medical Center: Lt. Colonel Michael S. Xydakis and others, "Analysis of Battlefield Head and Neck Injuries in Iraq and Afghanistan," *Otolaryngology—Head and Neck Surgery,* vol. 133, no. 4 (October 2005), pp. 497–504. The paper was originally presented at the American Academy of Otolaryngology Head and Neck Surgery Annual Meeting, New York, September 2004. Lt. Colonel Xydakis and his colleagues found that among 2,483 battle-injured patients evacuated from Iraq or Afghanistan and treated at Landstuhl through March 19, 2004, some 21 percent had head or neck trauma. However, neck injuries affect the area below the helmet line and are distinct from brain injuries; TBIs (as a primary diagnosis) would be treated by neurologists rather than otolaryngologists. Moreover, the 21 percent incidence rate would at most apply only to those patients evacuated to Landstuhl and classified as "battle-injured," not to the much larger (and, on average, less-seriously wounded) pool of all wounded troops, over half of whom return to duty within 72 hours.

cost of $2,610 per OIF/OEF veteran who used VA health care in 2006, versus an overall average of $5,765 per year for all VA patients.

Projections of VA's Costs for Medical Care, Disability Compensation, and Survivors' Benefits

CBO has developed projections of VA's costs to treat all veterans of OIF and OEF who are eligible for VA medical care and who demand that care. However, some of those veterans would have been eligible for such care and would have used the VA medical system even if they had not deployed to Iraq and Afghanistan (for example, for treatment of normal age—or training-related injuries to the musculoskeletal system). Those costs that are not specifically attributable to deployments to Iraq or Afghanistan should be subtracted from the gross cost estimates. Conversely, some veterans may develop service-connected conditions during their tours in Iraq and Afghanistan, yet not present for VA medical care until many years after they separate from active duty. CBO is continuing to refine its projection model to account for those possibilities.[22]

Along with medical care, the Department of Veterans Affairs provides compensation and various other benefits, including life insurance and educational benefits, to veterans. Calculations of the cost of the war to VA should include the costs of these other benefits over and above the costs that would have been incurred had the war not been fought. The two programs most likely to be significantly affected by the current operations are disability compensation paid to veterans with service-connected disabilities, and dependency and indemnity compensation benefits paid to survivors of service members.[23]

Disability compensation is a monetary payment made to veterans who have became disabled as a result of a medical condition incurred or aggravated during their active-duty service. The level of a veteran's disability is rated between 0 and 100 percent, in increments of ten percent. Compensation is based on the veteran's disability rating, with special payments for the most severely injured veterans. In 2007, those tax-free payments ranged from $115 per month for veterans with a ten percent disability to $2,471 per month for those rated 100 percent disabled. Special payments could range up to $7,070 per month. CBO estimates that VA paid a total of $26.6 billion in disability compensation in 2007, of which $126 million was paid to veterans of OIF and OEF.

DIC, or survivors', benefits are monthly payments made to survivors of certain deceased veterans, including those who died while on active duty and those who died of service-connected disabilities. In 2007, surviving spouses were awarded a base monthly payment of $1,067, although additional payments could be made depending on the circumstances. CBO estimates that VA paid a total of $4.4 billion in survivors' benefits in 2007, of which $35 million went to survivors of veterans of OIF and OEF.

CBO has projected VA's potential costs for medical care, disability compensation, and survivors' benefits under the assumption that historical casualty rates (per deployed service member per year, see Table 1) for operations in Iraq and Afghanistan over the 2003–2006 period will continue into the future and that the necessary funds are appropriated. CBO presents two broad illustrative scenarios for the force levels in-theater over the coming years. Under the first scenario, the number of deployed troops would decline from an average of approximately 210,000 active-duty, Reserve, and National Guard personnel on the ground in fiscal year 2007 to 30,000 in 2010 and would remain at that level over the 2010–2017 period, though not necessarily in Iraq and Afghanistan. In the second scenario, the number of deployed

[22] The projections in this testimony update those reported in the statement of Allison Percy, Principal Analyst, Congressional Budget Office, *Future Medical Spending by the Department of Veterans Affairs,* before the Subcommittee on Military Construction, Veterans Affairs, and Related Agencies, House Committee on Appropriations (February 15, 2007), and Congressional Budget Office, *Potential Growth Paths for Medical Spending by the Department of Veterans Affairs* (July 2006).

[23] The current testimony does not include the costs of any increases in veterans' pensions or vocational rehabilitation provided by VA. Nor does it include the costs of disability retirement pay, disability severance pay, or Survivor Benefit Plan payments provided by DoD, which would be largely offset by VA benefits. Finally, the testimony excludes payments from the Servicemembers' Group Life Insurance or Traumatic Servicemembers' Group Life Insurance programs. DoD pays the additional costs incurred by those insurance programs for claims related to operations in Iraq and Afghanistan.

troops would decline more gradually over a 6-year period, until 75,000 remained overseas in 2013 and each year thereafter.[24]

Because VA's costs could also depend on how long DoD sustains the increase in force levels currently in the Iraq theater, CBO estimated the costs for both scenarios under the assumption that the current force level in Iraq would be sustained for periods of, respectively, 12 or 24 months. CBO found that the costs to VA over the 10-year period would not vary substantially with the number of months that deployed forces were maintained at the current level before troop levels began to decline. Consequently, in this testimony, CBO presents solely the estimates for VA's costs based on the larger troop presence lasting 12 months.

Under the first scenario, in which the number of deployed troops drops to 30,000 by 2010, VA would incur costs of about $9.7 billion over the 2008–2017 period for medical care, disability compensation, and survivors' benefits. Alternatively, if deployed forces declined more slowly to 75,000 by 2013, as in the second scenario, VA's costs would reach almost $13 billion for those purposes over the next 10 years, CBO estimates (see Table 4).

[24] The two scenarios are described in more detail in the Statement of Robert A. Sunshine, Assistant Director for Budget Analysis, Congressional Budget Office, Estimated Costs of U.S. Operations in Iraq and Afghanistan and of Other Activities Related to the War on Terrorism, before the House Committee on the Budget (July 31, 2007). CBO has more recently constructed long-term scenarios in which the United States maintains a military presence of about 55,000 troops in Iraq, similar to the level of U.S. forces in the Republic of Korea and the Northeast Asia region; see Congressional Budget Office, The Possible Costs to the United States of Maintaining a Long-Term Military Presence in Iraq (September 2007). However, the current testimony, which focuses on the next 10 years, does not provide projections of VA's costs under those alternative long-term scenarios.

Table 4.
Estimated Spending by the Department of Veterans Affairs on Veterans of OIF and OEF Under Two Scenarios, 2008 to 2017

	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	10–Year Projections, 2008–2017
	Low Option with 12–Month Surge										
Medical Care	692	741	796	745	669	621	607	622	660	712	6,866
Disability Compensation	166	188	197	207	218	228	239	251	263	275	2,233
Dependency and Indemnity Compensation	43	47	50	52	54	57	59	62	64	67	555
Total	901	976	1,043	1,005	940	906	906	935	987	1,055	9,654
	High Option with 12–Month Surge										
Medical Care	692	741	833	892	940	970	980	996	1,038	1,106	9,187
Disability Compensation	166	202	237	267	292	314	336	359	382	407	2,962
Dependency and Indemnity Compensation	43	50	57	64	69	74	78	83	88	93	699
Total	901	993	1,127	1,223	1,302	1,358	1,394	1,437	1,508	1,606	12,849

Source: Congressional Budget Office.

Notes: OIF = Operation Iraqi Freedom; OEF = Operation Enduring Freedom.

Costs for Medical Care

Under the assumptions in the first scenario, CBO estimates, VA's costs would reach almost $7 billion from 2008 through 2017 for medical care for veterans with service-connected conditions incurred in Iraq and Afghanistan. Under the second scenario, VA's costs would be over $9 billion.[25]

For 2008 through 2017, CBO projects that VA's costs to treat veterans of OIF and OEF will be related to the number of service members wounded in action, with most veterans presenting for care at VA medical facilities shortly after they separate from active duty. Because the majority of veterans return to work and obtain employer-sponsored insurance that they may prefer to use, CBO anticipates that those veterans will move out of the VA medical system over time, although some will continue to seek part or all of their care from VA. CBO projects that VA's per capita cost of care will grow at the same rate as national health expenditures, with nominal growth rates at about 7 percent per year from 2008 through 2017.

Costs for Disability Compensation

According to CBO's projections, VA's spending on disability compensation related to operations in Iraq and Afghanistan would total $2.2 billion under the first scenario and $3.0 billion under the second scenario over the 2008–2017 period.

DoD provided data on the number and VA disability ratings of service members who were injured in and evacuated from Iraq and Afghanistan and who later separated from the military. CBO applied projections of annual payments to people with varying disability ratings to estimate total costs for disability compensation. In addition, CBO assumed that approximately three times the number of claims associated with medical evacuation would eventually be made by veterans who incur service-connected conditions as a result of operations in Iraq and Afghanistan that are not severe enough to require medical evacuation from the theater. CBO assumed that those additional veterans would, on average, receive a 40 percent disability rating.

Costs for Dependency and Indemnity Compensation

For the 10-year period from 2008 through 2017, CBO projects spending on DIC payments made to the dependents of service members who die in the current operations at about $550 million under the first scenario and $700 million under the second. To construct those estimates, CBO assumed that 60 percent of service members dying in OIF and OEF would have dependents eligible for DIC and that payment amounts would rise at about 2.2 percent per year in the future.

Prepared Statement of Hon. Michael J. Kussman, M.D., MS, MACP, Under Secretary for Health, Veterans Health Administration, U.S. Department of Veterans Affairs

Mr. Chairman and members of the Committee, thank you for this opportunity to discuss how Veterans Affairs (VA) is addressing medical care costs for the Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) population. Today, my testimony will focus on how VA continues to enhance its programs and projects its annual budget in order to meet the needs of this newest generation of veterans.

Since the onset of combat operations in Iraq and Afghanistan, VA has demonstrated flexibility in its ability to create new services and to adapt resource allocations to meet the unique medical need of returning OEF/OIF veterans. We continue to have confidence in our planning and budgeting processes and we are committed to utilizing all necessary resources to provide timely and quality health care to all our veterans.

VA has grown from four Traumatic Brain Injury Centers into an entire Polytrauma System of Care, expanded its Readjustment Counseling Services by establishing new Vet Centers across the country and enhanced our mental health system to more robustly address Post Traumatic Stress Disorder (PTSD) and suicide, among other mental health issues. Mr. Chairman, we would like to thank this Committee for its continued support in our efforts to provide the best health care for all veterans.

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[25] CBO's projection of $692 million in OIF/OEF medical costs for 2008 compares to the figure $752 million that VA included in its 2008 budget request.

Planning and Utilization

Since 2002 thru the end of the 3rd quarter of fiscal year (FY) 2007, 751,273 OEF/OIF veterans who left active duty have become eligible for VA health care. Thirty-five percent (263,909) of the total separated OEF/OIF veterans have come to VA to obtain VA health care. We follow and analyze trends and other data to ensure that VA is ready and able to meet future demands for medical care, particularly for our OEF/OIF veterans.

Polytrauma System of Care

Prior to FY 2002, Traumatic Brain Injury (TBI) Lead Centers provided acute medical and rehabilitation care to veterans suffering from severe TBI and one or more other major traumatic injuries such as amputation of a limb(s), or blindness. Due to the unique and severe injuries caused by improvised explosive devices, VHA created the Polytrauma System of Care that provides a continuum of care when these heroes are able to move from acute care to less intensive levels of care. The networks provide three levels of care from acute to less intensive outpatient care. These less intrusive care levels are provided at facilities throughout the 21 Veteran Integrated Systems Network (VISNs). To give this Committee a sense of the magnitude of severe injuries in the OEF/OIF population, there have been 681 patients with amputations, and 110 patients with spinal cord injuries. VA has accepted 436 transfers from Military Treatment Facilities to the polytrauma centers.

This system of care consists of four regional Polytrauma Rehabilitation Centers (PRC) and provides acute intensive medical and rehabilitation care for complex and severe polytraumatic injuries. The Secretary of Veterans Affairs recently announced the decision to locate a fifth Polytrauma Center in San Antonio, TX. The PRCs serve as hubs for acute medical and rehabilitation care, research, and education related to polytrauma and TBI.

Transition Patient Advocates

VHA developed new programs to provide additional transition assistance and case management for OEF/OIF veterans. In 2007, VA hired 100 Transition Patient Advocates (TPAs). TPAs serve as veteran advocates when severely injured veterans transition to VA from a Military Treatment Facility. The TPA works closely with the VA Social Work Liaison to ensure a smooth health care transition. These specialized case managers are located in VA medical centers and the number assigned to a specific VAMC is based on the number of OEF/OIF veterans treated by the medical center. Annually, VA distributes approximately $19 million among the Veteran Integrated Service Networks to cover TPA salaries.

Vet Centers

Vet Centers serve veterans and their families by providing professional readjustment counseling. Currently, there are 209 VA Vet Centers located in all 50 states, the District of Columbia, Guam, Puerto Rico and the U.S. Virgin Islands. The Vet Centers operate in the community outside of larger medical facilities. With the onset of the hostilities in Afghanistan and Iraq, the Vet Centers stepped up to actively outreach and extend services to the OEF/OIF veterans. From early FY 2003 through the end of the third quarter FY 2007, the Vet Centers provided services to 183,530 veterans and clinical services to 58,504 veterans. During the same time period, more than 1,570 family members have been referred to the Vet Centers for bereavement counseling.

From 2001 through 2003, the Vet Center program operated with a total of 206 Vet Centers and 943 total staff nationwide. The program's annual operation budget was flat except for annual cost of living increases. However, investments in Vet Centers became a higher priority in 2003. Starting in 2003, the Vet Centers recruited the first 50 of a total of 100 Global War On Terror (GWOT) veteran outreach specialists to conduct a focused outreach campaign to their fellow veterans returning from OEF/OIF. The second 50 GWOT outreach specialists were hired in 2005. The associated recruitment cost for the 100 GWOT veterans was approximately $5 million. Also in 2005, the Readjustment Counseling Service (RSC) established a new four-person Vet Center in Nashville, TN, at a recurring cost of approximately $350,000. In 2006, RCS established two new four-person Vet Centers in Atlanta, GA, and Phoenix, AZ, and augmented the staff of 11 existing Vet Centers by one position each. This initiative added 19 permanent positions to the Vet Center program with a cost of approximately $1.5 million.

Today, the Vet Center program is undergoing the largest expansion since the early days of the program's founding. The planned expansion complements the efforts of the Vet Center outreach initiative by ensuring sufficient staff resources are available to provide the professional readjustment services needed by the new vet-

erans as they return home. In February 2007, VA announced plans to increase the number of Vet Centers from 209 to 232, and to augment the staff at 61 existing Vet Centers. The expansions, started in 2007 and planned for completion in 2008, will increase the Vet Center program's annual recurring budget by approximately $14 million.

In May 2007, VA announced that it planned to add yet an additional 100 new staff positions to the Vet Center program in FY 2008. VHA has also targeted an additional 100 positions for FY 2009, which will further augment the Vet Centers' ability to address the readjustment needs of combat veterans and their families. These staff augmentations will result in an annual recurring increase of approximately $8.3 million. Collectively, starting from the first 50 GWOT veterans in 2004, the Vet Center program will realize a total of 473 new positions by the end of 2009, or a 50-percent increase over pre-2004 staffing levels.

Mental Health

Of the OEF/OIF veterans who sought care from VA, about 38 percent have received at least a preliminary diagnosis of a mental health condition, and 18 percent have received a preliminary diagnosis for PTSD, making it the most common, but by no means the only, mental health condition related to the stress of deployment. To meet the specific mental health needs of these returning veterans, VHA has developed new and enhanced existing mental health programs and services. For example, veterans with a serious mental illness are seen in specialized programs, such as mental health intensive case management, day centers, work programs and psychosocial rehabilitation. General and psychogeriatric mental health services are also being integrated into primary care clinics.

VA continues to promote the recruitment and retention of mental health professionals. At the local level, opportunities have been developed for VA facilities to engage in local advertising and recruitment activities and to cover interview-related costs, relocation expenses, and provide limited hiring bonuses for exceptional applicants. VA employs full- and part-time psychiatrists and psychologists who work in collaboration with social workers, mental health nurses, counselors, rehabilitation specialists, and other clinicians to provide a full continuum of care for mental health services for veterans.

The cost of mental health services and programs specifically dedicated for OEF/OIF veterans was $2.4 million in FY 2005, $11.7 million in FY 2006, and $19.0 million in FY 2007. Most returning veterans receive mental health services in programs serving veterans of all eras. At present, OEF/OIF veterans represent approximately 10 percent of all veterans with a mental health diagnosis, and, therefore, the costs of their mental health care can be estimated at 10 percent of VHA's $3 billion of expenditures in this area.

Mr. Chairman, this concludes my statement. I am pleased to respond to any questions you or the members may have.

Thank you.

Prepared Statement of Hon. Daniel L. Cooper, VADM (Ret.), Under Secretary for Benefits, Veterans Benefits Administration, U.S. Department of Veterans Affairs

Mr. Chairman and members of the Committee, it is my pleasure to be here today to describe the budget formulation process used to project the long-term costs of our veterans compensation program. I am pleased to be accompanied today by Mr. Jimmy Norris, Chief Financial Officer of the Veterans Benefits Administration (VBA).

VBA is responsible for administering a wide range of benefits and services for veterans, their families, and their survivors. At the heart of our mission is the Disability Compensation Program, which provides monthly benefits to veterans who are disabled as a result of injuries or illness incurred or aggravated during their military service. VBA's role in serving the veteran population is extensive and complex. Our budget formulation process ensures sufficient resources to provide the benefits to those who have sacrificed so much in defense of our freedom.

Our Compensation and Pension Model has proven to be a reliable method for projecting veterans' compensation benefits. I will discuss our mandatory budget process, including the primary methods and data we use in estimating the costs of compensation benefits.

Disability Compensation Benefit Model

As of the end of FY 2007, over 2.8 million veterans of all periods of service were receiving VA compensation benefits. This is a net increase of more than 500,000 veterans since 2000. In 2007, these veterans were paid $29 billion in compensation benefits, an increase of $13.5 billion over the 2000 level.

To adapt to the changing trends in veterans' compensation benefit payments, VBA developed a benefits budget forecasting model for veterans of all periods of service. The model uses a combination of historical data, current experience, and workload and performance projections. Our current model was developed in 2004 in conjunction with the Office of Management and Budget, the Congressional Budget Office, VA's Office of the Actuary, and several other internal VA offices. The working group established to develop the current model determined that the most effective means of forecasting must be based on veterans' historical degree-of-disability statistics.

Detailed historical data is the basis for projecting both the caseload and the average amount of benefits to be paid for the next ten years. Our model incorporates specific data for approximately 99 percent of the beneficiaries dating back to 1992. By comparing data from one year to the next, we are able to recognize developing changes in our recurring caseload and predict trends for both accessions and terminations from the compensation benefit program. It is important to note that 95 percent of VA's compensation payments is issued in recurring monthly payments to veterans; the remaining 5 percent encompasses retroactive and one-time benefit payments.

To project future compensation obligations, observed trends in historical data are combined with educated forecast assumptions. Two of the more important assumptions used to estimate future caseload are projected workload and accession rates. Projected workload comes from the discretionary budget formulation process and begins with an estimate of incoming workload (new claims). Projected incoming claims, anticipated inventory, future performance assumptions and productivity targets are used to derive the volume of both original and reopened cases expected to be completed each year. The accession rate is the percent of completed cases that are awarded benefits and is applied to projected workload to estimate new compensation cases.

To forecast obligations, we must also estimate the average amount of benefits that will be paid to each beneficiary. A portion of the increases in average payments can be specifically attributed to annual COLAs. However, the total increase is also impacted by significant increases in the average degree of veterans' disabilities, the number of veterans determined to be individually unemployable and receiving benefits at 100-percent rate, and veterans receiving Special Monthly Compensation. The average degree of disability for all beneficiaries increased 26 percent over the past ten years, from 30.9 percent in 1996 to 38.9 percent at the end of 2006, with resultant increases in average benefit payments.

Once the mandatory benefits projection is developed, it is adjusted based on recent program changes, which might include newly enacted legislation, regulations, or recent court decisions. Our latest 10-year plan projects annual veterans' compensation payments to increase by $27 billion over the next ten years, continuing the trend of the past decade and nearly doubling our current obligations for the compensation program by the year 2017.

Projections of Current Conflict

Projections of incoming claims workload is one of the key assumptions in the formulation of our mandatory budget requests. The number of veterans filing disability compensation claims has increased every year since 2000. Disability claims from returning Afghanistan and Iraq conflict veterans, as well as from veterans of earlier periods of war, increased from 578,773 in FY 2000 to 838,141 in FY 2007. For FY 2007 alone, this represents an increase of over 259,000 claims or 45 percent over the 2000 base year. Claims workload itself is a function of a number of variables, such as the size of the active duty force. It should be noted that resubmitted claims for increased benefits from veterans already on our disability compensation rolls represent about 54 percent of the total claims volume.

The budget model analyzes changes to individual benefit payments. It does not forecast by war period or specific area of military assignment. This method has been determined to be reliable for projecting total compensation costs, but does not allow us to provide long-term disability compensation cost projections specifically for OIF/OEF veterans.

As a result of VA's current efforts to enhance data sharing with DoD, we now have a means to identify OIF/OEF combat veterans and are able to begin to analyze their benefits usage. The most recent data file from DoD includes veterans separated through May 2007. This data file was compared to VA records through Sep-

tember 2007. This match identified 223,564 OIF/OEF veterans who have filed claims for disability benefits either prior to or following their OIF/OEF deployment (approximately 30 percent of the 754,911 OIF/OEF servicemembers separated through May 2007). Of these 223,564 veterans, 198,522 have received decisions on their claims (89 percent) and 25,042 have claims pending (11 percent). Of the 198,522 OIF/OEF veterans who have received decisions, 181,151 were found to have service-connected disabilities (91 percent).

Projecting future demand and long-term costs for the OIF/OEF conflict, or any specific period of service, remains extremely difficult for a number of reasons.

- Many OIF/OEF veterans had earlier periods of service, and their injuries or illnesses could have been incurred either prior to or subsequent to their OIF/OEF deployment. VA does not maintain data that would allow us to attribute veterans' disabilities to a specific period of service or deployment. Therefore we are unable to identify which OIF/OEF veterans filed a claim for disabilities incurred during their actual overseas OIF/OEF deployment.
- VA has significantly expanded its outreach efforts to separating servicemembers to ensure they are fully informed about their VA benefits. Over the last five years, VBA military services coordinators conducted over 38,000 briefings attended by over 1.5 million active duty and reserve personnel and their family members. Additionally, through the Benefits Delivery at Discharge Program, servicemembers are assisted in filing for disability benefits prior to separation. We believe these efforts have been very successful in encouraging separating servicemembers with disabilities to submit disability compensation claims. However, the impact of these additional efforts on future application trends and benefits usage is not known.
- VBA lacks historical data on benefits claims activity by veterans of prior wars or conflicts on which to base projections of benefits usage for OIF/OEF veterans. VBA does not have data to show how many veterans of prior wars or conflicts ever filed claims or received benefits specifically due to service in combat theatres. The only comparative data available are the numbers and percentages of veterans currently receiving benefits by era of service (e.g. World War II Era or Vietnam Era). First-time claimants continue to be added to our compensation rolls many years after military service, primarily as a result of diseases added to the list of conditions presumed to be related to exposure to Agent Orange while serving in Vietnam and post-traumatic stress disorder. We do not have a basis for determining whether service in Iraq and Afghanistan will result in similar claims patterns.

Conclusion

The compensation budget formulation process is based on a complex combination of historical data, current experience, workload assumptions, external influences, and program judgment. The budget evolves as these factors and inputs are refined, revised, and revisited. But, throughout all this complexity and change, the prime motivation is fulfilling our mission to help disabled veterans receive the benefits they have earned through their service to our nation.

Mr. Chairman, this concludes my statement. I will be happy to respond to any questions that you or other members of the Committee might have.

POST-HEARING QUESTIONS AND RESPONSES FOR THE RECORD

Committee on Veterans' Affairs
Washington, DC
November 27, 2007

Daniel P. Mulhollan, Director
Congressional Research Service
The Library of Congress
101 Independence Avenue, SE
Washington, DC 20540–7500

Dear Dan:

In reference to our Full Committee hearing on "The Long-Term Costs of the Current Conflicts" on October 17, 2007, I would appreciate it if you could answer the enclosed hearing questions by the close of business on January 8, 2008.

In an effort to reduce printing costs, the Committee on Veterans' Affairs, in cooperation with the Joint Committee on Printing, is implementing some formatting changes for materials for all full committee and subcommittee hearings. Therefore, it would be appreciated if you could provide your answers consecutively and single-spaced. In addition, please restate the question in its entirety before the answer.

Due to the delay in receiving mail, please provide your response to Debbie Smith by fax at 202–225–2034. If you have any questions, please call 202–225–9756.

Sincerely,

BOB FILNER
Chairman

Congressional Research Service
Library of Congress
Washington, DC
February 13, 2008

MEMORANDUM

TO: The Honorable Bob Filner, Chair, House Committee on Veterans' Affairs

FROM: Amy Belasco,[1] Specialist in U.S. Defense Policy and Budget, Foreign Affairs, Defense, and Trade Division

SUBJECT: Data that would be useful in determining future war costs

As a follow-up to the hearing held by the House Committee on Veterans' Affairs on October 17, 2007, on "The long-term Costs of the Current Conflicts," the Committee on Veterans' Affairs asked the Congressional Research Service (CRS) to specify the types of data, not currently provided to Congress by DoD and the Department of Veterans Affairs (VA), that would be helpful in determining long-term war costs (see attached). It is my understanding that the Committee's interest is in those costs likely to be addressed by the Veterans Administration.

Gaps in Current Knowledge about Future War Costs

One of the most significant gaps in data and discrepancies that became apparent during the Committee's hearing was the potential size and scale of near-term and long-term costs of health care and disability claims for veterans of the conflicts in Iraq and Afghanistan, particularly for types of medical problems like mental illness that may not arise immediately and may persist for long periods of time. For the Department of Veterans Affairs to plan and budget adequately for such costs, greater accuracy and transparency in the likely cost of caring for veterans of Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) is important.

Differing Estimates of the Cost of Disability Claims and Medical Costs

During the hearing, the Committee was provided with substantially different estimates of likely VA costs for OIF/OEF veterans from the Congressional Budget Office (CBO) and Professor Linda Bilmes of the Kennedy School of Government. CBO projected that over the next ten years, the cost of VA medical care and disability claims for veterans of Iraq and Afghanistan could range from an average of about $1 billion

[1] This memo was prepared with the help of CRS analysts Christine Scott, Sidath Panangala, Richard Best, and Charles Henning.

per year if troop levels declined to 30,000 by 2010 to an average of $1.3 billion per year if troop levels declined to 75,000 by 2013.[2]

In a study submitted for the record, Professor Bilmes estimated that the *lifetime costs* of disability claims and medical costs for OIF/OEF veterans could range from $349.8 billion to $662.8 billion depending on how long the wars last.[3] This estimate is *not* comparable to the CBO's estimate for the next ten years, however, because it covers a period of about 40 years, includes discounting of future costs, and relies on very different assumptions, including some that appear to be questionable or erroneous.[4]

For example, Professor Bilmes assumes in her estimates that about 48% of OIF/OEF veterans will seek medical care every year at an average cost of $5,000, assumptions that she claims reflect the Persian Gulf War experience.[5] In fact, VA experience has been that Gulf War veterans sought treatment from the VA in only some years at an average cost of a couple of hundred dollars per year.[6] In a long term estimate like the one by Professor Bilmes, the effect of underlying errors in assumptions is magnified, as, for example, her reliance on overly high assumptions about usage rates and average costs like that cited above.

Another way to see the differences in estimates by CBO, VA, and Professor Bilmes is compare annual cost estimates over the next few years. In a January 2007 study, Professor Bilmes estimated that in 2006, annual war-related VA disability claims and medical care would reach about $1.9 billion, including $940 million in disability claims and $1 billion in medical costs.[7]

In FY2006, the VA reported that medical costs for OIF/OEF veterans were $405 million or less than half of the Bilmes estimate.[8] Professor Bilmes estimates that these costs would rise to over $10 billion annually by 2012. In their October 17, 2007 testimony, CBO estimates that the cost of VA medical costs and disability would range from $940 million to $1.4 billion in 2012 depending on future troop levels.[9] Based on an "apples-to-apples" comparison, then, Professor Bilmes' estimate would be roughly seven to nine times larger than the CBO estimate.

The differences in the CBO, VA and Bilmes' estimates appear to spring primarily from widely divergent projections about the average cost of medical treatment and disability claims by OIF/OEF veterans. To address these differences, Congress could use better information about:

- the incidence or frequency and severity of particular types of injuries and illnesses among OIF/OEF veterans (e.g., Traumatic brain injury and Post Traumatic Stress Disorder);
- the frequency and types of disability claims among OIF/OEF veterans;
- the types and length of treatment likely to be needed; and hence,
- the current and longer-term costs associated with illnesses and injuries experienced by OIF/OEF veterans.

Requiring New Analysis Of Past and Current Data Sources within DoD and VA

To get a better sense of the costs likely to be faced in the next several years and for the longer term, it could be useful to require that the Department of Defense and the Department of Veterans Affairs pool their data and jointly analyze patient information data and disability claims for OIF/OEF military personnel and veterans over the past six years. Such a joint analysis could:

- compare the first Gulf War and OIF/OEF experience to date in the frequencies and severity of different types of war-related injuries and illnesses sustained thus far, using DoD and VA's ICD–9 medical codes that range from muscular/skeletal injuries to mental health problems;

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[2] Congressional Budget Office, Statement of Matthew S. Goldberg, "Projecting the Costs to Care for Veterans of U.S. Military Operations in Iraq and Afghanistan," October 17, 2007, pp. 16–17.

[3] Linda Bilmes, "Soldiers Returning from Iraq and Afghanistan: The Long-term Costs of Providing Veterans Medical Care and Disability Benefits," Faculty Research Working Papers Series, RWP07, John F. Kennedy School of Government, Harvard University, January 2007, p. 17; http://ksgnotes1.harvard.edu/Research/wpaper.nsf/rwp/RWP07-001/$File/rwp_07_001_bilmes.pdf.

[4] *Ibid,* p. 14 and 17.

[5] *Ibid,* p. 13.

[6] Email communication from Matt Goldberg, CBO, Feb. 12, 2008.

[7] *Ibid,* p. 10 and p. 14.

[8] Department of Veterans Affairs, *Fiscal Year 2008 Budget Estimate, Medical Care,* p. 9–14, February 2007.

[9] Congressional Budget Office, Statement of Matthew S. Goldberg, "Projecting the Costs to Care for Veterans of U.S. Military Operations in Iraq and Afghanistan," October 17, 2007, p. 16–17.

- compare initial and later disability ratings in the first Gulf War with those in the Iraq and Afghanistan wars and the effect on costs;
- determine the average cost of medical care received by military personnel and veterans who have served in the OIF/OEF theaters including splits by active-duty and reserve personnel, and career vs. short-term enlistees to capture the fact that the make-up of the force is significantly different for OIF/OEF and the first Gulf War;
- determine the lag between time of service and when injuries, illnesses, or disabilities first appear, when claims or medical care are received, and how long treatment is required;
- estimate the effect of Sec. 1707, Title 17, of the FY2008 National Defense Authorization Act (P.L. 110–181), which provides automatic eligibility to VA care for five years for OIF/OEF veterans, on the number and cost of treating OIF/OEF veterans eligible for VA medical care in the short and longer term;
- estimate annual, ten-year, and longer-term costs based on assumptions that reflect experience to date.

In addition, such an analysis would need to make some illustrative projections of future levels of troops deployed in Iraq, Afghanistan and surrounding areas. Given the uncertainty, the study might best run several different scenarios.

DoD and VA could analyze the data sources that both agencies have collected, exploiting their respective expertise, to estimate likely future costs of medical care, annually, in the next ten years and further into the future based on several alternate scenarios about troop levels. With such information, both agencies could better plan and estimate their requirements, and perhaps, reconcile some of the discrepancies in other estimates to date.

It would also be very useful for CBO and CRS to have access to the data and methodology in order to make an independent assessment of the projected cost and numbers of veterans who now, and may in the future rely on VA medical care or qualify for VA disability benefits.

Current Sources of Cost Data

Although the Wounded Warrior Act included in the FY2008 National Defense Authorization Act (H.R. 4986/P.L. 110–181) requires DoD and the VA to develop plans and coordinate the care of OIF/OEF veterans for transition services and treatment (e.g. for Post Traumatic Stress Disorder and Traumatic Brain Injury), and includes various reporting requirements, the Act does address the issue of the current and future cost of health and disability benefits. So, requiring an analysis like that suggested above would not appear to duplicate current requirements.

To fund the study, VA and DoD could tap funds in the Joint Incentive Fund, a program established to encourage "collaboration and new approaches to problem solving that mutually benefits both VA and DoD." [10]

I would be happy to answer additional questions and can be reached at (202) 707–7627.

Enclosure

Committee on Veterans' Affairs
Washington, DC
November 27, 2007

J. Michael Gilmore
Assistant Director for National Security
Congressional Budget Office
Ford House Office Building, 4th Floor
Washington, DC 20515–6925

Dear Michael:

In reference to our Full Committee hearing on "The Long-Term Costs of the Current Conflicts" on October 17, 2007, I would appreciate it if you could answer the enclosed hearing questions by the close of business on January 8, 2008.

In an effort to reduce printing costs, the Committee on Veterans' Affairs, in cooperation with the Joint Committee on Printing, is implementing some formatting changes for materials for all full committee and subcommittee hearings. Therefore,

[10] Title 38, section 8111 (d)(4), U.S. Code amended.

it would be appreciated if you could provide your answers consecutively and single-spaced. In addition, please restate the question in its entirety before the answer.

Due to the delay in receiving mail, please provide your response to Debbie Smith by fax at 202–225–2034. If you have any questions, please call 202–225–9756.

Sincerely,

BOB FILNER
Chairman

Responses to Chairman Filner's Questions From October 17, 2007, Hearing, "The Long-Term Costs of the Current Conflicts"
Dr. J. Michael Gilmore, Assistant Director for National Security
Congressional Budget Office

1. CBO's testimony in February before the Appropriations Committee stated that the number of veterans is expected to decline through 2025.

- What effect on the overall demographic trends in the veterans' population will veterans of OEF/OIF have? Do you still estimate that this population will continue to decline through 2025?
- Are there any long-term scenarios that CBO has looked at regarding U.S. presence in Iraq that would have a demonstrable effect on the long-term demographic trends affecting the veterans' population?

CBO estimates that the population of living veterans will continue to decline with the aging of veterans who served in World War II, the Korean War, and the Vietnam War. Neither the activation of additional reservists to serve in Iraq and Afghanistan, nor the Administration's plan to increase the size of the active Army and Marine Corps, is large enough in magnitude to reverse the decline in the size of the veterans population.

The Department of Veterans Affairs' (VA's) Veteran Population Model projects the size and demographic characteristics of the future population of veterans. In preparation for briefing the House Appropriations Committee, CBO obtained data that VA generated using that model. To estimate the future population of veterans, the model combines data from the current population with historical and projected numbers of deaths as well as separations from active duty. CBO used the projections from the 2004 version of the Veteran Population Model (documentation released in 2007).

The VA model projects that the population of veterans will decline from roughly 24 million in 2007 to about 16.5 million by 2025. Almost 700,000 veterans died in 2007, with deaths expected to decline to just over 500,000 by 2025; an average of 600,000 veterans will die each year between 2007 and 2025. Most of those deaths reflect the aging population of veterans who participated in World War II, the Korean War, or the Vietnam War.

Conversely, the number of new veterans entering the population is relatively low, largely because the size of the military is considerably smaller now than it had been in the past. The active force peaked at over 12 million service members in 1945, but averaged about 3 million in the 1960s and fell to under 1.5 million members by the late-1990s. The VA model projects that the number of separations from active duty (among both reservists and active-component members) will drop from a recent high of 290,000 in 2003 to 212,000 in 2009, then stabilize at about the latter value through 2025.

Higher activation levels of reservists due to wartime personnel demands have and will continue to increase the number of new veterans who subsequently qualify for veterans' benefits after deactivation, but not enough to close the excess of deaths over separations from active duty. The number of reservists deployed in support of OIF/OEF has totaled 450,000 through 2007 (with some additional reservists activated to backfill positions in the United States vacated by active-component members who, in turn, deployed overseas). However, over half of the activated reservists had prior active service, so they would have qualified for veterans' benefits anyway, notwithstanding their service in OIF/OEF. Thus, the incremental number of additional veterans due to OIF/OEF is around 200,000. Noting that about 200,000 service members left active duty in 2000 and again in 2001, operations in Iraq and Afghanistan have accounted for a total of about one years' worth of additional separations.

The higher-end force levels that CBO has considered to sustain operations in Iraq and Afghanistan would not affect substantially the decline in the number of veterans. Reversing that trend would require either more than 300,000 additional annual separations of active-component personnel, or that number of additional federal

activations of reservists without prior service. The Administration has announced a plan that would, by 2011, increase the size of the active-duty Army by 65,000 personnel and the Marine Corps by 27,000 personnel. Sustaining the additional 92,000 personnel would generate about 15,000 additional annual separations, CBO estimates—not nearly enough to reverse the declining population of veterans. Force levels would have to increase by about 2 million personnel—more than doubling relative to current levels—in order to generate the 300,000 additional annual separations necessary to offset the deaths of World War II, Korean war, and Vietnam-era veterans over the next decade and a half.

2. Please specify what types of data, that is not currently provided by DoD and VA, would be useful in determining costs.

DoD and the VA periodically update several reports that CBO would find helpful in determining the costs of health care and other benefits that OIF/OEF veterans receive. Those reports include:

- "GWOT Major Trauma Report"—formerly known as the "Deployment Health Report" and compiled by DoD. The report details the numbers of traumatic brain injuries (TBIs) and amputations.
- "Defense and Veteran Brain Injury Center (DVBIC) Fact Sheets." These releases detail the number of TBIs treated at DVBIC sites.
- Tabulations from DoD's post-deployment health assessment surveys of veterans returning from OIF/OEF.
- "Analysis of VA Health Care Utilization Among U.S. GWOT Veterans," Veterans Health Administration, Office of Public Health and Environmental Hazards, Department of Veterans Affairs
- "Gulf War Veterans Information System (GWVIS) Quarterly Reports," Veterans Benefits Administration, Department of Veterans Affairs
- "Veterans Benefits Activity Report: Veterans Deployed to GWOT," Veterans Benefits Administration, Office of Performance Analysis and Integrity, Department of Veterans Affairs

CBO does not currently receive on a routine basis the updates prepared to these reports.

Committee on Veterans' Affairs
Washington, DC
November 27, 2007

Honorable Gordon H. Mansfield
Acting Secretary
U.S. Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Dear Mr. Secretary:

In reference to our Full Committee hearing on "The Long-Term Costs of the Current Conflicts" on October 17, 2007, I would appreciate it if you could answer the enclosed hearing questions by the close of business on January 8, 2008.

In an effort to reduce printing costs, the Committee on Veterans' Affairs, in cooperation with the Joint Committee on Printing, is implementing some formatting changes for materials for all full committee and subcommittee hearings. Therefore, it would be appreciated if you could provide your answers consecutively and single-spaced. In addition, please restate the question in its entirety before the answer.

Due to the delay in receiving mail, please provide your response to Debbie Smith by fax at 202–225–2034. If you have any questions, please call 202–225–9756.

Sincerely,

BOB FILNER
Chairman

The Honorable Bob Filner, Chairman,
House Veterans' Affairs Committee, October 17, 2007, Long-Term Costs of the Current Conflicts

Question 1: OEF/OIF Estimates—Your FY 2008 budget request included an estimate of OEF/OIF patients of 209,308 for FY 2007 and 263,345 for FY 2008. Your testimony states that through the end of the 3rd quarter of FY 2007, your have

treated 263,909 OEF/OIF veterans, 35 percent of the total number of those separated. In light of this, what are your current estimates as to FY 2007 and FY 2008? What additional costs will the VA incur in FY 2008 for OEF/OIF veterans that were not included in your FY 2008 budget submission?

Response: The 263,939 Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) patients treated is the cumulative total of separated OEF/OIF veterans that have obtained health care from the Department of Veterans Affairs (VA) since fiscal year (FY) 2002. The numbers in the budget (209,308 in FY 2007 and 263,345 in FY 2008) represent the estimate of the number of unique patients treated in that particular year. The current number of OEF/OIF patients treated in FY 2007 was approximately one percent lower than the budget estimate.

Question 2: Infrastructure/Personnel Needs—The GAO released a report in March 2007 that recommended the VA should better monitor implementation of its Capital Asset Realignment for Enhanced Services (CARES) decisions and the impact of CARES. GAO stated that the "challenge now is to ensure that CARES becomes an ongoing and effective part of [the VA's] capital management efforts and that CARES decisions are carried out."

Question 2(a): Has the VA modified any of its capital asset advance planning to incorporate increased demand from returning service members?

Response: Yes. Capital initiatives use 20-year workload projections for developing strategies to address anticipated workload. OEF/OIF veterans are included within these workload projections; subsequently, the increased service member demand is part of all capital planning. Specific to construction planning for both Major and Minor projects, the prioritization of construction project submissions has been modified due to the anticipated returning service members to give a heavier emphasis to such issues as poly trauma, seriously mentally ill, and post traumatic stress disorder (PTSD) patients to ensure infrastructure needs are available upon their anticipated need.

Question 2(b): What has the VA done to integrate or modify the impact of returning servicemembers on its CARES projections or decisions? Response: The health care needs of OEF/OIF veterans are included in the actuarial projections that are used to identify and plan appropriate capital projects to ensure timely, high quality care to these returning service members.

Question 2(c): What specific steps is the VA taking now to deal with any possible increased infrastructure or personnel costs that it will face as a result of OEF/OIF?

Response: Medical center staff use anticipated workload based on workload projections as the basis for analyzing capital needs, which includes leases, renovation and new construction. Depending on the size and type of capital initiative, medical center staff are able to immediately address the smaller increased infrastructure demands through leases or renovations of existing medical space. Larger initiatives are part of the planning cycle and need additional funding or approval. Lease and project submissions for FY 2009 and FY 2010 have been based on anticipated workload projections, which include the increased service member demands. A number of these submissions have been through the Minor Construction program. With the additional funding for the Minor Construction program in FY 2007 and FY 2008, infrastructure demands are in process to meet the increased workload. Personnel costs associated with providing care to OEF/OIF veterans are also being addressed by each veterans integrated service network (VISN), medical center and program office.

Question 3: Long Term Benefits Impact: Admiral Cooper, I was struck by your testimony regarding the difficulty of isolating the effects on VBA of OEF/OIF veterans, especially when you state that "first-time claimants continue to be added to compensation rolls many years after military service". Are there any trends based upon VBA's past experience that may be important in attempting to get a handle as to what we might expect in the future regarding OEF/OIF claims?

Response: Projecting future demand for the OEF/OIF conflict remains difficult, largely due to the issues I identified in testimony. However, with the full implementation of VETSNET and through the use of the RBA 2000 application, VA will be able to collect long-term trend data on OEF/OIF veterans and other specific categories of veterans. The data available through the VETSNET system will allow VA to compile additional information on current veterans and make more confident projections of future needs.

The Honorable Michael H. Michaud
For Michael J. Kussman, M.D., MS, MACP, Undersecretary for Health

Question 1: Your testimony states that OEF/OIF veterans represent approximately 10 percent of all veterans with a mental health diagnosis. Do you have a

professional opinion or projection as to how high you expect that percentage to rise in the next five 2 years? Is VA tracking cost differences in treating severe PTSD as opposed to less severe PTSD?

Response: There is no reliable basis for making long term projections of the proportion of OEF/OIF veterans among all VA patients with mental disorders. There is no definitive differentiation of "severe" PTSD from other levels of the diagnosis. VA is tracking the cost difference between treating PTSD, which requires inpatient care (one meaningful index of severity), as compared to PTSD that can be managed on an outpatient basis (which can be considered "less severe"). In the past several years, there have been fewer than 10,000 veterans admitted for inpatient care annually for PTSD, as opposed to over 300,000 veterans treated as outpatients for PTSD. The average cost for a mental health admission in FY 2006 was approximately $15,000, while the average outpatient costs was about $2,500 per patient per year. It would be expected that a veteran who required inpatient care would also require outpatient care as well, raising the cost for severe PTSD according to this definition to $17,500 per patient per year. (Estimates based on data from VA databases described in Northeast Program Evaluation Center [NEPEC] Reports: Long Journey Home XIV PTSD FY 2006 Service Delivery & Performance and National Mental Health Program Performance Monitoring System FY 2006 Report)

Question 2: There will be 473 new positions in the Vet Center program by the end of FY 2009 which equates to a 50-percent increase over pre-2004 staffing levels. Do you know what mix of staff positions this represents? In other words, are they all outreach specialists or are there some Social Workers, Psychologists and psychiatrists in that increase?

Response: The total number of additional staff includes the 100 OEF/OIF veteran outreach specialists hired in FY 2004 and FY 2005 to promote early intervention through an aggressive outreach campaign by contacting new veterans and bringing them into VA for needed services. Of the new staff positions 26 are office managers assigned to each of the new vet centers to perform administrative functions. The remaining new staff positions are primarily professional, intended to augment existing vet center staff to ensure sufficient staff resources are available to provide the professional readjustment services needed by the new veterans as they return home. The mix of the latter includes social workers, psychologists, psychiatric nurse clinical specialists, and other Master degree level licensed counselors.

Question 3: The new Transition Patient Advocates assist severely injured veterans transitioning to VA from a Military Treatment Facility. VHA has 100 of them. Are these TPAs professionals such as nurses or social workers trained in case management? Any plans to grow that program and hire more of them?

Response: VA's TPAs serve as ombudsmen to assist severely ill and injured service members and their families as they transition from the Department of Defense (DoD) to VA and move through the VA system of care. The TPAs, who are located at VA Medical Centers across the country, serve as communicators, facilitators and problem solvers and provide long term assistance to severely ill and injured veterans.

The TPA is not a clinical role. Rather, TPAs are one component of the OEF/OIF case management team and work closely with the clinical members of the team, which include at a minimum a nurse or social worker program manager and nurse and social worker case managers. The program managers and case managers provide clinical case management for all severely ill or injured service members and veterans and nonseverely ill or injured OEF/OIF veterans who would benefit from case management services.

At this time, the program is adequately staffed based on the preliminary workload data using an application within the Veterans Health Administration (VHA) Vista health information system called the primary care management module (PCMM). Using PCMM will facilitate local and national tracking of severely ill and injured OEF/OIF veteran caseloads which can be used at both the local and national level to identify staffing requirements. VA is monitoring the caseloads closely and will staff positions as indicated by workload data.

Question 4: Accurate future projections to treat PTSD and TBI are critical when assessing VHA's capacity, infrastructure and staffing needs to provide quality, safe treatment to not only the returning veterans, but veterans from all past conflicts. Could you tell us today what VHA's projection is for future treatment of PTSD and TBI—taking into consideration all costs associated with that treatment?

Response: The numbers of veterans of all service eras treated by VA for PTSD have increased at an average rate of 12.5 percent per year for the past several years. This rate is relative to the number of active duty service members that discharged from the military and is not a rate that is compounding every year (there is no change in prevalence). The percentage of OEF/OIF era veterans treated for

PTSD is less than 10 percent of the overall population of veterans who are treated for PTSD; in FY 2006, 345,712 veterans were treated for PTSD, of which 27,141 were OEF/OIF era veterans. As of the third quarter of FY 2007, 14,805 additional OEF/OIF veterans received provisional diagnosis of PTSD. If this trend is maintained for the fourth quarter of FY 2007, it would result in 19,740 new OEF/OIF veterans with PTSD in FY 2007, an increase of 2,700 from FY 2006. The great majority of veterans with PTSD (over 90 percent) require only outpatient services. The average cost for a veteran to receive outpatient services in FY 2006 was approximately $2,500 per year. These rates and the associated costs (incorporating inflation) can be anticipated to continue for the next several years. VHA has enhanced overall mental health resources by over $300 million in FY 2007 to meet the influx or veterans with mental and emotional problems, of all service eras. Issues of prompt access to care of the highest quality employing evidence based practices are in place. Access and care needs are monitored in an ongoing manner to maintain efficient and effective services.

In order to project the cost of care for veterans with mild traumatic brain injury (TBI), VA is using data from the mandatory TBI screening of all OEF/OIF veterans who seek care in the VA, and follow up TBI evaluations of veterans with positive screens.

In FY 2007, 30,726 veterans received services in VA for primary or secondary TBI diagnosis at a cost of $165,889,000. Estimated costs for all treatment associated with TBI (mild to severe) in FY 2008–FY 2010 are presented in the table below:

Projected Patients With Traumatic Brain Injury/TBI Diagnosis

	FY08	FY09	FY10
Patients	34,885	38,961	42,955

Beginning in FY2009, the cost of TBI care will be submitted as a select program in all future VA budget requests. This will ensure that VA fulfills its commitment to meet the health care needs of the veteran population with TBI.

For TBI patients with moderate to severe injuries, VA projects that 10 percent of TBI patients will require long term institutional care. An additional 25 percent will benefit from some level of non-institutional care services such as home based primary care, adult day care, respite care/purchased skilled home health care, and homemaker/home health aid. The projected number of these veterans is relatively low at this time (fewer than 300). VA is actively enhancing existing programs, developing new programs, and exploring other options to meet the needs of this new generation of veterans.

VA is investing more than $150 million to further develop the capacity and infrastructure to provide the highest quality TBI care. A fifth poly trauma rehabilitation center has recently been approved for San Antonio, TX, and is currently under design. The continuum of TBI rehabilitation services in the polytrauma TBI system of care has expanded to include several new programs that provide services for veterans with different severity of TBI, and at different stages of recovery. Targeted resources have been allocated to support staffing requirements, upgrade equipment, technologies, and physical space, and to promote advanced rehabilitation practices.

For Daniel L. Cooper, Undersecretary for Benefits

Question 1: In your written statement, you state that 89 percent of OEF/OIF veterans who have filed claims have received decisions on these claims, and that 91 percent of those who received decisions were found to have service-connected disabilities. How does this match up with statistics from previous conflicts and, if there is a disparity, what factors do you believe explain this disparity?

Response: The Veterans Benefit Administration (VBA) does not have data to show how many veterans from past wartime eras filed claims or received benefits based on service in specific combat theatres. The only data available are the numbers of veterans currently receiving benefits by era of service. Valid comparisons are also made difficult because a significant number of first-time claimants from prior eras continue to be added to our rolls many years after service, along with Global War on Terror (GWOT) veterans just returning from active duty.

Question 2: In your testimony, you highlight the problems that VBA faces in quantifying the impact of returning servicemembers on VBA. Do you have plans to attempt to capture more specific data regarding OEF/OIF veterans? What additional data would you find useful?

Response: We continue to partner with 000 to receive higher quality and more timely data about OEF/OIF service members. We now receive data from the joint patient tracking application, which provides us information about service members very shortly after their initial injuries. Additionally, we are partnering with 000 on a single examination pilot initiative that will allow us to obtain and analyze data on veterans undergoing the medical evaluation board and physical evaluation board processes.

With the full implementation of VETSNET and through the use of the RBA 2000 application, VA will be able to collect long-term trend data on OEF/OIF veterans and other specific categories of veterans. The data available through the VETSNET system will allow VA to compile additional information on current veterans and make more confident projections of future needs.

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