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EXAMINING THE LIFETIME COSTS OF SUPPORTING THE NEWEST GENERATION OF VETERANS

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

ONE HUNDRED TWELFTH CONGRESS

FIRST SESSION

JULY 27, 2011

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C O N T E N T S

JULY 27, 2011

SENATORS

	Page
Murray, Hon. Patty, Chairman, U.S. Senator from Washington	1
Brown, Hon. Scott P., U.S. Senator from Massachusetts	3
Tester, Hon. Jon, U.S. Senator from Montana	4
Johanns, Hon. Mike, U.S. Senator from Nebraska	4
Begich, Hon. Mark, U.S. Senator from Alaska	5
Isakson, Hon. Johnny, U.S. Senator from Georgia	55
Boozman, Hon. John, U.S. Senator from Arkansas	57

WITNESSES

Rieckhoff, Paul, Executive Director, Iraq and Afghanistan Veterans of America	7
Prepared statement	9
Posthearing questions submitted by Hon. Mark Begich	12
Hosek, James, Senior Economist, RAND Corporation	12
Prepared statement	14
Nicely, Crystal, Caregiver and spouse of OEF veteran	18
Prepared statement	20
St. James, Lorelei, Director, Physical Infrastructure Issues, United States Government Accountability Office	22
Prepared statement	23
Posthearing questions submitted by Hon. Patty Murray	27
Response to request arising during the hearing by Hon. Patty Murray	59
Golding, Heidi L.W., Principal Analyst for Military and Veterans' Compensation, Congressional Budget Office	27
Prepared statement	29
Posthearing questions submitted by Hon. Patty Murray	49

APPENDIX

Wersel, Vivianne Cisneros, Au.D., Chair, Government Relations Committee, Gold Star Wives; prepared statement	67
Sullivan, Paul, Executive Director, Veterans for Common Sense; letter	72
Whitehouse, Sheldon; prepared statement	77

EXAMINING THE LIFETIME COSTS OF SUPPORTING THE NEWEST GENERATION OF VETERANS

WEDNESDAY, JULY 27, 2011

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 10:04 a.m., in room 562, Dirksen Senate Office Building, Hon. Patty Murray, Chairman of the Committee, presiding.

Present: Senators Murray, Tester, Begich, Isakson, Johanns, Brown of Massachusetts, and Boozman.

OPENING STATEMENT OF HON. PATTY MURRAY, CHAIRMAN, U.S. SENATOR FROM WASHINGTON

Chairman MURRAY. Good morning, and welcome to today's hearing where we are going to examine the lifetime costs of supporting our newest generation of veterans.

As we all know, when our Nation goes to war, it is not just the costs of fighting that war that must be accounted for. We must include the cost of caring for our veterans and families long after the fighting is over. And that is particularly true today, at a time when we have more than half a million Iraq and Afghanistan veterans in the VA health care system. That is an over 100 percent increase since 2008.

This presents a big challenge, and one that we have no choice but to step up to meet if we are going to avoid many of the same mistakes we saw with the Vietnam generation. But it is more than just the sheer number of new veterans that will be coming home that poses a challenge for the VA. It is also the extent of the wounds, both visible and invisible, and the resources it will take to provide our veterans with quality care.

Through the wonders of modern medicine, servicemembers who would have been lost in previous conflicts are coming home to live productive and fulfilling lives. But they will need a lifetime of care from the VA.

Today, we will hear from the Congressional Budget Office, the Government Accountability Office, the RAND Corporation, and Iraq and Afghanistan Veterans of America in an effort to help us quantify and understand these costs and to ensure that we can meet the future needs of our veterans and their families.

And today we are so fortunate to be joined by one of those brave family members, Crystal Nicely, who is not only a wife but also a

caregiver to her husband, Marine Corporal Todd Nicely. Todd was seriously injured by an IED in the southern Helmand Province of Afghanistan. Since that time, he has come home to fight every day, focus on his recovery, and I even heard yesterday that he is already starting to drive again, and I want to take a moment to say thank you so much for your service to our country. You have shown bravery not only as a Marine in Afghanistan, but also through the courage you have displayed during your road to recovery.

I invited Crystal here today because I think it is incredibly important that we hear her perspective. The costs we have incurred for the wars in Iraq and Afghanistan—and will continue to incur for a very long time—extend far beyond dollars and cents.

When I first met Crystal last month while touring Bethesda Naval Base, her story illustrated that. Crystal is here today to talk about the human cost, and that cost is not limited exclusively to the servicemembers and veterans who fought and are fighting our wars, but it is also felt by the families of these heroes who work tirelessly to support their loved ones through deployments and rehabilitation day in and day out. Many, like Crystal, have given up their own jobs to become full time caregivers and advocates for their loved ones.

Last month, while testifying before the Senate Appropriations Subcommittee on Defense, Chairman of the Joint Chiefs of Staff, Admiral Mullen, told me that "without the family members we would be nowhere in these wars." I could not agree more; and after you hear Crystal's story, that will be even more clear.

As the Members of this Committee know, over the course of the last few hearings we have examined how the veterans of today's conflicts are faced with unique challenges that VA and DOD are often falling short of meeting.

We have explored mental health care gaps that need to be filled, cutting-edge prosthetics that must be maintained, a wave of new and more complex benefit claims that are taking too long to complete, the need to fulfill the promise of the Post-9/11 GI Bill, and the need to support veterans who are winding up out-of-work and on the streets.

All of these unmet challenges come with costs. Some costs we will be able to calculate. Some will not be fully known for decades.

But today's hearing will be a reminder that in order to meet these costs we must safeguard the direct investments we make in veterans care and benefits. We must get the most value out of every dollar we spend, and we must start planning today at a time when critical long-term budget decisions are being made.

As we all know, there is no question that we need to make smart decisions to tighten our belts and reduce our Nation's debt and deficit. But no matter what fiscal crisis we face, no matter how divided we may be over approaches to cutting our debt and deficit, no matter how heated the rhetoric in Washington D.C. gets, we must remember that we cannot balance our budget at the expense of the health care and benefits our veterans have earned.

Their sacrifices have been too great. They have done everything that has been asked of them. They have been separated from their families through repeat deployments. They have sacrificed life and limb in combat. They have done all of this selflessly and with

honor. And the commitment we have to them is non-negotiable, not just today but far into the future.

So, thank you all of our witnesses for being here today and our Committee Members. I will now turn to Senator Brown for his opening statement.

STATEMENT OF HON. SCOTT P. BROWN,
U.S. SENATOR FROM MASSACHUSETTS

Senator BROWN OF MASSACHUSETTS. Thank you, Madam Chair, for holding this important hearing. I want to recognize Corporal Nicely and his wife Crystal for taking time and obviously, Crystal, for you to be here and for your devoted service to our country and the Corp.

As you know, today we are here also to discuss the resources the VA will need in the future to care for current generations of wounded warriors and, as the Chairwoman noted, out of the total of 2.3 million servicemembers who have been deployed, 45,000 have been wounded in action; and as we look to the future and beyond for the next 10 years, it is important to understand where we have been and what we have learned because, as over the last 10 years, we have seen a large increase in the VA's medical care accounts. And since 2001, the VA medical care budget has grown by $27 billion or 130 percent.

Last October, the Congressional Budget Office published an analysis on this topic, and their analysis indicates that, you know, we have some very real challenges coming up; and we all agree that we must provide the funding needed to support this generation of wounded warriors and continue caring for those who have previously borne the visible and hidden scars of war.

And as you know, this morning we will hear from Crystal, the wife of a wounded warrior, and her husband Todd who was severely injured in March 2010 when he stepped on IED while on patrol in Afghanistan that left him as a quadruple amputee.

He has been able to move on with his life somewhat and yet he ran into and, I believe, continues to run into bureaucratic hassles and delays in trying to complete the integrated disability evaluation system, a process that was supposed to alleviate these types of problems. And if a prompt determination cannot be made for someone who has lost all four limbs, what hope is there for the others who have lesser wounds or invisible wounds.

Members of the RAND Corporation will talk about the gaps in access to mental health services at the VA, in particular the long wait times for appointments.

I am disappointed, however, that the VA, our friends at the VA, will not be here to offer their testimony. I am sure we will follow up with them, Madam Chair, with your leadership.

There are a few problems. These are just a few problems that we have and they continue to persist. As we have all learned as Members of the Committee and have all noted these throughout our time here.

So, we have to look at the costs for caring for injured troops, and we should keep in mind that money cannot be the only solution to the problems that they face. If that were the case, Corporal Nicely

would have breezed through the IDES process, and Loyd Sawyer would have gotten an appointment at the VA without any delay.

With our country's current financial crisis, we need to reassess every dollar that we spend to make sure that it is being used effectively to deliver the services and benefits that our wounded warriors and veterans need in order to give them an opportunity to live healthier and more productive lives.

So, thank you, Madam Chair. I look forward to hearing the testimony.

Chairman MURRAY. Thank you very much, Senator Brown.

Senator Tester.

STATEMENT OF HON. JON TESTER,
U.S. SENATOR FROM MONTANA

Senator TESTER. Well, thank you, Madam Chairman. I want to thank you for convening this hearing.

I want to welcome all the witnesses. I very much appreciate you all being here. I am going to single out Paul Rieckhoff. Thank you very much for being here, but more importantly thank you for your advocacy for the veterans. I very much appreciate it. You have been a bulldog.

Crystal Nicely, thank you very, very much for being here. We always say when a soldier goes to war, their spouse goes with them and their family goes with them too. We appreciate you being here to tell your story. It is going to be a great perspective to hear.

The welfare of the young men and women who defend this country is always at the forefront of our minds and the question whether to send them into harm's way to begin with is something that can never be taken lightly. In doing so, we have to prepare ourselves for the human and the monetary costs of these decisions.

It is not just about providing the troops armaments and the equipment that they need and the tools they have to be successful in their missions, it is about ensuring that we are fully capable of caring for them and their families when they return home.

To quote the VFW commander, "The day this Nation cannot afford to take care of her veterans is the day this Nation should quit creating them."

A very true statement. Something we should keep in mind as our veterans come home in need of care with injuries both seen and unseen.

I very much look forward to this hearing and I appreciate, Madam Chair, you convening these folks.

Chairman MURRAY. Thank you very much.

Senator Johanns.

STATEMENT OF HON. MIKE JOHANNS,
U.S. SENATOR FROM NEBRASKA

Senator JOHANNS. Madam Chair, let me also express my appreciation, and thank you for having this hearing.

To the members of the panel, thanks for being here and thanks to your commitments.

Let me, if I might, just associate myself with comments that have been made both by the Chair and by the Ranking Member. I believe they are hitting the nail on the head.

In my view of the world, part of the cost of war is caring for our veterans. There will be a point at which the uniform is set aside and they come home and need to find a place if you will. If they have medical needs, then we need to find a way to address those needs.

One of the things that is also enormously perplexing to me is the inability to transition so many veterans into the workforce. I appreciate the economic times are difficult and challenging. We all know that, but it is so disheartening when I talk to veterans and I go around the room and try to figure out where they are out in their life and how they are transitioning into the workforce.

So many of them say, well, I have not been able to find a steady job. And the remarkable thing for me is that is in a State where our unemployment is actually quite low, 4.1 percent.

So, if I might just cue something for those who are going to testify today and maybe, Paul, I will point to you specifically. I am especially interested to hear testimony about the challenges our veterans are experiencing in transitioning from military life into a civilian job. It just seems to me we can do a better job here.

I know that Hiring A Hero Act includes several provisions to address these issues. That is good. I applaud any efforts that have been made that might make this situation a little bit better, but I am especially interested in where we are not meeting the issues of training and in some cases rehabilitation so veterans can be prepared to enter the workforce.

With that, to all of you who advocate for veterans to those who have served and those families who have been such an important part of that service, I do want you to know how much I appreciate your commitment to our country.

Thank you, Madam Chair.

Chairman MURRAY. Thank you.

Senator Begich.

STATEMENT OF HON. MARK BEGICH,
U.S. SENATOR FROM ALASKA

Senator BEGICH. Thank you very much, Senator Murray, for putting this forum together today, and I want to thank the witnesses for being here. I will not be able to stay. I have to chair an Oceans, Fisheries, and Coast Guard Subcommittee hearing in about 12 minutes.

But I want to at least let you know, first, I received all of your written testimony. I appreciate that. I have some questions that I will submit for the record.

I will tell you, in my short time here in the Senate as a Member of this Committee, I have heard the incredible testimony from our brave warriors and families over the last two and a half years, and I want to be clear that examining the lifetime costs in supporting this new generation of veterans does not mean that we will not be there for you. You answered the call of duty. You have been there for our country, and we will be there for you.

The costs that veterans and the families have suffered as the consequences associated with the scars of war, both financially and emotionally, place burdens that can last a lifetime.

With Alaska having the highest number of veterans per capita of any State in this country, I have seen these impacts firsthand, and I will tell you what I tell every time I see a veteran when I am at home, "Thank you, thank you, thank you for the service and the sacrifice, not only as an individual but also as a family. And we promise to continue to fight every day to do what we can to make sure that those services are there."

One of the issues that I will submit for the record for you all hopefully to answer is the question that I know I face, like Senator Tester, and Senator Johanns with rural veterans, veterans that have an extremely difficult time accessing health care.

More and more veterans are choosing to live in rural communities. In my State, 80 percent of the rural communities cannot be accessed by road. So, it is very difficult for them to access the health care they need. It may be physical or mental services that they may need.

I think I would be interested in your comments, if you have them, that you can put on the record again or I will submit as I am for the record a written question about how do we figure out the access points to ensure that the quality care no matter where you live as a veteran, it does not matter if you live in a small village in Alaska of 50 people or a large urban city, how we make sure we get the health care they need, they are owed in a timely basis.

So, I would be anxious for your comments. I know it is a question that we have a piece of legislation we are talking about, the Alaska Heroes Card, to create some access points again for roadless areas that are just impossible for our veterans to get the quality service they need. So, I would be interested in your comments on that.

Again, Madam Chair, thank you for holding this important hearing because, as we engage in wars, it is a two-parts cost. One is the action of the war and the actions after. And sometimes, and I can tell you as a new Member here, my personal opinion is when we engaged in the wars of Iraq and Afghanistan, not a lot of people thought about the next cost.

And so, I am glad this hearing is here. It is a commitment we have to make, and it is owed to the veterans and the families of veterans. So, thank you again for all of you being here. And again, thank you, Madam Chair.

Chairman MURRAY. Thank you very much.

So at this time we will now turn to our witnesses. We will first hear from Mr. Paul Rieckhoff, the Executive Director and founder of Iraq and Afghanistan Veterans of America.

Next we will hear from Dr. James Hosek, a senior economist from the RAND Corporation. We will then hear from Mrs. Crystal Nicely who, as I mentioned in my opening statement, is a caregiver and spouse of an Operation Enduring Freedom veteran.

Following her testimony, we will hear from Mrs. Lorelei St. James, the Director of Physical Infrastructure for the Government Accountability Office; and closing out our panel this morning will be Mrs. Heidi Golding, who will be testifying on behalf of the Congressional Budget Office. She is CBO's principal analyst for military and veterans' compensation in the National Security Division.

So thank you again to all of you for being here this morning for this important hearing.

Mr. Rieckhoff, we will begin with you.

STATEMENT OF PAUL RIECKHOFF, EXECUTIVE DIRECTOR, IRAQ AND AFGHANISTAN VETERANS OF AMERICA

Mr. RIECKHOFF. Thank you, Madam Chair, Members of the Committee. On behalf of IAVA, Iraq and Afghanistan Veterans of America, and over 200,000 of our members and supporters, many of whom are here today, thank you for inviting us to testify on the long-term costs of war for our generation of veterans.

I served in Iraq from 2003 to 2004 as a platoon leader with the Third Infantry Division. When my unit returned and I came home from war, we returned to a country confused by and a bit uncomfortable with its warriors. People wanted to help. They just did not know how. So bringing to light the true costs of these wars is part of the reason we formed the IAVA in a cramped studio apartment back in 2004.

This hearing comes at a critical time. Right now our Nation teeters on the edge of default and servicemembers and veterans are left concerned and a bit scared.

IAVA members from across the country have contacted us in the past few days. They still do not know if they will get disability, retirement, GI Bill checks that day so rightfully earned, or even their base pay. They have enough to deal with already, and they deserve the answers to these questions. It is up to Congress and the President to get us these answers.

But we are here today to examine the lifetime costs of this new generation of vets, and I will start with the bottom line up front, something I learned to do in the Army. It is going to be expensive and it is going to be complex, but history shows us that it will be less expensive and less complex if we invest as a Nation in our veterans now.

Doing so also has the added bonus of cultivating a new generation of leaders, future teachers, doctors, CEOs, and maybe even a few Members of Congress. They will lead our Nation the only way they know how, from the front.

The current condition of new veterans' readjustment into civilian society is not pretty. Officially, 13.3 percent are unemployed as of this past June, more than 4 percentage points higher than the national average.

We see numbers in our membership closer to 20 percent. In Indiana, it is 24 percent. In Michigan, it is nearly 30 percent. Nationwide that means approximately 260,000 people in real numbers are out of work. That is about the same size as the entire Marine Corps.

It does get worse. The military and veterans communities also are facing a suicide epidemic. In 2010 alone, there were 468 suicides throughout the military. It is estimated between 2005 and 2009 one servicemember committed suicide every 36 hours, and more committed suicide in 2010 than died in combat.

These numbers, while bleak, are really just the tip of the iceberg. The legacy of these wars will be the cumulative impact of the multiple deployments year after year, a burden of many carried by few.

And as these wars wind down, the military will likely downsize just as it has done in all postwar periods.

A new surge of veterans is already returning to local communities nationwide and cost will be a word thrown around a lot. Investment, though, probably will not be and it should be because these are not just costs; they are investments.

This Committee and the public sector in general have done many good things for new veterans returning home. The best example, of course, was the Post-9/11 GI Bill, which has provided close to 500,000 returning servicemembers with educational opportunities they otherwise they would not have dreamed of, and the exciting and urgently needed Hire Heroes Act, which the Members of this Committee are certainly familiar with, proves that you have not rested on your laurels.

This bill can and should be the first jobs bill passed by this Congress. But legislation and government can only do so much. The private sector must do its part too. Companies that commit to hiring veterans will find it is not charity. It is a smart investment. It is good for their bottom line.

Veterans are entrepreneurial by nature; and although they represent less than 1 percent of Americans, 9 percent of American firms are veteran owned. Many have specific skills that relate directly to the civilian trades: logistics, operations, communications, medicine and engineering.

If folks really want to support the troops, they should hire them. Something companies and organizations have already realized. For example, IAVA has been proud to partner with companies like Google, JCPenney's, CBRE, Schwab, and the Chamber of Commerce in efforts to turn the tide on veteran employment.

These are not just government problems or business problems or nonprofit problems; they are American problems. Take the experience of specialist Nick Colgin.

While serving in Afghanistan with the 82nd Airborne Division as a medic, Colgin proved himself over and over again. He saved the life of a French soldier that was shot in the head and was ultimately awarded a Bronze Star for his actions over the course of his deployment. He also suffered a Traumatic Brain Injury due to an RPG attack.

He was honorably discharged 2 months after he left the war. Unable to find a job anywhere in the medical field, he was looking to work as a first responder, which was the equivalent of what he did overseas, but employers said he lacked the proper certificates.

While waiting many months for the VA to process his disability claim, he was forced to collect unemployment checks to make ends meet. But Colgin turned things around. The VA eventually did process his disability claim. He got the right paperwork to be a first responder; and after using some of the GI Bill benefits, he will begin his senior year at the University of Wisconsin Stevens Point this fall.

Not all new veterans have the happy ending of a Nick Colgin, though sometimes we must all remember as we plan for the future. Long-term it is estimated the cost of these wars will be between $600 billion and $1 trillion.

Those are imposing numbers to be sure especially in this time of economic recession and spiraling debt. Those numbers will only increase with time if we slash veterans programs in the shortsighted rush.

The costs are clear and they are tremendous but so are the sacrifices that our men and women have made for our Nation and so is the potential for return.

Before I deployed to Iraq, I worked on Wall Street. If I were analyzing the potential return on this investment, I would say my generation gets a strong buy rating. Investing in the innovation generation is like buying shares of Apple in 1980. I am here to tell you to put your money where your mouth is. Please invest in this generation. We are worth it. We will deliver, and we will not let America down. We never have, and we never will.

Thank you for your time, and I look forward to your questions.

[The prepared statement of Mr. Rieckhoff follows:]

PREPARED STATEMENT OF PAUL RIECKHOFF, EXECUTIVE DIRECTOR AND FOUNDER, IRAQ AND AFGHANISTAN VETERANS OF AMERICA

Chairman Murray, Ranking Member Burr, and Members of the Committee, on behalf of Iraq and Afghanistan Veterans of America's over 200,000 Member Veterans and supporters, thank you for inviting us to testify on the long-term costs of war for our new generation of vets.

My name is Paul Rieckhoff and I am the Executive Director and Founder of IAVA. I served in Iraq from 2003 to 2004, as an infantry platoon leader in the U.S. Army National Guard. When my unit and I returned home from war, we returned to a country confused by and uncomfortable with its warriors. People wanted to help, they just didn't know how. Bringing to light the true costs of these wars is part of the reason we formed IAVA in my cramped New York studio apartment in 2004.

We are here to "Examine the Lifetime Costs of a New Generation of Vets." I'll start with the bottom line up front, something I learned in the Army—it's going to be expensive. And it's going to be complex. But history shows us that it will be less expensive and less complex if we as a nation invest in our veterans now. Investing in these brave men and women now has the added bonus of cultivating a new generation of battle-born leaders, future teachers, doctors, business leaders and maybe even a few Members of Congress, that will lead our Nation the only way they know how—from the front. The alternative—missing critical investments, shortchanging their benefits and services—will cost our country terribly.

The current condition of new vets' readjustment into civilian society isn't pretty. Officially, thirteen-point-three (13.3) percent are unemployed as of this past June, more than 4 percentage points higher than the national average. We see numbers in our membership closer to 20%. In Minnesota the number is 22.9%. In Indiana, 23.6%. And in Michigan, it's 29.4%. So nationwide, that means approximately 260,000 people in real numbers are out of work—about the same size of the entire Marine Corps. To use a military term, that is un-sat.

Not only are younger veterans at a greater risk of homelessness than the general population, but even when compared to the older veteran population, their risk is higher. Over 11,000 homeless vets officially listed as homeless in 2009 were between the ages of 18 and 30. That's a full Army Division.

It gets worse. The military and veteran community is also facing a suicide epidemic. In 2010 alone, there were 468 suicides throughout the military. It's estimated that between 2005 and 2009, 1 servicemember committed suicide every 36 hours. And more committed suicide in 2010 than died in combat. But that's just part of the mental health problem, because once individuals separate from the military, it's impossible to track them unless they enroll in the VA—something only 51 percent of separated OIF and OEF veterans have done.

And these numbers, while bleak, are really just the tip of the iceberg. The legacy of these wars will be cumulative impacts of the multiple deployments, year after year; a burden of many carried by few. Personal issues that are delayed for the needs of a unit can be put off temporarily, for another deployment, but they can't be put off forever. As these wars wind down, the military will likely downsize, just as it has done in all postwar periods. As a result, this new surge of veterans is already returning to local communities nationwide. Those initial months back home

are key to the transition process; veterans will either return home to a job opportunity or an unemployment check, either have their own roof over their head or move from shelter to shelter, and either feel included in the community they fought for or feel isolated from it. And our Nation will either repeat the mistakes of the way we treated veterans after Vietnam, or it will turn the page. The public, private, and nonprofit sectors must work together to ensure it's the positive return our servicemembers experience—and not the slap in the face of patchwork or non-existent real support.

This Committee, and the public sector in general, have done many good things for new veterans returning home. The best example, of course, was the Post-9/11 G.I. Bill in 2008, which has provided close to 500,000 returning servicemembers with educational opportunities they otherwise wouldn't have dreamed of. In 2009, advance funding for VA healthcare was passed into law. In 2010, the Caregivers Bill joined it. And the exciting and urgently needed Hiring Heroes Act, which the Members of this Committee are certainly familiar with, proves that you haven't rested on your laurels this year. This bill can and should be the first jobs bill passed by this Congress.

Creative thinking for these complex issues is being used off of Capitol Hill, too. Veterans' courts are a great example. Designed to try cases of non-violent offenses and to deal with the invisible wounds of war, over 59 courts have been established since 2008, spanning at least 24 states. As part of the sentencing process, veterans in these courts agree to appropriate treatment that can include mentoring sessions and counseling. And it works. Big time. Of the veterans enrolled in the first year of the original veterans' court in Buffalo, New York, roughly 90 percent successfully finished it and none have committed any more crimes.

But legislation and government can only do so much. The private sector must do its part, too. Companies will need to play a huge role in the hiring of new vets. That can't happen in a meaningful way until civilian employers better understand how military service and skill-sets translate into the civilian sector—something 60 percent of human resource managers said was a challenge. The civilian and military divide is very much alive, and it's a shame. Companies that commit to hiring veterans will find it's not charity. It's a smart investment. Vets are entrepreneurial by nature; although they represent less than 1 percent of Americans, 9 percent of American firms are veteran-owned. And yet the unemployment numbers for Iraq and Afghanistan veterans continue to rise. If folks really want to support troops, they should hire them—something some companies and organizations have already realized. For example, IAVA has been proud to partner with leaders like Google, J.C. Penney, CBRE, Schwab and the Chamber of Commerce, in efforts to turn the tide on vet unemployment.

Jobs are the horse that drives this cart of solutions. The U.S. Government invested hundreds of thousands, if not millions, of dollars and training in these men and women for war. Many have specific skills that relate directly to civilian trades, such as logistics and operations, communications, medicine, and engineering. And they have worked in teams with a mission-focused approach, and in dynamic, high-stakes environments that require flexibility and adaptation. They are entrepreneurial. They are innovative. And they are tough. As a society with an all-volunteer force, and one trying to invigorate our economy, we have an obligation (and an opportunity) to seek out these incredibly valuable civic assets, and engage and empower them in our domestic workforce. They've had our back overseas. When times were tough, they delivered for America. And they can do it again back home.

These aren't just government problems, or business problems, or nonprofit problems. They are American problems. Take the experience of Army Specialist Nick Colgin. While serving in Afghanistan with the 82nd Airborne Division as a combat medic, Colgin proved himself over and over again. He saved the life of a French soldier that was shot in the head. His quick decisionmaking also led to 42 locals being rescued from a flooding river, and he was ultimately awarded the Bronze Star for his actions over the course of his deployment. He also suffered a Traumatic Brain Injury due to an RPG-attack on his convoy.

Colgin was discharged honorably from the Army two months after he returned from war. He was unable to find a job anywhere in the medical field. He was looking to work as a first responder in Wyoming, which was the equivalent of what he did overseas, but employers said he lacked the proper credentials and certificates. While waiting for many months for the VA to process his disability claim, he was forced to collect unemployment to make ends meet. He readily admits to having serious readjustment issues, something brought on by a sense of isolation, a lack of daily purpose like he found in the military, and a lack of structural support for new vets in his community.

But Colgin got things turned around. While the private sector failed him, the public sector did eventually process his disability claim (but after he waited for six months). He also got linked up with nonprofits like ours and the Wounded Warrior Project, where, on a fishing trip, he came face-to-face with veterans "like him" for the first time. This had a very positive effect on him, he said, as he realized that it was OK that the war had changed him. He eventually got the right paperwork to be a first responder, after using some of his New G.I. Bill benefits, and will begin his senior year at the University of Wisconsin-Stevens Point in the fall. Not all new veterans have the happy ending of a Nick Colgin, though. It's important to remember that those numbers I referenced earlier are living, breathing people just like Nick, or anyone at this testimony, with hopes and dreams and ambitions of their own. And every single one will have a cost. But every single one is worth it.

Folks, we are at a crossroads in terms of veterans care. We can turn to history for some guidance on what to do and what not to do. World War II veterans returned to a nation fully engaged and invested in the war effort. Ticker-tape parades occurred across the country to celebrate the vets' victories in Europe and the Pacific. VA loans for homes and farms were made available at low interest rates. Approximately 50 percent of the "Greatest Generation" of veterans used their educational benefits provided by the original G.I. Bill. All of this played a huge role in the economic prosperity of the post-World War II years.

Compare that, then, to Vietnam. Instead of returning to parades celebrating their sacrifices, they came home one by one in the middle of the night, all too often hiding their uniforms and crew cuts. The struggles to transition back home didn't end there. Long after the end of that war, in the 1980s, Vietnam vets earned about 15 percent less than their civilian counterparts. And even as late as 1991, they made up 49 percent of the veteran inmate population. While factors like these did lead to the formation of some wonderful nonprofit organizations, like our friends at Vietnam Veterans of America, the overall contrast of their experience with that of the World War II generation couldn't be more evident. They deserved better. And they've fought to ensure guys like me have gotten it. But we still have a long way to go.

Which brings us to today, when a new group of 2.3 million combat-tested veterans return home from their own battles abroad. American society has finally learned to separate politics from the warrior. There's a "sea of goodwill" for the returning vet, which is a great thing. But now comes a harder task—tapping into that sea, channeling it, directing it into supporting the troops in a meaningful, lasting way. Into more than just yellow ribbons and care packages.

Long term, it's estimated that it'll cost between $600 billion and $1 trillion to care for them alone. Those are imposing numbers, to be sure, especially in this time of an economic recession and spiraling debt. But those numbers will only increase with time if we slash veteran program funding in a shortsighted rush.

But of course paying the bills is only a part of the solution. In 2010, the U.S. Government spent $57.5 billion on veterans' benefits. The government programs that used that money can only ask the following question: was that money spent as efficiently and deliberately as possible? As these vets learned trying to rebuild villages and cities in Iraq in Afghanistan, money itself is a weapons system. But it's a precision weapon, not an area weapon, and we'd all be wise to remember that as we go forward.

The Department of Defense has recently explored various "resiliency models" for its servicemembers and families, most notably the Army's Comprehensive Soldier Fitness program. The stated goal of this program is to "master the skills necessary to achieve balance in their lives and build resilience in order to thrive in an era of high operational tempo and persistent conflict." This is a great example of the military's can-do spirit and something that can be—and should be—applied to their lives after they leave the military. But the right tools and training need to be available for that to happen. It's a tough world out there right now, for everyone, vets and civilians alike. But this country will bounce back, just like it always has in times of difficulty. And it will be the military veterans that lead the way. The stage is set for the Next Greatest Generation—the Innovation Generation—if, during this formative time in their lives, the proper resources are provided for them to reach their full potential. Investing in Iraq and Afghanistan veterans now saves us money in the future and plants the seeds for continued national prosperity. We are at the crossroads. Now, where do we go? Will we make the easy turn and slash veteran program funding, or the hard turn, and invest in the future?

The costs are clear. And they are tremendous. But so is the sacrifice these men and women have made for our Nation. And so is the potential for return. Before I deployed to Iraq, I worked on Wall Street for a bit. And if were analyzing the potential for return on this investment, my generation of veterans would get a "strong

buy" rating. Investing in the Innovation Generation is like buying shares of Apple stock in 1980.

In some ways, the battles on the homefront will be more challenging than those fought in Iraq and Afghanistan. If there were an easy way to reincorporate the 1 percent into the other 99 percent, someone would've done it by now. But that doesn't make it impossible. We're up to the challenge, America has done it before. But it's going to take everyone, from Capitol Hill to Wall Street to Main Street, to make it happen.

The upside is huge. And the time is now. And we are the closest thing you'll ever have to a sure thing in this town. On behalf of our generation of veterans around the world, I am here to tell you to put your money on the table. We are worth it. We will deliver. We won't let America down. We never have and we never will.

Just watch.

Thank you for your time. I look forward to your questions.

POSTHEARING QUESTIONS SUBMITTED BY HON. MARK BEGICH TO PAUL RIECKHOFF, EXECUTIVE DIRECTOR AND FOUNDER, IRAQ AND AFGHANISTAN VETERANS OF AMERICA

Question 1. In examining the long-term costs we cannot forget the rural veterans. You may know that I introduced an Alaska Hero's Card which would offer Alaska veterans services in their most rural communities. I recently visited the Sunshine Clinic in Talkeetna, Alaska, over a hundred miles from Anchorage. They told me they are getting a lot of new rural vets. These young vets are more and more coming back and settling into rural areas.

• Do you have any suggestions or do you know of plans regarding how the VA is going to take care of so many vets that live far away from a VA facility?

[Responses were not received within the Committee's timeframe for publication.]

Chairman MURRAY. Thank you very much, Mr. Rieckhoff.

Dr. James Hosek.

STATEMENT OF JAMES HOSEK, SENIOR ECONOMIST, RAND CORPORATION

Mr. HOSEK. Thank you. I would like to thank Chairwoman Murray, Ranking Member Burr, and the Committee for the opportunity to testify.

During the nearly 10 years since 9/11 more than 2.2 million active and reserve members have been deployed. Hallmarks of the era are the growing public recognition of the stresses borne by servicemembers and their families, and the invisible wounds that can haunt servicemembers who deployed.

In my written testimony, I have given an overview of RAND's of studies on deployment, and this morning I hope to highlight selected findings.

These touch on the following topics: The importance of total months on deployment in understanding the effects of deployments, the prevalence of PTSD and major depression among those who have deployed, the barriers to care they face, the importance of providing evidence-based care, and unemployment.

In our research we found that extended length of deployment can have family and societal impacts ranging from the financial and emotional stress of increased divorce rates, academic and emotional consequences for children, to burdens of reduced reenlistment within the Armed Services. Here are some specifics.

Exposure to combat trauma is the single best predictor of PTSD, major depression, and Traumatic Brain Injury, and the chance of exposure increases with months deployed.

High months of deployments put negative pressure on Army and Marine Corps reenlistment that they countered with bonuses. This meant that personnel with high months of deployment who otherwise would have left were kept in service and were at risk of further deployment and exposure to combat trauma.

We found that military divorces increase with total months of deployment. Deployment probably causes additional divorces among veterans but this has not been studied.

More months of deployment were associated with more behavioral and emotional problems for children. For instance, 30 percent of the children had elevated symptoms of anxiety, twice the rate found in other studies. We do not know if children's problems abate when the servicemember leaves the military and becomes a veteran.

We found that almost one in five returning servicemembers has symptoms of PTSD or major depression, problems that may affect veterans for years to come.

In our survey, 18.4 percent of all returning servicemembers in the spring of 2008 met criteria for either PTSD or major depression. Applying this percentage to the 2.2 million servicemembers who had deployed by last September implies that 405,000 met criteria for PTSD or depression. We do not know the lifetime prevalence of these problems as some will develop later and others may diminish.

Servicemembers and veterans in our studies reported barriers to care. Efforts are underway to reduce these barriers but more research may be needed on why veterans do not seek care and what might induce them to do so.

We found that about half of those with probable PTSD or depression had not sought care in the prior year. Their reasons include concerns about confidentiality, potential negative career repercussions if care was sought, long wait times, and the side effects of medications.

Other barriers were the diverse, seemingly disorganized and incomplete sources of information about where to seek care, what services were available, who was eligible and how to apply.

Further, much of the care provided was not evidence-based care. Evidence-based care is care that statistical analysis has shown to be effective. Of those who had PTSD or depression and sought treatment, just over half received minimally adequate treatment, and the number who received evidence-based care would be even smaller.

In our cost analysis, we found that delivering high-quality, evidence-based care to all veterans who have PTSD or major depression would save money on net for society and improve the outcomes for those treated.

Finally, veterans' transitions from the military to nonmilitary life often involve finding a job or going to school. As many realize, steps to assist in job search or in obtaining educational benefits can make the transition smoother.

RAND studied unemployment among returning reservists. We found that many chose not to return to their pre-activation jobs but instead drew unemployment compensation for ex-servicemembers.

Although aimed at helping reservists who did not have a job, these benefits were also helping reservists to search for better positions.

Also, we have identified difficulties in the early implementation of the Post-911 GI Bill. This research may help the VA and institutions of higher education focus their efforts to make these benefits more accessible and easier to use. It would be helpful to have research taking an integrated view of the job search, education, and health care of servicemembers who are transitioning from the military, particularly those with behavioral health conditions. Studies in this area, including RAND studies, have not taken an integrated view.

Thank you once again for the opportunity to address the Committee. I hope that RAND's work on these subjects can be helpful to the Committee in fulfilling its important mission of serving our Nation's veterans.

[The prepared statement of Mr. Hosek follows:]

PREPARED STATEMENT OF JAMES HOSEK,[1] THE RAND CORPORATION

INSIGHTS FROM EARLY RAND RESEARCH ON DEPLOYMENT EFFECTS ON U.S. SERVICEMEMBERS AND THEIR FAMILIES[2]

PUBLICATION CT–367

I would like to thank the Committee for the opportunity to testify. As the Committee has requested, I will address my comments to findings from the recent RAND publication, *How is Deployment to Iraq and Afghanistan Affecting U.S. Servicemembers and Their Families?* I will also touch on more recent research that builds on and extends these findings.

September 11, 2011, will mark ten years since the terrorist attacks that precipitated the war on terrorism and the military operations in Iraq and Afghanistan that continue today. During these ten years more than 2.2 million servicemembers from the active and reserve components have deployed for hostile duty. Each war has unique features, and the unique features of the current operations have included the absence of massed forces and a recognizable front line, the use of opportunistic small arms attacks and improvised explosive devices, and the religious and cultural currents that have led to shifting alliances and raised concern about the nature of the peace when it comes. But apart from these battlefield and diplomatic realities, another unique feature has been the public recognition of the stresses borne by servicemembers and their families in wartime and, equally important, the recognition of invisible wounds that can haunt our servicemembers who have deployed and that can follow them after they leave the military. Let me review some of what we know from our early studies on deployment and its effects.

We found that experiencing a deployment affects a servicemember's willingness to reenlist. Interestingly, if deployment is not too extensive, deployment increases reenlistment over what it would have been in the absence of deployment. But extensive deployment causes reenlistment to decrease. In Iraq and Afghanistan, soldiers and marines have borne the majority of ground combat. Soldier tours have typically been 12 months (but some have been 15 to 18 months or longer) and marine tours have been 7 months, and many servicemembers have had more than one tour. We found that total months of deployment was a key variable in understanding the relationship between deployment and reenlistment. For soldiers, deployment of 11 or fewer months in the 36 months preceding their reenlistment decision had a positive effect on reenlistment, but 12 or more months had a negative effect—and 18 or months had a still more negative effect. By 2006, two-thirds of those facing a reen-

[1] The opinions and conclusions expressed in this testimony are the author's alone and should not be interpreted as representing those of RAND or any of the sponsors of its research. This product is part of the RAND Corporation testimony series. RAND testimonies record testimony presented by RAND associates to Federal, state, or local legislative committees; government-appointed commissions and panels; and private review and oversight bodies. The RAND Corporation is a nonprofit research organization providing objective analysis and effective solutions that address the challenges facing the public and private sectors around the world. RAND's publications do not necessarily reflect the opinions of its research clients and sponsors.

[2] This testimony is available for free download at http://www.rand.org/pubs/testimonies/CT367/.

listment decision had 12 or more months of deployment. The high percentage of troops with long months of deployment coupled with the negative effect on reenlistment of long months of deployment put serious downward pressure on overall reenlistment. This was perilous as a drop in reenlistment would jeopardize the Army's ability to maintain its battlefield strength and would accelerate the deployment cycle, creating a vicious circle. Fortunately, the Army was able to stabilize its reenlistment rate by the extensive use of reenlistment bonuses. The same basic story held for the Marine Corps. Earlier RAND research on deployment also found that deployment, if not too long, led to higher reenlistment, while lengthy deployment decreased this positive effect and could make it negative. This pattern held across the services.

Deployment brings a variety of stressors. As early as 2003, a survey of soldiers and marines serving in Iraq found that 89 percent of soldiers and 95 percent of marines reported having been attacked or ambushed. Deployed troops have had to face snipers, suicide bombers, improvised explosive devices (IEDs), and they have seen their fellow soldiers and friends killed or shattered by blasts, and may have had to kill enemy fighters, handle human remains, and may have inadvertently killed or injured civilians. Average temperatures in Iraq are over 120 degrees in July and August and below freezing in January. Sandstorms pelt personnel and equipment with fine grit, and camel spiders are a lurking danger of sleeping in the open. Extensive research shows that stress in moderation can actually improve performance, but extreme stress can hurt performance, leading to mistakes and bad decisions and possibly to failed missions and unnecessary casualties. A person under constant excessive stress may screen out peripheral stimuli and lose the ability to process information and analyze complicated situations. However, research also shows that training and other moderators can reduce the negative effects of stress. Training, for example, can decrease the likelihood that a given stressor will actually cause an elevated level of stress, and it can increase the likelihood that a stressed person can nevertheless perform effectively.

Having well trained, experienced personnel available to deploy helps to maintain the fighting effectiveness of deploying units, yet at the same time the personnel who re-deploy are subject to further combat-related stressors as well as separation from family and friends. RAND's Invisible Wounds of War study found that in the of spring 2008, 18.4 percent of all returning servicemembers currently met criteria for either Post Traumatic Stress Disorder (PTSD) or major depression. This may be compared with a more recent RAND study, A Needs Assessment of New York State Veterans, that found 22 percent of the sample (Iraq and Afghanistan veterans who had separated from the military and were eligible for VA care) met criteria for probable PTSD or major depression. The Invisible Wounds of War study also found that 19.5 percent reported experiencing a probable Traumatic Brain Injury (TBI) during deployment. For all these conditions, exposure to combat trauma was the single best predictor even after controlling for the number of months deployed and time since deployment return. It is reasonable to expect that the chance of exposure to combat trauma increases with the number of months deployed. Since 2003, a number of studies have been done to examine the extent of PTSD and depression among returning troops. Percentages of returning servicemembers with PTSD, depression, or the percent reporting that they experienced a TBI may vary depending on the study population as well as the method and timing of the assessment. However, studies of similar populations and methodologies consistently show that the rate of post-deployment mental health problems among returning servicemembers is about 15–20 percent at any given point in time. For the sake of illustration, if one wanted to understand the size and scope of the problem at a given point in time, applying the estimate of 18.4 percent to 2.2 million deployed servicemembers implies that about 405,000 Iraq and Afghanistan veterans meet criteria for with PTSD or depression. The number who may have experienced a probable TBI during deployment would be roughly similar, and there is significant overlap between those who experience PTSD, depression, and a probable TBI. It is important to note that these figures represent a snapshot of the size of the problem at a given point in time. We do not know yet the life-time prevalence of these problems among returning veterans, as some will develop problems later and others may recover.

In our 2008 study, about half of the returned servicemembers with probable PTSD or depression had not sought care for a mental health problem in the prior year, and only 43 percent of those with probable TBI during deployment reported that they had been clinically evaluated. The chief reasons for not seeking care were related to access and organizational and cultural factors, including concerns about confidentiality and potential negative career repercussions that they may experience if they sought care. Access barriers included long wait times for appointments, particularly in facilities resourced primarily to meet the demands of older, more chron-

ically ill veterans. The long wait times in part reflected the limited availability of providers. While significant efforts have been implemented to increase the supply of mental health providers, access barriers remain a concern for veterans. The more recent study on New York veterans' needs also pointed to the diverse and seemingly disorganized and incomplete sources of information about where to seek care, what services were available, who was eligible and how to apply, and to concerns about the side effects of medications. From the VA's perspective, perhaps the key lesson here is to increase awareness of the benefits of mental health treatment, as well as to continue to improve the application process and the capacity to deliver care.

Studies consistently show that evidence-based treatment for PTSD and major depression is more effective than non-evidence based care. Our work documented a number of therapies that have been shown effective in treating these conditions, including cognitive behavioral therapy. However, of those who had PTSD or depression and also sought treatment, only slightly over half received minimally adequate treatment, and the number who received high-quality care would be even smaller. Thus, in addition to improving access and increasing the number of providers it is important that the providers be trained and supported to provide evidence-based care. In a cost-analysis, the *Invisible Wounds of War* study found that delivering high quality, evidence-based care to all veterans who have PTSD or major depression on net would save money for society and improve outcomes for those treated.

The importance of providing healthcare to our servicemembers and veterans is without question, but the cost of doing so is not inconsequential. A challenge is how to organize the healthcare delivery system in an efficient way. This is partly a VA responsibility, but the healthcare system extends beyond the VA, bearing on both VA and non-VA providers, with the goal being to provide access to high quality care for veterans. Many, but by no means all, veterans may have health insurance through their employers and obtain healthcare through private providers. Structuring incentives so that veterans take full advantage of their other coverage and working with provider groups to promote evidence-based treatment will reduce the strain on the VA system and likewise help to hold down VA cost growth. At the same time, it will promote quality care for all veterans, whether or not they live near a VA facility. Similar points are discussed in recent RAND research on TRICARE Reserve Select.

The extensive use of the reserve components in Iraq and Afghanistan has demonstrated the prowess of reserve forces and substantiated the role of the reserves as one that is both strategic and operational. It has also raised questions about reserve earnings and family support. Both survey data and editorials have suggested that reservists who had deployed took a cut in earnings. A loss in earnings was thought to be unfair for reservists and could lead some reservists to leave the military earlier than planned and cause potential enlistees not to join the reserves. RAND approached this question by using actual pay records and precise definitions of earnings. The pay data came from privacy-protected individual-level military pay files and Social Security earnings records. The analysis found that most reservists—upwards of 83 percent—actually earned more when they were deployed than they did at their civilian job. It is true that on average a reservist's civilian earnings decreased, but deployed earnings were roughly two dollars for each lost dollar of civilian earnings. The average reservist deployed for nine months or longer in a year gained over $19,000 on net. These findings helped to allay concerns about reservists' earnings losses.

Another concern has been whether reservists returning from deployment would be able to transition back to their previous job, and more generally, whether their job security and career prospects within a firm were safely protected by the Uniformed Services Employment and Reemployment Rights Act (USERRA). The complementary side of this is whether employers are adversely affected by the more frequent use of reservist employees. RAND has a project underway on the latter topic with the objective of determining the implications of worker protections under USERRA for employers with different characteristics, and if needed, recommending possible changes to USERRA, potential improvements to DOD and service policies and practices governing reserve activation and utilization, and ways to modify Employer Support to the Guard and Reserve (ESGR)'s to provide better support to employers.

From the perspective of the returning reservist, RAND studied the 75 percent increase in enrollment in Unemployment Compensation for Ex-Servicemembers (UCX) that occurred during 2002 to 2004. Part of the increase occurred simply because more reservists were being activated than in previous years. Also, significant numbers of reservists chose not to return to their pre-activation jobs. At the risk of speculating why that was so, it could be that many returning reservists were seeking new job or career opportunities, and UCX benefits, though initially aimed at helping

reservists who did not have a job, were also helping reservists search for better positions.

Further research on earnings is underway at RAND for the 11th Quadrennial Review of Military Compensation. This research focuses on the employment and earnings of wounded warriors and asks two questions: did they experience an earnings loss in the years following their injury relative to their expected earnings, and did disability compensation payments offset the loss? The analysis, which will be published this fall, takes into account the severity of the injury, and again is based on military pay and Social Security earnings records, and factors in the effects of their injury on their spouse's earnings.

Other recent RAND research has looked into the Post-9/11 GI Bill. This legislation increases the generosity of the GI benefit and, like the GI Bill of World War II, holds the promise of allowing veterans to pursue and complete higher education. By identifying difficulties in the early implementation of the Post-9/11 GI Bill, this research may help the VA and institutions of higher education focus their efforts to make these benefits more accessible and easier to use.

In 2007, RAND research on the needs and support of reserve families found that most reserve families (62 percent) reported coping "well" or "very well" with deployment. Deployment brought challenges to the family yet also had positive aspects. The mention of problems related to deployment varied by type of respondent. Reservists frequently cited disruption to employment or education as problems. Reservist spouses cited personal and emotional problems, household responsibilities, and children's issues. Reserve experts cited financial, legal, and healthcare issues. On the positive side, reservists mentioned financial gain while reservist spouses mentioned family closeness; patriotism, pride, and civic duty; and independence, confidence, and resilience. The resources the families relied upon during deployment included TRICARE, family support organizations, and extended families. Deployment affected the reservists' intentions to stay in the military. About 30 percent had an increased desire to stay, 40 percent had no change, and 30 percent had a decreased desire to stay. RAND continues to study reserve component families and ways to improve reintegration support.

The study of reserve family needs and support, like the studies above, pointed to the importance of understanding family readiness for the full cycle of deployment and family resilience in the face of the challenges and uncertainties it would bring. RAND has now has begun longitudinal studies of family resilience and coping in each of the services. This series, called the Deployment Life Study, will be a landmark analysis that will follow a cohort of military families, from all service components, across a full deployment cycle. These studies are in an early phase and expect to have results over the next several years.

The deployment of a servicemember parent affects children on the homefront. In 2008–2009, RAND surveyed parent caregivers, usually the mother, and their children ages 11 to 17 who had applied to Operation Purple Camp, a summer camp for children of servicemembers. We found that the children in the study experienced behavioral and emotional difficulties at rates above the national average. This finding was apparent in the first survey and remained much the same in the follow-up surveys at 6 and 11 months.

- Anxiety was a specific problem. Anxiety is characterized by feeling frightened or having difficulty sleeping, for example. 30 percent of the children in the study sample had elevated symptoms of anxiety, which is twice the rate found in other child studies. In contrast, the children in the study were similar to the national average in peer and family functioning, academic engagement, and risk behaviors.
- Older teens experienced more difficulties such as having to take on more household responsibilities, take care of siblings, and missing school activities, and had trouble getting to know their deploying parent again and adjusting to the parent fitting back into the household routine.
- Girls reported more difficulties during the parent's reintegration into the family, including worrying about the parent's next deployment, dealing with the parent's mood changes, and worrying about how parents were getting along.
- Children in families where the non-deployed parent is coping with emotional health issues tended to experience more difficulties.
- Also, just as longer total months of deployment were found to have a negative effect on reenlistment, they were associated with more problems for children. This held true across the services and in both active and reserve components.

Overall, the results suggest that because children with a deployed parent are experiencing more emotional and behavioral difficulties, they may need more assistance in addressing their needs. Further, it might be useful to target the assistance. Perhaps families can be screened for emotional problems during routine healthcare

visits. Also, support might be targeted on families facing more cumulative months of deployment, with the support being provided across the deployment cycle and not just at the start or end.

Finally, related to the findings on the children of deployed parents and on family effects more generally, RAND has recently done research on the effect of deployment on military divorce. We find that the probability of divorce increases as total months of deployment increases.

Thank you once again for the opportunity to address the Committee.

Chairman MURRAY. Thank you very much, Dr. Hosek.

Now, I will now turn to Mrs. Crystal Nicely.

STATEMENT OF CRYSTAL NICELY, CAREGIVER AND SPOUSE OF OEF VETERAN

Ms. NICELY. The morning, Chairman Murray and Members of the Committee. Thank you for inviting me to share me and my husband Todd's experiences with you today.

My hope, through my testimony today, that those looking in will understand my frustration and heartache.

Ever since my husband was injured, I have assumed a higher responsibility to care for him and support him as we transition into a new life.

My husband lost his arms and his legs while serving his country in Afghanistan. During a combat patrol through the village of Lakari, which is in the southern Helmand Province, Todd was hit by an IED.

It has been a long journey since that day in early 2010, and you would think that it would be quite easy for someone to lose hope and motivation after such a catastrophic injury. But my husband has been a fighter since day one.

In recovery he displayed the same irresistible warrior spirit for which the Marines are so beloved, first, fighting off infection and disease, and then working aggressively with his physical medicine and rehabilitation. He continues fighting through progression in prosthetic training and also fighting for me and our future together.

The community of wounded warriors at Walter Reed is diverse, and each Marine has their own particular needs. Many of them are fortunate enough to be accompanied by their loved ones. For most of the family members, we were thrown into this new role unexpectedly and unprepared. We have discovered that we could never have prepared ourselves for what we face on a day-to-day basis while caring for our loved ones.

Many of us left our lives back home and assumed a new role at Walter Reed. Life here is not a picnic. There is not much my husband can do without me or someone assisting. Without his prosthetics Todd is unable to perform many of the very basic activities of daily living that people take for granted.

We attempt to function independently, but the reality of his injuries requires that I or someone be at his side continuously. This is our new norm. For me, I am not only my husband's caregiver, nonmedical attendant, appointment scheduler, cook, driver, and groomer, but I am also his loving wife faced with my own stresses and frustrations.

To be clear, this is not an issue of being overwhelmed with caring for my husband, but what is upsetting is the lack of support, com-

passion, and benefits for these individuals. It needs to be just a little bit easier.

For the family members, we must go through a very tedious process to serve as a nonmedical attendant, especially at a time when we must oversee all other parts of our households and our lives, that I have to continually re-apply to keep serving as a nonmedical attendant, feels as though I am being judged on my loving care for Todd.

Helping him through his treatment is what I want to do but I need the system to work with me to do that. It is almost disheartening to think that they believe someone else, no matter how willing they can be, can care for my husband more than I can.

As caregivers, we leave our jobs and schools and there are those who have children to look after as well. We leave all of this to inherit another full-time job. I rely on compensation that is provided to nonmedical attendants to assist maintaining my household.

With Todd's injuries, the bills do not stop coming and, in fact, it has gotten more expensive. We are grateful for what assistance we do get from the Marine Corps, but had we not been greeted by a host of people who wanted to assist, we would have been lost in the recovery process.

Although my husband is one of only four surviving quadruple amputees, his struggles and hardships are very similar to many wounded warriors.

The process in transitioning out of the military has been particularly difficult. Todd has been a part of an integrated disability evaluation system, which I understand is supposed to be faster—a more efficient way to complete evaluations and transition out of the military service.

That has not been our experience. At one point, a simple summary of my husband's injuries sat on someone's desk for almost 70 days waiting for approval. I thank Chairman Murray for helping get the issue resolved but it should not take me talking to a U.S. Senator to help my husband. More importantly, what about all the other wounded Marines who have not had the chance to ask for that kind of help.

Coordination of care for Todd has also been a problem. There seems to be so many coordinators that they are actually not all on the same page at this time doing opposite things. Though she was trying to help, I rarely saw my Federal recovery coordinator who seemed to have too many people she was responsible for.

This lack of communication has also extended to benefits and programs. I have received very little information on how to participate or enroll in what is offered by the VA.

For the benefits we know about, we are faced with problems in actually receiving them. For instance, periodically the stipends stop which makes things very difficult. I do not know why this occurs, and it is especially difficult to get a clear definite answer. But we need help.

Chairman Murray, I appreciate all that is currently being done to assist future wounded warriors and their families. As for me I will never be able to fully express my appreciation for what assistance we do get and for what is available to us now because every little bit counts.

I hope my testimony today has been helpful to you as you continue working to resolve these issues. Thank you very much, and I am happy to answer any questions you have.

[The prepared statement of Ms. Nicely follows:]

PREPARED STATEMENT OF CRYSTAL NICELY, CAREGIVER AND SPOUSE OF AN OEF VETERAN

Good Afternoon. Chairman Murray, Ranking Member Burr, Members of the Committee, Thank you for inviting me to share my and my husband Todd's experiences with you today.

I hope, through my testimony today, that those looking in will feel my frustration and heartache. Ever since my husband was injured I have assumed a higher responsibility to care for him and support him as we transition into a new life. I'm sharing my personal experiences and feelings which I hope will be useful to you in creating a better system of support for wounded warriors and their families. My husband lost his arms and legs while serving his country in Afghanistan. During a combat patrol through the village of Lakari, which is in the southern Helmand Province, Todd was hit by an IED.

It has been a long journey since that day in early 2010. Under normal circumstances, one would think that it would be quite easy for someone to lose hope and motivation after such a catastrophic injury. But my husband has been a fighter since day one. In recovery he displayed the same irresistible warrior spirit for which the Marines are so beloved. First fighting off infection and disease, then working aggressively with his physical medicine and rehabilitation, through progression in prosthetic training, and also fighting for me and our future together.

Although my husband is one of only three surviving quadruple amputees in the Marine Corps, his struggles and hardships are very similar to other Wounded Warriors, regardless of their injuries. I am here today, not only on behalf of my husband, but also the countless other wounded Marines and their caregivers.

COORDINATION AND TRANSITION

The process of transitioning out of the military has been particularly difficult. Todd has been part of the Integrated Disability Evaluation System (IDES), which I understand is supposed to be a faster, more efficient way to complete the evaluations and transition servicemembers. That has not been our experience. At one point, a very simple narrative summary of my husband's injuries sat on someone's desk for almost 70 days waiting for a very simple approval. I thank Chairman Murray for her help in getting that resolved, but it should not take my talking with a United States Senator to make that happen. More importantly, what about all the other wounded Marines who have not had the chance to ask for that kind of help?

Coordination of care for Todd has also been a problem. There seem to be so many coordinators that they are actually not all on the same page and sometimes doing things opposite of each other. Though she was trying to help, I rarely got to see our Federal Recovery Coordinator, who seemed to have too many people she was responsible for. The lack of communication also extended to benefits and programs. While I'm optimistic for the new VA caregiver program, I have gotten hardly any information on how to participate. There has been a similar lack of information about a variety of VA and other benefits.

For the benefits we know about, we are also faced with problems in actually receiving them. Periodically the stipends stop, which makes things very difficult. I do not know why this occurs, especially as it is difficult to get a clear and definitive answer, but we need help.

CAREGIVER NEEDS

The community of wounded Marines at Walter Reed is diverse, and each has their own particular needs. Many of them are fortunate to be accompanied by their loved ones. For most of the family members, we were thrown into this new role unexpectedly and unprepared, but we have taken it in stride with determination and hope of the future. What we have discovered is that we could never have prepared ourselves for what we face on a day to day basis while taking care of our loved ones.

For me, I am not only my husband's caregiver, non-medical attendant (NMA), appointment scheduler, cook, driver, and groomer, but I am also his loving wife faced with my own stresses and frustrations. To be clear, this is not an issue of being overwhelmed with caring for my husband for there is no other place on earth I want be other than by his side. I am sure that many of the other caregivers would agree.

What is upsetting is the lack of support, compassion, and benefits for these individuals. It needs to be just a little bit easier. Many of us, left our lives back at home, and assumed a new role and life at Walter Reed, as many caregivers have done across the country. Simply put, life here isn't a picnic. It is a bittersweet struggle of coping with new identities and new norms, whatever those may be.

I first wish to address the most difficult and disheartening issue that continues to be a problem and barrier at Walter Reed. There is not much these days my husband can do without me or someone at his side. We attempt to function independently, but the reality of his injuries requires that I be close to his side, and even if I am away for only short periods someone must be there. This is part of our new normal. Without his prosthetics Todd is unable to perform many of the very basic Activities of Daily Living (ADL) that are taken for granted by so many.

The process to serve as an NMA is tedious, particularly at a time when we must oversee all the other parts of our household and our lives. I am not enlisted so it is frustrating when I'm expected to carry on as if I were, when the circumstances I have now are so much bigger than that. This is an additional and unnecessary burden for the spouses and family members.

This continual process of reapplying to be an NMA feels as though I am being assessed on my love and care for Todd, or my value to him and his condition. But helping him through his treatment is what I want to do. How could I ever ask someone else to step away from their lives to come do what we so proudly do, loving and caring for our husbands. It's almost disheartening to think that someone no matter how willing they may be can care for my husband more than I can. It hurts just to consider having someone else there instead of me sharing and growing in this experience with my husband. A lot of us come from jobs or school, and there are those that have children to look after as well. Personally, I was attending school before this. Now I have to consider the very expensive life that lies ahead for my husband and me. However, none of these factors would change my decision or take me away from my involvement in helping Todd's recovery. I believe it is helpful when we can be there learning together to learn these new life skills so, in the near future, I can step away without worry knowing that he can perform everyday activities safely and, eventually, without someone else there.

Many of us caregivers are unable to work, there just are not enough hours in the day, and in my case, leaving my husband's side is just not an option. Thus, I do rely on the compensation that comes with being an NMA to assist with maintaining my household and saving for our future. With Todd's injury the bills did not stop coming and, to be honest, things have become more expensive. We are grateful for what assistance we do get from the Marine Corps, but had we not been guided by our case managers, other volunteers like the Semper Fi Fund, and other families of wounded warriors, we would have been lost in this recovery process.

WARRIOR TRANSITION UNITS

Frequent rotation of section leaders in the warrior transition units is another problem area. When the new leaders take over, they know less about what is required than the spouses. This is no fault of their own, for most of these individuals that are sent here to support the wounded come from military occupational specialties that are unrelated to what there are about to be asked to do. So it is a learning process, but by the time they understand, it is time for new section leaders to take over, again without the requisite skillsets, and the challenges continue. I have to seek out other sources and individuals to assist me. Additionally, in these situations, trust is a key part of an effective relationship, but the continual turnover hinders the development of that trust.

CONCLUSION

It should not take a newspaper article or appearing at a Senate hearing to address these problems, but I am glad to have the opportunity to express this to you and seek your help. I want to take a moment to express my appreciation for what is being done now to aid in future assistance of the wounded and their families. I know that issues are being worked toward and I will never be able to fully express my appreciation for what assistance we do get and for what is available to us now, for every little bit counts. I hope my testimony today has been helpful to you as you continue working to address these issues. Thank you very much and I would be happy to answer any questions you have.

Chairman MURRAY. Crystal, thank you so much for your courage in being here today and sharing your story. I really appreciate all you and your husband have done to help educate me about what

you are going through and so many others are. So thank you for being here.

Mrs. Lorelei St. James.

STATEMENT OF LORELEI ST. JAMES, DIRECTOR, PHYSICAL INFRASTRUCTURE ISSUES, UNITED STATES GOVERNMENT ACCOUNTABILITY OFFICE

Ms. ST. JAMES. Chairman Murray, Senator Brown, and Members of the Committee, I am pleased to be here today to talk about GAO's recent work on VA's approaches to estimating future capital and health care budgets.

For the aging veteran population and for younger veterans returning from Afghanistan and Iraq, it is vital that VA effectively estimate the facilities and health care that veterans may need.

Let me first talk about VA's capital planning process. VA has thousands of facilities to provide health care and other services to millions of veterans estimating the type and location of facilities and services is a complex process; and as we recently reported, VA over the course of several years has changed its approach to this planning.

VA's current planning process is the Strategic Capital Investment Planning Process or SCIP. However, I cannot tell you if SCIP is an effective planning tool. It is too early to tell. But I can say that VA incorporated a number of leading practices into SCIP.

For example, VA now considers capital investments across the organization using weighted criteria and expanded its 5-year planning horizon to 10 years.

Also prior to SCIP, VA's planning process appeared to be moving in the right direction. For example, VA reduced the number of hospitals and opened 82 community-based outpatient clinics, but it is not all good news.

VA faces a daunting backlog of repairs, about $10 billion; and as we reported in January, 24 ongoing construction projects needed an additional $4.4 billion to complete.

Moreover, the VA continues to face age-old challenges such as getting stakeholders to agree on needed changes, legal and budgetary limitations, and getting rid of excess or underutilized property.

Let me now turn to VA's approach to developing its health care budget estimate. In January of this year, we reported that VA used the Enrollee Health Care Projection model and other methods to estimate its health care budget for fiscal years 2011 and 2012.

We found the model uses data reflecting the types of health care that veterans might need, the projected or potential costs, and the number of veterans who might enroll for health care.

Overall, the model projects the resources to meet demand for over 60 health care services that account for about 83 percent of the VA's health care cost estimate.

The model's projections only provide a starting point for the budget. Throughout the budget process, the health care estimate is reviewed and weighed against other VA and OMB priorities; and in June we reported that VA's budget estimate using the model for 2012 and 2013 changed as it moved throughout the budget formulation process.

In general, at the end of the process, VA's estimate or the President's request to Congress could be higher or lower than the model's estimate as VA and OMB weigh the estimate against other priorities or initiatives.

Along the way VA has a voice in the process. For example, if the OMB estimate for nonrecurring maintenance is lower than the amount that the model projects, VA determines the impact on health care services and decides what action, if any, it will take up with OMB. VA could also propose a lower estimate for nonrecurring maintenance than the model projects based on other VA priorities.

For example, compared to the models estimate, nonrecurring maintenance was $904 million lower for 2012 and $1.27 billion lower for 2013.

But before that, one has to recognize that the model is based on imperfect data and assumptions that change. Also projections are made three to 4 years into the future and budgets are developed months in advance.

In summary, VA uses sophisticated and complex methods to estimate its capital planning and health care budget. These methods do help to provide transparency into VA's methods; but the estimates they produce, like the processes and models themselves, are not perfect and all must compete for funding and sometimes unforeseen priorities.

Thank you. I am happy to answer any of your questions.

[The prepared statement of Ms. St. James follows:]

PREPARED STATEMENT OF LORELEI ST. JAMES, DIRECTOR, PHYSICAL INFRASTRUCTURE ISSUES, U.S. GOVERNMENT ACCOUNTABILITY OFFICE

Madam Chairman Murray, Ranking Member Burr, and Members of the Committee: I am pleased to be here today as you examine the lifetime costs of supporting the newest generation of veterans. The Department of Veterans Affairs (VA) operates one of the largest health care delivery systems in the Nation, providing care to a diverse population of veterans. VA operates about 150 hospitals, 130 nursing homes, and 820 outpatient clinics through 21 regional health care networks called Veterans Integrated Service Networks. VA is responsible for providing health care services to various populations—including an aging veteran population and a growing number of younger veterans returning from the military operations in Afghanistan and Iraq. Budgeting for this vital health care mission is inherently complex. It is based on current assumptions and imperfect information, not only about program needs, but also on future economic and policy actions that may affect demand and the cost of providing these services. Adding to this complexity, VA has recognized over the years the need to plan and budget for facility modernization, and realign its real property portfolio to provide accessible, high-quality, and cost-effective access to its services.

My statement today addresses VA's real property realignment efforts and VA's approach to developing budget estimates for health care. It is based on our prior real property realignment work, where we examined the extent to which VA's capital planning efforts resulted in changes to its real property portfolio, helped VA identify facility planning priorities, and reflected leading Federal practices for real property management.[1] It is also based on our prior budget estimate work, where we examined how VA develops its health care budget estimate, addressed what VA identified as the key changes that were made to its budget estimate to develop the President's budget request for fiscal years 2012 and 2013, and explained how various sources of funding for VA health care and other factors informed the President's budget re-

[1] See GAO, *VA Real Property: Realignment Progressing, but Greater Transparency about Future Priorities Is Needed*, GAO–11–197 (Washington, DC: Jan. 31, 2011).

quests.[2] To perform the work related to real property realignment efforts, we reviewed leading capital planning practices and data on VA's real property portfolio and future priorities. We also interviewed VA officials and veterans service organizations, and visited sites in 5 of VA's 21 Veterans Integrated Service Networks. To perform the work related to budget estimates for health care, we reviewed VA documents on the methods, data, and assumptions used to develop VA's health care budget estimate that informed the President's two most recent budget requests for fiscal year 2011, 2012 and 2013.[3] Our review of those most recent budget requests focused on the three appropriations accounts for VA health care services: Medical Services, Medical Support and Compliance, and Medical Facilities.[4] We also interviewed VA officials responsible for developing this estimate and staff from the Office of Management and Budget (OMB). Our work was performed in accordance with generally accepted government auditing standards. More detailed information on our objectives, scope and methodology for this work can be found in the issued reports.

SUMMARY

Through its capital planning efforts, VA has taken steps to realign its real property portfolio from hospital based, inpatient care to outpatient care, but a substantial number of costly projects and other long-standing challenges remain. For example, VA reported in its 5-year capital plan for fiscal years 2010–2015 that it had a backlog of $9.4 billion of facility repairs. The 5-year plan further identified an additional $4.4 billion in funding to complete 24 of the 69 ongoing major construction projects. We also found that VA, like other agencies, has faced underlying obstacles that have exacerbated its real property management challenges and can also impact its ability to fully realign its real property portfolio. We have previously reported that such challenges include competing stakeholder interests, legal and budgetary limitations, and capital planning processes that did not always adequately address such issues as excess and underutilized property. Furthermore, we found that VA's capital planning efforts generally reflected leading practices, but lacked transparency about the cost of future priorities that could better inform decisionmaking. VA concurred with our recommendation to improve the transparency of its budget submissions. We have not yet assessed the extent to which VA has implemented our recommendation in relation to the President's 2012 budget.[5]

VA uses what is known as the Enrollee Health Care Projection Model (EHCPM) to develop most of its health care budget estimate and uses other methods for the remainder. The EHCPM's estimates for these services are based on three basic components: projected enrollment in VA health care, projected use of VA's health care services, and projected costs of providing these services. The EHCPM makes a number of complex adjustments to the data to account for characteristics of VA health care and the veterans who access VA's health care services. For example, these adjustments take into account veterans' age, gender, geographic location, and reliance on VA health care services compared with other sources, such as health care services paid for by Medicare or private health insurers. VA officials identified changes made to its estimate of the resources needed to provide health care services to re-

[2] GAO, *Veterans' Health Care Budget Estimate: Changes Were Made in Developing the President's Budget Request for Fiscal Years 2012 and 2013*, GAO–11–622 (Washington, DC: June 14, 2011); and GAO, *Veterans' Health Care: VA Uses a Projection Model to Develop Most of Its Health Care Budget Estimate to Inform the President's Budget Request*, GAO–11–205 (Washington, DC: Jan. 31, 2011).

[3] The Veterans Health Care Budget Reform and Transparency Act of 2009 provided that VA's annual appropriations for health care include advance appropriations that become available 1 fiscal year after the fiscal year for which the appropriations act was enacted. Pub. L. 111–81, § 3, 123 Stat. 2137, 2137–38 (2009), codified at 38 U.S.C. § 117. The act provided for advance appropriations for the Medical Services, Medical Support and Compliance, and Medical Facilities appropriations accounts.

[4] The Medical Services account funds health care services provided to eligible veterans and beneficiaries in VA's medical centers, outpatient clinic facilities, contract hospitals, state homes, and outpatient programs on a fee basis. The Medical Support and Compliance account funds the management and administration of the VA health care system, including financial management, human resources, and logistics. The Medical Facilities account funds the operation and maintenance of the VA health care system's capital infrastructure, such as costs associated with nonrecurring maintenance, utilities, facility repair, laundry services, and groundskeeping.

[5] VA's budgets for new construction exist in two accounts—Major Construction and Minor Construction—which are funded as separate line items within VA's appropriation. Major construction projects are those estimated to cost more than $10 million, while minor construction projects are those estimated to cost $10 million or less. See 38 U.S.C. § 8104(a)(3)(A). Nonrecurring maintenance projects that may result in a change in space function or a renovation of existing infrastructure are funded through the VHA Medical Facilities budget account.

flect policy decisions, savings from operational improvements, resource needs for initiatives, and other items. The President's request for appropriations for VA health care for fiscal years 2012 and 2013 relied on anticipated funding from various sources, including new appropriations, collections, unobligated balances of multiyear appropriations, and reimbursements VA receives for services provided to other government entities.

REAL PROPERTY REALIGNMENT EFFORTS PROGRESSING, BUT GREATER TRANSPARENCY NEEDED ABOUT FUTURE PRIORITIES

In January 2011, we reported that through its capital planning efforts, VA had taken steps to realign its real property portfolio from hospital based, inpatient care to outpatient care, but a substantial number of costly projects and other long-standing challenges also remain. Several of VA's most recent capital projects—such as community based outpatient clinics, rehabilitation centers for blind veterans, and a spinal cord injury center—were based on its Capital Asset Realignment for Enhanced Services (CARES) efforts and subsequent capital planning. VA officials and veterans service organizations we contacted agreed that these facilities have had a positive effect on veterans' access to services. However, VA had identified several high-cost priorities such as facility repairs and projects that have not yet been funded. For example, VA reported in its 5-year capital plan for fiscal years 2010–2015 that it had a backlog of $9.4 billion of facility repairs. The 5-year plan further identified an additional $4.4 billion in funding to complete 24 of the 69 ongoing major construction projects. Besides substantial funding priorities, we also found that VA, like other agencies, has faced underlying obstacles that have exacerbated its real property management challenges and can also impact its ability to fully realign its real property portfolio. We have previously reported that such challenges include competing stakeholder interests, legal and budgetary limitations, and capital planning processes that did not always adequately address such issues as excess and underutilized property.

Furthermore, we found that VA's capital planning efforts generally reflected leading practices, but lacked transparency about the cost of future priorities that could better inform decisionmaking. For example, VA's 2010–2015 capital plan linked its investments with its strategic goals, assessed the agency's capital priorities, and evaluated various alternatives. Also, VA's new Strategic Capital Investment Planning (SCIP) process strengthened VA's capital planning efforts by extending the horizon of its 5-year plan to 10 years, and providing VA with a longer range picture of the agency's future real property priorities. VA officials told us that the SCIP process builds on its existing capital planning processes, addresses leading practices, and further strengthens VA's efforts in some areas. We have not fully assessed SCIP and it remains to be seen what impact SCIP will have on the results of VA's capital planning efforts. While these changes were positive steps, we found that VA's planning efforts lacked transparency regarding the magnitude of costs of the agency's future real property priorities, which may limit the ability of VA and Congress to make informed funding decisions among competing priorities. For instance, for potential future projects, VA's 2010–2015 capital plan only listed project name and contained no information on what these projects were estimated to cost or the priority VA had assigned to them beyond what was then the current budget year. Transparency about future requirements would benefit congressional decisionmakers by putting individual project decisions in a long-term, strategic context, and placing VA's fiscal situation within the context of the overall fiscal condition of the U.S. Government. It is important to note that providing future cost estimates to Congress for urgent, major capital programs is not without precedent in the Federal Government. Other Federal agencies, such as the Department of Defense, have provided more transparent estimates to Congress regarding the magnitude of its future capital priorities beyond immediate budget priorities.

We concluded in our report that billions of dollars have already been appropriated to VA to realign and modernize its portfolio. Furthermore, VA had identified ongoing and future projects that could potentially require several additional billion dollars over the next few years to complete. Given the fiscal environment, VA and Congress would benefit from a more transparent view of potential projects and their estimated costs. Such a view would enable VA and Congress to better evaluate the full range of real property priorities over the next few years and, should fiscal constraints so dictate, identify which might take precedence over the others. In short, more transparency would allow for more informed decisionmaking among competing priorities, and the potential for improved service to veterans over the long term would likely be enhanced. To enhance transparency and allow for more informed decisionmaking related to VA's real property priorities, we recommended that the

Secretary of Veterans Affairs provide the full results of VA's SCIP process and any subsequent capital planning efforts, including details on the estimated cost of all future projects, to Congress on a yearly basis. VA concurred with the recommendation. We have not yet assessed the extent to which VA has implemented our recommendation in relation to the President's 2012 budget.

VA USES A PROJECTION MODEL TO DEVELOP MOST OF ITS HEALTH CARE BUDGET ESTIMATE AND CHANGES WERE MADE TO THE ESTIMATE FOR FISCAL YEARS 2012 AND 2013

We reported in January 2011 that VA uses what is known as the Enrollee Health Care Projection Model (EHCPM) to develop most of its health care budget estimate and uses other methods for the remainder. Specifically, VA used the EHCPM to estimate the resources needed to meet expected demand for 61 health care services that accounted for 83 percent of VA's health care budget estimate for fiscal year 2011.The EHCPM's estimates for these services are based on three basic components: projected enrollment in VA health care, projected use of VA's health care services, and projected costs of providing these services. To make these projections, the EHCPM uses data on the use and cost of these services that reflect data from VA, Medicare, and private health insurers. The EHCPM makes a number of complex adjustments to the data to account for characteristics of VA health care and the veterans who access VA's health care services. For example, these adjustments take into account veterans' age, gender, geographic location, and reliance on VA health care services compared with other sources, such as health care services paid for by Medicare or private health insurers. VA uses other methods to develop nearly all of the remaining portion of its budget estimate for long-term care and other services, as well as initiatives proposed by the Secretary of VA or the President. Long-term care and other services accounted for 16 percent and initiatives accounted for 1 percent of VA's health care budget estimate for fiscal year 2011.

In June 2011, we reported on the President's budget request for fiscal years 2012 and 2013. We reported that VA officials had identified changes made to its estimate of the resources needed to provide health care services to reflect policy decisions, savings from operational improvements, resource needs for initiatives, and other items to help develop the President's budget request for fiscal years 2012 and 2013. One of the changes that VA identified was in its estimates for non-recurring maintenance to repair health care facilities. Non-recurring maintenance funds are used for expansion, renovation, and infrastructure improvements that cost more than $25,000.[6] VA's estimate for non-recurring maintenance was reduced by $904 million for fiscal year 2012 and $1.27 billion for fiscal year 2013, due to a policy decision to fund other initiatives and hold down the overall budget request for VA health care. VA's estimates were further reduced by $1.2 billion for fiscal year 2012 and $1.3 billion for fiscal year 2013 due to expected savings from operational improvements, such as proposed changes to purchasing and contracting. Other changes had a mixed impact on VA's budget estimate, according to VA officials; some of these changes increased the overall budget estimate, while other changes decreased the overall estimate.

The President's request for appropriations for VA health care for fiscal years 2012 and 2013 relied on anticipated funding from various sources. Specifically, of the $54.9 billion in total resources requested for fiscal year 2012, $50.9 billion was requested in new appropriations. This request assumes the availability of $4.0 billion from collections from veterans and private health insurers, unobligated balances of multiyear appropriations, and reimbursements VA receives for services provided to other government entities. Of the $56.7 billion in total resources requested for fiscal year 2013, $52.5 billion was requested in new appropriations, and $4.1 billion was anticipated from other funding sources. The President's request for fiscal year 2012 also included a request for about $953 million in contingency funding to provide additional resources should a recent economic downturn result in increased use of VA health care. Contingency funding was not included in the advance appropriations request for fiscal year 2013. As mentioned earlier, budgeting for VA health care is inherently complex because it is based on assumptions and imperfect information used to project the likely demand and cost of the health care services VA expects to provide. The iterative and multilevel review of the budget estimates can address some of these uncertainties as new information becomes available about program needs, Presidential policies, congressional actions, and future economic conditions.

[6] In addition, expansion, renovation, and infrastructure improvements can be categorized as minor or major construction and funded by the respective appropriations accounts. The Minor Construction account funds projects estimated to cost as least $500,000 but not more than $10 million, and the Major Construction account funds projects estimated to cost more than $10 million.

As a result, VA's estimates may change to better inform the President's budget request. The President's request for VA health care services for fiscal years 2012 and 2013 was based, in part, on reductions to VA's estimates of the resources required for certain activities and operational improvements. However, in 2006, we reported on a prior round of VA's planned management efficiency savings and found that VA lacked a methodology for its assumptions about savings estimates.[7] If the estimated savings for fiscal years 2012 and 2013 do not materialize and VA receives appropriations in the amount requested by the President, VA may have to make difficult tradeoffs to manage within the resources provided.

Madam Chairman Murray, Ranking Member Burr, and Members of the Committee, this concludes my prepared remarks. I would be happy to answer any questions that you may have.

POSTHEARING QUESTIONS SUBMITTED BY HON. PATTY MURRAY TO MS. LORELEI ST. JAMES, DIRECTOR, PHYSICAL INFRASTRUCTURE, GOVERNMENT ACCOUNTABILITY OFFICE

Question 1. Please provide more information on the true depth of VA's backlog in construction projects involving improvements needed to protect the privacy and safety of women veterans?

Question 2. How will the lack of investment in keeping up with ongoing maintenance and repairs affect VA's utilization of limited resources and future proposals of its infrastructure portfolio?

Question 3. Especially in the context of current fiscal issues, all aspects of VA operations must be assessed for their potential to operate most efficiently. With respect to VA's capital planning process, please provide an assessment of how underutilized property can be of best use.

[Responses were not received within the Committee's timeframe for publication.]

Chairman MURRAY. Thank you very much, Ms. St. James.

And we will turn to Ms. Heidi Golding.

STATEMENT OF HEIDI L. W. GOLDING, PRINCIPAL ANALYST FOR MILITARY AND VETERANS' COMPENSATION, CONGRESSIONAL BUDGET OFFICE

Ms. GOLDING. Thank you. Madam Chairman, Senator Brown, and Members of the Committee, thank you for the opportunity to appear before you today to discuss the health care of our veterans returning from overseas contingencies operations in Iraq and Afghanistan, which I will refer to as OCO.

I will address some of the medical conditions they have, their use of health care provided by the Veterans Health Administration, VHA, and that CBO's projections of future potential costs to treat them. All costs will be expressed in 2011 dollars.

About 2.3 million active and reserve personnel have deployed to overseas operations through March 2011. The medical conditions resulting from their participation affect the numbers of veterans who will require medical care in the future, including that provided by be VHA.

In total, about 69,000 servicemembers have been evacuated from the combat theaters because of injuries and other medical conditions and diseases. Many more seek care in-theater or after returning home.

Traumatic Brain Injury, TBI, and Post Traumatic Stress Disorder, PTSD, are conditions whose treatment could result in sub-

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[7] GAO, Veterans Affairs: Limited Support for Reported Health Care Management Efficiency Savings, GAO–06–359R (Washington, DC: Feb. 1, 2006).

stantial future costs for VHA. However, the problems of TBI and PTSD, that is, the proportion of people with those conditions, whether diagnosed with them or not, is uncertain partly because the conditions can be challenging to identify.

This makes resource planning for treatment of OCO veterans more difficult. Nonetheless, data helpful to resource planning does exist. For example, through March 2011 DOD had diagnosed a total of 35,000 TBI's among OCO servicemembers. About 90 percent of those were classified as mild TBI's, which typically heal quickly within weeks or months with relatively little medical intervention.

Both DOD and VHA have implemented programs to clinically screen for TBIs. VHA screening indicates that about 7 percent of its new OCO patients have TBI with ongoing symptoms.

In addition, VHA as diagnosed about 27 percent of OCO patients with PTSD. That rate is relatively high compared to published studies of prevalence that generally range from about 5 to 25 percent, but it is not surprising if veterans who have health problems are more likely than other veterans to seek care.

The number of veterans who are eligible for VHA benefits and the extent to which they use those services will affect future VHA costs. About 1.3 million OCO veterans have become eligible for health care through VHA. Just over half of them have sought that care through March 2011. The number of OCO veterans who have ever used VHA has grown by about 100,000 per year since 2005.

Roughly half of those, those who have used a VHA, began using it within about 12 months of separating from service. Their use is typically highest in the months immediately after they enroll in that system.

VHA spent almost $1.9 billion or $4800 per OCO patient in 2010, and a cumulative total of $6 billion to treat OCO veterans through 2010. Although OCO veterans were 7 percent of all veterans treated in 2010, they represented 4 percent of VHA spending.

CBO has projected the resources that VHA would need between 2011 and 2020 to treat all of OCO veterans who seek care. CBO examined two scenarios.

Under scenario one, CBO assumes that the number of deployed servicemembers drops to 30,000 by 2013 and remains there through 2020. In addition, VHA's health care expenditures per OCO enrollee grow at about the same rates as the national averages.

Under this scenario, VHA would treat 1.3 million OCO veterans at least once before the end of the decade. The annual cost for their care would nearly triple over the decade, rising from $1.9 billion in 2010 to roughly $5.5 billion in 2020 for a 10-year total of $40 billion.

The largest growth would be early in the projection period due to a large influx of new enrollees. Because OCO patients are less expensive to treat than the average VHA patients, OCO veterans would consume 8 percent of VHA's total spending in 2020.

For scenario two, CBO assumes that the number of servicemembers deployed drops to 60,000 in 2015 and remains there. In addition, CBO assumes VHA's expenditures per OCO in enrollee grow

at an annual rate that is about 30 percent higher than in scenario one.

Under scenario two, the cost to treat OCO veterans in 2020 is more than 50 percent higher than in scenario one, $8.4 billion. Costs over 10 years would total $55 billion. Almost 2/3 of the cost difference is due to the faster growth in expenditures per enrollee.

Thank you very much. I am happy to answer any questions.

[The prepared statement of Ms. Golding follows:]

PREPARED STATEMENT OF HEIDI L. W. GOLDING, PRINCIPAL ANALYST FOR MILITARY AND VETERANS' COMPENSATION, CONGRESSIONAL BUDGET OFFICE

Congressional Budget Office

Testimony

Statement of
Heidi L. W. Golding
Principal Analyst for Military and
Veterans' Compensation

Potential Costs of Health Care for Veterans of Recent and Ongoing U.S. Military Operations

before the
Committee on Veterans' Affairs
United States Senate

July 27, 2011

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Chairman Murray, Senator Burr, and Members of the Committee, thank you for the invitation to appear before you today to discuss the prospective demands that veterans returning from recent and ongoing military operations will place on the health care system of the Department of Veterans Affairs (VA). Those operations (overseas contingency operations, or OCO) are Operation Iraqi Freedom, which ended in August 2010; Operation New Dawn, the ongoing military engagement in Iraq; and Operation Enduring Freedom, in Afghanistan. My testimony, drawn primarily from the Congressional Budget Office's (CBO's) October 2010 study *Potential Costs of Veterans' Health Care*, addresses the costs that VA's health care system—the Veterans Health Administration (VHA)—could face in meeting those veterans' health care needs over the 2011–2020 period. (The results of that analysis presented here are slightly different from those in the report because CBO has updated all costs for the effects of inflation, converting them to 2011 dollars. All years referred to in this testimony are federal fiscal years, which run from October 1 to September 30.)

Summary

CBO's analysis of VHA's costs indicated the following:

- In 2010, VHA spent $1.9 billion to treat 400,000 OCO patients. VHA obligated $4,800 per OCO patient, on average, compared with an average of $8,800 per patient for veterans from all eras who were being treated at VHA.[1] OCO veterans are typically younger and healthier than the average VHA patient and as a result are less expensive to treat; indeed, the amount of resources devoted to the average OCO veteran is similar to that devoted to the average non-OCO veteran under the age of 45. Thus, although OCO patients made up 7 percent of the veterans VHA treated in 2010, they were responsible for only 4 percent of the total amount that VHA obligated for medical care and research.

- The medical costs associated with VHA's treatment of OCO veterans could, in CBO's estimation, total between $40 billion and $55 billion over the 10-year period from 2011 through 2020, depending on the number of military personnel deployed to overseas contingencies in the future and the rate of growth of medical expenditures per person. That amount would be in addition to the $6 billion that VHA had spent on OCO veterans' health care by the end of 2010. VHA is funded by annual discretionary appropriations (unlike Medicare, for example, which is funded by permanent appropriations); therefore, the estimated amounts would only be spent if lawmakers decided in the future to fully fund the care that OCO veterans are receiving from VHA under current policies.

The number of OCO veterans using VHA in the future, and the potential costs for treating them, are affected by the number and types of medical conditions that service members develop while deployed to overseas contingency operations. Consequently,

1. 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.

CBO's analysis examined the number of veterans who already use VA's health care services and the number who may use them in the future, as well as their primary health conditions:

- Of the 2.3 million active-duty military personnel and reservists who had deployed to combat operations in Iraq and Afghanistan by the end of March 2011, 1.3 million have become eligible for VA's health care services. Of those 1.3 million people, almost 685,000 (52 percent) have sought medical care from VHA since 2002.

- Through June of this year, close to 44,600 service members had been wounded in action during those operations. For the recently concluded Operation Iraqi Freedom, the survival rate among all wounded troops averaged 90.2 percent; by comparison, the survival rate during the Vietnam conflict was 86.5 percent.

- Department of Defense (DoD) statistics indicate that through the end of March 2011, about 1,570 service members had required amputations, including over 3 percent of all troops wounded in action. Service members who undergo amputations receive their initial treatment in the military health care system. Many choose to remain in uniform; those who separate from the military may continue to receive their medical care and rehabilitation services through VHA.

- Through March of this year, the most common medical conditions diagnosed among the OCO veterans who had ever used VA's health care services were musculoskeletal disorders, which affect muscles, nerves, tendons, ligaments, joints, cartilage, or spinal disks (55 percent of OCO veterans who had ever used VHA), and mental health problems (51 percent of such veterans). (Those numbers sum to more than 100 percent because veterans may be diagnosed with multiple conditions.)

Traumatic brain injury, or TBI (an injury to the brain arising from sudden trauma to the head), and mental health disorders—particularly post-traumatic stress disorder, or PTSD (an anxiety disorder triggered by a traumatic event)—are often cited as conditions whose treatment could result in substantial future costs for VHA. At the request of the House Committee on Veterans' Affairs, CBO is analyzing the number of veterans diagnosed with those conditions within VHA and the costs to treat them, but those results are not yet available. For the numbers presented here based on last fall's study, CBO projected the total costs to treat OCO veterans on the basis of broad categories of medical services, incorporating observed changes in OCO veterans' use of services in the years following their enrollment;[2] it did not build the projections using the prevalence or costs of specific medical conditions. CBO's analysis to date suggests the following:

2. VHA is required by law to manage the provision of its services through an enrollment system, which assigns veterans to one of eight priority groups for treatment.

- A great deal of uncertainty surrounds the prevalence of PTSD and TBI within the OCO population and, hence, the number of veterans with those conditions whom DoD, VHA, and other health care providers may encounter in the future. (Prevalence is an estimate of the proportion of cases of a disease or condition in a population, whether or not an individual has received a diagnosis from a medical professional.) Published research has offered a wide range of estimates of the prevalence of the two conditions, because of substantial differences in the assessment tools researchers used to identify the conditions, the stringency of the criteria they employed to determine cases, and the subgroups of service members they studied.

- By the end of March of this year, DoD clinicians had diagnosed PTSD in about 75,000 service members either during their deployment to an overseas contingency operation or after their return. Among OCO veterans who had received medical care from VHA over the same period, about 187,000 (27 percent) had been diagnosed with PTSD. The estimates from DoD and VHA are not additive: There is an unknown amount of overlap because some veterans have been treated in both systems. Published studies of OCO service members or veterans have reported estimates of the prevalence of PTSD that generally range between 5 percent and 25 percent; the rate of diagnoses among VHA patients is at the high end of that range. Such a relationship would not be surprising if veterans who suspected they had mental health or other medical problems were more likely than other veterans to seek medical care from VHA.

- Through March 2011, DoD clinicians had diagnosed symptomatic TBI (in which symptoms, such as headaches, memory difficulties, or sleep problems, persisted at the time of medical screening or examination) in a total of 35,000 service members during or just after they returned from deployments to overseas contingency operations. The most recent data available indicate that about 90 percent of those injuries were classified as mild TBI—also known as a concussion—in which the brain typically heals quickly (within a few weeks or months).

- VHA researchers have reported that its clinicians diagnosed symptomatic TBI in about 26,000 (7 percent) of new OCO patients who were screened from the implementation of its screening program in 2007 through 2009. That rate of diagnosis is consistent with the limited data published by other researchers. (The two departments' estimates do not yield a comprehensive total through 2011 because their reporting time frames are different.) Although the rate of diagnosis within VHA should not be used to estimate the prevalence of TBI in the overall OCO population, it remains useful in projecting the medical services that veterans will expect from VHA and the costs VHA could face as a result. Other factors also influence veterans' use of services, including VHA's outreach efforts, the availability and cost of other options for health care (for instance, employment-based health insurance), and veterans' satisfaction with the quality of the care that VHA provides.

VA's Health Care Program

With appropriations of $52 billion in fiscal year 2011 for medical care and research, VHA operates VA's medical centers and clinics and provides health care and rehabilitation services to veterans. VHA's medical personnel also provide emergency management services, train medical students and other health care providers, and conduct research. The health care system consists of about 150 medical centers; 950 ambulatory care and community-based outpatient clinics; 230 facilities known as Vet Centers, which provide readjustment counseling and outreach services; 130 nursing homes; and more than 150 rehabilitation and home care programs. In 2010, VHA's outpatient clinics tallied over 80 million visits by veterans for services that included routine health assessments, specialty care, and outpatient surgery. VHA employed a total of about 245,000 full-time-equivalent employees in 2010, including nearly 17,000 physicians and 67,000 nurses and nursing assistants.

To better care for injured veterans of recent overseas contingency operations, VHA established what it calls its Polytrauma System of Care, which includes four Polytrauma Rehabilitation Centers and additional secondary sites and clinical teams. Those facilities provide rehabilitation and treatment for returning service members and veterans who are recovering from multiple traumatic injuries. VHA has also enhanced its mental health services, adding more than 7,500 full-time-equivalent mental health staff and training more than 4,000 staff members in providing psychotherapy for veterans who suffer from post-traumatic stress disorder. In 2007, VHA began screening all OCO veterans who use VHA's services to identify cases of symptomatic TBI (in which symptoms, such as headaches or sleep problems, persist at the time of a veteran's medical screening or examination).[3]

VHA expects to obligate $2.4 billion in fiscal year 2011 to provide health care to OCO veterans, a real (inflation-adjusted) increase of 24 percent above the $1.9 billion it obligated for that purpose in 2010 (see Table 1). Between 2005 (the year VHA began to separately report spending for OCO veterans' care) and 2010, the agency spent a total of $6 billion (in 2011 dollars) on those veterans' treatment. In real terms, the year-to-year growth in VHA's spending for OCO veterans averaged nearly 50 percent in those years. A large portion of that growth stemmed from rising enrollment in VA's health care system; however, increases in the number of services used per enrollee and in the rate of medical inflation above that of general inflation also contributed. For example, the use of ambulatory services (such as visits to physicians) per OCO enrollee grew by 7 percent or more annually from 2006 to 2010.

In 2010, VHA obligated an average of $4,800 per OCO patient, compared with the $8,800 per patient it obligated for veterans of all eras and conflicts being treated at VHA. As a result, although OCO veterans accounted for 7 percent of all enrollees

3. VA policy mandates that all new OCO patients be screened for symptomatic TBI; however, those veterans who report a prior traumatic brain injury are not required to complete the screening questionnaire and are not included in the TBI rates reported by VHA researchers.

Table 1.

Number of OCO Veterans Treated Each Year by VHA and Average Amounts Obligated Each Year per OCO Patient

	Actual						Projected,
	2005	2006	2007	2008	2009	2010	2011
Number of OCO Veterans Treated	101,800	155,300	205,600	261,000	332,900	400,100	476,500
Amounts Obligated							
Millions of 2011 dollars	260	440	690	1,060	1,490	1,930	2,400
Percentage change from previous year	n.a.	69	57	54	41	30	24
Average Amounts Obligated Yearly per OCO Patient (2011 dollars)	2,600	2,840	3,370	4,080	4,490	4,820	5,030

Source: Congressional Budget Office based on budget requests by the Department of Veterans Affairs for fiscal years 2007 through 2012.

Notes: Overseas contingency operations (OCO) are recent and ongoing military operations in Iraq and Afghanistan.

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

VHA = Veterans Health Administration; n.a. = not applicable.

who used VHA's services in 2010, their care was responsible for 4 percent of VHA's total medical costs for that year. The lower cost of OCO veterans' care is largely attributable to their relative youth; the cost of the care provided to non-OCO veterans under the age of 45 is similar.[4] Moreover, CBO expects that over time, as the OCO veterans develop age-related medical conditions, the costs for their care will rise and be close to those for the care of other older veterans who use VHA's services.

Eligibility for and Use of VHA

Two of the factors that determine VHA's future costs are the number of veterans who are eligible for health benefits and the extent to which thoseveterans use VHA's services.

Eligible Veterans

Eligibility for health care provided by VHA is based primarily on a veteran's military service. Generally, veterans who had been part of the active component of one of the services must have served 24 continuous months on active duty and been discharged under other than dishonorable conditions. Reservists and National Guard members who are called to active duty under a federal order may also qualify for VA's health

4. Nearly 70 percent of OCO veterans who use VA's health care services are under the age of 40, and all but 1 percent are under the age of 60. By contrast, about 45 percent of all veterans enrolled in VHA are age 65 or older.

care benefits. Those broad criteria, however, do not necessarily guarantee access to medical treatment because VA restricts enrollment according to the resources it has available. Specifically, VHA operates an enrollment system that assigns a veteran to one of eight categories to establish his or her priority for using its health care services. Veterans with higher priority include those who have service-connected disabilities, low income, or both. In January 2003, VA imposed a general freeze (with some subsequent modifications) on new enrollments in the lowest priority group (Priority Group 8).[5]

The Veterans Programs Enhancement Act of 1998 (Public Law 105-368) guarantees access to VA's health care system, after separation from active military service, to members of the armed forces who have served on active duty in combat operations since November 1998; moreover, reservists and members of the National Guard are included under that guarantee. The law gave combat veterans a two-year period of eligibility for enrollment after leaving active duty, waiving any requirements for them to document that their income is below established thresholds or to demonstrate a service-connected disability, which veterans who have not served in combat operations must do. In 2008, lawmakers extended the eligibility period to five years.[6] Once enrolled, OCO veterans may continue to use VHA's services when the five-year period of enhanced eligibility ends, but their priority group for enrollment may change, depending on their disability status and income. In particular, OCO veterans may be moved to a lower priority group, including Priority Group 8. Once reclassified, veterans are required to make the standard copayments for services that are applicable to their priority group.

Under those legislative authorities, VHA provides free health care for medical conditions directly or potentially related to a veteran's military service in combat operations over the past decade. VHA also treats combat veterans for non-combat-related conditions but may bill the veteran's third-party insurance (if any) or charge the veteran a copayment unless he or she is in a higher priority group. By the end of March 2011, about 1.3 million veterans of recent U.S. military operations had become eligible for VHA's services—710,000 members who had served in the active component and 605,000 members who had served in the reserves and National Guard.[7]

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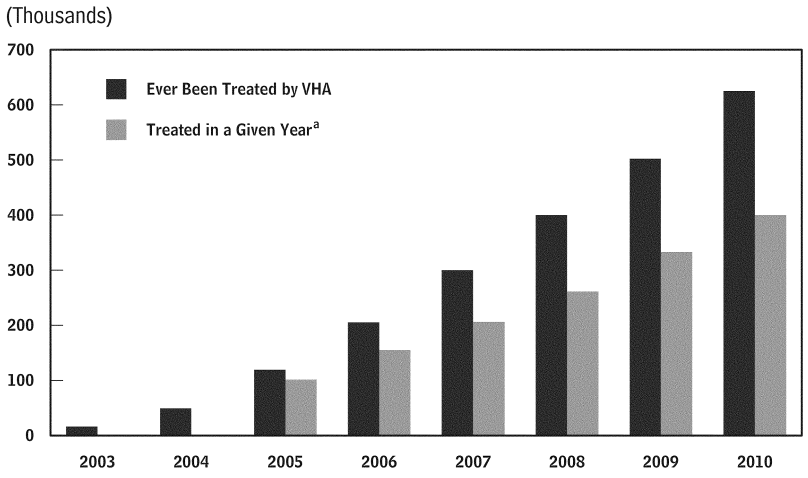
5. Priority Group 8 veterans are those who have no service-connected disabilities or who, VA has determined, have service-connected disabilities that are ineligible for monetary compensation; they also have annual income or net worth above both VA's means-test threshold and its regional income threshold.

6. See title XVII of the National Defense Authorization Act for Fiscal Year 2008, P.L. 110-181, 122 Stat. 493.

7. Some members of the reserves and National Guard who have returned from recent military operations may retain their reserve affiliations—making them potentially subject to future call-ups—but at the same time be immediately eligible to enroll in VA's health care system.

Figure 1.

Number of Veterans of Overseas Contingency Operations Treated by VHA



Source: Congressional Budget Office based on data from the Veterans Health Administration (VHA).

Note: Overseas contingency operations are recent and ongoing military operations in Iraq and Afghanistan.

a. Data on veterans of overseas contingency operations who were treated by VHA in a given year are not available before 2005.

Extent and Nature of the Services Used by Veterans of Overseas Contingency Operations

Of the 1.3 million OCO veterans eligible for VA's health care services, just over half had used such services at least once by the end of March 2011—specifically, 375,000 (52 percent) of the 710,000 active-component members who had separated from military service plus 310,000 (51 percent) of the 605,000 demobilized members of the reserves or National Guard.[8] The number of such veterans (those who have ever used the system) has grown rapidly—by upwards of 100,000 veterans annually—in most of the past several years (see Figure 1). In any given year, not all of those veterans seek care: By the end of fiscal year 2010, for example, some 625,000 OCO veterans had used VHA's services at some point, but only 400,000 of them were treated during that year.

8. Department of Veterans Affairs, Veterans Health Administration, Office of Public Health, *Analysis of VA Health Care Utilization Among Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), and Operation New Dawn (OND) Veterans* (July 2011).

For those veterans who use VA's health care system, most seek care for the first time shortly after they leave military service. For example, 15 percent of active-duty personnel who separated from the military in 2005 used the system within three months of separation, and an additional 16 percent did so within the next nine months. In the second year after separation, 7 percent of that 2005 cohort became new users of VHA's services, and about 4 percent sought care for the first time in each of the following three years. In general, the proportion of veterans who seek care at VHA soon after they separate from the military has been increasing with each successive separating cohort. That trend may indicate that more veterans are aware of the services that VHA provides or that more are in greater need of its services.

Through March 2011, musculoskeletal disorders and mental health problems were the most common diagnoses among the OCO veterans who had used VA's health care services. According to VHA data, since 2002, a total of about 377,000 OCO veterans, or 55 percent of those who had ever been treated by VHA, had received a diagnosis for a musculoskeletal condition. In addition, 350,000 such veterans, or 51 percent of the total, had been diagnosed with a mental health condition.[9] (Those numbers are not mutually exclusive; veterans may be diagnosed with multiple conditions.)

VHA data through 2008 show that the use of ambulatory and inpatient hospital services to treat OCO veterans' conditions follows similar patterns. On average, the use of such services is greatest in the months immediately after a veteran enrolls and then declines steadily during the following several months, stabilizing at the end of the first year after enrollment. By the end of the second year, the use of both types of services drops to about one-third of the initial rate. The only notable exception to that pattern is found in outpatient psychiatric visits, which hold steady at about 110 per month for every 1,000 enrollees through the three years following enrollment. Enrollees' use of pharmacy services also follows a different pattern from that for ambulatory and inpatient services: Use of pharmacy services spikes soon after enrollment and then increases steadily for the next few years.

The generally downward trend in the use of ambulatory and inpatient hospital services within each new group of enrollees has several possible explanations. Some veterans who find civilian employment—or, in the case of reservists, those who return to their previous jobs—may prefer to use private health care providers for most or all of their care, particularly if they do not have any service-connected injuries or conditions. Other veterans may turn to private sources of care after receiving a health screening or completing treatment for a medical condition at VHA. As those veterans develop age-related conditions over the next decades, however, their medical needs will increase, and some of them may return to VHA or use more of its services. That

9. Some of those diagnoses were provisional and might or might not have been confirmed during subsequent visits.

sort of pattern has been observed for veterans who deployed to the first Gulf War (August 1990 through July 1991).[10]

Medical Status of Military Personnel Who Return from Overseas Contingency Operations

As of the end of March 2011, 2.3 million military personnel had deployed to contingency operations in Iraq or Afghanistan. Some of those personnel have been killed or injured or have developed medical conditions that require ongoing treatment. The number of service members who have been wounded and the types and severity of the wounds they have suffered are two of the factors that affect the number of veterans who will use VHA's services and the resources that will be needed to pay for that care.

Medical Conditions of Military Personnel While Deployed

A total of almost 44,600 service members have been wounded in action during Operation Iraqi Freedom, Operation New Dawn, and Operation Enduring Freedom. Because Operation Iraqi Freedom officially came to a close on August 31, 2010, final tallies of casualty statistics are available. During that conflict, a total of 31,930 service members were wounded in action. About 40 percent of them, or 12,880 service members, did not return to duty within 72 hours of being wounded, and among those, 8,940 required aeromedical evacuation out of the Iraq theater of operations. An additional 10,360 service members were evacuated because of nonbattle injuries (those resulting from occupational accidents, motor vehicle accidents unrelated to combat, and other causes), and 30,030 service members were evacuated because of a disease or another medical condition.[11]

In Operation Iraqi Freedom, the 31,930 service members wounded in action sustained those injuries at a rate of 2,380 per 100,000 person-years at risk (the standard metric for such calculations, which is derived from the number of full-time-equivalent service members in the combat theater).[12] That rate is much lower than the rate

10. Department of Veterans Affairs, *Gulf War Era Veterans Report: Pre-9/11* (February 2011), www.va.gov/vetdata/Report.asp.

11. The casualty statistics are drawn from a Department of Defense Web site, http://siadapp.dmdc.osd.mil/personnel/CASUALTY/castop.htm.

12. Because deaths and injuries occur throughout a given year and troop levels vary, a single-point-in-time inventory provides a poor measure of risk. Nor would it be satisfactory, in the case of Operation Iraqi Freedom, to count the total number of troops passing through the Iraq theater of operations during one year because the lengths of the tours of duty of service members varied: The Marine Corps generally rotated units through the theater every 7 months, whereas the Army, at different points in time, had either 12-month or 15-month deployments. By analyzing DoD's quarterly reports on numbers of troops deployed to the Iraq theater, CBO estimated that U.S. military forces had about 1.3 million person-years at risk during Operation Iraqi Freedom. The calculations here update those in Matthew S. Goldberg, "Death and Injury Rates of U.S. Military Personnel in Iraq," *Military Medicine*, vol. 175, no. 4 (April 2010), pp. 220–226, which are in turn based on a methodology developed by Samuel Preston and Emily Buzzell, "Mortality of American Troops in the Iraq War," *Population and Development Review*, vol. 33, no. 3 (September 2007), pp. 555–566.

during the Vietnam War: 11,640 per 100,000 person-years at risk. In addition, the survival rate of troops wounded in Iraq is higher than the survival rate during the Vietnam War: 90.2 percent of the service members wounded in action during Operation Iraqi Freedom survived their wounds versus 86.5 percent of all troops wounded during the Vietnam War. Had the survival rate after being wounded in Operation Iraqi Freedom been equal to the rate prevailing during the Vietnam War, about 1,300 additional wounded service members—the equivalent of two battalions—would have died in the operation.

The widespread use of body armor and hemostatic bandages (which promote blood clotting) has enabled some soldiers to survive what would otherwise have been fatal injuries. Battlefield medicine has changed in other ways as well: Instead of evacuating wounded troops to medical stations, medical teams often move with frontline troops or to them when injuries occur.[13] In addition, when wounded troops need to be evacuated to receive more sophisticated medical care, that process takes place much more rapidly than it did during the Vietnam War. During that earlier conflict, it typically took 1 day to evacuate a wounded soldier to a field hospital, 7 days to evacuate him to a theater-level hospital (one that offered significant capability in the surgical subspecialties), and a total of 45 days to return him to the United States. In the Iraq operation, the timelines were shortened: A wounded soldier typically arrived at the theater-level hospital between 1 and 24 hours after an injury, at Landstuhl Medical Center in Germany (via specially equipped C-17s) within 24 to 72 hours, and then in the United States within a matter of days.

DoD data indicate that the great majority of service members evacuated as a result of battle-related injuries through 2007 were able to resume their military duties: By the end of that year, only one-quarter of them had separated from military service for any reason. Nevertheless, some service members have sustained severely disabling injuries, such as amputations and serious brain injuries, while deployed to Iraq or Afghanistan. Although definitive data on the number of seriously ill or disabled veterans of those operations are not readily available, a recent study sheds some light on the magnitude. The authors of that study estimate that during the 2003–2008 period, about 4,500 seriously wounded, injured, or ill veterans (0.5 percent of all veterans who had served in those conflicts through 2008) needed a caregiver and those caregivers were required for an average of 19 months.[14] Additional data from VA's Traumatic Injury Protection Under Servicemembers' Group Life Insurance (TSGLI) program also allow a rough estimate of the number of service members who have been severely disabled by war-related injuries. TSGLI provides a financial benefit to service members who experience certain traumatic injuries (on or off duty), such as total and permanent loss of hearing, sight, or speech; amputation; or severe brain injury. (The benefit does not cover all injuries that may lead to severe impairment.) Through

13. Richard Jadick, *On Call in Hell: A Doctor's Iraq War Story* (New York: NAL Caliber, 2007).

14. Eric Christensen and others, *Economic Impact on Caregivers of the Seriously Wounded, Ill, and Injured* (Alexandria, Va.: CNA Corporation, April 2009), p. 3.

September 2010, a total of 6,000 veterans of recent overseas contingency operations, equal to 0.5 percent of all veterans who had served in those conflicts by that date, had received benefits from the TSGLI program.

For every service member evacuated from Iraq or Afghanistan as a result of a battle injury, roughly one other has been evacuated because of a nonbattle injury, and three others have been evacuated as a result of a disease or some other medical condition. Among the 41,800 service members who have been evacuated to facilitate treatment for a disease or another medical condition, disorders of the musculoskeletal system or connective tissue (19 percent) and mental disorders (16 percent) were the most common. Among mental disorders, the two most common classes seen were depression and depressive disorders (4.5 percent of all medical evacuations for a disease or other medical condition) and adjustment disorders, including post-traumatic stress disorder (4.2 percent of such evacuations).

War-Related Medical Conditions Receiving Widespread Attention: Amputations, Traumatic Brain Injury, and Post-Traumatic Stress Disorder

In public discussion of the wars in Iraq and Afghanistan, three types of injuries or medical conditions have variously been identified as "signature conditions" of those conflicts: amputations, post-traumatic stress disorder, and traumatic brain injury. About 75 percent of the amputations undergone by service members who served in overseas contingency operations resulted in the loss of one or more major limbs; the remaining 25 percent involved the loss of fingers, toes, hands, feet, or partial limbs. PTSD, which is induced by exposure to a traumatic event, is characterized by symptoms that include a reexperiencing of the event, hyperarousal (such as irritability or exaggerated startle response), and diminished responsiveness to or avoidance of stimuli associated with the trauma. TBI, arising from sudden trauma to the head, may result in a decreased level of consciousness, amnesia, or neurological or intracranial abnormalities. TBI is classified at the time of the injury as mild, moderate, or severe. (Mild TBI, which is also known as a concussion, may lead to ongoing symptoms that include headaches, memory difficulties, or sleep problems.)[15]

Of those three conditions, PTSD was the one most commonly diagnosed among service members by DoD clinicians through March 2011 (accounting for about 75,000 cases), followed by mild and more-severe cases of TBI (about 29,000 and about

15. The standard definition of mild TBI is given in T. Kay and D.E. Harrington, "Definition of Mild Traumatic Brain Injury," *Journal of Head Trauma Rehabilitation*, vol. 8, no. 3 (September 1993), pp. 86–87. Among other criteria, any loss of consciousness in mild TBI is limited to at most 30 minutes, and loss of memory for events after the accident (post-traumatic amnesia) is limited to at most 24 hours. DoD and VA impose one additional criterion for mild TBI: normal brain imaging results. Service members who meet the criteria for mild TBI but have abnormal brain imaging results are rated as having moderate TBI. Service members who meet the criteria for more than one severity level are rated at the higher severity. See Department of Defense and Department of Veterans Affairs, *VA/DOD Clinical Practice Guideline for Management of Concussion/Mild Traumatic Brain Injury* (March 2009).

3,000, respectively) and amputations (involving about 1,600 service members). TBI and PTSD seem to co-occur with some frequency: According to one study, among soldiers who had just returned from a deployment to Iraq, about one-third who reported suffering a traumatic brain injury also screened positive for PTSD.[16]

The prevalence of those conditions in the current and future OCO veteran population and those veterans' subsequent use of VHA's services will affect the agency's future costs. (Prevalence is an estimate of the proportion of cases in a population, whether or not an individual has received a diagnosis from a medical professional.) For some medical conditions, such as amputations, a census of affected service members exists, and prevalence is known; for other conditions, such as PTSD and TBI, prevalence is uncertain, which makes it more difficult to gauge the resources needed for the treatment of those conditions.

Methodologically, the "gold standard" for determining the prevalence of PTSD and TBI in the OCO population would be to develop a representative, or random, sample of people from that population and have medical personnel evaluate each person for the presence of the conditions. But achieving such an ideal would be expensive and difficult to undertake. Instead, some researchers use administrative data on diagnoses to tabulate numbers of cases, a method that will generally understate prevalence in the population because not everyone seeks care from either DoD or VHA for their deployment-related conditions. Other researchers use clinical screening tools, such as questionnaires or structured interviews, as the basis for identifying cases. Some researchers who report the numbers of cases of PTSD on the basis of such tools use low thresholds for assessing that condition. In so doing, however, they may also generate "false positives" (results that indicate the condition is present when it is not) and overestimate the number of cases. Conversely, researchers who process screening results using more-restrictive thresholds could underestimate cases.

Another problem with existing research on prevalence is that most studies to date have oversampled certain groups within the OCO population, an approach that is unlikely to yield accurate measurements. On the one hand, using samples drawn from combat units, whose members tend to experience more intense physical and psychological trauma than do the members of other types of units, may lead to prevalence estimates that are too high to apply to the general population of service personnel in a combat region, which includes logistical and support units. On the other hand, using samples based on returning uninjured troops may lead to prevalence rates that are too low.

Amputations. Through March 2011, more than 3 percent of service members wounded in action during the conflicts in Iraq and Afghanistan (1,359 service members) had required amputations; another 209 service members had required amputations as a result of nonbattle injuries (most often motor vehicle or other accidents or crush injuries) or disease. As of the end of March, the rates of amputation

16. Charles W. Hoge and others, "Mild Traumatic Brain Injury in U.S. Soldiers Returning from Iraq," *New England Journal of Medicine*, vol. 358, no. 5 (January 31, 2008), pp. 453–463.

resulting from injuries in battle were 3.5 percent among the wounded in Operation Enduring Freedom and 3.1 percent among the wounded in Operation Iraqi Freedom and Operation New Dawn combined. Of all battle-related amputations, 925 (68 percent) were due to the effects of improvised explosive devices.[17] Among the total of 1,568 service members who required amputations for any reason, 867 lost a single major limb, 292 lost two limbs, and 27 lost three or more limbs. Several hundred other service members lost (sometimes in combination) fingers, toes, hands, feet, or partial limbs. Future health care costs for veterans with amputations will vary: Virtually all will receive some forms of physical and occupational therapy, but the more severely injured may have related long-term medical issues and will also be provided with and trained in the use of prosthetic replacements.

Traumatic Brain Injuries. The number of traumatic brain injuries attributable to service in overseas contingency operations is difficult to measure. Some cases of TBI may be identified in the combat theater, most easily when a soldier suffers a penetrating head wound but also, in other cases, on the basis of indications such as loss of consciousness or amnesia. Cases of TBI that are not diagnosed in the combat theater may be diagnosed later, in many instances after the service member returns home if he or she continues to experience symptoms (for example, headaches, difficulties with memory, or sleep problems). DoD began a program in 2008 to screen all service members returning from overseas combat operations for indications of symptomatic TBI.

Between October 2001 and March 2011, DoD reports, military clinicians diagnosed TBI in 35,000 service members who showed symptoms during their deployment to overseas contingency operations or soon after they returned.[18] As of DoD's most recent report, about 90 percent of those cases of TBI were deemed mild. (Most people who have mild cases recover in weeks or months, although a small portion may have effects that linger for more than a year.)[19]

Other findings on the prevalence of TBI are available from a few recent studies that used data from DoD. Estimates of the proportion of service members deployed to overseas contingency operations who experienced a traumatic brain injury (including

17. An improvised explosive device (IED), also known as a roadside bomb, is a homemade bomb constructed and deployed in ways other than in conventional military action. IEDs may be constructed of conventional military explosives, such as an artillery round, attached to a detonating mechanism; they may be used in terrorist actions or in unconventional warfare by guerrillas or commando forces in a theater of operations.

18. Department of Defense, *Medical Surveillance Monthly Report*, vol. 18, no. 6 (June 2011), p. 17, www.afhsc.mil.

19. See Michael A. McCrea, *Mild Traumatic Brain Injury and Postconcussion Syndrome: The New Evidence Base for Diagnosis and Treatment* (New York: Oxford University Press, 2008); and Heather G. Belanger and others, "Factors Moderating Neuropsychological Outcomes Following Mild Traumatic Brain Injury: A Meta-Analysis," *Journal of the International Neuropsychological Society*, vol. 11 (2005), pp. 215–227.

those who no longer had symptoms) generally range from 15 percent to 23 percent, depending on the methods a given study used to assess the presence of an injury and the population being sampled.[20] That range, however, does not reveal the intensity or persistence of symptoms over time but merely how many service members may have sustained such an injury. In addition, the estimates of prevalence from those studies may be inaccurate because the analyses suffer from some of the biases discussed above. A limited body of research suggests that only a fraction of the service members who sustained a TBI continued to experience symptoms over the longer term that might have been caused by that injury. In one study, 23 percent of soldiers in an Army brigade combat team experienced a traumatic brain injury during a one-year deployment to Iraq; however, only 9 percent of soldiers within that brigade reported at least one ongoing symptom when they were screened a few days after returning home from the deployment, and only 4 percent reported at least two ongoing symptoms.[21]

From the implementation of VHA's screening program for TBI through 2009, about 7 percent of the new OCO patients screened were diagnosed with symptomatic TBI. Those cases are in addition to the cases identified by DoD. The VHA data may be useful in planning for the medical services that veterans will need from VA's health care system, but they do not answer the broader question of how many veterans in total have symptomatic TBI. If service members who have separated from the military are more likely than those who have remained on active duty to have service-connected health problems, then the rate of diagnosis among VHA patients will be higher than the rate in the entire OCO population. It is possible, however, that the rate in the overall OCO population could be greater than the rate diagnosed among VHA patients if sufficient numbers of veterans with symptomatic TBI were either being treated for the condition elsewhere or not being treated at all. For example, some veterans have employment-based health insurance; others seek care from sources that are not tied to their military service, perhaps because providers are located more conveniently or are perceived to be more private; and still other veterans forgo care altogether.

Post-Traumatic Stress Disorder. DoD reports that from October 2001 through March 2011, military clinicians diagnosed PTSD in about 75,000 service members during or after their return from deployments to overseas contingency operations. Through March 2011, VHA had assigned a diagnosis of PTSD to 187,000 OCO veterans, or 27 percent of all such veterans who were using VHA's services.[22] And for the

20. Terry Schell and Grant Marshall, "Survey of Individuals Previously Deployed for OEF/OIF," in Terri Tanielian and Lisa H. Jaycox, eds., *Invisible Wounds of War* (Santa Monica, Calif.: RAND Corporation, April 2008), pp. 87–115; Heidi Terrio and others, "Traumatic Brain Injury Screening: Preliminary Findings in a U.S. Army Brigade Combat Team," *Journal of Head Trauma Rehabilitation*, vol. 24, no. 1 (January/February 2009), pp. 14–23; and Charles W. Hoge and others, "Mild Traumatic Brain Injury in U.S. Soldiers Returning from Iraq."

21. Terrio and others, "Traumatic Brain Injury Screening."

22. Department of Veterans Affairs, Veterans Health Administration, Office of Public Health, *Analysis of VA Health Care Utilization among Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), and Operation New Dawn (OND) Veterans*.

same period, an additional 15,000 veterans who were not treated for PTSD at VHA hospitals did receive such treatment at Vet Centers. (DoD's and VHA's tabulations overlap by an undetermined amount, however, so the number of individuals diagnosed with PTSD is less than the sum of 277,000.)

The rates of diagnosed PTSD cases among VHA's patients should not be extrapolated to estimate the prevalence of that condition in the entire population of service members who have returned from overseas contingency operations. If veterans who suspected they had mental health or other medical problems were more likely than other veterans to seek medical care from VHA, the rate of diagnosed PTSD among VHA's patients would probably be higher than the prevalence among the entire OCO population. However, some veterans might not seek care from VHA for various reasons, perhaps because of concerns about the stigma associated with having a mental health problem or because of the inconvenience of undergoing additional evaluation and treatment. Such considerations could lead the rate of diagnosis among VHA's patients to be an underestimate of prevalence in the OCO population. Although the rate of diagnosed PTSD among VHA's patients is not necessarily indicative of the prevalence of PTSD in the overall population of OCO veterans, such information can be used to help project the kinds of medical services that veterans may need in the future and the potential costs for VHA to meet those needs.

In several published studies reporting the prevalence of PTSD among different groups of service members or veterans who deployed to overseas contingency operations, estimates have generally ranged between 5 percent and 25 percent. Those estimates vary widely because of substantial differences among the researchers in the assessment tools they used to determine the presence of the condition, the stringency of their criteria for identifying cases, and the subgroup of service members they studied.[23]

Projections of VHA's Costs for Providing Medical Care

CBO has projected the resources that VHA would need between 2011 and 2020 to treat all OCO veterans who enrolled in VA's health care system.[24] (The fact that VHA is funded by annual discretionary appropriations, however, means that policymakers will ultimately choose the amount of funding.) The projections reflect the rapid growth occurring in the size of the OCO veteran population, the type and number of

23. For a survey of the literature, see Rajeev Ramchand and others, "Disparate Prevalence Estimates of PTSD Among Service Members Who Served In Iraq and Afghanistan: Possible Explanations," *Journal of Traumatic Stress*, vol. 23, no. 1 (February 2010), pp. 59–68.

24. The costs CBO projected are those for treating OCO veterans, but not all of those costs are specifically attributable to the veterans' participation in contingency operations in Iraq and Afghanistan. Some OCO veterans would have been eligible for VHA's services and would have used that system even if they had not deployed to those operations (for example, for treatment of normal age- or training-related injuries to the musculoskeletal system). If the objective of CBO's analysis were to estimate the incremental costs of the war, the costs for treating conditions not related to those veterans' deployments would have to be subtracted from the estimates of gross costs.

VHA's services that those veterans use, and trends in the cost of health care throughout the economy. To account for uncertainty about the numbers of service members deployed to overseas operations and the rate of growth of medical expenditures, CBO used two scenarios, incorporating plausible but different assumptions about those and other factors, to capture some of the span of possible outcomes. In CBO's estimation, the potential costs in 2020 for treating all enrolled OCO veterans would range between $5.5 billion and $8.4 billion (in 2011 dollars) under the two scenarios. Those figures compare with the $1.9 billion that VHA spent to treat enrolled OCO veterans in 2010 and the total of $6 billion that it spent between 2003 and 2010. (The projections in this section originally appeared and are described in more detail in the October 2010 CBO report *Potential Costs of Veterans' Health Care*.)

Using historical data from DoD and VHA, CBO estimated how many veterans would enroll in VHA in each year of the 2011–2020 projection period. It then estimated OCO veterans' use of seven broad categories of medical services in each year after enrollment, assuming that past trends in the use of services continued into the future. (That approach allows the mix of services to change as each cohort of enrollees ages.) CBO then applied projections of the growth in medical expenditures per person to the seven categories of services and estimated an annual stream of VHA's potential costs.

The two scenarios that CBO used differed on two main points. For Scenario 1, CBO assumed that the number of deployed service members would drop to 30,000 active-duty, reserve, and National Guard personnel by 2013 and remain at that number thereafter (although those personnel would not necessarily be in Iraq and Afghanistan).[25] Currently, the number of actual separations since 2002 among military personnel who have served in overseas contingency operations is 1.3 million; under this scenario, total separations through 2020 would equal 2.2 million personnel. For Scenario 1, CBO also assumed that VHA's health care expenditures per OCO enrollee for the seven major categories of service would grow at about the same rates as the national average expenditures for those services and that the patterns of enrollment among future OCO veterans and their use of services after they left the military would be similar to those of recent years.

For Scenario 2, CBO assumed that the number of service members deployed to overseas contingency operations over the 2011–2020 period would be a little more than twice the number reflected in the assumption underlying Scenario 1. Specifically, CBO assumed that forces would be drawn down more slowly through 2014, stabilize at 60,000 personnel at the beginning of 2015, and remain at that number thereafter. Separations by military personnel who deployed for overseas contingency operations

25. That drawdown, as well as the drawdown to 60,000 deployed service members assumed for Scenario 2, is described in Congressional Budget Office, *The Budget and Economic Outlook: Fiscal Years 2010 to 2020* (January 2010), pp. 14–15. The total number of troops that would be deployed under either scenario excludes U.S. military personnel who are permanently based overseas (in locations such as South Korea or Okinawa, Japan) but who are not engaged in contingency operations.

from 2002 through 2020 would exceed 2.6 million under this scenario. For expenditures per OCO enrollee under Scenario 2, CBO projected higher rates of growth than the rates it incorporated in Scenario 1. In general, CBO assumed that VHA's expenditures per OCO enrollee would grow at annual rates that were 30 percent higher than the rates underlying Scenario 1. Indeed, the cost per enrollee of providing medical services has generally been rising faster within VHA in the past few years than the cost per person in the general population and may continue to do so.

Projected Costs Under Scenario 1

Under Scenario 1's assumption that the number of deployed service members would drop to 30,000 by 2013, CBO estimated that from the beginning of hostilities in October 2001 through 2020, VHA would enroll 1.4 million OCO veterans and treat a total of 1.3 million of them. In that case, the annual resources (in 2011 dollars) required to provide care to those veterans would nearly triple over the coming decade, rising from $1.9 billion in 2010 to roughly $5.5 billion in 2020 (see Figure 2), for a total of $40 billion.[26] By comparison, the annual resources needed to treat veterans in VHA from 2001 to 2020 who did not serve in overseas contingency operations would rise by almost 40 percent, CBO projects, from $46 billion in 2010 to $64 billion in 2020.

Annual costs would increase most rapidly in the early years of the projection period. The greatest amount of growth would occur in 2011 and 2012, when potential costs are projected to increase by 15 percent or more annually because of a large number of new enrollees. After that, the number of new enrollees per year would begin to fall. VHA's annual costs also would grow at a slower rate in part because enrollees incur the highest costs in the year after they enroll. By 2015, annual real increases in costs would be less than 10 percent and would fall to about 6 percent by the end of the projection period.

Rising enrollment over the period is responsible for a large portion of the increase in the estimated resources required to treat OCO veterans under Scenario 1. Treating the additional 720,000 OCO veterans projected to enroll between 2011 and 2020 would cost nearly $3 billion in 2020, an amount equal, in CBO's estimation, to roughly half the costs projected for all OCO veterans in that year. The OCO veterans who had enrolled before 2011 would account for the remainder of those projected costs.

The aging of the OCO population is likely to have only a small effect on costs through 2020. According to data from VHA, nearly 70 percent of OCO veterans who use VA's health care system are under the age of 40, and all but 1 percent are under the age of 60. By contrast, about 45 percent of the U.S. population is over 40 years old, and almost 20 percent is at least 60 years old.[27] Because a large fraction of the OCO veteran population is relatively young—that is, in an age group in which medical costs

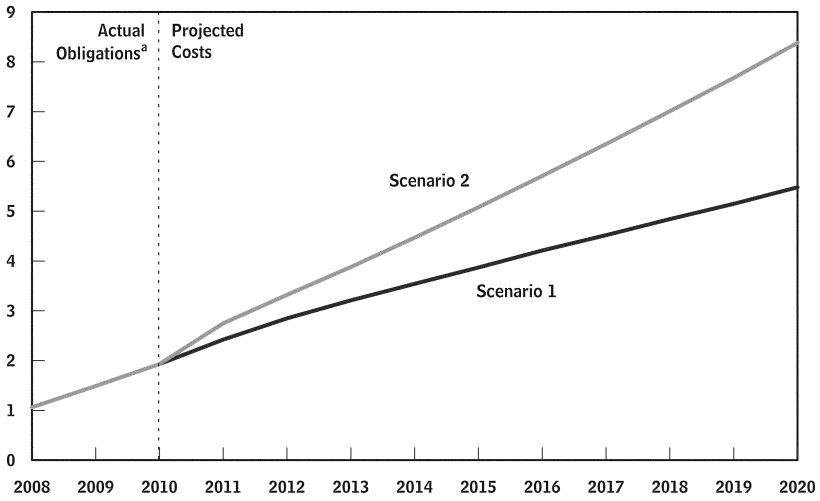
26. Including the funding already devoted to those veterans from 2002 to 2010 would boost that amount to $46 billion.

27. The statistics about national aging are CBO's calculations based on data from the Census Bureau's Population Division.

Figure 2.

VHA's Potential Costs for Providing Health Care Services to Enrolled Veterans of Overseas Contingency Operations

(Billions of 2011 dollars)



Source: Congressional Budget Office.

Notes: At the time CBO performed its analysis, in 2010, actual data on the Veterans Health Administration's (VHA's) obligations for that year were not available. As a result, CBO used VHA's preliminary estimate of those obligations as the starting point for its projections of health care costs for veterans of overseas contingency operations (recent and ongoing military operations in Iraq and Afghanistan). The projections in the figure above are the same as those presented in the 2010 report of CBO's analysis, but they have been converted to 2011 dollars.

VHA is required by law to manage the provision of its services through an enrollment system; that system assigns veterans to one of eight priority groups for treatment. By comparison with Scenario 1, Scenario 2 incorporates assumptions of a larger number of enrolled veterans of overseas contingency operations and faster growth of medical expenditures per enrollee. (For additional details on the scenarios, see the text.)

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

are largely stable—their aging over the decade will probably have only a small effect on the resources required per OCO enrollee in 2020.[28]

Moreover, because OCO veterans are typically younger and healthier than the average VHA enrollee, they are less expensive to treat. Accordingly, the costs overall to treat OCO veterans would remain relatively small throughout the projection period, consuming 8 percent of VA's resources for health care services in 2020 under Scenario 1. In later years, as OCO veterans reach older ages for which spending on medical care tends to be higher, the costs of medical care for OCO veterans might represent a larger share of VHA's total costs.

Projected Costs Under Scenario 2

Under Scenario 2's assumptions that a larger force would deploy and that medical expenditures per enrollee would grow faster than was assumed for Scenario 1, CBO projected that VHA would enroll 1.7 million OCO veterans and, from the beginning of hostilities through 2020, treat a total of 1.5 million of them. By CBO's estimates, the resources VHA would need to treat OCO veterans in 2020 under Scenario 2 would be substantially greater than those required under Scenario 1—$8.4 billion (in 2011 dollars), compared with $5.5 billion (see Figure 2). As was the case under Scenario 1, the largest growth in costs under Scenario 2 would occur early in the projection period: Costs would rise by more than 40 percent in 2011 and by 20 percent in 2012. After that, annual growth would slow, dropping to 9 percent by 2020. Costs over the entire period under Scenario 2 would total $55 billion, compared with $40 billion under Scenario 1.

The faster growth in expenditures per enrollee under Scenario 2 accounts for roughly two-thirds of the difference between the two scenarios' projected costs for 2020. By comparison, the assumption incorporated in Scenario 2 of a larger number of service members deployed to overseas contingency operations accounts for only about one-third of the difference in costs.

Although Scenario 2 would involve higher costs for treating OCO veterans than would Scenario 1, those costs would still represent, in CBO's estimation, only about 10 percent of VHA's total costs in 2020.

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28. See E. Meara and others as cited in Uwe Reinhardt, "Does the Aging of the Population Really Drive the Demand for Health Care?" *Health Affairs*, vol. 22, no. 6 (2003), p. 28. That research indicates that annual medical costs for the U.S. population between the ages of 35 and 44 are similar to costs for people ages 25 to 34. Costs for people ages 44 to 54 are about 40 percent higher than costs for those between 25 and 34 years of age. The largest increases in costs occur after age 55: Compared with costs for 25-year-olds, costs are twice as high for people ages 55 to 64 and three times as high for those ages 65 to 74.

POSTHEARING QUESTIONS SUBMITTED BY HON. PATTY MURRAY TO MS. HEIDI GOLDING, PRINCIPAL ANALYST, NATIONAL SECURITY DIVISION, CONGRESSIONAL BUDGET OFFICE

Question 1. Please provide more information regarding how addressing excess and duplication at VA will raise efficiency and maximize a return on resources without negatively impacting services?

Question 2. Many of the deficit and debt reduction proposals included across the board spending cuts and caps. Please provide any information your agency has regarding what impact such a cap will have on VA's ability to provide health care for over 8.3 million veterans in the coming years?

[Responses were not received within the Committee's timeframe for publication.]

Chairman MURRAY. Thank you very much. Thank you again to all for your testimony today. It is really appreciated.

Mrs. Nicely, I want to start with you. When I first met you up at Bethesda, I was really disconcerted when you told me that you had been waiting forever for your husband to finish his joint disability evaluation process. You had to wait almost 70 days for approval of a simple narrative summary.

Now, I went and checked. What I understand is that the summary only needed to state the obvious, that your husband was indeed missing two legs and two arms, and that essentially sat on somebody's desk for more than 2 months. That is just really unacceptable, and my apologies to you and your family on behalf of everyone for that.

But I wanted you, as you shared with me, to talk to me a little bit about what you were going through for those 70 days while this country essentially bureaucratically put you on hold.

Ms. NICELY. I think Todd's therapy is very important but he got to a point in his therapy where he was able to do more stuff more independently which did not require his therapist to be there I guess during the whole time.

So, it is a requirement. I do not know if it is just Marine Corps procedure or whatever that they go into therapy; and if Todd was not being taught new things or it was just getting redundant, he was doing the same things over and over again, so he had pretty much accomplished much of what he has wanted to within that timeframe, which meant he was taking up more space that other people could have been utilizing the therapist.

So, I guess why pay for his therapy or why if you could be paying it for somebody else. So, it was just a waste of time I guess.

Chairman MURRAY. What were you spending your time doing?

Ms. NICELY. Support. Taking Todd back and forth to therapy and just helping him with the daily living.

Chairman MURRAY. You talked to me a little bit about coordinators of care, that they were coming through changing every 2 months and that you knew more than they did and they left and you were training the coordinators of care.

Can you share with us a little bit about that?

Ms. NICELY. I do not want to say that all of them are at fault due to the situation because of the way it is. But the way that the military side has the liaisons coming in and out is very frustrating because they are not MOS specific. They are not trained in the jobs to get done that are being asked of them.

So, they come here without the knowledge of what they are expected to do and take the time while they are here to learn what they are doing, and by the time that they have adjusted and maybe have absorbed some of it, it is time for them to leave again, and new individuals come in who are not still not MOS specific.

So, that does not help us with what they are here for is the frustration and helping them take the stress off of the families and able to do the things that are necessary.

Instead me personally had to look for outside assistance from whether it was other family support or my case manager but was not assisted on the military side of things.

That also does not aid, and for me in the beginning of the family process, it is really hard to open up to people and trust individuals. So, to be able to get a connection with somebody and have somebody there for that short period of time and then transition out and give us somebody else new is not allowing us to have that connection or allow us to want to open up to them because we are like, OK, if we come to you what are you going to do for me because I know more than you do.

So, it is extremely frustrating. I know that they are working on it but it is still frustrating.

Chairman MURRAY. You are a tremendous advocate for your husband, and I am extremely impressed what Todd is capable of doing, and I know that you are proud of that as well. I also know that he needs you at his side, and you are there every single minute doing that.

You met many people through this process. What does somebody do that does not have a wife or a live-in caregiver?

Ms. NICELY. That is hard because you do see it. In some cases the family support is maybe not there or maybe not there for the right reasons. I think because of the lack of, I do not want to say lack of knowledge but their ability to assist in a lot of ways and the lack of compassion when it comes to a lot of these guys, their next choice would be to reach out to somebody I do not know whether it is through the military side of things or through the hospital because the hospital staff is wonderful. I guess there is not really a way to say that.

Chairman MURRAY. Maybe if you can share with this Committee, as you did with me, a little bit about what your day is like.

Ms. NICELY. Well, here recently a lot easier than normal because Todd has strived to become very independent with his prosthetics. Without his prosthetics, I would be doing the work for two people every day. And with his prosthetics and because of his knowledge and what he has been able to absorb through his therapist and his daily work in putting into therapy, I basically just observe and watch and, if he needs assistance, then I assist him if he asks, of course.

Chairman MURRAY. Thank you. And thank you for your courage in being here again too.

Mr. Rieckhoff, our government's ability to fulfill the sacred responsibility has been called into question by the ongoing debt crisis that is in front of us today.

If the debt limit is not raised, some have speculated that the government will not have enough money to provide veterans' benefits

checks. As you can imagine, and I am sure you know this, this uncertainty has caused an incredible amount of anxiety among our veterans and, of course, their families. I understand that the IAVA was at The White House yesterday, and I wanted to ask you if you can describe what the impact of a default would be on veterans.

Mr. RIECKHOFF. We do not know, and that is what we hoped to find out at The White House yesterday. We came back with no real additional information for our members.

So, I would ask you all what the impact will be. I think the bottom line for our members right now is they do not know what is going to happen August 1. They do not know what is going to happen September 1. They do not know if disability checks are coming. They do not know if paychecks are coming. They do not know if GI Bill checks are coming, and they are extremely concerned. They are scared.

Some of these folks who are 100-percent disabled have gotten no additional information and we have been getting quite a few e-mails, tweets, Facebook posts. People are more and more concerned by the day. And I think they understand generally where the debate is. They do not understand the specifics of how it will impact them. No one has been able to project with any kind of certainty how they should plan for their next 60 days.

Chairman MURRAY. I assume there is a lot of frustration.

Mr. RIECKHOFF. Incredible frustration, just devastating disappointment. And it has become demoralizing. I mean, not even from folks just here Stateside but overseas. There is a guy on a checkpoint in Afghanistan right now who does not know for certain what is going to happen to him and his family in 30 days.

That is ridiculous and it is outrageous and our members are beyond upset, and so, I would ask this Committee if you can help us get certainty. We have e-mails standing by. I can send it out to them within an hour and let them know what is going on but we need clarity and guidance from you all in this town about what to tell them. We have not gotten it yet.

Chairman MURRAY. Thank you. Thank you for much.

Senator Brown.

Senator BROWN OF MASSACHUSETTS. Thank you very much.

Crystal, I was concerned a little bit. You mentioned in your initial testimony about you have to go and get recertified on a regular basis to be in your position as a home care?

Ms. NICELY. Yes, sir.

Senator BROWN OF MASSACHUSETTS. Can you tell me a little bit about that? Like what they have told you, what is the process, how long does it take, why have they told you that you need to do it?

Ms. NICELY. In the beginning, from my understanding, it requires a doctor's approval. So, like a re-evaluation of the military servicemembers' health and how they are getting better on a day-to-day basis.

So, the use of or the need of a medical attendant, I believe, is why they make us re-apply for it, and it takes quite a long time. In the beginning, I do not know, months almost. I know there was a waiting list for a nonmedical attendant assistants.

From my understanding, they are working on it to improve that and it has improved speedwise, but going about how to get ap-

proved and the stipulations, and a better understanding of its is a need I would have to say.

Senator BROWN OF MASSACHUSETTS. So, how long does your certification actually last?

Ms. NICELY. I think the longest that you can request a nonmedical attendant is 6 months.

Senator BROWN OF MASSACHUSETTS. So, how many times have you had to recertify?

Ms. NICELY. I have only actually had to do it once for myself due to, I guess, the stipulations or the requirements of the law that due to I am transferred by record book to where my husband is that I no longer rate it. So, but I know certain from other family members and other individuals that have gone through it had to reapply many times. I do not know if that is due to the process, the loss of paperwork, or——

Senator BROWN OF MASSACHUSETTS. So, thank you for that. I am wondering how long has Todd been part of the IDES?

Ms. NICELY. What do you mean by that?

Senator BROWN OF MASSACHUSETTS. Well, he has been going through I know the expedited disability system.

In listening to your testimony, you said it was very frustrating, and there were breakdowns. I have a sense that you did not want to blame anybody because you are thankful obviously for the things that you have.

But on the other hand, you are upset at the fact that no one seems to be coming and saying, hey, listen, this is what you have, this is how you get it, and this is where you go, and this is, you know, how much you are going to get or the assistant. Has anyone ever done that and actually sat down and laid it all out to you on a piece of paper so you can actually almost have a flowchart?

Ms. NICELY. Before Senator Murray spoke to us, nobody sat down and gave us a better understanding of how the med board process works, nor what was to be expected of it, except that it was going to take a very long time. That was what we were informed of.

Senator BROWN OF MASSACHUSETTS. So how long was it from point "A" to Senator Murray getting involved?

Ms. NICELY. It started, Todd's Med Board I would say January timeframe because they said that there was a possibility that it would take quite a long time. So, by the time Todd was ready, and therapy was completed and he was ready to leave the hospital that it should be completed.

Senator BROWN OF MASSACHUSETTS. So you mentioned just a summary took 7 months, it was on somebody's desk you said.

Ms. NICELY. 70 days.

Senator BROWN OF MASSACHUSETTS. I am sorry. 70 days. Thank you. 70 days. Were you given any reason for that?

Ms. NICELY. Officially that it was just sitting on someone's desk. I believe that is what we were informed of that it was just sitting and waiting.

Senator BROWN OF MASSACHUSETTS. That is certainly not acceptable. Are you recognizing any additional hassles or problems of things moving along more expeditiously now?

Ms. NICELY. Oh, yes. She, as in Senator Murray, really put, kick them in the butt and we have not had any issues since.

Senator BROWN OF MASSACHUSETTS. That is great.

It is interesting because, according to our original estimates, it is 42,000. Does it take a Senator to kick people's butts to get help for the other soldiers and family members that are having very similar problems?

You have a husband who is obviously extremely injured. For him to have to go through this stuff and you as well, I just find once again, you know, we are getting back to the fact that the VA is not here. I would suggest, I am just sitting in as the Ranking Member today but with Senator Burr's consideration also that we find out like why.

Chairman MURRAY. Senator Brown, I appreciate that. I will say that the military was responsible at this point, and Secretary Lynn is personally involved.

Senator BROWN OF MASSACHUSETTS. Great. Thank you. My time is up and there are other Members. I will come back. Thank you.

Chairman MURRAY. Thank you very much.

Senator Tester.

Senator TESTER. Thank you, Madam Chair and thank you all for your testimony. Crystal, thank you especially.

You talked about your gratitude for Chairwoman Murray, and we all are grateful for Chairwoman Murray but the fact is our gratitude goes the other way. We thank you for what you do. We thank you for the sacrifices that your husband and you have given this country. We cannot repay you. That is just the way it is. There is nothing we can do to repay what you sacrificed.

And I think the VA is probably listening to this hearing, and I think the constructive criticism you have given is very positive. The questions about the IDES process, the section leader, the NMA recertification were already asked. I am not going to ask them again. I think you did a fine job.

Obviously, there needs to be more education done. There needs to be some streamlining because, quite honestly, with the number of disabled vets that are out there, the action of a Senator, there is no way we can do it all. So, the VA has to step up in a bigger way, and I think they are hearing that message through C-SPAN or whatever means it might be today.

Paul, I would like to echo your testimony. I think that the lifetime costs are huge but I think intervention in the beginning can save money and make quality-of-life better for our veterans.

It seems like a lot of the problems stem from access. A lot of problems stem from education. It is particularly difficult in rural America. We have tried to do some things. We have tried to enhance mileage. We tried to get more clinics out there, tried to get telemedicine going. More employment counselors in rural America.

The challenges are many. This is not a fair question, but I am going to ask it anyway. If you are going to look from my rural America perspective, the challenges that are out there, we have made some improvements.

Is there more we need to be doing and what areas would you invest in if you were sitting in this chair?

Mr. RIECKHOFF. Yes, sir. There is a lot of room for improvement, and that is what we hear consistently from our members. One thing that I think is important for this Committee and for this entire town to really wrap their heads around is that right now only 52 percent of our generation of veterans are enrolled in VA health care. Only half.

So we have got to think more creatively. The country thinks that the VA is a one-stop, the only solution, the silver bullet that is going to solve all the problems of this generation, and the VA I know is improving.

Obviously, we are disappointed they are not here. They have a long way to go. But we have also got to think more creatively. And I think we have to have a sustained effort that invests in community-based nonprofits, that enrolls the private sector, that involves the faith-based community, the people who are in those rural communities, because the VA has not innovated as a nationwide model. It is still catching up from 30 years ago in every way shape or form.

So, what we have seen as successful is involving those communities, leveraging technology especially. That is how you can get to those folks where they have decent access to the Internet, but that does give you a tremendous opportunity for innovation and for impact. You are not going to be able to bring everybody 400 miles to the nearest facility.

So, we have got to think creatively and find ways to invest in the community-based solutions that are working, you know, find those pilots and then take them to scale, because that is where we see in the field the most consistent entrepreneurial attitude.

It is that community-based church group or VFW hall or folks who are at the point of attack who are trying to deal with those problems. We have not seen a lot of innovation that has really been encouraged and taken to scale outside of the VA.

So, that is kind of I think a big bite of the apple that we as a Nation have to start to take on. The President has got to reframe it as well. He has to talk about more than the VA when we talk about veterans.

Senator TESTER. Thank you. I want to talk about local contracting. I guess initially it would be for Ms. St. James but whoever would like to answer this.

It is a huge issue in my State. The inability for the VA to recruit and retain doctors and surgeons is a big, big, big issue. We have not had a full-time orthopedic surgeon in Montana for several months. The VA is trying to recruit one. They cannot get them.

Now, we have got veterans who have to travel out of State, out-of-pocket care, quality-of-life goes down. There are 400 veterans on a wait list now that is approaching 2 years for orthopedic surgeries. It is completely unacceptable, and I know Montana is not the only State in this boat.

I do not think it is cost-effective to ship somebody miles and miles, hundreds of miles away from their home for surgery when it could be contracted locally in areas where we cannot get docs in the VA.

Can you tell me if this makes sense to you, to locally contract if you cannot get a doctor that is a specialist? If it is not you, Mrs. St. James, somebody else can answer the question.

But it appears to me that this could help solve any problem where we have need and we cannot fill the positions, it just seems to me that it would be a natural follow-on, to contract locally, take care of it so you do not have to travel halfway across the western United States and back again.

Ms. ST. JAMES. I think that is more appropriate for someone else on the panel.

Senator TESTER. OK. Anyone else want to take a shot at it. If not, it is yours, Paul.

Ms. GOLDING. All I can say on that, because I am not an expert on that aspect, is that I know there is some fee-based care in VHA. I do not know how they decide when it goes to fee-based care or not.

Senator TESTER. Paul.

Ms. GOLDING. I am shooting it back to you, Paul.

Mr. RIECKHOFF. Sir, when you are in the fight and you need ammo, you put your hand back and you want ammo, OK, these folks are out in the fight. You have heard from Mrs. Nicely. They need immediate care.

Senator TESTER. Right.

Mr. RIECKHOFF. And I think whether or not it is a contract is like DC talk to folks in the field.

Senator TESTER. Right.

Mr. RIECKHOFF. They want to know, who can I call right now that can help me.

Senator TESTER. Right.

Mr. RIECKHOFF. And I think whatever it takes to creatively deliver to that point of impact is what we need to come up with.

Senator TESTER. Right. That is my perspective too. I think that having people that need knee or hip replacement on a list for 2 years, it is not a good way to run a ship. I understand the problem with recruitment in rural America. It is in the private sector and in the public sector both. So, it is really important.

My time has run out long past, and I thank you all for your testimony and appreciate your perspectives.

Chairman MURRAY. Thank you very much.

Senator Isakson.

STATEMENT OF HON. JOHNNY ISAKSON, U.S. SENATOR FROM GEORGIA

Senator ISAKSON. Well, I want to compliment Crystal on her courage and their bravery to be here, and I want to take the presumptive position of recommending to the Chairman and the Ranking Member that our testimony be mailed to every Member of the U.S. Senate as required reading because I think it is a story that needs to be told over and over.

Sometimes, we get so busy doing things like we are doing right now, which is running around in circles, we do not really take into consideration those who are meeting tremendous challenges in life because of what they have to do.

You are a real hero to me, and I hope the Chair will do that and make sure every Member of the Senate at least gets the opportunity to read what a true American hero and Crystal and her husband really are.

Chairman MURRAY. I would hope that all of America hears it.

Senator ISAKSON. Absolutely.

Paul, I appreciate you being a very articulate spokesman on behalf of our Iraqi and Afghanistan veterans. They are going to need it over the years. There are a lot of them, and the challenges just like Crystal has described are greater.

The advances we have had in health care are wonderful but it also means there are a lot of people surviving battlefield injuries that did not before that require a tremendous amount of help and support. So, I appreciate what you are doing.

Crystal, on the nonmedical attendant, when you were answering Senator Brown, you said the VA provides one for up to 6 months. I thought I heard you say.

Ms. NICELY. I think it is actually military compensation because the VA does not pick you up until after the servicemember has retired. So, it is military compensation. It is up to 6 months. I think that is the requirement from my understanding.

When I first initially applied for the nonmedical attendant, they did it for a year, and then I was informed that it could only be 6 months, and then I was informed before applying it again that I did not rate it because I was transferred with Todd by record book.

Senator ISAKSON. So you are compensated by the VA as a nonmedical attendant during that period of time?

Ms. NICELY. Not yet, no, sir.

Senator ISAKSON. What I was trying to get at, Scott's question was right on point with me, why in the world you would have to continue to re-apply to the main nonmedical attendant over and over again.

Ms. NICELY. It is frustrating, I guess, if the servicemember does need the assistance and the family is here to care or a friend or whatever the case may be. I do not know. I just know that they do require you to re-apply.

Senator ISAKSON. Walter Reed is being closed in the next 30 days, if I am not mistaken. Have you had any consultation with the new move to Bethesda? I guess Todd will be going to Bethesda. Is that right?

Ms. NICELY. Actually, due to Senator Murray's kick in the butt——

Senator ISAKSON. She is good at that by the way.

Ms. NICELY. Yes, she is. We actually have a date on which he is going to retire. So, we actually will not have to do the move. But they are, they just recently had a town hall meeting for servicemembers to come to so that way they could explain the move and ask questions if need be.

Senator ISAKSON. Thank you very much again, Crystal.

Mrs. St. James, I know you are in the physical evaluation which means the bricks and mortar, that type of thing. Do you feel like the VA is making adequate plans in terms of that?

And going to Senator Tester's statement about contract services, particularly in States like Montana and take South Georgia where

we have 63 counties where we do not have a physician private or VA for that matter.

Do you think the VA is making adequate plans to deal with what is going to be a higher volume of services because of the veterans of Iraq and Afghanistan in terms of the physical plant?

Ms. ST. JAMES. We looked at their planning process both on the part of bricks and mortar, as you mentioned, as well as looking at their enrollee health care projection model.

And on the physical infrastructure side, the new planning process that they have, which is called SCIP, we have not had time really to evaluate that, and to know whether or not it is taking into account what needs to be done.

VA appears to take into account the overall plan of what needs to be done on the health care side for those services. But quite honestly, the SCIP process is new. We have not had time to evaluate it.

I can only say that VA appears to have progressed from its earlier days of capital planning, but the SCIP process was just used to inform the 2012 budget.

So, we do not know how effective it is going to be.

Senator ISAKSON. Thank you.

Thank you, Madam Chairman.

Chairman MURRAY. Thank you.

Senator Boozman.

STATEMENT OF HON. JOHN BOOZMAN, U.S. SENATOR FROM ARKANSAS

Senator BOOZMAN. Thank you, Madam Chair.

And again, Crystal, we really do appreciate your testimony. You have done a good job. It has been very informative.

You represent your family and your husband very, very well, and more importantly, I think all of the other families that are in the same situation. So, give yourself a pat on the back. Like I say, you have done very, very well and very helpful.

Here so much comes from the top down, and it is so important and I just appreciate you, Madam Chair, having her here in the sense that, you know, we do not dwell from the bottom up meaning relating to the people that are actually out there fighting the battle, like you are doing, on a daily basis. It really is very helpful to hear.

Paul, I think the comments you made about the faith-based communities or the faith-based interaction in the communities, not just the faith-based but just all of the, you know, the nonprofits, the charitable organizations are trying to do a good job.

One of the problems that we have we see all of these deployments from our guard units, and they are going off with a regular unit and then coming back, you are still with your buddies and life goes on, but just all of a sudden you are thrown back and many times, myself representing a southern State, many times going back and I think that is probably true throughout the country, going back to small communities where there is not a lot of resources, you know, very limited with the VA, and then just the nature of the beast of how they are separated, it really is real important.

So, we would like to work with you to strengthen, you know, your ideas on how we strengthen those relationships and encourage that to flourish.

Could you comment about that for a second?

Mr. RIECKHOFF. Yes, sir. I think it is about wrapping the communities around these veterans when they come home. What is so unprecedented is the small percentage of people who are serving relative to the overall population. So, if we can find creative ways to galvanize around those veterans, it would be a worthy investment.

I think what I see—in the local communities and in the rural areas especially—is a patchwork of services. If someone calls me from rural Montana and says my husband is suicidal, the services available to them are going to be dramatically different than Kansas or Florida or somewhere else.

And so, our team has a really difficult time of being able to deliver or even connect them with reliable services because they are so fragmented. I really firmly believe there has not been a significant investment nationwide in community groups of all kinds.

The comparison that we have started to draw on recently is that what veterans face right now is kind of like AIDS 25 or 30 years ago when you did not have existing infrastructures.

There is no massive philanthropic investment. There is no corporate investment. A lot of the nonprofits only started seven, 8 years ago. Some of them out of people's trunks. So, we are really in the earliest stages of creating an entire national network around a totally new set of issues, whether it is multiple amputations, or traumatic brain injury or women's issues.

A lot of the stuff is new, and there is not a system in place nationwide to tackle it. So, I think we have really got to issue a national call over and over again on some of the issues that Senator Tester talked about earlier.

The fact that we still do not have enough qualified mental health care workers is ridiculous. I have been coming here every year talking about this. If the President stood up tomorrow and said if you want to serve your country, be qualified as a mental health care worker, go work at the VA, go work at the DOD and we are going to pay you and we are going to support you and we are going to train you, that is a great way for people to serve their country, and I think they would step up.

We have got to make those calls clear and we have to think more creatively than outside of the existing bureaucracies.

Senator BOOZMAN. Very good. I agree. We have to put that infrastructure in place and then another problem, and you might comment on this, Crystal, is the fact that we do have stuff in place now and yet families do not know about it. It is not readily accessible.

If you can comment on that or ways that we can improve that. But I see that as something that we really need to get aggressive with.

Ms. NICELY. Like many have said that the strides that have been made are amazing because many years ago you did not have what we have now.

But I think that, as that being said, what should be focused on now is these things and the improvements that are going to be

there for the future because the war is not going away and people are still going to be wounded.

So, the accessibility to the things that the servicemembers are needing. In my husband's case, prosthetics are a big thing. So, if we did move to a small town or a small area, would we have to go further away from our home due they did not have the technology or the things needed to be able to assist him with what he does need to make life easier on a daily basis.

So, those drives are amazing and great and improvement is always something to be proud about. But it is a problem that is not going away, and the improvements will always be needed.

Senator BOOZMAN. Good. Thank you, Crystal. Thank all of you for being here. We appreciate your testimony.

Chairman MURRAY. Thank you very much.

Mrs. St. James, I want to ask you while you are here, I recently heard some were disturbing complaints from a female veteran. She told me she had a great deal of difficulty in accessing appropriate safe care for herself. She had some exams from a doctor where he left the exam room open to a crowded hallway, had been harassed by male veterans while trying to get mental health care and other concerns.

I am concerned about the lack of separate women-only inpatient mental health care units that we are hearing about as well. So, I am very concerned that the VA is not strategically planning for the increasing number of women veterans. Something Mr. Rieckhoff mentioned as one of the costs of this war.

Can you share with this Committee how many of VA's backlogged construction projects involve improvements needed just to protect the privacy and safety of women veterans?

Ms. ST. JAMES. I really do not have that specific information. I do know that there are initiatives that VA includes in its planning process but I do not know specifically if that is one.

Chairman MURRAY. Is that something you can find out for us?

Ms. ST. JAMES. We can certainly get back to you on that.

Chairman MURRAY. I would really appreciate that.

RESPONSE TO REQUEST ARISING DURING THE HEARING BY HON. PATTY MURRAY TO LORELEI ST. JAMES, DIRECTOR, PHYSICAL INFRASTRUCTURE ISSUES, U.S. GOVERNMENT ACCOUNTABILITY OFFICE

Question 1. Can you share with this Committee how many of VA's backlogged construction projects involve improvements needed just to protect the privacy and safety of women veterans?

Response. GAO's current work on Department of Veterans' Affairs (VA) facilities and health care issues does not directly include a total number of projects that involve improvements to protect the privacy and safety of women veterans. We asked VA to provide a more specific total, but the agency was unable to provide an answer by the Committee's August 17, 2011, deadline. We will forward that information to the Committee as soon as it is available from VA. While we do not know the number of backlogged construction projects that relate to the privacy and safety of women veterans, our past work has identified that VA drafted a set of weighted criteria by which it plans to evaluate capital investment projects, one of which is to assess whether capital investments address selected key major initiatives and supporting initiatives identified in VA's strategic plan.[1] VA's strategic plan outlines its major

[1] GAO, VA Real Property: Realignment Progressing, but Greater Transparency about Future Priorities Is Needed, GAO–11–197 (Washington, DC: January 31, 2011).

initiatives, including a goal to enhance veterans' access to health care.[2] For example, the strategic plan calls for continued realignment of the VA health care delivery system because of a shift in demographics, specifically an increase in the number of women veterans.

We have also found that VA identified a number of key challenges in providing health care services to women veterans. For example, in our report on services available to women veterans, officials at VA medical facilities told us that space constraints have raised issues affecting the provision of health care services to women veterans particularly related to ensuring their privacy and safety.[3] According to VA officials, most VA medical centers have planned renovation, construction, or relocation projects as part of their efforts to expand services and implement comprehensive primary care for women veterans. In our recent report regarding sexual assaults and other safety incidents, VA medical facilities we visited used a variety of precautions intended to prevent sexual assaults and other safety incidents.[4] However, we found some of these measures were deficient, compromising medical facilities' efforts to prevent such incidents. For example, medical facilities used physical security precautions, such as closed-circuit surveillance cameras, to actively monitor areas, and locks and alarms to secure key areas. However, at the five sites we visited, we found significant weaknesses in the implementation of these physical security precautions, including poor monitoring of surveillance cameras, alarm system malfunctions, and the failure of alarms to alert both VA police and clinical staff when triggered. Further, inadequate system configuration and testing procedures also contributed to these weaknesses. To address vulnerabilities in physical security precautions at VA medical facilities, we recommended that VA ensure that alarm systems are regularly tested and kept in working order and that coordination among stakeholders occurs for renovations to units and physical security features at VA medical facilities. VA concurred with our recommendations and provided an action plan to address them.

Chairman MURRAY. Ms. Golding, you testified that the medical costs for Iraq and Afghanistan veterans between 2011 and 2020 could total between $40 billion and $55 billion. That number, of course, does not take into account the cost of paying for our previous generations of veterans that we are still responsible for.

Ms. GOLDING. Correct.

Chairman MURRAY. CBO did another report earlier this year on possible ways to reduce the deficit where they made a couple of recommendations about veterans programs.

I do not support those specific proposals because they negatively impacted benefits, which I believe we should not be touching. But I do believe there are some ways that we can be more effective with taxpayer dollars but not diverting it from direct delivery of services and health care.

I wanted to ask you this morning: do you believe there is enough excess and duplication that can be addressed to make VA more efficient without negatively impacting services?

Ms. GOLDING. Just one or two points that I want to make on that, and the first is that we also had projections for the 2011–2020 timeframe for VHA for all veterans; and the budget would grow, not the budget but the amount of the cost to treat those individuals would rise from the $48 billion in 2010 to, under the one scenario, $69 billion, and in the much higher scenario which includes higher medical inflation and so forth, I think it was $85 billion.

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[2] Department of Veterans Affairs, VA Strategic Plan Refresh FY 2011–2015, (Washington, DC: Undated).

[3] GAO, VA Health Care: VA Has Taken Steps to Make Services Available to Women Veterans, but Needs to Revise Key Policies and Improve Oversight Processes, GAO–10–287 (Washington, DC: March 31, 2010).

[4] GAO, VA Health Care: Improvements Needed for Monitoring and Preventing Sexual Assaults and Other Safety Incidents, GAO–11–736T (Washington, DC: June 13, 2011).

So, in the lower case we are talking about an increase of about 45 percent over the next 10 years, which is a substantial increase in order to be able to provide the health care for all enrolled veterans.

Now, we do not make policy recommendations, and we have not in that paper looked at options for cutting that growth. We have not looked at efficiencies.

So, I cannot tell you about that specifically. I mean, you are aware of our budget options apparently. So, we do have a couple of options in that but it may also involve not just efficiencies but it may involve shifting some costs or some other things.

Chairman MURRAY. If we just do efficiency and shifting costs, will we meet that projection that you just made?

Ms. GOLDING. I cannot tell you unfortunately.

Chairman MURRAY. Mr. Hosek, a 2008 RAND study concluded that there is a possible connection between having PTSD, TBI, and major depression and being homeless.

Last month, Admiral Mullen expressed concern about repeating the mistakes we made after the Vietnam War and he said, we are generating a homeless generation, many more homeless female veteran; and if we are not careful, we are going to do the same thing we did last time, unquote.

Can you walk me through the costs, both budgetary and human, of caring for veterans after they become homeless and of using care as a tool to prevent homelessness?

Mr. HOSEK. Unfortunately, I cannot give you estimates of the cost.

Chairman MURRAY. Do you want to turn on your mike.

Mr. HOSEK. Thanks. Unfortunately, I cannot give you estimates of the cost. My concern, which I foreshadowed in my testimony, is that there may be a value in being more proactive in guiding people as they leave the service.

Right now when servicemembers leave the service, they receive an outbrief. That outbrief covers, among other things, the benefits they are entitled to and advises them, of course, that they will have a post-deployment health assessment and a 6-month follow-up of that if they are still in the service and then leave later on.

But this information comes at them very fast; and even though it is provided, which is a good thing, I am afraid that many of them do not really absorb it at the time. And when they leave the military and go out and need care or need to learn about their VA benefits or need to learn about job search support, they really do not know where to turn.

They have not necessarily absorbed or remembered what they were told, and our research indicates that there are not readily available cohesive, easily accessible sources of information.

Now, people absorb information in two ways, when it is pushed at them or when they pull for it. And a lot of the discussion that we have received has to do with the push of information, that is, just making it available.

But the fact that there are not readily available cohesive sources of information, something that Paul referred to, I think is important too.

I mention in my testimony that one thing we really do not know much about are people who leave the service. We do not know about their joint seeking of educational benefits and further education or work and their health care. And we are particularly interested in, or particularly concerned about servicemembers——

Chairman MURRAY. Are you looking at the cost of that? Is that something——

Mr. HOSEK. These are simply ideas I am responding to you for your questions. These are not, to my knowledge, studies we have underway at RAND. I realize the importance of this, and I wish I could give you a specific estimate.

It is important, I think, to think about this sort of jointly occurring set of concerns that servicemembers have. If there happen to be roughly one in five, perhaps fewer, servicemembers who leave with major depressive disorder or Post Traumatic Stress Disorder and they also want to find a job or they want to seek health care, we are finding a lot of them are having trouble finding jobs.

The lot of them are not seeking care. We have talked about the barriers to care. That has come up in several of the testimonies today, and I know in your hearing last week. All of those things come together.

Trying to make things easier for veterans to provide that information, this is something that Paul's outfit is particularly concerned with but it is not only something that should be left to volunteer organizations.

It is possible that more effective support could be provided by the services or by contractors, or simply by making more effective Web-based services available.

For example, the Military OneSource source of information has been a big boon to servicemembers, providing them with information on many service-related resources for servicemembers and their families before, during, and after the deployment.

Developments in that direction for veterans are likely to be helpful. As I mentioned in my testimony, veterans have reported difficulty knowing where services are offered, what kind of services are available, how to apply for them, who is eligible. Those are fundamental questions.

The fact that half of those with probable PTSD or MDD had not seen a physician and had not been evaluated within the prior year or two to our survey was striking. These are individuals who arguably ought to be evaluated.

There are certainly many veterans who leave, who can do well on their own. But for people with these probable symptoms—and sometimes individuals do not report their symptoms, so that is one of the reasons for the wide variance in estimates of PTSD and MDD—they should be incentivized and have the information to seek help.

We clearly have in the VA system an issue of surge capability. The VA caseload largely consists of older veterans, and VA handles many individuals who need health care.

The immediate growth of the new generation of veterans, as you have referred to it here in the hearing, is a challenge for them because they need to adapt their provider mix, and those are growth problems.

To the extent that there are also providers available in the private sector, I will suggest, without the basis of research, that it is certainly worth thinking about trying to figure out how to make use of extant capacity in the private sector.

Chairman MURRAY. And I appreciate that. One of the points of this hearing is the cost of war, just providing it in the private sector is not free. It is still a cost, and we have to keep focused on that.

Senator Brown.

Senator BROWN OF MASSACHUSETTS. Thank you.

Crystal, I just want to go back to you, and I apologize. I had to go down to a HSGAC hearing, and I will have some questions. So, if you have answered this, I apologize.

But during your time going through what you were going through, did you ever go to any outside agencies, outside the military, outside the VA to get some additional assistance?

If so, could you kind of explain what you did and what that response was like?

Ms. NICELY. Well, in the beginning, I really did not know of what was available. But due to my case manager, Jordan Hall, he gave us some information in regards to some foundations that could help; and when we sought those foundations, they were able to assist us like the Semper Fi Fund, Operation Homefront, and Soldiers' Angels. I mean there are so many that are great foundations, that help and assist. Yes.

Senator BROWN OF MASSACHUSETTS. Great. Thank you.

Mr. Rieckhoff, in your written testimony you state that long-term, it is estimated it will cost between $600 billion and $1 trillion to care for OEF/OIF veterans alone. I am interested in learning a little bit more about your estimate.

Is this a study conducted by you folks or any other organization that would come up with those figures?

Mr. RIECKHOFF. I think this is actually to the doctor's earlier point. Estimates are all over the place, and in part because we do not have real good research on a lot of things.

So, these are high-end, low-end estimates that come from a variety of places ranging from RAND to Harvard researchers to veterans' groups. I think two things we have to identify are accurate numbers for homelessness and suicide. VA just released their new numbers of 10,000 homeless veterans.

Those numbers are really fuzzy. Places like New York do not even count veterans when they go out to count homeless people. So, we really do not know what the cost of that is going to be.

On suicide specifically, we do not know how many veteran suicides there are. That is really troubling. We hear anecdotally about suicides from the community on a regular basis that are not counted. If you separate from the military and you are a veteran who doesn't use the VA, you do not get counted. And we cannot even begin to calculate those costs.

So, I think it is important that we recognize that some of the best research that came from the RAND study back in 2008 is still the best research now. And that was privately funded.

So, to answer your question, sir, is we do not know and I do not think anybody knows. And anybody who tells you they do know, let us see the research.

Across this industry, as you guys try to think in the next couple of years about how to spend money and how to support different programs, we need much more research and we all have a hard time I think finding really good data.

And I think the suicide is the best example. We have no idea how many veterans have committed suicide since 9/11. Nobody knows because there is nobody counting the veterans population. I think that is a major problem when we tried to forecast any kind of cost.

Senator BROWN OF MASSACHUSETTS. Thank you.

Dr. Hosek, did you notice at all a difference between active Army, active military versus Guard and Reserve in terms of getting the materials, because you indicated that when somebody leaves, they have an outbriefing obviously?

I know being from Massachusetts that not only do we, as a Guard and Reservist, not only do you get an outbrief, you have to go through basically a total top to bottom exit interview. They give you the packet. They give you everything so when you are saying they do not have anywhere to go, quite frankly I would suggest that they look in the packet that they have been given as we do it in Massachusetts.

What are your observations in that?

Mr. HOSEK. Well, to begin with a specific answer, I have not seen any research whatsoever comparing the outprocessing support for active versus Reserve. So, I am not sure what that difference would be.

I agree with you that individuals actually receive briefings. They receive materials. They basically should have a starting point on where to go, and that is good. At the same time, the recently done RAND New York State Veterans Needs paper, as well as the earlier paper on invisible wounds, indicated that many of the respondents were not sure where to turn, what to seek.

This could reflect differences among individuals in their capacity to remember and recall information or to process complicated information.

So I think, as I said a minute or two ago, while I think that what is being done right now is probably very helpful, it is not totally effective. There is a question about how to continue to reach people after they leave the service and begin actively seeking some sort of support or assistance, health care, GI Bill benefits, what have you.

Senator BROWN OF MASSACHUSETTS. Thank you.

Ms. St. James, in your analysis of the VA's 5-year capital plan for 2004 to 2009, GAO noted VA's real property portfolio changed to with an increase in leases and leased spaces. This was VA's efforts to adjust their real property portfolio to match the agency's overall mission to move the delivery of care toward more outpatient facilities.

Beyond CBOCs and Vet Centers, in what ways can the Veterans Health Administration expand their inventory of leased buildings,

and also, is there any effort to have these buildings within already government on properties to, in fact, save money?

Ms. ST. JAMES. There were improvements in the use of space and I believe our report indicated that there had been some improvements in that.

Leasing is part of an initiative that is included in their planning as is the need for the planning of community-based outpatient clinics which is directly tied to trying to give care to the more rural community.

So, leasing is a factor in their planning. More could be done in terms of better use of all space. I think it is an issue government-wide of having more space than is actually needed, coupled with the need to take care of historical properties that are quite expensive to take care of.

So, if I have not answered your question, let me know and I will get back to you.

Senator BROWN OF MASSACHUSETTS. Thank you.

Chairman MURRAY. Thank you very much, Senator Brown. I have some questions that I will submit for the record. If you have any, you can as well.

Senator BROWN OF MASSACHUSETTS. Thank you.

Chairman MURRAY. I want to thank each of our witnesses for their testimony on the lifetime costs of caring for our newest generation of veterans, and I especially again, Crystal, want to thank you and Todd for being here and for Todd's service to the country. You have shown incredible courage again in sharing your story with us.

You are really an example to a lot of other veterans, their families who are traveling down this road to recovery, and I really believe that your testimony today will go a long way in helping us do a better job.

As I said at the beginning of this hearing, caring for veterans is a cost of war that we have to account for. As today's hearing has really made clear, the cost of caring for this new generation of veterans is not going to end when they come home. It will be incurred over a lifetime.

So, as we are here today and the deadline for reaching a debt ceiling agreement quickly approaches and various proposals to cut or cap spending are out there, we have got to remember the sacred responsibility we have to care for our veterans and servicemembers. We as a Nation must honor our obligations in good times and in bad.

So, I appreciate all of you being here today to participate and share your perspectives on the lifetime costs of this war.

Thank you very much. This hearing is adjourned.

[Whereupon, at 11:39 a.m., the Committee adjourned.]

A P P E N D I X

PREPARED STATEMENT OF GOLD STAR WIVES OF AMERICA, INC., PRESENTED BY VIVIANNE CISNEROS WERSEL, AU.D., CHAIR, GOVERNMENT RELATIONS COMMITTEE

With malice toward none; with charity for all; with firmness in the right, as God gives us to see right, let us strive to finish the work we are in; to bind up the Nation's wounds, to care for him who has borne the battle, his widow and his orphan."

~President Abraham Lincoln, Second Inaugural Address, March 4, 1865

Chairman Murray, Ranking Member Burr, and members of the Senate Veterans' Affairs Committee, thank you for the opportunity to submit testimony for the record on behalf of Gold Star Wives of America pertaining to "Examining the Lifetime Costs of Supporting the Newest Generation of Veterans."

Gold Star Wives of America, an all volunteer organization founded in 1945, is a congressionally chartered organization of spouses of servicemembers who died while on active duty or who died as the result of a service-connected disability during World War II, the Korean War, the Vietnam War, the first Gulf War, the wars in Iraq and Afghanistan, and every period in between.

Gold Star Wives is an organization of those who are left behind when our Nation's heroes, bearing the burden of freedom for all of us, have fallen. We are that family minus one; we are spouses and children, all having suffered the unbearable loss of our spouses, fathers or mothers. We are those to whom Abraham Lincoln referred when he made the government's commitment "* * * to care for him who shall have borne the battle, and for his widow, and his orphan."

For the purpose of this specific testimony, Gold Star Wives will include the silent cost of the war as well as the measurable cost of legislative inequities affecting surviving families of today's veterans; however the legislative inequities include survivors of previous wars.

According to the Department of Defense, as of December 2010, approximately 6,128 of our Nation's military heroes have given the ultimate sacrifice during Operation Iraqi Freedom, Operation Enduring Freedom and Operation New Dawn. It's estimated approximately 49% left behind a family to carry on without them. After the flag is folded, the surviving spouse is left to carry on the duties of their family despite the tragic loss of their loved one. The long term cost of the war for Gold Star Families is unfortunately not included in the Congressional budget nor is it a line item in the President's budget. The lifetime cost of survivors has to be included in the DOD budget to include the survivors of the military, regardless of circumstance of death.

Surviving spouses are faced with inequities in their survivor benefits as well as the emotional challenges of raising a family alone after the death of their spouse, or having the missed opportunity to even start a family.

For the purpose of testimony I will review both the quantitative and qualitative costs of this war pertaining to "Examining the Lifetime Costs of Supporting the Newest Generation of Veterans."

Presently the lifetime costs of supporting the newest generation of veterans does not include survivors and their benefits; only the living veteran. The lifetime costs for supporting the surviving spouse are only projected in legislative bills that have not passed and/or are not calculated as a reality despite the overwhelming congressional support of cosponsors. However the life time cost for the surviving spouses not receiving their entitled benefits can be estimated depending on the individual. These estimates reflect the lifetime quality of life for the surviving spouse and their family. These benefits include the calculation change of the Dependency Indemnity Compensation, removing the Survivor Benefit Plan (SBP) offset by the Dependency Indemnity Compensation (DIC), Education, and the dental plan for children.

For the surviving spouse of today's veterans, financial challenges arise when benefits are not provided as intended. Congress created two programs for survivors of

our military members. In 1956, Dependency and Indemnity Compensation (DIC) was established by the Servicemen's and Veteran's Survivor Benefit Act. *The purpose of DIC is an indemnity payable to survivors when a military member dies as a result of a service-connected cause* yet Congress enforces a dollar for dollar offset. It is very apparent that financial stability is the overriding concern of these families. Gold Star Wives believes the most significant long-term advantage to the family's financial security would be to end the Dependency Indemnity Compensation dollar for dollar offset to the Survivor Benefit Plan. This cost should be considered as a cost of war for legislation. This is not a new subject for us to testify about before Congress. For the survivors with children, feel forced to assign the SBP to their children to avoid the offset; however, they're placing a shelf life on the benefit as it terminates when the child becomes of age. We recognize that jurisdiction resides elsewhere, but we know each Member of this Committee can and should be concerned within the context of your own jurisdiction that this inequity should be fixed, and fixed immediately.

In 1972, Congress created the Survivor Benefit Plan (SBP). The purpose of SBP is to insure that a portion of the military member's retirement will be provided to the surviving widow after the military member's death. Two different plans, one paid by retiree premiums or an active duty military member's life and the other paid by the Department of Veterans Affairs.

The financial hardships of losing a military spouse are also coupled with the emotional strain of losing a loved one and parenting their children alone. There is a silent cost of war that is not projected in any military budget nor is it considered in legislation when addressing survivor benefits for the family of today's veteran.

The following is a letter from a Gold Star wife in Florida named Jennifer. She wrote this letter back in 2009, No changes have been made since that time, so therefore a letter of complaint written four years ago is still applicable to our discussion today:

> "I have to begin by asking why our sacrifice as military families, not spouses alone but whole families, being devalued. I am the widow of a Marine killed in Iraq. I have three very young children to raise. At the time of his death, our children were 7, 5 and 1, the eldest have required therapy from the time that they lost their father. As the benefits we receive do not fully cover this I was happy to pay the rest to ensure my children would be able to cope with all of the devastation to their lives. From the day I received the phone call about my husband's injury through to his death my children lost me as well. I was beside him in Germany then Bethesda for two months. After my husband's passing I was so scared I was no longer the Mom they had always known. I was now the only thing they had to cling to and I was falling apart. I needed help with almost everything just to keep them safe and well. I am still scared, I have many years ahead of me where I have to provide for my children and myself. I am confused by the arguments that seem to play back infinitely when the questions regarding SBP/DIC offset are raised, 'We can't afford to do it' or 'We can't find the mandatory spending offsets' due to other more important issues' Do we lack importance? Some of these programs deemed 'more important' are $250 billion sometimes $300 billion. Where is the $6 billion for military widows? When do we become worth it? When do our children become worth it? When do you turn around and say you deserve it for your sacrifice? We are simply asking for what is due to us. If this were a civilian insurance policy they would have to pay. An offset would never enter the discussion. The government, ironically would make them, so why then does the government relinquish itself from this responsibility of payment by way of exercising this "offset"?
>
> "By my understanding DIC is a compensation paid for Military members who were killed while on active duty or died from service-connected physical problems after retirement. It was clearly created for a very different reason than was SBP. SBP is a benefit for servicemembers to ensure that their family is cared for in the event of their death."

She further stated that it appears that Congress gives with their right hand for everyone to see but they take out of our back pocket with their left.

> She continues in her letter "I don't think there is any recipient of the 'special allowance' who perceives getting $50 (now $60) a month as adequate compensation when they are entitled to over 20 times that amount."
>
> "It makes me ill to reduce my husband's sacrifice, his life, to a dollar amount but I can't raise his children on letters, flags and Veteran's Day

speeches. If any of the words that I hear are to ring sincere then remove this offset and speak to us, impact us through your actions."

For your consideration, very sincerely,

Jennifer

Losing a spouse is devastating; however, when a child loses a parent, the impact is greater than anyone can grasp. We continue to hear of studies regarding the effects of war on children. We put to you there is no greater cost than that of a parentless child. Approximately 4,300 children have lost a parent in the Iraq and Afghanistan wars. The numbers are higher when including service-connected deaths or line of duty non-hostile deaths.

It is a known fact that a wartime death presents unique hardships for children. Many families relocated shortly after a death and lost their network of support. For boys, besides losing a father, they lost their male role model to guide them through their lives. It is a consensus of our organization that today's surviving spouses have significant challenges with raising boys alone without their dad. Again, this cannot be found on a CBO score card and is not considered a financial cost of war, but a ripple effect of war.

According to my son, the day he lost his father was also the day he also lost his mother; I was not the same mother to him and he wanted her back. No solution for this problem has been found since it was identified during the Vietnam war era as noted in the book *After the Flag has been Folded, A Daughter Remembers the Father She Lost to War and the Mother Who Held The Family Together* by Karen Spears Zacharias. Again, the cost of holding the family together as well as lost opportunities for these children for a lifetime is immeasurable.

Kristen, whose husband was recently killed in Afghanistan, spoke about the challenges of raising a 12 year old son alone. According to Kristen, "Children of the Fallen as they try to move forward in their lives, they want to be a normal child. However, I think when I take my son to events like a baseball game they always thank the servicemembers and first responders, but never say anything about the fallen soldiers or children that could be there." Measuring the cost of missed opportunities going to a sporting event with dad cannot be scored.

Many of our children have been treated for depression and unfortunately some of our members' children have attempted suicide. One child, five years out from death shared with his counselor that he had few memories of his Dad because he was perpetually deployed prior to his death. It is difficult to measure the dynamic challenges of a child grieving the loss of a parent as it can change as they age. The lack of access to local VA care for mental health requires some members to seek services from the public sector with a cost involved.

When Congress improves survivor benefits, not all survivors are included. The practice of selective benefit entitlement for different circumstances and eras must stop. Every time Congress institutes a cutoff period for a program, some child, or some surviving spouse is left behind wondering when the servicemembers' death will count.

Many of our members are not able to return to work after an unexpected death, yet their benefits are not significant enough to pay their existing mortgage and or rent. Some of our young members have been diagnosed and treated for Post Traumatic Stress Syndrome (PTSD) yet awareness is not prevalent. Others suffer and cope with their loss while raising their children, frustrated and worried about the future, the clock ticking until their SBP terminates when the children become of age, if they chose child option.

Costs are measured in dollars, there is another cost that is not calculated; the silent cost. The question asked is what are the long term costs of war? The child who sits solemnly alone while other fathers visit the school classroom already knows. The young daughter walking down the marital aisle without her loving father already knows. The young surviving spouse who is so exhausted from serving in the roles of both mother and father already knows. The family with the empty seat at a meal already knows. The long term caregiver who suffers from secondary PTSD and caregiver stress, whose own health has failed already knows. The military commander who sends someone to knock on the door to notify the family of the Fallen already knows.

This testimony provides you with information about the cost of war for the Gold Star Family and should be considered when determining passing legislation as a line item for the cost of war. The mission of the VA is clearly stated "To care for him that has borne the battle his widow and his orphan." We are waiting for this statement to be evident. The issues affecting surviving spouses and children need to be remedied. Long standing queued issues such as the SBP/DIC offset elimination, requests to increase DIC to 55 percent of 100% disability compensation, in-

creases in education benefits (in line with other Federal survivor programs), programs to assist with dental and vision remain unimplemented.

Secretary of Veterans Affairs, Eric Shinseki, stated, "Taking care of survivors is as essential as taking care of our Veterans and military personnel. By taking care of survivors, we are honoring a commitment made to our Veterans and military members." We're asking you to honor that commitment.

Thank you for this opportunity to testify. The families of the Nation's fallen have already suffered the greatest loss; there is no need to make these families struggle further.

Gold Star Wives appreciates the compassionate work the Members of this Committee and the staff do on our behalf. We always stand ready to provide this Committee with any additional you may need.

Gold Star Wives Legislative Issues:

I. Increase Dependency and Indemnity Compensation (DIC)

In 1956, Dependency and Indemnity Compensation (DIC) was established by the Servicemen's and Veteran's Survivor Benefit Act. The purpose of DIC is an indemnity payable to survivors when a military member dies as a result of a service-connected cause.

GSW seeks parity with other Federal survivor programs when calculating DIC. This affects more than 330,000 widows. DIC is currently paid to widows at 43% of the VA Compensation received by the veteran with a 100% service-connected disability. Other Federal survivor programs provide 55% of the disability pay of the Federal employee to the widow. Bringing DIC's computation to 55% would provide parity with other Federal survivor programs and would increase DIC by approximately $300 per month. Why military widows are forced to accept a lower percentage than other Federal survivor programs is incomprehensible to GSW. In addition, DIC has had no increase since 1993, 18 years since the flat-rate replaced the ranked-based DIC.

The continued economic stresses our country is now enduring places widows one step away from a car that stops running or an unpaid house payment or utility bill. Many of our elderly widows are in financial distress, unable to pay for food and utilities. Equalizing the computation of DIC would offer some relief from worry and would improve financial independence and confidence for GSW members. The increase in DIC should not subject the SBP to further offset.

GSW recently received a call from an elderly DIC widow inquiring why the DIC payment has not changed in years. When explained that DIC would increase if there was a Cost of Living Allowance (COLA) increase, she stated that whoever determines COLA apparently never visited her town because her rent, gas and electric has increased and so has the price of milk and bread. She then said, "I can't cut any more corners." These types of calls are received frequently from our members.

Congress should make the ethical decision now to change the DIC compensation to 55% which is afforded other Federal survivors.

II. Eliminate the Dependency and Indemnity Compensation (DIC) Offset to the Survivor Benefit Plan (SBP)

GSW encompasses approximately 10,000 DIC recipients. Some of our members are eligible for and receive SBP. For those widows who receive SBP, either the retired military member chose to purchase SBP upon retirement or the military member died while on active duty.

When a widow is eligible for both SBP and DIC, the widow becomes subject to the "widow's tax"—a dollar-for-dollar reduction in the SBP by the amount of DIC received. Military members dying on active duty did not pay premiums. (Prior to 9/11, a servicemember dying on active duty had to be retirement eligible for his survivor to receive SBP without payment of premiums.) Their surviving spouse became eligible for SBP on the date of the active duty death. Retired military members chose to purchase SBP and pay premiums with hard-earned retirement. Until 2005 and the implementation of concurrent receipt, some disabled retirees received no retirement pay with which to pay premiums. Many were forced to pay from disability compensation. The offset, never mentioned to the military member, only becomes visible to their widow once the military member has died.

Surviving spouses impacted by the DIC offset to their SBP are quite often shocked to learn they are subject to an offset. Completely unaware of the offset and how it would affect them financially forces them to make many hard adjustments in their day-to-day lives to accommodate the offset's effects.

Attempts to Fix the Offset

Congress has chosen not to eliminate the offset for eleven years for the small group of widows impacted by the offset. Instead, Congress further divided and subdivided this small group with Band-Aid fixes for the offset. Three of the Band-Aid fixes, also called options, create even more confusion about benefits and who is eligible and often do little to eliminate the financial distress initially caused by the offset in the first place. Even reporting these options and their consequences to Congressional members is difficult as they do not understand the impact, ramifications and end-result these options caused. The options are outlined below.

First, the reassignment of a spouse's SBP to her children. In 2003, a new law passed, Public Law 108–136, authorizing active duty widows the ability to assign the SBP annuity to their children, if any, permanently forfeiting any right the widow had to SBP. This reassignment allows full receipt of SBP by the child(ren) without offset until they reach the age of majority, when the benefit terminates. The widow is forced to make this decision very soon after notification of her spouse's death and her decision then becomes irrevocable. Complications from this new law often require that the widow be granted guardianship of her own child(ren) by a court of law. A widow whose husband died in retirement is not eligible for this option.

Second, remarriage. In August 2009, the U.S. Court of Appeals in the matter of *Sharp, et al.* v. *The United States*, 82 Fed. Cl. 222 (2008), ruled that DIC payments may not be deducted from SBP annuities if a person, entitled to both benefits has remarried after age 57. It does not make sense to have two separate standards in the law, one that allows payment of full SBP and DIC for widows who remarry after age 57 and another forcing a dollar-for-dollar offset between the SBP and DIC for all others. GSW is concerned that the Federal Government now requires a remarriage in order for an annuity to be paid in full.

Third, Special Survivor Indemnity Allowance (SSIA). The NDAA FY 2008 established a Special Survivor Indemnity Allowance for widows who are the beneficiary of the SBP annuity and their SBP annuity is partially or fully offset by the DIC. The SSIA also applies to the widows of members who died on active duty whose SBP annuity is partially or fully offset by their DIC. SSIA began at $50 per month and increases each fiscal year until 2017, when the SSIA terminates.

GSW understands that Congress does not permit the private sector or other Federal benefit programs to reduce or terminate retired annuities because the survivor is also eligible for DIC. So it begs the question, how can the full receipt of SBP and DIC be considered double dipping when in 2004 it was determined by Congress that the 100% disabled would receive their full retirement and disability compensation payments? Survivor compensation is provided to widows based on the military member who is rated at 100% disabled. There is no greater disability than death.

III. Education Benefits

GSW seeks an increase in the monthly stipend for Chapter 35 benefits as it has not kept current with the increases in educational tuition and fees. While tuition increases vary state-by-state, all have increased, some dramatically. A housing allowance also should be included with the Chapter 35 education benefits.

GSW further requests that the New G.I. Bill allow the transfer of educations benefits to a qualified widow or child who is not eligible for the Gunnery Sergeant John David Fry Scholarship Program (Fry Scholarship).

GSW is greatly encouraged by the Fry Scholarship and requests this program be included in the Yellow Ribbon Education Program (Yellow Ribbon Program). The Yellow Ribbon Program does not currently apply to children of the fallen, yet it would help ensure these children have a brighter future. We believe this was an oversight when the Fry Scholarship was created with the intention of matching education benefits to the New G.I. Bill.

Additionally, many encounter a problem transitioning from Chapter 35 education benefits to the Fry Scholarship that greatly delays payments. We are willing to work with both the Senate and House VA Committees to help rectify this unique problem and the backlog experienced with the Chapter 35 education benefit.

GSW is grateful and appreciates that surviving children have access to an education program that is above and beyond Chapter 35 through the Fry Scholarship. However, many other surviving children do not qualify for this scholarship and are in need of more adequate support. We would appreciate the opportunity to work with the VA to help remedy these issues and avoid future problems with the benefits.

GSW requests that the time period for eligibility to utilize Chapter 35 education benefits for military widows of retirees who died of a service-connected cause be extended from ten (10) to twenty (20) years. This extension would allow all military

widows a greater opportunity to use the education benefit and improve their quality of life. In addition, it brings into alignment the time period for widows of both active duty deaths and widows of retirees who died of a service-connected cause.

PREPARED STATEMENT OF PAUL SULLIVAN, EXECUTIVE DIRECTOR, VETERANS FOR COMMON SENSE

INTRODUCTION

Veterans for Common Sense (VCS) thanks Committee Chairman Patty Murray, Ranking Member Richard Burr, and Senators on the Senate Committee on Veterans' Affairs for allowing us to submit this written statement for the record for your hearing, "Examining the Lifetime Costs of Care for the Newest Generation of Veterans," specifically the enormous escalating human financial consequences of the Iraq and Afghanistan conflicts for the United States.

VCS is a non-profit based in Washington, DC, focusing on the causes, conduct, and consequences of war. We provide public relations and government relations advocacy for our servicemembers, veterans, and families.

VCS LEADERSHIP

VCS continues leading the national effort uncovering the human and financial costs of the Iraq and Afghanistan wars. Our servicemembers, veterans, families, and the American public have a right to know the facts about the costs of war. In their groundbreaking book published in 2008, The Three Trillion Dollar War: The True cost of the Iraq Conflict, Linda Bilmes and Joseph Stiglitz wrote:

> By now it is clear that the U.S. invasion of Iraq was a terrible mistake * * *. Understanding the costs of the war has not been easy, and it would not have been possible without the help of many. The fact that so much of the data and information that should have been publicly available was not meant that some critical pieces of information have had to be obtained through the Freedom of Information Act (FOIA). We thank Paul Sullivan of Veterans for Common Sense, who helped us to understand the situation facing returning Iraq and Afghanistan war veterans, and who provided us with crucial data from the Defense Department and Department of Veterans Affairs obtained under FOIA.

In the past year, VCS was honored to provide DOD and VA reports to Catherine Lutz at Brown University for her larger study on the costs of the Iraq and Afghanistan wars. Please see the web site http://costsofwar.org/ for further details.

KEY FACTS: ONE MILLION PATIENTS BY 2013, WITH A 40-YEAR COST OF $1 TRILLION

VCS begins by presenting the Committee with the most current and salient official government statistics about the human and financial costs of the current conflicts. These are facts VA and DOD refuse to provide on a consistent, complete, or transparent manner to the Congress or the public.

As of December 2010, VA reports reveal 654,384 new, first-time veteran patients were treated VA hospitals and clinics since 2001. Based on an average of nearly 10,000 new patients each month, VCS estimates the count of new Iraq and Afghanistan war veteran patients treated by VA will exceed 720,000 on July 31, 2011.

According to their September 30, 2010, testimony before the House Committee on Veterans' Affairs, Linda Bilmes and Joseph Stiglitz now estimate the financial cost of the Iraq and Afghanistan wars to be in the trillions of dollars. Bilmes and Stiglitz have criticized the government for failing to collect current and future cost data. Using data obtained by VCS, it is estimated that:

> Taking these costs into account, the total budgetary costs associated with providing for America's war veterans from Iraq and Afghanistan approaches $1 trillion.

VCS REQUEST FOR ACTION BY CONGRESS

VCS has two major requests today. We urge Congress to pass a new law mandating the Administration collect robust, consistent, and accurate data in a transparent manner so DOD, VA, and Congress can accurately estimate, monitor, and plan for the influx of post-war casualties from the current wars as well as any future wars.

Furthermore, VCS urges Congress to establish a Trust Fund so future generations of veterans are protected from unwarranted assaults on funding for VA healthcare and benefits.

RECENT OFFICIAL STATISTICS

Government statistics pieced together from several reports paint a disturbing picture of enormous human suffering among our Iraq and Afghanistan war servicemembers and veterans. VCS obtained the following facts from DOD and VA using FOIA:

According to DOD:

• At the end of June 2011, a total of 6,098 U.S. servicemembers died in the Iraq War and Afghanistan War combat zones; this includes 289 confirmed suicides.

• At the end of June 2011, a total of 100,600 U.S. servicemembers wounded in action or medically evacuated due to injuries or illnesses that could not be treated in the war zones.

• The grand total of U.S. battlefield casualties reported by DOD is nearly 107,000.

According to VA:

• As of December 2010, VA treated and diagnosed 654,384 new, first-time Iraq War and Afghanistan War veteran patients. Based on our analysis of 10,000 new patients per month, VCS estimates VA will have treated 720,00 patients as of July 31, 2011.

• Please note that VA's report excludes veterans who sought private care, retired veterans treated by the military, and student veterans treated at campus clinics. VA's count also excludes medical treatment for wounded, injured, or ill civilian contractors from the U.S. deployed to the war zones.

• As of December 2010, VA received 552,215 disability compensation and pension claims filed by our Iraq War and Afghanistan War veterans.

VCS Analysis:

• When VA and DOD reports are viewed side-by-side, VA data reveals more than 100 new, first-time veteran patients for each battlefield death reported by DOD.

• At the current rate of nearly 10,000 new veteran patients and claims entering the VA medical and benefits systems each month, VCS estimates a cumulative total of one million patients and claims by the end of 2013.

VCS Sources:

DOD, "Global War on Terrorism—Operation Enduring Freedom, By Casualty Within Service, Oct. 7, 2001, Through July 5, 2011" (Afghanistan War).

DOD, "Global War on Terrorism—Operation Iraqi Freedom, By Casualty Category Within Service, Mar. 19, 2003, Through July 5, 2011" (Iraq War, Mar. 2003 through Aug. 2010).

DOD, "Global War on Terrorism—Operation New Dawn, By Casualty Within Service, Sep. 1, 2010 Through July 5, 2011" (Continuation of Iraq War since Sep. 2010).

VA, "VA Benefits Activity: Veterans Deployed to the Global War on Terror," Through Sep. 2010, Feb. 2011.

VA, "Analysis of VA Health Care Utilization Among US Global War on Terrorism Veterans, 1st Quarter, Fiscal Year 2011," Apr. 2011.

VA, "VA Facility Specific OIF/OEF Veterans Coded with Potential PTSD Through 1st Quarter FY 2011," Apr. 2011.

MISSING FACTS PROMPT NEED FOR REPORTS

In order for VA and DOD to properly manage the human and financial cost of providing medical care for our casualties, more robust data must be collected by the Administration and then and analyzed immediately by the Administration, Congress, academics, and advocates in a transparent and easy to understand manner. In short, the best policies for our servicemembers and veterans are designed, implemented, and then evolve over time with the best available information.

• VA must be able to answer simple, straightforward questions. For example, what is the total number of unique deployed Iraq and Afghanistan war veterans who have received any VA benefit since returning home? The list of benefits includes, but is not limited to healthcare at VA clinics and hospitals, counseling at VA Vet Centers, disability compensation, life insurance benefits, home loan guaranty, and vocational rehabilitation. VCS remains highly alarmed VA remains incapable and unwilling to answer these easy questions. Congress can and must fix this now with a new law mandating reports.

• DOD and VA must prepare an official accounting of the financial costs for VA benefits. What did taxpayers pay for treatments and benefits? For the past several years, VCS has requested this information from VA and DOD using the Freedom of Information Act. VA has not provided any cost data. Starting in 2001, VA employees urged VA leaders to begin tracking war-related benefit use and costs, and nearly all requests were refused by political appointees of the previous administration.

• DOD must provide an accounting of all discharges by type and branch of service, sorted by year, to monitor trends for both deployed and non-deployed servicemembers since 1990. Two prior hearings by Congress documented how the military improperly discharged tens of thousands of servicemembers. In many cases these veterans were at high risk of readjustment challenges due to Traumatic Brain Injury (TBI) and Post Traumatic Stress Disorder (PTSD). As the number of less than fully honorable discharges increases, additional highly vulnerable veterans flood into society. Many of these veterans either don't seek VA assistance or are refused VA help, instead turning to private, state, local, or university campus programs for assistance that should have been provided by the Federal Government. VCS also believes the military, in many cases, releases servicemembers from active duty with less than fully honorable discharges in an effort to avoid long-term healthcare and disability benefit costs.

• VA should monitor negative post-deployment outcomes, such as homelessness, suicides, divorce, and crime, as well as state, local, and privately funded expenditures on veterans. The most important oversight remains the Administration's inability to provide complete and accurate active duty, Reserve, National Guard, and veteran suicide data. Every year DOD has set new, and highly disturbing, records of active duty suicides. Most of the initial monitoring began with FOIA requests from advocacy organizations or journalists investigating patterns of disturbing developments such as suicides, homicides, unemployment, and homelessness. VA and DOD only began limited monitoring and research after repeated advocacy organization, media, and Congressional inquiries.

• The Department of Labor should monitor unemployment and underemployment, both for veterans and families. Veterans often move from the military installation to their home town shortly after discharge. Often, these cross-country moves uproot spouses from their jobs. The use of the Post-9/11 GI Bill, legislation introduced by Senator Jim Webb of Virginia, by hundreds of thousands of Iraq and Afghanistan war veterans may be masking already alarming reports of high unemployment among returning veterans.

• VA and DOD should monitor and report on the positive post-combat, post-deployment, and post-military outcomes of our veterans. For example, new businesses started by veterans, higher wages earned by veterans, diplomas earned by veterans, increased homeownership among veterans, and other signs of a vibrant post-war adjustment to civilian life. We ask for this information because our Nation remains woefully ignorant of the tremendous positive benefit of the Post-World War II "GI Bill" social programs that provided government funded assistance for higher education and home purchases, creating a post-war economic recovery that lasted decades.

• VA and DOD are urged to sort the data. For example, National Guard and Reserve status are often overlooked as key demographic factors among returning veterans. In addition, standard sorting methods, such as age, gender, rank, and branch of service should be available, too.

URGENT NEED FOR TRUST FUND AND NATIONAL PLAN

In September 2010, VCS testified before the House Committee on Veterans' Affairs in support of a National Trust to provide care and benefits for veterans. We believe our Nation must learn from the past so we do not repeat mistakes. VCS endorses the Vietnam Veterans of America, when they remind us that, "Never again shall one generation of veterans abandon another."

This is why Veterans for Common Sense fully endorses the proposal by Linda Bilmes and Joseph Stiglitz to create a Trust Fund to make sure our veterans receive the healthcare and benefits they earned.

As a non-profit advocacy organization, VCS uses FOIA to obtain data from DOD and VA to monitor and publicize the needs of our veterans. VCS was honored to provide our data to Linda Bilmes and Joseph Stiglitz for their book. The authors called for the creation of "A Veterans Benefit Trust Fund * * * so that veterans' health and disability entitlements are fully funded as obligations occur." In their book, the experts stated:

> There are always pressures to cut unfunded entitlements. So, when new military recruits are hired, the money required to fund future health care

> and disability benefits should be set aside ("lockboxed") in a new Veterans Benefit Trust Fund. We require private employers to do this; we should require the Armed Forces to do it as well. This would mean, of course, that when we go to war, we have to set aside far large amounts for future health care and disability costs, as these will inevitably rise significantly during and after any conflict ("Reform 12," page 200).

The issue of establishing a Trust Fund is timely because we have now endured nearly ten years of war in Afghanistan, and more than seven years of conflict in Iraq. In 1995, Congress was forced to intervene and appropriate $3 billion in emergency funding for VA. One of the main reasons cited by VA for the funding crisis was the unexpected and unanticipated flood of Iraq and Afghanistan war veterans. Thanks to the strong pro-veteran leadership of Senator Patty Murray, the daughter of a World War II veteran, VA was given additional resources to meet the tidal wave of new, first-time Iraq and Afghanistan war veteran patients flooding into VA. With her leadership, and the efforts of this Committee and staff, there has been a sustained and deeply appreciated effort to fund VA at a higher level to meet the obligation of our country to our veterans.

The threat against veterans in Congress is real. As recently as July 2011, Senator Tom Coburn introduced an amendment to eliminate the presumption of service connection for Vietnam War veterans exposed to the poison Agent Orange. Fortunately, for veterans, the proposal was defeated. Similarly, in January 2011, Representative Michele Bachmann proposed cutting $4.3 billion from VA's healthcare and benefits budget. After an outcry from veteran organizations led by VCS, she withdrew her plan.

PRIOR ADMINISTRATION FAILURES

The significant post-deployment statistics about our veterans must be contrasted with serious mistakes made during 2002. Nine years ago the previous Administration prepared no casualty estimate for the Iraq War. There was no plan to monitor or estimate fatal or non-fatal casualties, even though VA staff sought to create such systems. There was no plan to provide long-term medical treatment and disability compensation for non-fatal casualties.

Honoring and remembering our fallen, our wounded, our injured and ill, VCS quotes the eloquent poetry of Archibald MacLeish, a World War I veteran and former head of the Library of Congress. During World War II, MacLeish wrote:

> They say, We leave you our deaths: give them their meaning: give them an end to the war and a true peace: give them a victory that ends the war and a peace afterwards: give them their meaning.

As an organization of war veterans, Veterans for Common Sense is here today to give meaning to all of our Nation's fallen, wounded, injured, and ill who deployed to Southwest Asia since 1990: Our Nation must learn the painful lessons from prior wars and take care of our veterans who enlist in our military to protect and defend our Constitution, even when the American public does not support the war. This also means monitoring post-war activity among veterans so their needs are promptly met.

VCS tried to inform our Nation about past government mistakes. On March 10, 2003, as our Nation prepared to re-invade Iraq, VCS petitioned for calm and reason. As war veterans who actually served on Iraqi battlefields during 1991, VCS wrote a detailed letter to President George W. Bush co-signed by 1,000 veterans:

> Over the long term, the 1991 Gulf War has had a lasting, detrimental impact on the health of countless people in the region, and on the health of American men and women who served there. Twelve years after the conflict, over 164,000 American Gulf War veterans are now considered disabled by the U.S. Department of Veterans Affairs. That number increases daily * * * . Further, we believe the risks involved in going to war, under the unclear and shifting circumstances that confront us today, are far greater than those faced in 1991. Instead of a desert war to liberate Kuwait, combat would likely involve protracted siege warfare, chaotic street-to-street fighting in Baghdad, and Iraqi civil conflict. If that occurs, we fear our own nation and Iraq would both suffer casualties not witnessed since Vietnam.

We regret to inform you the White House never answered our letter. Our veterans who raised serious, legitimate concerns about escalating the Gulf War with another invasion of Iraq were brushed aside in the rush to war. This must not happen again.

Earlier, on October 12, 2002, our VCS Executive Director, Charles Sheehan Miles, published an editorial criticizing the Congressional Budget Office (CBO) for failing

to estimate the cost of caring for war and post-war casualties. The decorated Gulf War veteran wrote:

> In a surprisingly rosy cost estimate of something which can't be accurately estimated, the Congressional Budget Office Monday released an analysis of what Gulf War II might cost in real dollars paid by U.S. taxpayers. Only they left out the most important part: the casualties. The CBO estimate is naive and unrealistic when you consider the kind of war we are preparing to enter—an open-ended war of regime-change and occupation and empire building that may involve heavy casualties in an urban setting such as Baghdad. The CBO report is illuminating and instructive for what it avoids. CBO uses the word "assume" 30 times, "uncertain" 8 times, "unknown" 4 times. Finally, twice it says there is "no basis" for an estimate on key items. In other words, it's a wild guess: kind of like taking your broker's advice to buy Enron or WorldCom last summer. CBO states up front: "CBO has no basis for estimating the number of casualties from the conflict," therefore, any discussion of casualties was simply excluded.

VCS advocates pre- and post-deployment exams, as required by the 1997 Force Health Protection Act (PL 105–85) as well as hiring more DOD medical professionals to provide exams and treatment. VCS believes early evaluation and treatment are best because treatments are the most effective and often the least expensive. Recently published medical research conducted by Dr. Susan Frayne, of the VA Palo Alto Health Care System and Stanford University supports our VCS advocacy. Dr. Frayne told *Businessweek* on September 24, 2010:

> Looking to the future, the impetus for early intervention is evident. If we recognize the excess burden of medical illness in veterans with PTSD who have recently returned from active service and we address their health care needs today, the elderly veterans of tomorrow may enjoy better health and quality of life.

As of July 2010, the military began implementing the Force Health Protection Act on a limited basis. VCS urges full DOD compliance with the law: universal face-to-face medical exams and prompt treatment for our servicemembers when needed. We also thank the President for sending condolence letters to the families of our servicemembers who completed suicide in the war zone. President Barack Obama has improved understanding of war-related mental health conditions and reduced stigma and discrimination against veterans with a stroke of his pen.

There are very serious lessons to be learned from the Administration's failure to monitor returning veterans. As of 2009, the widely respected and credible Institute of Medicine, part of the National Academy of Science, estimated as many as 250,000 Gulf War veterans remain ill after exposures to toxins while deployed to Southwest Asia during Desert Shield, Desert Storm, and Provide Comfort between 1990 and 1991. This research, mandated by the "Persian Gulf Veterans Act of 1998," is confirmed by VA's Research Advisory Committee on Gulf War Veterans' Illness. If DOD and VA had not fought so viciously against Gulf War veterans and scientific research, then facts and research would have been found sooner. Sadly, despite extensive scientific researcher, a few top officials at DOD and VA still deny the existence of Gulf War illness.

CONCLUSION

Thank you for the opportunity to submit this statement for the record. VCS hopes to hear from this Committee as well as individual Senators about how they intend to force DOD and VA to prepare reports about the consequences of the war. We also hope to hear from Senators about establishing a Trust Fund so veterans never again face attacks to cut our earned healthcare and benefits.

If we are to truly demonstrate our Nation cares for our veterans, then we must do more than provided funding, care, and benefits. Our nation must also assure our servicemembers, veterans, families, and citizens the government is constantly paying attention to the needs for those who protect and defend our Constitution. VCS wants future generations of Americans to want to server our Nation and know our Nation will care for them when they return home.

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PREPARED STATEMENT OF SHELDON WHITEHOUSE

Chairman Murray, Ranking Member Burr, and distinguished Members of the Committee, I thank you for the opportunity to weigh in on such an important issue. I commend the Chairman for her passionate advocacy on veterans' issues and her tireless efforts to ensure that our veterans get the care they need and the benefits they deserve.

Today's hearing is crucial to understanding the extent to which the current wars are impacting the newest generation of veterans and their families and determining what it will take to meet their needs as they return home. Our veterans have given so much for our country, and they deserve our steadfast support.

For the last ten years, hundreds of thousands of our women and men in uniform have been making enormous sacrifices on our behalf. They have asked for little in return, despite the high operational tempo, which has required repeated deployments and unprecedented use of our Reserve components. These repeated deployments often put severe strain on families and broader communities. I have seen the impact firsthand in my home state of Rhode Island, where our Guard and Reserve members are, per capita, the second most deployed from any state.

From working closely with the military and veterans community in my state, I've learned that we must identify and address the emergent needs of our returning servicemembers in all aspects of their transition back to civilian life. We must ensure that returning servicemembers have access to the best medical care, and that they have the training and resources to find good jobs in the civilian economy. We also must make sure that our military families have ample time to get their finances in order. To that end, I was pleased to work with Chairman Murray and other Members of this Committee to better protect servicemembers against wrongful foreclosures.

In addition, we must be cognizant of the mental and emotional effects that repeated tours of duty in tense combat conditions can have on our returning veterans. All too often, complications from combat related trauma, such as Post-Traumatic Stress Disorder (PTSD), can contribute to criminal offenses committed by veterans. For many of these individuals, their offending behavior would not have occurred prior to their repeated deployments. As a former prosecutor, I have focused close attention on the increasing numbers of veterans and active duty military personnel entering the criminal justice system.

In my home state, a coalition of leaders from the legal and veterans communities are developing a pilot program for veterans who enter the criminal justice system. The Rhode Island veterans' court program, which is led by Chief Judge Jeanne LaFazia of the Rhode Island District Court, seeks to identify and address the underlying causes of criminal behavior by referring veterans to treatment programs or providing other alternatives that can keep them out of jail and help them to lead safer, more productive lives. Last month, U.S. Attorney General Eric Holder joined me in Rhode Island for a roundtable discussion on the program.

I also held a hearing in my Judiciary Subcommittee on Crime and Terrorism last week to examine how specially designed veterans courts can be cost-effective solutions for protecting public safety and reducing recidivism. We heard from Chief Judge LaFazia and several other witnesses, who testified that veterans' courts are a cost-effective and safe way to rehabilitate low-level offenders, and to provide those who have served dutifully a chance for a future. Today, as the Senate Veterans' Affairs Committee examines the costs of supporting today's generation of veterans, I urge members to consider how veterans courts can provide cost savings and other benefits for our veterans and our country.

I thank the Committee for the opportunity to submit this statement for the record, and thank the Chairman and Ranking Member for their leadership.

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